



DEFENSE
HEALTH AGENCY

HPOS

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**CHANGE 120
6010.56-M
MARCH 4, 2014**

**PUBLICATIONS SYSTEM CHANGE TRANSMITTAL
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The TRICARE Management Activity has authorized the following addition(s)/revision(s).

CHANGE TITLE: REMOVAL OF MINIMUM CASE QUANTITY REQUIREMENT

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PAGE CHANGE(S): See page 2.

SUMMARY OF CHANGE(S): This change removes the case quantity requirement from the TOM.

EFFECTIVE DATE: March 4, 2014.

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

CHANGE 120
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REMOVE PAGE(S)

CHAPTER 13

Section 1, pages 1 and 2

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General

1.0 CONTRACTOR'S PROGRAM INTEGRITY RESPONSIBILITY

1.1 The contractor shall incorporate into its organizational management philosophy a published corporate strategy that underlines commitment to health care fraud detection and prevention. The strategy, developed and endorsed by corporate management, shall include maintaining a focus on increased health care fraud awareness, developing processes which identify fraud, aggressively referring health care fraud cases, assisting in the prosecution of the cases, and developing deterrents to health care fraud. Internal procedures shall be in place for all offices to provide potential fraud and abuse cases to the contractor's program integrity function. The strategy and internal procedures shall be provided to the TRICARE Management Activity (TMA) Program Integrity Office (PI) 30 calendar days prior to start of health care delivery, with annual updates, or as changes occur, whichever comes first.

1.2 Program integrity is a contractor responsibility to ensure that necessary medical, pharmacy, or dental services are provided only to eligible beneficiaries by authorized providers or reimbursement made to eligible beneficiaries or providers under existing law, Regulation and TMA instructions. Further, the program integrity responsibility extends to applying the expertise of the contractor staff to the evaluation of the quality of care, and to ensure that payment is made for care which is in keeping with generally accepted standards of medical, pharmacy, or dental practice. In carrying out this function, the contractor is required to apply all the standards and requirements addressed in this and all other chapters of this manual. The contractor shall have a dedicated program integrity function, solely for the government line of business, which shall perform the program integrity activities listed below and shall respond to requests and direction from the TMA Office of General Counsel (OGC) and TMA PI.

1.3 Contractors shall develop and maintain those internal management controls necessary to prevent theft, embezzlement, fraud, or abuse of benefit funds. These controls shall be addressed in the annual letter of assurance. (See [Addendum A, Figure 13.A-7.](#))

1.4 The contractor shall conduct the following functional activities:

1.4.1 On-line manipulation and analyses of professional and institutional health care data associated with type, frequency, duration and extent of services, to identify patterns highly indicative of fraudulent or abusive practices by providers and/or beneficiaries. When applicable, this includes pharmacy or dental data. Commercial anti-fraud software designed for such purposes, or upon approval of the TMA, the contractor's own link-analysis program will be used. Software must be state-of-the-art and have the ability to use layered logic and artificial intelligence, to receive queries in English, to ask questions in English and to produce comprehensive fraud detection reports. The application must be on-line and accessible by the contractor's Program Integrity Unit fraud specialists and shall be used on a daily basis. It is expected that as a result of the use of this software, a minimum of 10 cases a year shall be identified, developed, and if warranted,

referred to TMA. This is in addition to cases being developed under other methods, i.e., receipt of beneficiary complaints, law enforcement inquiries, other private plan referrals, etc. Finally, utilizing all methods of identifying fraud/abuse cases, this shall result in referring a minimum **number** of cases **as specified in Section C of the contract** (meeting the criteria outlined in Section C) to TMA each **calendar** year. The list of cases and their disposition shall be included as an addendum to the fourth quarter Fraud and Abuse Summary Report. This **paragraph 1.4.1** is not applicable to the TRICARE Dual Eligibility Fiscal Intermediary Contract (TDEFIC).

1.4.2 Perform validation audits on statistical samples of claims or other appropriate units of measurement (e.g., line item or Episode Of Care (EOC)) for care provided by specific provider(s), pharmacy(ies), or dental practice(s). Perform audits of claims or other appropriate units of measurement submitted by specific beneficiaries to verify services with the provider, pharmacy, or dental practice. Transmit the audit and its health care database information via electronic media. (See **Section 4, paragraph 2.0** for postpayment procedures.)

Note: In the vast majority of cases, the unit to be statistically sampled is the entire claim (which includes all line-items). Occasionally, circumstances dictate that the unit to be sampled is the entire patient encounter which we define as the complete patient EOC. In this case, the unit to be sampled will consist of multiple claims. In other unusual circumstances, a probe sample may be required (i.e., an audit that is not statistically valid). A statistically valid sample may or may not follow the probe sample.

1.4.3 Provide technical and professional consultation and information (to include documentation) concerning:

- The delivery of health care services in the Continental United States (CONUS), Outside of the Continental United States (OCONUS) when applicable (this includes pharmacy or dental services);
- Claims processing requirements (i.e., submission, adjudication, and reimbursement of claims for health care services, pharmacy, or dental services);
- All anti-fraud activities;
- Case specific data needed during development and investigative process.

1.4.4 Identify and provide expert witnesses at Grand Jury proceedings, criminal and civil trials as requested by TMA PI.

1.4.5 Provide documents, reports, correspondence, and other applicable data or items as directed by the TMA PI or OGC in support of investigations, compliance monitoring, anti-fraud activities, or other program integrity related issues.

1.4.6 Evaluate the effectiveness of prepayment screens and postpayment detection reports and initiate appropriate changes. Report all changes within 45 calendar days to TMA PI. Maintain the supporting documentation for the changes for two years unless the change is mandated by TMA.

3.2 Common Audits

3.2.1 Probe Audit

A probe audit is a sample of limited number of claims that are identified systematically to determine if claims are being billed inappropriately. The results of a sample audit may trigger the need for the contractor to perform a **statistically** valid random sample of 100% audit sample.

3.2.2 Statistically Valid Random Sample

3.2.2.1 If the case involves more than 50 claims/encounters (or other unit of measurement) within the most recent 24 months, a sample audit which is statistically valid, at a 90% confidence level, plus or minus 10% with a 50% occurrence rate shall be randomly selected from a claims/encounter history arrayed in claim/encounter Internal Control Number (ICN) ascending order. The contractor must have the capacity to electronically generate sample sizes and random numbers using a government approved system. [Addendum A](#) provides guidance concerning selection of samples, calculating overpayments, testing the validity of the sample by calculation of the standard deviation of the sample(s) and standard error of the mean(s). While this approach is geared towards "claims", it would be appropriate for treatment encounters (or other units of measurement) where no "claim" exists. Zero paid claims shall be eliminated from the universe before the sample selection. This includes claims which were not denied, have allowable amounts, but zero dollars were paid.

3.2.2.2 In a stratified sample, the contractor should determine the low, middle and high dollar stratum. The middle dollar stratum is determined by the dollar range of the vast majority of claim paid amounts. The middle dollar stratum is the stratum to be used for the statistical sample. The paid claims in the middle dollar stratum are the claims in the sample universe. The low dollar stratum should not be reviewed. The high dollar stratum while not part of the universe, may be separately 100% reviewed.

Note: A stratified sample is not necessary if all claims in the original universe are in a close dollar range.

3.2.3 One-Hundred Percent (100%) Claims Audit

If the case involves less than 50 claims/encounters within the most recent 24 months, the contractor shall audit the entire universe or for the specific period identified/required.

3.2.4 External Audit

A secondary method of determining probable fraudulent practices is an external audit to beneficiaries for confirmation of services. This may be used to supplement a claims audit method. These audits shall address 100% of the beneficiaries who received services from a provider within a recent period of no more than one year. If the case involves a provider seeing more than 50 beneficiaries for whom a claim has been submitted, a systematic sample (a sample selection using an interval such as every fifth, 10th, etc., claim) may be used to select beneficiaries for external audit validation of services. Generally, no less than 50 external audit letters shall be sent ([Addendum A](#), [Figure 13.A-2](#)). In cases where the beneficiary has altered a bill, an external audit to the provider shall be conducted ([Addendum A](#), [Figure 13.A-3](#)). The suspense period for receipt of the response

to the letters is 30 days with a follow-up, either written or by phone, at the 30th day.

3.3 Reporting Audit Findings

3.3.1 Audit findings must be reported in a clear and concise manner in an automated spreadsheet, accompanied by a description of the audit with summary information in quantifiable terms. The audit spreadsheets shall provide the criteria used for determination of overpayments (e.g., no entry, not a benefit). An analysis of the frequency of the occurrence of overpayments can lead to conclusions concerning further investigative actions. Other methods of analyses may be used concerning abusive practices.

3.3.2 Individual audit sheets shall be included documenting individual findings (which will then be summarized in the automated spreadsheet). Individual file folders, with identifying information, shall be generated as appropriate and must contain all applicable documentation/ data used and obtained in the audit process.

4.0 CASE DISPOSITION

4.1 General

Contractors shall refer to TMA only those cases that involve more than the threshold as stated in **Section C** of the contract or cases with any loss where patient harm has occurred. Contractor shall handle administratively, those cases that involve less than the threshold as stated in **Section C** of the contract.

4.2 Potential Fraud and Abuse Exposure Cases Under the Threshold As Stated in **Section C** of the Contract without Patient Harm

4.2.1 Cases determined on review to support allegations of fraud that fall below the threshold as stated in **Section C** of the contract without patient harm should not be referred to TMA.

Note: For purposes of this chapter, patient harm refers to a fraudulent or abusive practice directly causing a patient who is undergoing treatment for a disease, injury, or medical (or dental) condition to suffer actual physical injury or psychological injury or acceleration of an underlying condition. The determination that patient harm has occurred must be based on the opinion of a qualified medical or dental provider or pharmacist in the case of pharmacy claims.

4.2.2 The contractor's required administrative actions for cases not referred will routinely include: education, warning of the penalty for filing false claims, recoupment, prepayment review, and post-payment review monitoring. See [paragraph 5.0](#). A record of the action taken by the contractor must be completed and retained. All monies paid by previous TRICARE contractors and recouped by the current contractor will be refunded to the TMA Chief, Finance and Accounting Office (F&AO). The contractor shall send providers/pharmacies educational letters advising them to curtail their aberrant billing practices and provide guidance on how to bill correctly. These letters should be sent certified mail return receipt.

4.2.3 Recoupment action should be taken on any monies paid in error. Re-evaluate the providers in six months to a year to determine if the aberrant billing practices have been

discontinued. If they have not, follow the procedures for referring the case to TMA. A critical piece of evidence to include in the referral is the educational letter with the signed receipt.

4.2.4 Exception, if clear and convincing evidence of fraud/abuse is identified, circumstances may warrant referral of a case less than the threshold as stated in [Section C](#) of the contract, and will require the contractor to contact TMA PI to discuss allegations and findings.

4.3 Potential Fraud and Abuse Exposure Cases That Meet the Threshold as Stated in [Section C](#) of the Contract or Any Loss with Patient Harm

4.3.1 Cases determined on review to support allegations of fraud that meet the threshold as stated in [Section C](#) of the contract or cases of any loss with patient harm shall be developed for potential referral to TMA PI.

4.3.2 The contractor shall develop the case to determine the probable method of fraud/abuse and potential dollar value of the case, such as cases which involve an allegation that the provider, pharmacy, or dental practice is billing for services not rendered, the provider is not providing or referring the beneficiary for appropriate care which is medically necessary per medical standards (or in the case of dental, necessary per dental standards), or provider, pharmacy, or dental practice is falsifying medical records.

4.3.3 The contractor's review shall include all the provider, pharmacy, or dental numbers used by that provider or pharmacy. An audit shall be accomplished if there is evidence of possible fraud (e.g., repetitive occurrences of a pattern of abnormal billing).

4.3.4 The contractor or its representative shall not conduct personal interviews with beneficiaries, pharmacies, dental practices, or providers in developing the potential fraud/abuse case. Such interviews will be conducted, if necessary, by the appropriate Government investigative agency.

4.3.5 Administrative actions shall not be initiated without prior TMA PI approval. (See also [paragraph 5.0](#).)

4.4 Special Interest Cases

4.4.1 Unbundling

Unbundling of services refers to a form of procedure code manipulation which involves separately billing the component parts of a procedure instead of billing only the single/entire comprehensive procedure. See [Section 3, paragraph 3.7](#).

4.4.2 Problem Provider Cases

See [Section 4, paragraph 5.0](#).

4.4.3 Pharmacy Fraud

See [Section 3, paragraph 3.11](#).

4.4.4 Conflict of Interest; Federal Employees and Active Duty Military

See [Section 3, paragraph 3.4](#).

4.4.5 Eligibility Fraud

Cases of beneficiary eligibility fraud require the Social Security Number (SSN) or DoD Benefits Number (DBN) to be flagged to prevent further claims from being processed or providing services by a network provider or network pharmacy. Develop and refer to TMA only those cases that involve more than the threshold as stated in [Section C](#) of the contract. Handle administratively those cases that involve less than the threshold as stated in [Section C](#) of the contract.

4.4.6 Identification Theft

Cases involving identification theft are time sensitive and shall be expeditiously referred to TMA. Upon notification of beneficiary identification theft the contractor shall immediately flag the beneficiaries file for prepay review monitoring. After flagging the file the beneficiary should be contacted before payment of future claims to verify that the claims are valid. The contractor should provide the beneficiary with a copy of their billing history along with a request that the beneficiary review the billing history information to verify the validity of past claims. Identification theft cases shall be developed to determine if health care fraud/abuse has occurred. See [paragraph 4.0](#) for further guidance.

4.4.7 Drug Seeking Beneficiaries

4.4.7.1 The contractor shall screen drug claims and/or medical claims and/or dental claims for potential overutilization and substance abuse. If a potential drug abuse situation is identified by a private physician, a physician reviewer in the course of business for the contractor, a dentist, pharmacist, or a physician in a hospital setting, as representing an addictive state in the beneficiary, the beneficiary shall be placed on 100% prepayment review. The [32 CFR 199.4](#) precludes government cost-sharing of benefits to support or maintain potential drug abuse situations. This is true, whether or not the drugs are obtained by legal means and are otherwise eligible for benefit consideration under other circumstances. The contractor shall:

- Pend all claims for the beneficiary;
- Establish the necessity for the drugs and their appropriateness on the basis of diagnosis or definitive symptoms;
- Deny all related claims if a drug abuse situation does exist including office visits or emergency room visits if the purpose of the visit was to obtain drugs; and
- Reopen prior claims (most recent 12 months) for the beneficiary and review those claims to determine whether or not drug abuse existed at the time the earlier claims were paid. If drug abuse is ascertained for prior claims, recoupment action shall be taken for the erroneous payments.

4.4.7.2 The contractor shall request the beneficiary to select a physician, who will act as the primary care physician coordinating all care and making referrals when appropriate. This shall

include selection of a dentist, if applicable. For Prime enrollees, the contractor shall take action to manage the beneficiary's treatment as appropriate. The contractor shall not submit these cases to the TMA PI unless potential fraud is identified, such as altered prescriptions or drug receipts, or aberrant prescribing patterns by the physician. When appropriate, the contractor shall develop the case as stated in [paragraph 4.3](#). The contractor shall also coordinate efforts with other TRICARE contractors as needed to ensure medical, dental, and pharmacy benefits are not being abused and to ensure the beneficiary's care is appropriately managed. As appropriate, this can include coordination with military medical/dental personnel.

Note: Beneficiaries are entitled to benefits by law. Beneficiaries cannot be sanctioned to preclude them from seeking benefits for medical or dental care which is appropriate and medically (or dentally) necessary.

4.4.8 Possible Forgery of Check Endorsement

When the payee of a benefits check alleges that the endorsement on the check was forged, the contractor shall immediately initiate reclamation proceedings to have its bank credit the amount of the forged check to the account. This shall be accomplished as follows:

4.4.8.1 Affidavit Required

The contractor shall request the payee to submit an affidavit of the forgery. A supply of these forms can usually be obtained from the bank. In requesting the payee to complete the affidavit, the contractor shall explain to him or her that the issuance of a replacement check is contingent upon timely return of the completed affidavit and receiving a credit on the forged check.

4.4.8.2 Request for Credit

When the affidavit is received from the payee, the contractor shall forward it, along with the original of the allegedly forged check, to the contractor's bank with a request that the bank credit the amount of the forged check to the contractor's account. Under the Uniform Commercial Code (UCC), generally adopted by all states, a bank is liable for cashing a forged check and must credit the payment back to the account upon which the check was drawn when the forged check affidavit, executed by the payee, is received.

4.4.8.3 Issuing a Replacement Check

When the bank sends notice that it has credited the account for the amount of the forged check, the contractor can issue a replacement check to the payee.

4.4.8.4 Cooperating in Investigation/Prosecution

The forgery of a contractor check is a violation of state law; it also may violate several statutes. However, it is generally more efficient for local authorities to handle such cases. Therefore, the contractor shall rely upon the bank for appropriate referral of the matter for investigation by state authorities. When requested to do so, the contractor shall cooperate with the state authorities in their investigating efforts. Questions concerning the release of information to state authorities in these cases shall be directed to TMA OGC.

4.4.8.5 Reporting

Cases involving forgery and other unusual circumstances shall be reported immediately to TMA PI. Such circumstances might include a suspicion that the forgery involves contractor employee fraud or a pattern of forgery suggesting an organized effort. One time occurrence forgery cases shall be reported using the TRICARE Fraud and Abuse Report TMA Form 435 ([Addendum A, Figure 13.A-1](#)).

4.4.8.6 Time Limits

Contractors are required to take timely action. While the UCC holds the bank strictly liable for cashing forged checks, the states have generally adopted statutes of limitation relieving the banks of liability for any reclamation action not initiated within a specified time. These time limits generally vary from one to three years. Therefore, it is essential that the contractor promptly act upon notice that a payee did not receive a check or upon notice of an alleged forgery.

5.0 TMA REFERRALS

5.1 The contractor shall establish policies, procedures and organizational units for the purpose of preventing, detecting, developing, reporting and evaluating cases of suspected fraud and program abuse for referral to TMA. The contractor shall collect information on the effectiveness of its health care fraud detection and prevention programs by maintaining statistics on the costs of the fraud detection compared to the proportionate amount of health care funds recovered. Reports or a summary statement shall be submitted to the TMA PI quarterly with the fraud and abuse summary report.

5.2 In suspected cases of fraud/abuse, the contractor shall not send an educational letter or attempt recoupment unless an exception is specifically permitted elsewhere in this chapter (e.g., violation of participation agreement in reimbursement limitation, potential loss is less than the threshold as stated in the contract as determined by TMA PI). Administrative remedies can adversely impact civil or criminal prosecution of a case and are inappropriate if fraud is suspected.

5.3 The contractor has up to 180 days, after identification of potential fraud and/or abuse, to develop a case for referral (clerical and/or processing errors have been ruled out) in accordance with [paragraph 5.0](#). Identification means the contractor has been made aware of allegations of fraud/abuse by a beneficiary, provider, law enforcement, other source, or proactive measures. Once developed, the case shall be referred within 30 days of development completion. Exception to the above must be requested in writing and approved by the Director, TMA PI or designee.

Note: The contractor shall not report fraud and abuse cases which are suspected of violating Federal law directly to the Defense Criminal Investigating Service (DCIS), Military Criminal Investigation Organizations (MCIOs), Federal Bureau of Investigation (FBI), or any other investigative organization. All cases shall be reported to TMA PI in accordance with the procedures in this chapter.

5.4 The contractor shall not respond to direct requests for documentation from investigative agencies, private payer plans, anti-fraud associations, or other entities. The contractor shall promptly notify the TMA PI of any requests made directly to the contractor. If the contractor

responds directly to a request for documentation from an investigative agency or other entity, the costs of responding shall not be charged to the contract.

5.5 It is DoD policy that all employees, contractors and subcontractors shall cooperate fully with investigative agencies of the United States (US) upon the direction of the TMA PI. All requests for claims histories, medical and other records, regulatory/manual provisions, correspondence, audits and other documentation (e.g., newsletters, claims, checks) shall be provided by the contractor. Requests for witnesses and technical support will be completed by the contractor regardless of the time frames or dates of service identified in the request should this cross contractor jurisdiction or involve legacy contracts.

6.0 FRAUD AND ABUSE CASE REFERRAL CONTENT

6.1 General

TMA PI will evaluate each referred case in accordance with TMA PI criteria as outlined on the Case Referral Evaluation form. Each case referred to TMA PI by the contractor shall be submitted in duplicate. The contractor is required to provide complete copies of any case files TMA PI requests (i.e., utilization reviews, patterns of practice, etc.) at no cost to the government.

6.2 Case Summary

The contractor shall submit a Case Summary when referring cases of potential fraud or abuse that describes at a minimum the following:

- The allegations citing all the applicable TRICARE regulatory provisions that have been violated in regards to each allegation.
- A description of the individual or institution suspected of committing or attempting to commit the alleged wrongful behavior, including all appropriate information, such as the beneficiary's name, sponsor's status and SSN or DBN, beneficiary's relationship to sponsor, provider's specialty (e.g., General Practitioner, Dental Surgeon, or Pharmacy) and identification number, address, telephone number, etc.
- A description how the suspicious behavior was uncovered, e.g., audit, prepayment screen, beneficiary, pharmacy, provider complaint, tip, DoD Hotline, investigator notification, etc. In addition, indicate the date the allegations were identified.
- A description clearly summarizing the behavior which is suspected to be in violation of Federal law, regulation or policy; for example, billing for services, pharmaceuticals or supplies that were not provided, altering receipts or claim forms, duplicate billing, providing incorrect information when seeking preauthorization, etc. This shall include identifying specific facts that illustrate the pattern or summary conclusions. For example: submitted probable false claims to the contractor through the U.S. Post Office or via electronic mail, altered checks, misrepresented the description and coding of services, falsified the name of the actual provider of care, falsified the name of the actual pharmacy dispensing the prescription, altering medical records, etc.

- A description of all action taken during developmental stage, to include contacts made, information obtained, potential problematic issues, etc.
- A description of the estimate the number of claims or encounters, the length of time the suspicious behavior has occurred and the government's and contractor's loss.
- A description of the current status of claims or other requests submitted by the suspected provider, pharmacy or beneficiary, i.e., regular development, processing and payment or denial, claims suspension, prepayment review, etc.
- A description of any relevant documents provided, such as any correspondence with the provider, pharmacy or beneficiary, telephone conversation records, provider certification files, requests for medical records, educational letters, recoupment letters, etc.
- A description of previous and/or ongoing administrative measures (educational efforts, prepay review, etc.).
- A description of all actions taken to identify and determine the total TRICARE exposure, including coordination with other contractors. The Case Summary shall indicate the total monetary exposure to TRICARE and if actual patient harm has occurred.
- A description of any other facts that may establish a pattern of practice or indicate that the provider, pharmacy or beneficiary intended to defraud the government or the contractor.

6.3 Copies of Supporting Documents

The contractor shall include a copy of all relevant supporting document(s) when referring cases of potential fraud or abuse that includes at a minimum the following:

- A completed TRICARE Fraud and Abuse Report (TMA Form 435, [Addendum A, Figure 13.A-1](#)).
- Copies of the applicable TRICARE regulatory provisions violated.
- Enclose copies of each claim, explanation of benefits forms, medical records, pharmacy records, provider certification file and other documents demonstrating the suspicious behavior in individually labeled file folders.
- Enclose a history covering the most recent 24 month period (or the identified period of time, if longer than 24 months) in electronic media in dBase IV, or MS/Excel spreadsheet (Version 2000 or later) to electronic media and have the capability to compress the data using WIN-Zip self extracting software, with no less than version 2.4 or provide the data on a CD-ROM. Hard copy histories are acceptable only for histories of less than 100 claims/encounters.

Evaluation

Note: This section is not applicable to pharmacy.

1.0 PREPAYMENT/PRE-ENCOUNTER SCREENS, AUDITS, AND EDITS

On a quarterly basis, contractors shall evaluate the efficiency of the prepayment/pre-encounter review systems by reviewing those situations and cases where significant losses occurred due to fraudulent practices which could have been prevented by a safeguard in the system of prepayment or internal controls. The findings and proposed remedial action shall be reported to the TRICARE Management Activity (TMA) Program Integrity Office (PI) and the Procuring Contracting Officer (PCO) in an effort to prevent future losses. The design and application of prepayment/pre-encounter screens shall be accomplished with consideration that claims processing/treatment are not unnecessarily delayed.

2.0 POSTPAYMENT

The contractor must have written procedures for performing postpayment utilization reviews and producing the required reports. The contractor shall devise and implement utilization control screens to identify beneficiaries who may be receiving unnecessary services or services at an inappropriate level of care; e.g., repeated hospital admissions, frequent office visits, care provided by multiple providers, etc., or who may not be receiving medically necessary services under managed care. The contractor shall develop a written analysis of services provided by high volume institutional providers. The contractor shall develop a written analysis of services provided by high volume professional and outpatient institutional providers, to include dental providers. The analysis shall include review of current and archived claims history (including present and prior contractor data) and criteria for referring cases to professional review. The contractor shall maintain documentation of the action taken on each provider or beneficiary identified with a potential aberrancy by the postpayment utilization reports, including the rationale for the decision. The contractor shall analyze the reports on each provider/beneficiary identified by the postpayment system to determine whether potential fraud or abuse exists. Procedures, analysis, and documentation shall be provided to TMA PI upon request.

Note: High volume beneficiaries are those beneficiaries whose charges exceed the threshold as stated in **Section C** of the contract during a 12 month reporting period. High volume providers are considered institutional providers; individual providers; and groups/clinics whose payments exceeded the threshold as stated in **Section C** of the contract during a 12 month reporting period.

3.0 SIGNATURE RELAXATION PROGRAM AUDIT

3.1 The contractor's randomly selected, statistically valid postpayment audit requirement shall be used to verify provider compliance with the requirements for beneficiary or other authorized beneficiary representative signature on file. (See [Chapter 8, Section 4, paragraph 6.0.](#))

3.2 If there is some indication that there is potential fraud or abuse, the contractor shall follow the fraud and abuse procedures as specified in [Section 2.](#)

4.0 PROVIDER SIGNATURE AUTHORIZATION-ON-FILE IRREGULARITIES

4.1 The contractor shall verify facsimile or representative signature authorizations in accordance with [Chapter 8, Section 4, paragraph 6.2.2.](#)

4.2 If there is some indication that there is potential fraud or abuse, the contractor shall follow the fraud and abuse procedures as specified in [Section 2.](#)

5.0 PROBLEM PROVIDER CASES

5.1 On occasion, the efforts to correct a problem provider through the educational efforts of contractor provider relations personnel and contacts by professional peers will have little or no apparent effect. Such cases should be carefully reviewed by the contractor's medical or dental director and/or other peer advisors. If, in their opinion, the problem poses a threat to the welfare of beneficiaries or a significant problem in utilization of services, potential fraudulent/abusive behavior, etc., the contractor, with concurrence of the contractor's medical or dental director or advisor, should take the following action:

5.1.1 For contracted providers, the contractor should review its agreement with the provider for compliance and take appropriate action, which may include canceling the agreement.

5.1.2 For all providers, the contractor shall refer the case to the TMA PI with the following information:

- A summary of the issues;
- A description of how the problem was identified;
- A description of efforts made by the contractor to resolve the issues and why they were not successful;
- A description of actions taken, including whether the provider has been placed on 100% review;
- A copy of all relevant claims, Explanation Of Benefits (EOB), and correspondence and other contact records;
- A provider history for the most recent 24 month period in either magnetic disk and/or hard copy form; and