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TRICARE
MANAGEMENT ACTIVITY

OD

CHANGE 100
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**PUBLICATIONS SYSTEM CHANGE TRANSMITTAL
FOR
TRICARE OPERATIONS MANUAL (TOM), FEBRUARY 2008**

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

CHANGE TITLE: TRICARE SANCTION AUTHORITY FOR THIRD PARTY BILLING AGENTS

CONREQ: 16422

PAGE CHANGE(S): See page 2.

SUMMARY OF CHANGE(S): This change implements the Final Rule to sanction third party billing agents by invoking the administrative remedy of exclusion or suspension from the TRICARE program, i.e. in the case of fraud or abuse on the part of these agents in preparing and submitting claims to TRICARE for payment.

EFFECTIVE DATE: March, 28, 2013.

IMPLEMENTATION DATE: Upon direction of the Contracting Officer.

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Director, Operations Division**

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REMOVE PAGE(S)

CHAPTER 12

Section 3, pages 3 and 4

CHAPTER 13

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APPENDIX B

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has the right to reconsideration. Refer to the TPM, [Chapter 1, Section 6.1](#).

1.3.2.4 Provider Or Entity Sanction

If the decision to disqualify or exclude a provider **or entity** because of a determination against that provider **or entity** resulting from abuse or fraudulent practices or procedures under another federal or federally-funded program is not appealable, the provider **or entity** is limited to exhausting administrative appeal rights offered under the federal or federally-funded program that made the initial determination. A determination to sanction a provider **or entity** because of abuse or fraudulent practices or procedures under TRICARE is an initial determination which is appealable under 32 CFR 199. See [Chapter 13](#). A sanction imposed pursuant to [32 CFR 199.15\(m\)](#) is appealable as described in [32 CFR 199.15\(m\)\(3\)](#).

1.3.2.5 Network Provider Or Entity/Contractor Disputes

Disputes between a network provider **or entity** and the contractor concerning payment for services provided by the network provider are not appealable.

Note: Network pharmacies are not subject to hold harmless provisions, and, therefore, beneficiary liability and appeal rights arise from a denial issued at a network pharmacy. The beneficiary may appeal such a denial.

1.3.2.6 Provider Not Authorized

The denial of services or supplies received from a provider not authorized to provide care under TRICARE is not appealable.

1.3.2.7 Denial Of A Treatment Plan

The denial of a treatment plan when an alternative treatment plan is selected is not appealable. Peer to peer dialogue resulting in selection and approval of another treatment option is not a denial of care.

1.3.2.8 Denial Of Services By A PCM

The refusal of a PCM to provide services or to refer a beneficiary to a specialist is not an appealable issue. A beneficiary who has been refused services or a referral by a PCM may file a grievance under [Chapter 11, Section 9, paragraph 1.0](#). The decision by the contractor to deny a PCM's request to refer a beneficiary to a specialist is an appealable issue and is addressed in [paragraph 1.3.1.3](#).

1.3.2.9 Designation Of Providers

The contractor's designation of a particular network or non-network provider to perform requested services is not appealable.

1.3.2.10 Point Of Service (POS)

The decision by the contractor to cost-share services under the POS option is not

appealable, with the exception of the issue of whether the services were related to an emergency and are therefore exempt from the requirement for referral and authorization.

1.4 Must Be Filed Timely

An appeal must be filed before the expiration of the appeal filing deadline or within 20 calendar days of the date of the contractor's letter, referenced in [paragraph 1.2](#). In calculating the number of days elapsed, the day following the date of the previous determination is counted as day "one" with the count progressing through actual calendar days including the date the request is filed. The contractor or TQMC shall treat an untimely request for reconsideration as routine correspondence, and add the request to the claim file.

1.4.1 By Mail

If the appeal is not filed timely, the contractor shall advise the appealing party that the appeal cannot be accepted since the time limit for filing was exceeded, based on the receipt date of the appeal request or the postmark date on the envelope. For the purposes of TRICARE, a postmark is a cancellation mark issued by the United States Postal Service (USPS) (i.e., private mail carriers do not issue postmarks). If there is no postmark or the date of the postmark is illegible, the date of receipt by the contractor shall be used to determine timeliness of filing.

1.4.2 By Facsimile

A request for reconsideration submitted by facsimile transmission (fax) is considered filed on the date the fax is received by the contractor.

1.4.3 By Electronic Mail

A request for reconsideration submitted by electronic mail (e-mail) is considered filed on the date the e-mail is received by the contractor.

1.5 Must State The Issue In Dispute And Include Previous Determination

The request should state the specific issue in dispute and be accompanied by a copy of the previous denial determination notice. If a contractor or the TQMC receives a request for reconsideration which otherwise satisfies the requirements as stated above, the request shall be accepted notwithstanding the failure of the appealing party to provide a copy of the previous denial determination notice or to state the specific issue in dispute. In such cases, the contractor or the TQMC shall accept the request for reconsideration and shall supply a copy of the previous denial determination notice from its files or shall initiate communication with the appealing party to clarify the specific issue in dispute, as appropriate.

2.0 EXTENSION OF APPEAL FILING DEADLINE

If the appeal is untimely the appealing party shall be told that if it can be shown to the satisfaction of the contractor or the TQMC, that timely filing of the request was not possible due to extraordinary circumstances over which the appealing party had no practical control, an extension of the appeal filing deadline may be granted. A determination by the contractor or the TQMC that extraordinary circumstances do not exist is not appealable.

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, **entities**, 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.

Note: The dental contractor does not have access to the TRICARE DCS as this contractor does not generate TRICARE Encounter Data records (TEDs). Therefore, the dental contractor shall use their own DCS and such system must be approved by TMA.

- 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

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

3.7.2 Following the referral to TMA of the 10 most egregious providers **or entities**, who continue to submit unbundled billings, the contractor shall conduct a review of those providers **or entities** 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 **or entity** 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 **or entities** being referred to TMA PI. The contractor shall keep a record of the providers **or entities** selected to be sent to TMA so that no provider **or entity** is referred more than once (except as stipulated in [paragraph 3.7.2](#)) even if the provider **or entity** 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](#).

Provider Exclusions, Suspensions, And Terminations

1.0 SCOPE AND PURPOSE

1.1 This section specifies which individuals and entities may, or in some cases must, be excluded from the TRICARE program. It outlines the authority given to the Department of Health and Human Services/Office of Inspector General (DHHS/OIG) to impose exclusions from all Federal health care programs, including TRICARE. This section also outlines the TRICARE Management Activity (TMA) authority for exclusions and terminations. In addition, this section states the effect of exclusion, factors considered in determining the length of exclusion, and provisions governing notices, determinations, and appeals.

1.2 Service Point of Contacts (SPOCs) do not have the authority to overturn a TMA or DHHS exclusion.

2.0 PROVISIONS FOR EXCLUSIONS, SUSPENSIONS, AND TERMINATIONS

2.1 Authority For Sanctioning Providers, Pharmacies, Or Entities

2.1.1 32 CFR 199.9

2.1.1.1 32 CFR 199.9 provides for administrative remedies available to TMA for provider exclusions, suspensions, and/or terminations. The Director, TMA, or a designee, shall have the authority to exclude, suspend, and/or terminate an authorized TRICARE provider.

2.1.1.2 Effective March 28, 2013, third party billing agents or entities are also subject to TRICARE sanction authority.

2.1.2 32 CFR 199.15

32 CFR 199.15 establishes rules and procedures for the TRICARE Quality and Utilization Review Peer Review Organization (PRO) program otherwise referred to as Quality Improvement Organization (QIO). The applicability of program covers all claims submitted for health services under TRICARE and subjects these claims to review for quality of care and appropriate utilization. The Director, TMA, is responsible for establishing generally accepted standards, norms, and criteria as necessary for this program of quality and utilization review. This section also provides for the imposition of sanctions on health care practitioners and providers of health care services recommended by a PRO.

2.1.3 Health Insurance Portability And Accountability Act (HIPAA) of 1996, Public Law (PL) 104-191

HIPAA sets forth the DHHS/OIG's exclusion and Civil Money Penalty (CMP) authorities. HIPAA expanded the minimum mandatory exclusion authority; established minimum periods of exclusion; established a new permissive exclusion authority; and extended the application of CMP provisions to include all Federal health care programs. In addition, HIPAA strengthened and revised the DHHS/OIG's existing CMP authorities.

2.1.4 The Balanced Budget Act Of 1997 (BBA)

The BBA fraud and abuse provisions serve to strengthen the DHHS/OIG's exclusion and CMP authority with respect to Federal health care programs. The BBA enables the DHHS/OIG to direct the imposition of exclusions from all Federal health care programs.

3.0 DHHS/OIG APPLICATION OF SANCTION AUTHORITY

3.1 Exclusions

3.1.1 Mandatory Exclusions

3.1.1.1 DHHS/OIG will exclude the following individuals or entities from participation in any Federal health care program. (Note: Exclusion categories are subject to change by DHHS/OIG.)

- Felony conviction of program related crimes.
- Felony conviction related to patient abuse.
- Felony conviction relating to health care fraud (e.g., medical or pharmaceutical).
- Felony conviction related to controlled substance.
- Conviction of two mandatory exclusion offenses. Minimum period: 10 years.
- Conviction on three or more occasions of mandatory exclusion offenses. Permanent exclusion.
- Failure to enter an agreement to repay Health Education Assistance Loans. Minimum period: Until entire past obligation is repaid.

3.1.1.2 DHHS/OIG authority for mandatory exclusion applies where the criminal offense on which the conviction is based took place after August 21, 1996, and the conviction took place after January 1, 1997. DHHS/OIG authority does not apply if both conditions are not met. In these cases, TMA Program Integrity Office (PI) must initiate action to exclude.

3.1.1.3 Mandatory exclusions initiated by DHHS/OIG are for a minimum of five years, with the exceptions noted under [paragraph 3.1.1.1](#). Aggravating factors may be considered as a basis for lengthening the period of exclusion.

3.1.2 Permissive Exclusions

3.1.2.1 DHHS/OIG may exclude the following individuals or entities from participation in any Federal health care program: (Note: Exclusion categories are subject to change by DHHS/OIG.)

- Misdemeanor conviction related to health care fraud. Minimum period: 3 years.
- Conviction related to fraud in non-health care programs. Minimum period: 3 years.
- Misdemeanor conviction related to obstruction of an investigation. Minimum period: 3 years.
- Misdemeanor conviction relating to a controlled substance. Minimum period: 3 years.
- License revocation or suspension. Minimum period: No less than the period imposed by the state licensing authority.
- Fraud, kickbacks, and other prohibited activities. Minimum period: None.
- Entities controlled by a sanctioned individual or individuals controlling a sanctioned entity. Minimum period: Same as length of individual's exclusion.
- Entities controlled by a family or household member of an excluded individual and where there has been a transfer of ownership/control. Minimum period: Same as length of individual's exclusion.
- Failure to disclose required information, supply requested information on subcontractors and suppliers; or supply payment information. Minimum period: None.
- Failure to take corrective action. Minimum Period: None.
- Default on health education loan or scholarship obligations. Minimum period: Until default has been cured and obligations have been resolved to Public Health Service's satisfaction.
- Individuals controlling a sanctioned entity. Minimum period: Same period of entity.
- Failure to meet statutory obligations of practitioners and providers to provide medically necessary services meeting professionally recognized standards of health care (e.g., peer review, organization findings). Minimum period: 1 year.
- Claims for excessive charges, unnecessary services, or services which fail to meet professionally recognized standards of health standards of health care, or failure of an Health Maintenance Organization (HMO) to furnish medically necessary services. Minimum period: 1 year.
- Exclusion or suspension under a Federal or State health care program. Minimum period: No less than the period imposed by Federal or state health care program.

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Provider Exclusions, Suspensions, And Terminations

3.1.2.2 DHHS/OIG authority for permissive exclusions applies where the action (e.g., conviction, license revocation, etc.) took place after August 21, 1996, under Federal or State law. DHHS/OIG authority does not apply if this condition is not met. In these cases, TMA PI may initiate action to exclude.

3.1.2.3 Aggravating factors may be considered as a basis for lengthening the period of exclusion.

3.1.3 The contractor is required to provide written notice to TMA PI of any situation involving a TRICARE provider, pharmacy, or entity who meets the criteria under the mandatory or permissive exclusion authority granted DHHS/OIG.

3.1.4 TMA PI is responsible for requesting DHHS/OIG initiate mandatory and permissive exclusions of TRICARE providers, pharmacies, or entities and will provide appropriate documentation needed to initiate separate sanction action (e.g., indictment, plea agreement, conviction document, sentencing document).

3.1.5 TMA PI will advise DHHS/OIG of TRICARE imposed sanctions and is responsible for supplying DHHS/OIG with the appropriate documentation needed to initiate separate sanction action.

3.2 Notice, Effective Date, Period Of Exclusion, And Appeals Process

DHHS/OIG has sole responsibility for issuing a written notice of its intent to exclude a provider, pharmacy, or entity, the basis for the exclusion, the effective date, the period of exclusion, and the potential effect of exclusion. DHHS/OIG will handle appeal of exclusions under [paragraph 3.0](#). See also [Chapter 8, Section 1, paragraph 2.3.2](#), relative to exclusion of third party billing agents.

3.3 Requests For Reinstatement

DHHS/OIG has sole authority for terminating an exclusion imposed under their authority. DHHS/OIG will handle notifications of approval/denial of a request for reinstatement and are responsible for reversing or vacating decisions.

3.4 Program Notification Of Exclusion/Reinstatement

DHHS/OIG exclusions and reinstatements are issued on a monthly basis. DHHS/OIG will provide TMA PI with immediate access to this information via disk, which will then be forwarded to each contractor.

3.5 Scope and Effect Of The Exclusion

Exclusions taken by DHHS/OIG are binding on Medicare, Medicaid, and all Federal health care programs with the exception of the Federal Employee Health Benefit Program (FEHBP) (42 USC 1320a-7b(f)). No payment will be made for any item or service furnished on or after the effective date of exclusion until an individual or entity is reinstated by DHHS/OIG, and subsequently meets the requirements under [32 CFR 199.6](#).

4.0 TMA APPLICATION OF SANCTION AUTHORITY

4.1 Sanction Authority

4.1.1 TMA may exclude any individual or entity based on [32 CFR 199.9](#) provisions including:

- Criminal and/or civil fraud involving TRICARE.
- Administrative determination of fraud and/or abuse under TRICARE.
- Administrative determination that the provider, pharmacy, or entity has been excluded or suspended by another agency of the Federal Government or a state or local licensing authority.
- Revocation of provider credentials through the Department of Veterans Affairs (DVA) or Military Department credentials review process.
- Determination that the provider, pharmacy, or entity participated in a conflict of interest situation or received dual compensation.
- Violation of participation agreement or reimbursement limitations.
- Institutional providers who practice discrimination in violation of Title VI, of the Civil Rights Act of 1964.
- Administrative determination that it is in the best interests of TRICARE or TRICARE beneficiaries. Examples include unethical or improper practices or unprofessional conduct by a TRICARE provider or entity; a finding that the provider, pharmacy, or entity poses a potential for fraud, abuse, or professional misconduct; the provider or entity poses a potential harm to the financial or health status of TRICARE beneficiaries.
- QIO recommendation to exclude under the provisions set forth in [32 CFR 199.15](#).

4.1.2 The contractor is required to provide written notice to TMA PI of any situation involving a TRICARE provider, pharmacy, or entity who meets the criteria under the TMA sanction authority.

4.2 Period Of Exclusion/Suspension

The Director, TMA or designee, has the authority to exclude or suspend an authorized TRICARE provider, pharmacy, or entity. The period of exclusion or suspension is at the discretion of TMA. (See [32 CFR 199.9](#).)

4.3 Notice Of Exclusion Action

TMA PI has sole authority for issuing notification of exclusion action. TMA PI will send written notice of its intent, the basis for the proposed exclusion, and the potential effect of exclusion. The individual or entity may submit evidence and written argument concerning whether the exclusion is warranted. TMA PI also has sole authority to issue an Initial Determination of Exclusion. Written

notice of this decision will include the basis for the exclusion, the length of the exclusion, as well as the effect of the exclusion. The determination also outlines the earliest date on which TMA PI will consider a request for reinstatement, the requirements for reinstatement, and appeal rights available. TMA PI will notify appropriate agencies, to include contractors, of all exclusion actions taken. TMA PI will be responsible for initiating action based on reversed or vacated decisions.

4.4 Effect Of The Exclusion

Exclusion of a provider, pharmacy, or entity shall be effective 15 calendar days from the date of the Initial Determination. TMA-approved PRO sanctions will take effect 120 days from the date of the contractor's final notice. The contractor is responsible for ensuring that no payment is made to a sanctioned provider, pharmacy, or entity for care provided on or after the date of the TMA action. The contractor must also ensure that a sanctioned provider, pharmacy, or entity is not included in the network and that appropriate steps are taken to notify appropriate parties of exclusion action taken by TMA as outlined in [paragraph 5.0](#).

4.5 Request For Termination Of Exclusion

The Director, TMA or designee has sole authority for approval of any request for termination of an exclusion action. TMA PI will consult the contractor concerning any amounts owed prior to reinstatement of an excluded provider or entity. See [Section 7](#) for additional guidance.

4.6 Provider or Network Pharmacy Termination

Administrative remedies are available to the Director, TMA or designee, as well as contractors, for initiating termination action. TMA PI will terminate the authorized provider status of any provider, network pharmacy, or entity determined not to meet program requirements only in circumstances where exclusion is also warranted. A provider or entity shall submit a written request for reinstatement to TRICARE. A network pharmacy shall submit a written request for reinstatement to the contractor. The request for reinstatement will be processed under the procedures established for initial requests for authorized provider or network pharmacy status. See [Section 7](#) for further information.

4.7 Other Listings

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

5.0 CONTRACTOR APPLICATION OF SANCTION AUTHORITY

Contractors shall ensure the enforcement of all sanction action taken, **and** notify appropriate parties **of the application of sanctions. For example, any claim received from an excluded third party billing agent shall be returned to the provider with instructions to resubmit the claim directly or through another third party billing agent as the provider remains entitled to reimbursement for covered services as long as they remain an authorized TRICARE provider.**

5.1 Contractor Actions Under DHHS/OIG Exclusion Authority

5.1.1 The contractor is required to provide written notice to TMA PI of any TRICARE provider or entity who meets the criteria under the mandatory or permissive exclusion authority granted DHHS/OIG. The notice must include appropriate documentation relevant to the situation (e.g., notice of license revocation, notice of a misdemeanor convictions, etc.).

5.1.2 The contractor will be provided immediate access to the monthly issuance of DHHS/OIG exclusion and reinstatement actions and is responsible for:

5.1.2.1 Ensuring that no payment is made to a sanctioned provider, network pharmacy, or entity for care provided on or after the date of the DHHS/OIG action. (See [Addendum A, Figure 13.A-8](#).) Neither the provider, entity, nor the patient will be entitled to TRICARE cost-sharing once the exclusion is effective. The contractor must notify TMA PI should a provider, network pharmacy, or entity attempt to bill the program or if payment has been issued after the effective date of exclusion. It will not be necessary for the contractor to issue a separate letter notifying the provider or network pharmacy of the sanction action.

5.1.2.2 Ensuring that a sanctioned provider, pharmacy, or entity is not included in the network. If cancellation of a network, or if applicable, participating provider agreement is required, the contractor shall ensure that the network provider or network pharmacy whose contract has been cancelled clearly understands his/her status. This shall be accomplished by providing notice, by certified mail, return receipt requested, that the network provider's or network pharmacy's agreement has been cancelled.

5.1.2.3 Issuing a special beneficiary notice ([Addendum A, Figure 13.A-9](#)) for claims having a date of service following the effective date of the DHHS/OIG exclusion. The contractor shall also ensure that proper notification is given to the appropriate advisor (Health Benefit Advisors (HBAs)/ Beneficiary Counseling and Assistance Coordinators (BCACs)/Debt Collection Assistance Officers (DCAOs)) within the provider's service area (approximately 100 miles). TRICARE Regional Office (TRO) staff in the geographical area(s) of the provider's practice shall also be given notice of sanction action taken.

5.1.2.4 Initiating appropriate reinstatement action. DHHS/OIG will advise on the monthly listing if and when a previously sanctioned provider, pharmacy, or entity is reinstated. That is the date that the contractor is to use for reinstatement. The contractor does not need to advise the provider, pharmacy, or entity of the reinstatement by DHHS/OIG, but will be responsible for ensuring that the provider, pharmacy, or entity meets the regulatory requirements as an authorized TRICARE provider or pharmacy. See [Section 7](#), for additional guidance. The same agencies originally advised of sanction shall also be notified of the reinstatement.

5.2 Contractor Actions Under TRICARE Exclusion Authority - [32 CFR 199.9](#)

5.2.1 The contractor is required to provide written notice to TMA PI of any TRICARE provider, pharmacy, or entity who meets the criteria under the exclusion authority granted TRICARE. The notice must include appropriate documentation relevant to the situation (e.g., provider, pharmacy, or entity poses unreasonable potential for fraud).

5.2.2 The contractor will be notified immediately of an exclusion action taken by TMA PI and is responsible for:

5.2.2.1 Ensuring that no payment is made to a sanctioned provider, pharmacy, or entity for care provided on or after the date of the TMA action. Neither the provider, pharmacy, entity, nor the patient will be entitled to TRICARE cost-sharing once the exclusion is effective. The contractor must notify TMA PI should a provider, pharmacy, or entity attempt to bill the program after the effective date of exclusion. It will not be necessary for the contractor to issue a separate letter notifying the provider or pharmacy of the sanction action. However, notice of sanction action taken by TMA shall be given to all HBAs located within the provider's service area (approximately 100 miles) of the practice address of the excluded provider. TROs in the geographical area(s) of the provider's practice shall also be given notice of sanction action taken.

5.2.2.2 Ensuring that a sanctioned provider, pharmacy, or entity is not included in the network. If cancellation of a network provider agreement is required, the contractor shall ensure that the network provider whose contract has been cancelled clearly understands his/her status. This shall be accomplished by providing notice, by certified mail, return receipt requested, that the network provider's or network pharmacy's agreement has been cancelled (a copy to be provided to TMA PI).

5.2.2.3 Issuing a special notice to any beneficiary who submits a claim or for whom a claim is submitted, which includes services involving a sanctioned provider. The notice may be enclosed with the Explanation of Benefits (EOB), whether the claim is payable or not, or a separate letter may be sent. The substance of the message should be similar to the example shown under [Addendum A, Figure 13.A-9](#).

5.2.2.4 Initiating appropriate action, as instructed, following reversed or vacated decisions issued by TMA PI or termination of sanction action by TMA. The same agencies originally advised of sanction shall also be notified of the reinstatement.

5.3 Contractor Actions Under TRICARE Exclusion Authority - [32 CFR 199.15](#)

5.3.1 Under the TRICARE regulation, the provisions of 42 CFR 1004.1-1004.80 (Imposition of Sanctions by a PRO) shall apply to the TRICARE program as they do the Medicare program, except that the functions specified in those sections for the DHHS/OIG shall be the responsibility of TRICARE. As such, contractors shall adopt the DHHS PRO procedures and rules set forth under 42 CFR 1004.

5.3.2 The [32 CFR 199.15](#) establishes the process for imposition of sanctions on health care practitioners and providers of health care services by a QIO. The process includes:

- Setting forth certain obligations imposed on practitioners and providers of service under TRICARE;
- Establishing criteria and procedures for the reports required from QIOs when there is failure to meet those obligations;
- Specifying the policies and procedures for making determinations on violations and imposing sanctions; and

- Defining the procedures for appeals by the affected party and the procedures for reinstatements.

5.3.3 After meeting the objectives and requirements of the review system under [32 CFR 199.15](#) and taking appropriate action(s) as a result of the review, the contractor is required to notify TRICARE of all recommended actions.

5.3.4 Following notification to TRICARE PI of the proposed recommended action to sanction under the provisions of [32 CFR 199.15](#), TMA PI will follow the procedures set forth in [32 CFR 199.9](#).

5.4 Contractor Requirements For Terminating a Provider, Pharmacy, or Entity

When a provider's or network pharmacy's status as an authorized TRICARE provider is ended, the contractor will initiate termination action based on a finding that the provider, pharmacy, or entity does not meet the qualifications to be an authorized provider, etc. Foreign providers of care can be terminated from the contractor's network if it is determined that they are engaged in egregious patterns of billing or submitting abusive or fraudulent claims, in violation of any of the provisions in [32 CFR 199.9](#).

Note: Separate termination action by the contractor will not be required for a provider, pharmacy, or entity sanctioned under the exclusion authority granted DHHS/OIG.

5.4.1 Period Of Termination

The period of termination will be indefinite and will end only after the provider, pharmacy, or entity has successfully met the established qualifications for authorized status under TRICARE and has been reinstated under TRICARE.

5.4.2 Notice Of Proposed Action To Terminate

The contractor shall notify the provider **or entity** in writing of the proposed action to terminate **them**. **The contractor shall specifically notify the provider of the proposed action to terminate their** status as an authorized TRICARE provider when the provider falls within the contractor's certifying responsibility and the provider fails to meet the requirements of [32 CFR 199.6 \(Addendum A, Figure 13.A-10\)](#). The provider is not to be terminated when he/she fails to return certification packets. Such providers will be flagged as "inactive" (see [paragraph 5.4.4](#)). Do not send a copy of the proposed notice to TMA PI. The notice will be sent to the provider's **or entity's** last known business/office address, or home address if there is no known business/office address.

Note: The pharmacy contractor shall notify the pharmacy in writing of the proposed action to terminate the pharmacy status as a network pharmacy when it is not in compliance with its agreement and the pharmacy fails to meet the requirements of [32 CFR 199.6 \(Addendum A, Figure 13.A-10\)](#).

5.4.2.1 The notice shall state that the provider, pharmacy, **or entity** will be terminated as of the effective date of the sanction action. The notice shall also inform the provider, pharmacy, **or entity** of the situation(s) or action(s) which form the basis for the proposed termination.

5.4.2.2 For network providers, the notice shall inform the provider that his/her patients will be referred to another provider pending final action. For a network pharmacy, the notice shall inform the pharmacy that beneficiary prescriptions may not be filled there and any claims submitted will be denied as not part of the network.

5.4.2.3 The notice shall offer the provider, pharmacy, or entity an opportunity to respond within 30 calendar days from the date of the notice. An extension to 60 calendar days may be granted if a written request is received during the 30 calendar days showing good cause. The provider, pharmacy, or entity may respond with either documentary evidence and written argument contesting the proposed action or a written request to present in person evidence or argument to a contractor's designee at the contractor's location. Expenses incurred by the provider, pharmacy, or entity are their responsibility.

5.4.2.4 Once the notice of proposed action to terminate is sent, the provider's claims will be suspended from claims processing until an Initial Determination is issued. The provider will be notified via the proposed notice that the claims will be suspended from claims processing. However, beneficiaries will not be notified of the suspension.

5.4.2.5 For pharmacy claims, once the notice of proposed action to terminate is sent, the pharmacy's claims will not be processed as network claims until an Initial Determination is issued. The pharmacy will be notified via the notice that the claims will not be processed as network claims. Beneficiaries will be advised by the pharmacy that it is no longer a network pharmacy and that any prescription filled there will require submittal of a claim for reimbursement by the beneficiary.

5.4.2.6 If the provider being terminated is a Primary Care Manager (PCM), the contractor shall assist Prime enrollees with selecting a new PCM. The contractor is also responsible for assuring that the patient's medical records are transferred to the new PCM. Efforts shall be taken to notify Standard beneficiaries in a cost-effective manner.

5.4.3 Initial Determination

If after the provider, pharmacy, or entity has exhausted, or failed to comply with the procedures for appealing the proposed termination and the decision to terminate remains unchanged, the contractor shall invoke an administrative remedy of termination by issuing a written notice of the Initial Determination via certified mail. A copy of the Initial Determination will be sent to TMA PI along with supporting documentation. The Initial Determination shall include:

5.4.3.1 A Unique Identification Number (UIN) indicating the fiscal year of the Initial Determination, a consecutive number within that fiscal year and the contractor's name. A sample letter is found at [Addendum A, Figure 13.A-11](#).

5.4.3.2 A statement of the sanction being invoked and the effective date of the sanction. The effective date shall be the date the provider, pharmacy, or entity no longer meets the regulatory requirements. If there is no documentation the provider ever met the requirements, the effective date will be either June 10, 1977 (the effective date of the Regulation) or the date on which the provider or pharmacy was first approved, whichever date is later. In the case of a pharmacy, it would be the date on which the pharmacy first became part of the network.

5.4.3.3 A statement of the facts, circumstances, and/or actions that forms the basis for the termination and a discussion of any information submitted by the provider, pharmacy, or entity relevant to the termination.

5.4.3.4 A statement of the provider's, pharmacy's, or entity's right to appeal.

5.4.3.5 The requirements and procedures for reinstatement.

5.4.4 Providers Failing To Return Recertification Documentation

Providers failing to return recertification documentation shall not be terminated but will be placed on the "inactive" provider listing. The contractor shall first verify that the recertification package was mailed to the correct address and was not returned by the U.S. Post Office. The provider's file shall be flagged to deny claims for services regardless of who submits the claim. The provider shall be advised that such action will be taken. Refer to [Section 2](#) regarding development of possible fraud cases.

5.4.5 Requirement To Recoup Erroneous Payments

After the Initial Determination has been sent, the contractor shall initiate recoupment for any claims cost-shared or paid for services or supplies furnished by the provider (or pharmacy for any previously paid claims for pharmaceuticals or supplies furnished by the pharmacy) on or after the effective date of termination, even when the effective date is retroactive, unless a specified exception is provided by 32 CFR 199. This applies to claims processed by previous contractors as well. All monies paid by previous contractors and recouped by the current contractor will be refunded to TMA Finance and Accounting Office (F&AO). Refer to [Chapter 3](#).

5.4.6 Cancellation Of Network Provider or Pharmacy Agreements

The contractor shall ensure that a network provider or pharmacy whose contract has been cancelled clearly understands his/her status, and shall initiate termination action if required. This shall be accomplished by providing notice, by certified mail, return receipt requested, that the network provider's or pharmacy's agreement has been cancelled. Cancellation of a network provider contract and termination of a TRICARE provider are to be handled as two separate and distinct actions.

Note: The Health Integrity and Protection Data Bank must be notified immediately if a provider is released from a network provider agreement for cause (e.g., adverse reasons involving fraudulent/abusive practices). The contractor shall coordinate this notification with TMA PI.

5.5 File Requirements For A Terminated Provider, Pharmacy, Or Entity

The Initial Determination file shall only include documentation that is releasable to the provider, pharmacy, or entity. This file should also include:

5.5.1 Initial Determination of Termination Action as well as Proposed Notice to Terminate.

5.5.2 Provider certification file (i.e., the documentation upon which the original certification of the provider was based) or network pharmacy agreement.

5.5.3 All correspondence and documentation relating to the termination. Copies of the enclosures must be attached to the copy of the original correspondence.

5.5.4 Documentation that the contractor considered or relied upon in issuing a Determination.

5.6 Special Action/Notice Requirements When An Institution Is Terminated

When a TMA determination is made that an institutional provider does not meet qualifications or standards to be an authorized TRICARE provider, the contractor shall take appropriate action.

5.6.1 Provider And Beneficiary Notification

The contractor shall:

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

5.6.1.2 When the termination effective date is after the date of the initial determination, notify by certified mail any beneficiary (or their parent, guardian, or other representative) admitted prior to the date of the termination and that TRICARE cost-sharing ended as of the termination date. Advise the beneficiary (or their parent, guardian, or other representative) of their financial liability. (The contractor shall also use a fast, effective means of notice (e.g., phone, fax, express mail, or regular mail, depending on the circumstances.)

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

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

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

5.6.2 Cost-Sharing Actions

The contractor shall:

5.6.2.1 Deny cost-sharing for any new patient admitted after the effective date of the termination.

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

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

5.6.2.4 Cost-share covered care for those beneficiaries admitted prior to a grace period.

5.7 Requests For Reinstatement

See [Section 7](#).

6.0 CONTRACTOR ACTIONS IN CASES INVOLVING POTENTIAL VIOLATIONS BY PROVIDERS

Upon receipt of a complaint that an institution may be violating a TRICARE requirement, the contractor shall take the following actions:

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

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

6.3 TMA PI may request the contractor to conduct an on-site evaluation of a specific facility or to assist in conducting such a facility review. Specific instructions will be provided when participation in an on-site evaluation is required.

7.0 VIOLATION OF THE PARTICIPATION AGREEMENT OR REIMBURSEMENT LIMITATION

7.1 The contractor is responsible to ensure that providers adhere to their participation agreements and the reimbursement limitation. Corrective action is required for a provider who submits participating claims but does not honor the agreement to accept as the full charge the amount the contractor determines to be the allowable charge for the service or the provider who violates the 115% reimbursement limitation. Beneficiary complaints about breach of the allowable charge participating agreement or reimbursement limitation shall be resolved by the contractor staff, e.g., explaining to the provider the commitment made in accepting participation or regarding the Appropriations Act. All institutional violation letters must be addressed by name to the hospital administrator. The contractor shall get assurance that the provider will identify and refund any money inappropriately collected and refrain from billing beneficiaries for the reductions on participating claims or in violation of the 115% reimbursement limitation in the future. (See [Addendum A, Figure 13.A-12, Figure 13.A-13, Figure 13.A-14, and Figure 13.A-15](#)). The letter should be addressed to the name of the person who has the authority to resolve the administrative matter. (This could be the Chief Executive Officer (CEO), the billing manager, or the provider of services.) The provider shall be advised that violating the participation agreement or reimbursement limitation subjects the provider to sanction action. The letter should also contain the name, telephone number and e-mail address of whom to contact at the contractor. A request should be

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made for the provider to send the contractor a copy of the zero balance statement to verify that the issue has been resolved. In a violation of a participation agreement of balance billing limitation case, the contractor shall advise the provider to cease billing the beneficiary for amounts in excess of the appropriate amount and calculate the overpayment for the provider to refund to the beneficiary.

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

7.3 The contractor shall follow the same procedures listed above for those providers signing special TRICARE participating provider agreements (Residential Treatment Centers (RTCs), Partial Hospitalization Programs (PHPs), Substance User Disorder Rehabilitation Facilities (SUDRFs), and Marriage and Family Counseling Centers (MFCCs)).

- END -

Enrollment Transfer

A transfer of TRICARE Prime enrollment from one location or contractor to another:

- 1. Out-Of-Contract Enrollment Transfer.** An enrollment transfer between contractors, to include the Continental United States (CONUS) to CONUS, CONUS to Outside of the Continental United States (OCONUS), and OCONUS to CONUS. The term "contractors" also includes Designated Providers (DPs) under the Uniformed Services Family Health Plan (USFHP).
- 2. Within-Contract Enrollment Transfer.** An enrollment transfer within a TRICARE region, which involves a change of address and possibly a change of Primary Care Managers (PCMs), but not a change of contractors.

Entity

An entity includes a corporation, trust, partnership, sole proprietorship or other kind of business enterprise that is or may be eligible to receive reimbursement either directly or indirectly from TRICARE, as established by 32 CFR 199.2(b).

Exclusion

Exclusion from participation as a provider or entity under TRICARE means that items, services, and/or supplies furnished will not be reimbursed under TRICARE. This term may be used interchangeably with "suspension."

Explanation Of Benefits (EOB)

The document prepared by insurance carriers, health care organizations, and TRICARE to inform beneficiaries of the actions taken with respect to a claim for health care coverage.

Extraordinary Physical Or Psychological Condition (Respite Care Definition)

A complex physical or psychological clinical condition of such severity which results in the active duty beneficiary being homebound.

Federal Records Center (FRCs)

Centers established and maintained by the General Services Administration at locations throughout the United States for the storage, processing, and servicing of noncurrent records for Federal agencies.

Files Administration

The application of records management techniques to filing practices to maintain records easily and to retrieve them rapidly, to ensure their completeness, and to facilitate the disposition of noncurrent records.

Fiscal Year (FY)

The Federal Government's 12 month accounting period which currently runs from October 1 through September 30 of the following year.

Format (HIPAA/Privacy Definition)

The transaction data elements that provide or control the enveloping or hierarchical structure, or assist in identifying data content of, a transaction.

Formulary

A listing of pharmaceuticals and other authorized supplies to be dispensed with appropriate prescriber's order from a particular point of service. The formulary for any TRICARE contract will be managed by the DoD Pharmacy and Therapeutics (P&T) Committee with clinical guidance from the DoD Pharmacoeconomic Center (PEC). Applicable formulary information may be viewed on the TRICARE web site at: <http://www.tricare.osd.mil/pharmacy>.

Fragmented Billing

(See "Unbundled Billing")

Freedom Of Choice

The right to obtain medical care from any TRICARE-authorized source available, including TRICARE Prime, the DC system (MTF system), or obtain care from a provider not affiliated with the contractor and seek reimbursement under the terms and conditions of the TRICARE Standard Program (see definition). Beneficiaries who voluntarily enroll in TRICARE Prime must be informed of any restrictions on freedom of choice that may be applicable to enrollees as a result of enrollment. Except for any limitations on freedom of choice that are fully disclosed to the beneficiaries at the time of enrollment, freedom of choice provisions applicable to the TRICARE Standard Program shall be applicable to TRICARE Prime.

Freedom Of Information Act (FOIA)

A law enacted in 1967 as an amendment to the "Public Information" section of the Administrative Procedures Act, establishing provisions making information available to the public. TMA and contractors are subject to these provisions.

Freestanding

Not "institution-affiliated" or "institution-based."

Full Mobilization

When the President recommends and the Congress orders full mobilization. Full mobilization requires passage by the Congress of a public law or joint resolution declaring war and involves the mobilization of all Reserve Component (RC) units.

Third Party Billing Agent

Any entity that acts on behalf of a provider to prepare, submit, and monitor claims, excluding those entities that act solely as a collection agency, as established by [32 CFR 199.2\(b\)](#).

Third Party Liability (TPL) Claims

TPL claims are claims in favor of the Government that arise when medical care is provided to an entitled beneficiary for treatment or injury or illness caused under circumstances creating tort liability legally requiring a third person to pay damages for that care. The Government pursues repayment for the care provided to the beneficiary under the provisions and authority of the Federal Medical Care Recovery Act (FMCRA) (42 USC paragraphs 2651-2653).

Third Party Liability (TPL) Recovery

The recovery by the Government of expenses incurred for medical care provided to an entitled beneficiary in the treatment of injuries or illness caused by a third party who is liable in tort for damages to the beneficiary. Such recoveries can be made from the liable third party directly or from a liability insurance policy (e.g., automobile liability policy or homeowners insurance) covering the liable third party. TPL recoveries are made under the authority of the FMCRA (42 USC paragraph 2651 et sec. Other potential sources of recovery in favor of the Government in TPL situations include, but are not limited to, no fault or uninsured motorist insurance, medical payments provisions of insurance policies, and workers compensation plans. Recoveries from such other sources are made under the authority of 10 USC paragraphs 10790, 1086(g), and 1095b.)

Third Party Payer

An entity that provides an insurance, medical service, or health plan by contract or agreement, including an automobile liability insurance or no fault insurance carrier and a workers compensation program or plan, and any other plan or program (e.g., homeowners insurance, etc.) that is designed to provide compensation or coverage for expenses incurred by a beneficiary for medical services or supplies.

Timely Filing

The filing of TRICARE claims within the prescribed time limits as set forth in [32 CFR 199.7](#).

Toll-Free Telephones

All telephone calls are considered toll-free for the purposes of measuring the standards contained in [Chapter 1, Section 3, paragraph 3.4](#), except for those telephone calls to a TRICARE Service Center (TSC).

Trading Partner Agreement (HIPAA/Privacy Definition)

An agreement related to the exchange of information in electronic transactions, whether the agreement is distinct or part of a larger agreement, between each party to the agreement. (For example, a trading partner agreement may specify, among other things, the duties and responsibilities of each party to the agreement in conducting a standard transaction.)

Transaction (HIPAA/Privacy Definition)

The transmission of information between two parties to carry out financial or administrative activities related to health care. It includes the following types of information transmissions:

1. Health care claims or equivalent encounter information.
2. Health care payment and remittance advice.
3. Coordination of benefits.
4. Health care claims status.
5. Enrollment and disenrollment in a health plan.
6. Eligibility for a health plan.
7. Health plan premium payments.
8. Referral certification and authorization.
9. First report of injury.
10. Health claims attachments.
11. Other transactions that may be prescribed by regulation.

Transfer Claims

A claim received by a contractor which is for services received and billed from another contractor's jurisdiction. TRICARE claims and attendant documentation must be referred to the appropriate contractor for processing. Notification shall not be sent to the provider claimant explaining the action taken. Notification shall be sent to the patient claimant explaining the action taken, including the name and address of the correct contractor. Claims for active duty members which are sent to the appropriate Uniformed Service are not considered to be "transfer claims."

Transition

The process of changing contractors who serve a particular area or areas. Transition begins with the Notice of Award to the incoming contractor and is formally completed with the close out procedures of the outgoing contractor, several months after the start work date.

Transitional Patients Or Cases

Patients for whom active care is in progress on the date of a contractor's start work date. If the care being provided is for covered services, the contractor is financially responsible for the portion of care delivered on or after the contractor's start work date.