



DEFENSE
HEALTH AGENCY

HPOB

**OFFICE OF THE ASSISTANT SECRETARY OF DEFENSE
HEALTH AFFAIRS
16401 EAST CENTRETECH PARKWAY
AURORA, CO 80011-9066**

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ARENDALE.JOHN.LOUII.1150775368
DN: c=US, o=U.S. Government, ou=DoD,
ou=PKI, ou=TMA,
cn=ARENDALE.JOHN.LOUII.1150775368
Date: 2016.05.16 10:32:01 -06'00'

**John L. Arendale
Section Chief, Health Plan
Operations Branch (HPOB)
Defense Health Agency (DHA)**

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Claim Development

1.0 GENERAL

1.1 Pursuant to National Defense Authorization Act for Fiscal Year 2007 (NDAA FY 2007), Section 731(b)(2) where services are covered by both Medicare and TRICARE, and medical necessity documentation is required for claims processing, the contractor shall require only the documentation as specified by the Medicare Indemnity Program, for example, the Centers for Medicare and Medicaid Services (CMS)-Certificates of Medical Necessity. No additional documentation for medical necessity is generally required if the care has been preauthorized.

1.2 The contractor shall retain all claims that contain sufficient information to allow processing to completion. The contractor shall also retain all claims that have missing information that can be obtained from in-house sources, including Defense Enrollment Eligibility Reporting System (DEERS) and contractor operated or maintained systems or files (both electronic and paper). If the claim has missing information that cannot be obtained from in-house sources, the contractor shall either return the claim to the sender or retain the claim and develop for the missing information from external sources (e.g., beneficiary or provider). If the claim is returned, the contractor will return the claim to the sender with a letter stating that the claim is being returned, stating the reason and requesting the missing or required information. The letter shall request all known missing or required documentation. The contractor's system shall identify the claim as returned, not denied. Returned claims shall not be reported on TRICARE Encounter Data (TED) records. The government reserves the right to audit returned claims as required, therefore the contractor shall retain sufficient information on returned claims to permit such audits.

1.3 If a claim is to be returned to a beneficiary who is under 18 years of age and involves venereal disease, substance or alcohol abuse, or abortion, the contractor shall contact the beneficiary to determine how he or she wishes to complete it. See [Section 8, paragraph 6.0](#) regarding possible contact procedures and the need for both sensitivity and use of good judgment in the protection of patient privacy. **Mail development shall not be initiated on this type of claim without consent of the beneficiary irrespective of whether it is a network or non-network claim.**

2.0 AGREEMENT TO PARTICIPATE

2.1 If the provider has agreed to participate, payment to the full extent of program liability will be paid directly to the provider, but the payment to the provider from program and beneficiary sources must not exceed the contractor determined allowable charge except as provided in payments which include other health insurance which is primary. In such a case, the provisions of [32 CFR 199.8](#) and the TRICARE Reimbursement Manual (TRM), [Chapter 4](#) will apply.

2.2 In all cases in which the contractor has documented knowledge of payment by the beneficiary or other party, the payment shall be appropriately disbursed, including, when necessary, splitting payment. (See the TRM for cases where double coverage is also involved.) If it

comes to the contractor's attention that the terms have been violated, the issue shall be resolved as outlined in [Chapter 13, Section 5, paragraph 7.0](#), under procedures for handling violation of participation agreements. If the provider returns an adjustment check to the contractor indicating that payment had been made in full, an adjustment check shall be reissued to the beneficiary/sponsor. If the non-network provider is clearly not participating or the intent cannot be determined, pay the beneficiary (parent/legal guardian).

3.0 CLAIMS FOR CERTAIN ANCILLARY SERVICES

If laboratory tests billed by a non-network provider were performed outside the office of the non-network provider, the place where the laboratory tests were performed must be provided. The contractor shall approve arrangements for laboratory work submitted by network physicians. To be covered, the services must have been ordered by an Doctor of Medicine (MD) or Doctor of Osteopathy (DO) and the laboratory must meet the requirements to provide the services as required under the 32 CFR 199, and Defense Health Agency (DHA) instructions.

4.0 INTERNATIONAL CLASSIFICATION OF DISEASES, 9TH REVISION, CLINICAL MODIFICATION (ICD-9-CM) "V" CODES

4.1 The ICD-9-CM codes listed in the Supplementary Classification of Factors Influencing Health Status and Contact with Health Services, otherwise known as **V** codes, deal with circumstances other than disease or injury classifiable to the ICD-9-CM categories 001-999. **V** codes are acceptable as primary diagnoses on outpatient claims (rarely on inpatient claims) to the extent that they describe the reason for a beneficiary's encountering the health care system. Claims with dates of service or dates of discharge provided before the mandated date, as directed by Health and Human Services (HHS), for International Classification of Diseases, 10th Revision (ICD-10) implementation, with **V** codes as the primary diagnoses are to be processed as follows without development. Claims with dates of service or dates of discharge provided on or after the mandated date, as directed by HHS, for ICD-10 implementation, are to be processed in accordance with ICD-10-CM **Z** codes.

4.2 **V** codes which provide descriptive information of the reason for the encounter based on the single code, e.g., V03.X (Prophylactic vaccination and inoculation against bacterial diseases), V20.2 (Routine infant or child health check), V22.X (Supervision of normal pregnancy), V23.X (Supervision of high risk pregnancy), V25.2 (Sterilization), are acceptable as primary diagnoses. Claims with these codes may be processed according to TRICARE benefit policy without additional diagnostic information.

4.3 **V** codes for outpatient visits/encounters involving only ancillary diagnostic or therapeutic services are acceptable as the primary diagnosis to describe the reason for the visit/encounter only if the diagnosis or problem for which the ancillary service is being performed is also provided. For example, a **V** code for radiologic exam, V72.5, followed by the code for 786.07 (wheezing) or 786.50 (chest pain) is acceptable. If the diagnosis or problem is not submitted with a claim for the **V**-coded ancillary service and the diagnosis is not on file for the physician's office services, the claim is to be denied for insufficient diagnosis.

4.4 **V** codes for preventive services due to a personal history of a medical condition or a family history of a medical condition are acceptable as primary diagnoses when medically appropriate due to the personal or family history condition. Claims with these codes may be processed

Inquiry Services Department - General

1.0 INQUIRY SERVICE DEPARTMENT OBJECTIVES

Contractors shall implement an inquiry processing service which ensures that all inquiries received from TRICARE beneficiaries, providers, and other interested parties are processed in a timely and consistent manner and that information delivered about the TRICARE program is accurate. The services department shall be able to assist in settling TRICARE claims and provide program information whether the inquiry is by telephone, letter, or electronic media. For inquiries regarding active duty claims, contractors shall follow the procedures as outlined in the [Chapter 17](#).

2.0 WRITTEN INQUIRIES

The contractor shall process both routine and priority correspondence in accordance with the standards and requirements set forth in [Chapter 1, Section 3](#).

3.0 TELEPHONES

The contractor shall provide trained personnel to answer all TRICARE inquiries [beneficiaries, Regional Directors (RDs), providers, Assistant Secretary of Defense (Health Affairs) (ASD(HA)), TRICARE Management Activity (TMA), Beneficiary Counselling and Assistance Coordinators (BCACs), Debt Collection and Assistance Officer (DCAO), Health Benefit Advisors (HBAs), and congressional offices]. TRICARE has established the TRICARE Information Service (TIS), reachable by a series of 1-800-XXXX telephone numbers. The TIS will refer incoming calls to the appropriate contractor for action. The Managed Care Support Contractor (MCSC) and TRICARE Dual Eligible Fiscal Intermediary Contract (TDEFIC) contractor and the TRICARE Pharmacy (TPharm) contractor shall provide the Procuring Contracting Officer (PCO) with the single telephone number to which these calls shall be routed No Later Than (NLT) 150 calendar days prior to the start of services.

4.0 TRAINING OF SERVICE REPRESENTATIVES

All representatives must be knowledgeable with a high level of communication skills. Online access to claims history and all other necessary information shall be provided. Service representatives must be thoroughly trained in the areas outlined in [Chapter 1](#). Special emphasis should be placed on medical terminology, program benefit policies (including both TRICARE Standard, TRICARE Extra, and TRICARE Prime) and how the programs are applied in processing, Privacy Act and Freedom of Information Act (FOIA) requirements, contractor claims processing system capabilities, and training in the identification and reporting of potential fraud and abuse situations. All personnel shall receive communications training including how to listen for content, ensure customer courtesy and effectively manage time.

5.0 ONLINE TRICARE PROVIDER SEARCH TOOL

The contractor shall provide a regional online provider search tool on the contractor's public web site for use by beneficiaries to search for and display TRICARE network and TRICARE authorized (non-network) providers (Professional, Ancillary, Facility, Allied Health, and Behavioral Health) information. The tool shall allow the beneficiary, at a minimum, to search by provider name, provider organization (if applicable), provider type, provider specialty, and distance from their residence. The tool shall display, at a minimum, the provider's name, provider organization (if applicable), specialty, office location, office phone number (if available), and distance from the beneficiary's zip code. For network providers, the tool shall indicate whether the provider is accepting new patients. For non-network providers, the listing shall clearly indicate the provider is non-network. Also, for non-network providers, the listing shall be based on claims submissions for a rolling 14 month period not to include the latest two months of claims. Contractors are responsible to immediately remove provider information if a provider has been excluded, suspended, or terminated from TRICARE (see [Chapter 13, Section 5](#)). Upon request of the provider or organization, non-network provider information will be removed within 30 days and no longer further displayed. A standard disclaimer shall be posted on the tool and outputs of the tool that providers have accepted TRICARE patients in the past, but may not accept them routinely and to contact the provider to validate whether TRICARE beneficiaries are currently being accepted; if no telephone number is provided, consult their local telephone directory. The overseas contractor is exempt from providing an online directory of non-network providers.

- END -

Collection Actions Against Beneficiaries

1.0 GENERAL

1.1 No patient, family member or sponsor shall be subjected to ongoing collection action undertaken by or on behalf of a provider of services or supplies, as a result of the inappropriate non-payment of claims for services which should have been covered under TRICARE. When the Government becomes aware that such collection action has been initiated, it will intervene on behalf of the party against whom the collection action has been taken.

1.2 While the Government will assist in the resolution of collection matters, the ultimate responsibility for resolving collection actions lies with the patient, family member, or sponsor. The Government will not provide legal representation to resolve these issues and will not pay attorneys' fees, court costs, collection agency fees, accrued interest, late charges, etc. TRICARE can only assume responsibility for collection assistance for medically necessary supplies and services as authorized for coverage under the TRICARE regulation.

2.0 DEBT COLLECTION ASSISTANCE INTERVENTION

Upon notification of a problem, Department of Defense (DoD) will investigate and, when appropriate, resolve and/or assist in the clarification of collection issues for TRICARE beneficiaries.

3.0 CONTRACTOR RESPONSIBILITIES

3.1 Research Assistance

The contractor shall provide immediate assistance to the Government in support of the debt collection assistance function. In addition to identifying specific underpayments, the contractor shall also:

3.1.1 Designate specific individuals and provide resources to work collection issues with Government representatives during normal weekday business hours.

3.1.2 Provide Web-site access and/or e-mail addresses, mailing addresses, fax numbers and direct phone number(s) of specialized collections research and support staff to the Government.

3.1.3 Meet required response time for problem resolution (Standard: 85% within 10 days, 100% within 30 days). Resolution is the completion of research by the Managed Care Support Contractor (MCSC) (and/or their subcontractor(s)) to define the course of actions that have taken place on the claims that have gone to collection, to correct previous erroneous actions, if any, by the MCSC or its subcontractors, and to define clearly the remaining liability, if any, which is the responsibility of the patient. The date of resolution is the date a final, case-specific response is furnished to the Government. The response shall include all the information listed in [paragraph 3.1.6](#). If applicable,

the response to the DCAO should note that a check is being issued to the beneficiary or provider on a priority basis, and the approximate date payment is expected.

3.1.4 Maintain records and processing statistics on collection activity. The records to be maintained shall include a detailed chronological record of all actions taken, including names and telephone numbers of all parties contacted in the course of the actions taken, as well as copies of all correspondence sent and received.

3.1.5 When violation of the participation agreement or balance billing is not at issue, issue letters to providers and conduct provider education when the provider was at fault.

3.1.6 The contractor shall furnish reports of all completed collection cases.

3.1.7 In newsletters and other materials, publicize and educate beneficiaries and providers on the Debt Collection Assistance Program. This would include informing providers of the availability of the contractor's support services to assist in resolution of claims problems, and encouraging providers to contact the contractor's priority unit for assistance prior to initiating any collection action against beneficiaries. If the contractor participates in beneficiary, sponsor or provider training, workshops or briefings at Military Treatment Facilities (MTFs) or elsewhere in the Region in accordance with specific regional requirements, the Debt Collection Assistance Program should also be covered.

3.2 Expedited Payment

All requests for expedited payment will be coordinated through the TRICARE contractor for the region. When research reveals a processing error by the contractor or subcontractor, any additional payment due shall be processed on an expedited basis, and the MCSC's response to the Government shall reflect an expected date of payment.

3.3 Referrals to Program Integrity, DHA

When it has been determined that balance billing or violation of the participation agreement is at issue, the matter will continue to be handled in accordance with the existing program integrity guidelines contained in [Chapter 13, Section 5](#).

- END -

General

1.0 PURPOSE OF APPEAL PROCESS

An appeal under TRICARE is an administrative review of program determinations made under the provisions of law and regulation. An appeal cannot challenge the propriety, equity, or legality of any provision of law or regulation. This chapter sets forth the policies and procedures for appealing decisions made by TRICARE and the TRICARE Quality Monitoring Contractor (TQMC) that adversely affect the rights and liabilities of beneficiaries and participating providers, and providers denied the status of an authorized provider under TRICARE.

2.0 AUTHORITY

The procedures and principles included in this chapter are based on the requirements of [32 CFR 199.10](#). For additional information regarding the appeal process refer to [Chapter 13, Section 5](#) and the TRICARE Policy Manual (TPM), [Chapter 1, Section 4.1](#) and [32 CFR 199.15\(g\), \(h\), and \(i\)](#).

3.0 CONTRACTOR RESPONSIBILITIES

It is the responsibility of the contractor to ensure that the rights of appealing parties are protected at all levels of the appeal process in which the contractor participates. The contractor's responsibility begins with the initial determination and does not end until a final resolution is reached, including, where appropriate, timely payment following a reversal.

3.1 Initial Determinations

The contractor shall develop a written plan and implement a formal appeal process that incorporates the requirements for initial medical necessity and factual determinations set forth below. The contractor shall issue a dated initial determination in the form of an Explanation of Benefits (EOB) or a letter. The initial determination shall contain sufficient information to enable the beneficiary or provider to understand the basis for the denial. The initial determination shall state with specificity what services and supplies are being denied and for what reason. The contractor shall retain a legible hardcopy or microcopy of the initial determination or be able to produce a duplicate EOB from electronic records upon request. The initial determination shall include adequate notice of appeal rights and requirements. If a request for authorization for services or supplies is denied and a claim is later submitted for the services or supplies, both the denial of authorization and the claim denial are considered initial determinations and, therefore, either may be appealed. Suggested notices are at [paragraphs 3.4](#) and [3.5](#).

3.2 TRICARE/Medicare Dual Eligible - Initial Determinations

Services and supplies denied payment by Medicare will not be considered for coverage by TRICARE if the Medicare denial of payment is appealable under the Medicare appeal process. If,

however, a Medicare appeal results in some payment by Medicare, the services and supplies covered by Medicare will be considered for coverage by TRICARE. Services and supplies denied payment by Medicare will be considered for coverage by TRICARE, if the Medicare denial of payment is not appealable under the Medicare appeal process. The appeal procedures set forth in this chapter are applicable to initial denial determinations by TRICARE under the TRICARE Dual Eligible Fiscal Intermediary Contract (TDEFIC). A flow chart diagramming the appeal process relating to TRICARE/Medicare dual eligible appeals is at [Addendum A, Figure 12.A-7](#).

3.3 Written Notice Of Initial Determination (Not EOB)

Suggested wording for a nonexpedited written appeal notice (including factual determinations):

"An appropriate appealing party (i.e., (1) the TRICARE beneficiary, (2) the non-network participating provider of care, or (3) a provider of care who has been denied approval under TRICARE or the appointed representative of an appropriate appealing party who is dissatisfied with the initial determination has the right to request a reconsideration. To avoid a possible conflict of interest, an officer or employee of the United States, such as an employee or member of a Uniformed Service, including an employee or staff member of a Uniformed Service legal office, or a Health Benefits Advisor, subject to the exceptions in Title 18, United States Code, Section 205, is not eligible to serve as a representative. An exception usually is made for an employee or member of a Uniformed Service who represents an immediate family member. The request must be in writing, must be signed, and must be postmarked or received by **(insert name of contractor, postal address, e-mail address, and fax number)**, within 90 calendar days from the date of this decision and must include a copy of this decision. For purposes of TRICARE, a postmark is a cancellation mark issued by the United States Postal Service. If the postmark on the envelope is not legible, then the date of receipt is deemed to be the date of filing."

"Additional documentation in support of the appeal may be submitted; however, because a request for reconsideration must be postmarked or received within 90 calendar days from the date of this decision, a request for a reconsideration should not be delayed pending the acquisition of additional documentation. If additional documentation is to be submitted at a later date, the letter requesting the reconsideration must include a statement that additional documentation will be submitted and the expected date of submission."

"Upon receiving your request, all TRICARE claims related to the entire course of treatment will be reviewed."

3.4 Suggested Modified Wording For An Appeal Of A Preadmission/Preprocedure Initial Denial Determination

"A TRICARE beneficiary, or the appointed representative of the beneficiary, who is dissatisfied with the initial determination, may request an expedited

enter an appeal for a beneficiary unless the provider has been designated by the beneficiary, in writing, to act as his/her representative in the appeal process. A desire to assist the beneficiary is not, in itself, sufficient reason to permit others to act for the beneficiary without specific appointment by the beneficiary.

1.3.6 Appeal Filed For Deceased Beneficiary

An appeal may be filed for a deceased beneficiary by a person authorized to sign TRICARE claims on behalf of the deceased beneficiary under the provisions of [Chapter 8, Section 4, paragraph 5.0](#).

1.3.7 Inquiries Made By Members Of Congress On Behalf Of Beneficiaries

Inquiries submitted by Members of Congress regarding a specific appealing party's claim or claims are not considered requests for a reconsideration. If the letter from the Member of Congress is postmarked or received by the contractor or TQMC before the expiration of the appeal filing deadline and is accompanied by a letter from the appealing party which meets the requirements of a request for reconsideration, the appealing party's letter to the Member of Congress may be accepted as an appeal. The Member of Congress and the appealing party shall be advised that a reconsideration will be conducted and that the appealing party will be notified of the results. If the congressional inquiry is not accompanied by a letter from the appealing party which contains all the elements of a request for a reconsideration, the contractor shall explain the procedure for filing an appeal so that the Member of Congress may advise the appealing party. Response to Congressional inquiries are subject to the provisions of the Privacy Act of 1974 (see [Chapter 1, Section 5, paragraph 2.0](#)) and to the provisions of the Health Insurance Portability and Accountability Act of 1996 (HIPAA). Once an appeal has been accepted, the contractor may tell a Member of Congress inquiring on behalf of an appealing party only that an appeal has been filed and that it would be inappropriate for the contractor to comment on the case unless the appealing party has authorized the Member of Congress, in writing, to receive information on behalf of the beneficiary.

1.4 Participating Providers

A non-network participating provider is entitled to file an appeal of those claims in which the provider participated. For the purposes of filing an appeal of a preadmission/preprocedure denial, a non-network provider is considered a participating provider and is entitled to file an appeal. The non-network participating provider may file an appeal instead of, or in addition to, the beneficiary or beneficiary's representative. Although a network provider's input, claims history, medical records, etc., may be used in adjudicating the appeal, a network provider is never a proper appealing party. (A network provider's disputes are handled under the provisions of the provider's contract or the state court system.)

1.5 When denial of payment for claimed services is being appealed, a non-network nonparticipating provider is not a party to the determination and would not receive any information regarding the claim or claim determination without the signed authorization of the beneficiary or the beneficiary's representative.

Exception: Peer reviewer's comments may be released to non-network nonparticipating providers without the patient's permission, since these comments are directed toward the provider and the

provider's ability to document treatment. In order for the non-network nonparticipating provider to provide additional information on behalf of the patient, it is necessary for the provider to be aware of the peer reviewer's comments.

Note: In those cases in which a non-network participating provider files an appeal and the care also involves a network provider (e.g., a non-network participating professional provider renders care to a beneficiary in a network hospital), the non-network participating provider would be considered a proper appealing party.

1.6 Providers Denied Certification

A non-network provider who has been denied certification as an authorized provider under TRICARE is entitled to appeal the initial determination made by either the contractor or **Defense Health Agency (DHA)**. These initial determinations are considered factual initial determinations (see [Section 5](#)). When the denial is based on the exclusion of the provider by another Federal or Federally funded program, e.g., Medicare or Medicaid, because of fraud or abuse, the issue is not appealable through the TRICARE appeal system. Unlike beneficiaries or providers who appeal denial of a claimed benefit, providers denied approval are deemed to have met any required amount in dispute at all levels of appeal. A contractor determination denying network provider status to an authorized provider is not appealable. Additional information relating to the appeal process is included in [Chapter 13, Section 5](#).

2.0 APPEAL PROCESSING JURISDICTION

2.1 Jurisdiction

The contractor who made the adverse initial determination shall be responsible for the initial steps of the appeal process. A contractor receiving a request for reconsideration of an initial determination not within its jurisdiction shall send the request to the correct contractor within five working days of receipt and shall notify the appealing party of this action. The contractor shall make no comments on the merits of an appeal not within its jurisdiction and shall direct the appealing party to send any further correspondence relating to the appeal to the appropriate contractor.

2.2 More Than One Jurisdiction

Appeals may be received involving more than one jurisdiction. For example, a case may involve services processed by both the outgoing contractor and the incoming contractor in a period of transition and will require separate review. The contractor receiving the appeal shall notify the appealing party that the services will be reviewed separately by the outgoing contractor and the incoming contractor. The notification shall also include the name and address of each contractor performing the reviews. The contractor shall photocopy the written appeal request, the notification to the appealing party of the referral, and other relevant information and forward the photocopies to the other contractor with an explanation of the action taken within 21 calendar days of the stamped date of receipt of the appeal in the mailroom.

information from the appealing party, and additional evidence/information submitted by the appealing party.

4.5.3.2.5 Claims related to the episode of care, with attachments (in chronological order with no duplicates).

4.5.3.2.6 EOB forms (in chronological order with no duplicates).

4.5.3.2.7 Medical records (in chronological order with no duplicates).

4.6 File Documentation For A Provider Termination Case

For file documentation requirements in provider termination cases, see [Chapter 13, Section 5](#).

5.0 APPEAL SUMMARY LOG

The contractor and the TQMC (when appropriate) shall complete the Appeal Summary Log ([Addendum A, Figure 12.A-2](#)).

6.0 NOTICE TO APPEALING PARTY OF RESULTS OF RECONSIDERATION

The contractor and the TQMC shall inform the appealing party (or the representative, if a representative has been appointed) of the reconsideration determination in writing in accordance with the timeliness standards set forth in [Sections 4](#) and [5](#). The reconsideration determination shall be typewritten or computer-printed in its entirety. At the request of the appealing party, a reconsideration determination may be sent by facsimile transmission or by electronic mail, followed by mailing of the determination by means of the USPS. All claims that relate to the same incident of care or the same type of service to the beneficiary shall be addressed in a single reconsideration determination. If the appealing party is a non-network participating provider, a copy of the reconsideration determination shall be furnished to the beneficiary. Conversely, the non-network participating providers shall be furnished copies of the determination if the beneficiary filed the appeal. The notice shall include a caption identifying:

- The beneficiary (including whether the beneficiary is Standard, an Extra user, or a Prime enrollee);
- The sponsor;
- The last four digits of sponsor's Social Security Number (SSN);
- The type of care (e.g., Residential Treatment Center (RTC) care, outpatient psychotherapy, mammography, substance abuse, dental, etc.);
- The date(s) of service, the date(s) of service in dispute;
- Whether the appeal was processed as a preauthorization, concurrent review, or retrospective review; and

- The providers (identifying each provider as network or non-network participating, or non-network nonparticipating).

The notice shall include the following headings:

6.1 Statement Of Issues

The contractor and the TQMC shall summarize the issue or issues under appeal and shall be clear and concise. All issues shall be addressed; for example, a reconsideration determination in all cases requiring preadmission authorization shall address the requirement for preadmission authorization of the care as well as whether the requirement was met.

6.2 Applicable Authority

The contractor and the TQMC shall briefly discuss the provision of law, regulation, TRICARE policy or TRICARE guidelines on which the determination was made. Include pertinent specific citations and quotations of applicable text. The contractor should omit authority that is not applicable to the case under review (e.g., when citing cosmetic surgery policy, the contractor need not include a listing of all procedures considered by TRICARE to constitute cosmetic surgery, but should quote only the procedure(s) applicable to the case under review).

6.3 Discussion

The contractor and the TQMC shall discuss the original and any added information relevant to the issue(s) under appeal, clearly and concisely, and shall state the patient's condition, including symptoms. Usually one or two paragraphs will suffice unless the issues are complex. The contractor and the TQMC shall include a discussion of any secondary issues raised by the appealing party or which may have been discovered during the reconsideration process.

6.4 Decision

The contractor and the TQMC shall state the decision and whether the reconsideration upholds or reverses the original decision in whole or in part, and clearly and concisely state the rationale for the decision; i.e., fully state the reasons that were the basis for the approval or denial of TRICARE benefits. If applicable TRICARE criteria must be met, the patient's medical condition must be related to each criterion and a finding made concerning whether each criterion is met. The contractor and the TQMC shall state the amount in dispute remaining as a result of the decision and how the amount in dispute was determined (calculated). Also state whether payments are to be recouped.

6.5 Waiver Of Liability

Waiver of Liability provisions are only applicable to denials as described in [Section 4](#). For applicable cases, the contractor and the TQMC shall include a statement explaining waiver of liability determination as applied to the beneficiary and to each provider, including the rationale for each decision. A beneficiary found not to be liable for the entire Episode Of Care (EOC) will not be offered further appeal rights. Refer to the TPM, [Chapter 1, Section 4.1](#) for information relating to waiver of liability.

Appeal Of Factual (Non-Medical Necessity) Determinations

The contractor shall provide for an appeal system allowing full opportunity for proper appealing parties to appeal adverse factual determinations. Factual determinations are issued in cases involving: coverage issues, provider authorization (status) requests, hospice care, foreign claims, denials based on sections other than [32 CFR 199.4](#), and both medical necessity and factual determinations. Medical or peer review may be necessary to reach a factual determination; e.g., for advice on whether regulation or policy criteria are met. Waiver of liability is not applicable.

1.0 INITIAL DETERMINATION

An initial factual determination is a written decision that is other than a medical necessity determination under [Section 4](#). For further information relating to initial determinations, refer to [Section 1, paragraph 3.1](#). The initial denial determination is final and binding unless the initial determination is reversed by the contractor or revised upon appeal.

2.0 TIME LIMIT

A request for reconsideration must be filed by the appealing party within 90 calendar days after the date of the notice of the initial denial determination. The contractor shall complete the review and issue its reconsideration determination to all parties within 60 calendar days after the date of receipt of the reconsideration request.

3.0 NOTICE

The contractor shall issue a written reconsideration determination. Refer to [Section 3, paragraph 6.0](#) for the required content of the notice to the appealing party of the results of the reconsideration determination.

4.0 RECORD

Refer to [Section 3, paragraph 9.0](#) for the record of the factual reconsideration determination to be maintained by the contractor.

5.0 EXAMPLES OF FACTUAL DETERMINATIONS

5.1 Determinations Related To Coverage Issues

Denial determinations based on coverage limitations contained in 32 CFR 199, the TRICARE Policy Manual (TPM), and other TRICARE guidance, are considered factual determinations. If it is determined that a service or supply is covered, but is not medically necessary, at an inappropriate level of care, is custodial care or other reasons relative to reasonableness, necessity or appropriateness, the denial will be a medical necessity determination under [Section 4](#) (see Example

1). The following are examples of denials based on coverage limitations:

Example 1: A woman received an abortion and although the services were found to be medically necessary (i.e., generally accepted by qualified professionals to be reasonable and adequate for the treatment of her condition), the coverage criteria set forth in the TPM were not met. Although the care was determined to be medically necessary, since the coverage criteria were not met, benefits must be disallowed and appeal rights offered under this section. (Note: If the facts were reversed such that coverage criteria were met but the care was found not to be medically necessary, benefits would be disallowed and appeal rights offered under the [Section 4](#).)

Example 2: Payment is denied for surgical evacuation of hematomas following removal of breast implants from a previous noncovered augmentation mammoplasty because the beneficiary's hematomas do not constitute a separate medical condition under [32 CFR 199.4\(e\)\(9\)](#). Removal of the hematomas is medically necessary, but the denial is based on a coverage limitation because the complication is not a separate medical condition from the noncovered augmentation mammoplasty. This is an example of a case where medical review may be required to determine whether regulation or policy criteria are met. Notwithstanding the necessity for involvement of a medical reviewer, because the denial is based on a coverage limitation, a factual determination results that is appealable to a formal review conducted by the [Defense Health Agency \(DHA\) Appeals and Hearings Division](#).

5.2 Termination Of A Provider

Contractor requirements for terminating a provider's status as a TRICARE-authorized provider are found in [Chapter 13, Section 5, paragraph 4.2](#). Under [32 CFR 199.10\(c\)](#) and [\(d\)](#), an initial determination issued by the contractor terminating a provider is appealed directly to a hearing conducted by the [DHA Appeals and Hearings Division](#).

5.3 Provider Status

An initial determination denying a provider's request for approval as an authorized TRICARE provider is a factual determination. Under [32 CFR 199.10\(c\)](#), a reconsideration determination issued by the contractor denying a provider's request for approval as an authorized TRICARE provider is appealable to a formal review conducted by the [DHA Appeals and Hearings Division](#).

5.4 Hospice Care

An initial determination denying hospice care is a factual determination. Under [32 CFR 199.4\(e\)\(19\)\(vii\)](#), a beneficiary or provider is entitled to appeal rights for cases involving a denial of hospice care benefits in accordance with the provisions of [32 CFR 199.10](#). An adverse reconsideration determination issued by the contractor denying TRICARE cost-sharing for hospice care is appealed to a formal review conducted by the [DHA Appeals and Hearings Division](#).

5.5 Circumvention Of The TRICARE DRG System

A hospital dissatisfied with a determination regarding circumvention of the TRICARE Diagnostic Related Group (DRG) system may obtain a reconsideration. Circumvention is defined as

Chapter 13

Program Integrity

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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, 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 corresponding Contract Data Requirements List (CDRL) DD Form 1423 provides details on the contents and submission of the strategy and internal procedures, to include the published corporate strategy.**

1.2 Program integrity is a contractor responsibility to ensure that necessary medical, pharmacy, and dental services are provided only to eligible beneficiaries by authorized providers or reimbursement made to eligible beneficiaries or providers under existing law, Regulation and **Defense Health Agency (DHA)** 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 **DHA** Office of General Counsel (OGC) and **DHA** PI.

1.3 Use Of Anti-Fraud Analytics/Software

Contractor shall perform analyses of professional and institutional health care data associated with type, frequency, duration and extent of services, to identify patterns of fraudulent or abusive practices by providers and/or beneficiaries. Commercial anti-fraud software designed for such purposes, or upon approval of the **DHA** PI, the contractor's own **predictive analytics and fraud detection** program(s) will be used. Software must **have fraud detection analytics, predictive modeling, and statistical algorithm capabilities, along with the ability** to produce comprehensive fraud detection reports. The application must be on-line and accessible by the contractor's Program Integrity Unit fraud specialists and **available to** be used on a daily basis. This **paragraph** is not applicable to the TRICARE Dual Eligibility Fiscal Intermediary Contract (TDEFIC).

1.4 Anti-Fraud Support

1.4.1 Technical and professional consultation and information shall be provided by the contractor (to include documentation) as directed by DHA PI concerning:

- Delivery of health care services in the Continental United States (CONUS), and/or Outside of the Continental United States (OCONUS) when applicable;
- Submission, adjudication and reimbursement of claims for health care services, pharmacy or dental services;
- TRICARE operations and benefits;
- Anti-fraud activities.

1.4.2 Investigative and prosecutive support shall be provided by the contractor to include documents, reports, correspondence, and other applicable data or items.

1.4.3 Documents, reports, correspondence, and other applicable data or items shall be provided by the contractor in support of compliance monitoring, oversight activities, or other program integrity related issues.

1.4.4 Case specific data required during development and investigative process shall be provided by the contractor (i.e., initiated by contractor, law enforcement, Department of Justice (DOJ), or DHA PI).

1.4.5 At DHA PI's request, the contractor must identify and provide expert(s) or program witness(es) at Grand Jury hearings, criminal trials, civil hearings/depositions and administrative hearings. An expert witness is an individual having acquired a special skill or knowledge through training or experience on a particular subject being discussed. In addition, the type of expert witness that is covered by this section is either an individual including a PI specialist who worked on the case or an expert in PI functions who could testify as to the PI issues involved in the case. This also includes medical experts if medical experts were used in the case development. A prosecutor or defense attorney may request that a witness be declared an "expert witness" based on their knowledge, such as someone from the policy department or the contractor's claims processing section. Travel and per diem costs of witnesses subpoenaed by DOJ will be paid by DOJ in accordance with Federal guidelines.

1.4.6 Claims data shall be provided by the contractor in customary electronic format/media compliant with the Health Insurance Portability and Accountability Act (HIPAA). Other documentation or data to be provided may include, but is not limited to, the original or copies of claims, explanations of benefits, original or copies of checks (front and back), provider certification forms, correspondence, medical records, audit records/findings, or any other relevant information as requested (such as documents from other offices/units). The contractor shall have dedicated personnel and resources available to meet the timeliness requirement as directed by DHA PI for retrieval, transmission, and/or mailing of the information.

1.4.7 The contractor shall ensure compliance with the Alcohol, Drug Abuse and Mental Health Administration (ADAMHA) Reorganization Act, Public Law 102-321 (July 10, 1992) and

implementing regulations including 42 CFR Part 2, when data requested includes services related to substance abuse or mental health.

1.5 Standard Operating Procedures

The contractor shall develop and maintain standard operating procedures related to requirements/activities within this chapter (e.g., desk procedures). A copy, in electronic read-only format, shall be provided to DHA PI at the start of the contract with updates provided as changes occur. The corresponding CDRL, DD Form 1423 provides details on the contents and submission of this report.

2.0 ROLES AND RESPONSIBILITIES OF COOPERATING COMPONENTS

2.1 DHA

The Director, DHA, and designees administer the TRICARE program in accordance with Title 10, Chapter 55, United States Code (USC), "Medical and Dental Care," 32 CFR 199, and other applicable laws, regulations, directives and instructions.

2.2 DHA PI

DHA PI is responsible for anti-fraud and abuse activities to protect benefit dollars and safeguard eligible beneficiaries. DHA PI is the central coordinating office for allegations of fraud and abuse against the TRICARE program and is responsible for developing and executing anti-fraud and abuse policies and procedures, overseeing contractor program integrity activities, supporting investigations, developing cases for civil prosecution and civil litigation, and initiating administrative measures. DHA PI also exchanges information with DOJ, law enforcement agencies, and federal/state agencies.

2.3 DHA OGC

DHA OGC is responsible for providing legal counsel and legal services to DHA. It is the principal point of contact on all legal matters involving the DOJ and its Federal Bureau of Investigation (FBI). This office serves as DOJ's primary contact point in civil litigation involving benefit funds. DHA OGC is also responsible for actions pursued under the Program Fraud Civil Remedies Act (PFCRA) and, in developing or pursuing a PFCRA. Settlements that affect the agency (e.g., civil settlement, a provider's or pharmacy's TRICARE status, sanctions, etc/) must be coordinated with and approved by a DHA representative.

2.4 Department Of Defense Inspector General (DoDIG)

DoDIG has the responsibility to conduct, supervise, monitor, and initiate investigations relating to fraud within the DoD. This authority specifically includes DHA, its employees, contractors and subcontractors. This authority is not limited by the type of contract which has been entered into by the Director, DHA. All contractor, managed care, consultant, service, and other types of contracts are subject to the audit, investigation and evaluation authority of the DoDIG.

2.5 Defense Criminal Investigative Service (DCIS) Of The DoDIG

DCIS is responsible for all fraud and/or abuse investigations involving the Secretary of Defense, the Office of the Joint Chiefs of Staff (JCOS), the Defense Agencies (including the DHA), and any other fraud investigation deemed appropriate by the DoDIG or designated representative. This includes cases that may involve the use of facilities by medical providers on military installations and managed care cases (to include network providers or network pharmacies).

2.6 Military Criminal Investigation Organizations (MCIOs)

The MCIOs include the United States Army Criminal Investigative Division (USACID), Naval Criminal Investigative Service (NCIS), United States Air Force Office of Special Investigations (AFOSI), United States Coast Guard Investigations and Health and Human Services Inspector General's Office (for the United States Public Health Service (USPHS)). The MCIOs have jurisdiction to investigate cases concerning alleged fraud by active duty military service members and their family members, and retired service members and their family members, who have received health care services.

2.7 Defense Contract Audit Agency (DCAA)

Upon request, the DCAA provides audit assistance to DHA DCIS and MCIOs.

2.8 DOJ And United States Attorneys' Offices (USAO)

The DOJ, acting through its Civil and Criminal Divisions, and the USAO have responsibility for litigation and prosecution of cases involving violation of the civil and criminal laws of the United States. DOJ has jurisdiction for federal, criminal, and civil action.

2.9 FBI

The FBI is the principal investigative arm of the DOJ. It has primary responsibility for investigating federal employee bribery and conflict of interest cases and other violations of Federal law except those that have been assigned by law or otherwise to another Federal agency. In addition, it has the authority to investigate Federal agencies, Federal contractors, and Federal program fraud such as the submission of fraudulent TRICARE claims.

3.0 COORDINATION AND SUPPORT: OTHER CONTRACTORS AND EXTERNAL AGENCIES

3.1 Contractor Coordination With Other TRICARE Contractors

3.1.1 Contractors shall coordinate their activities and case data with other TRICARE contractors since potential fraud or abuse involving a provider, pharmacy, or beneficiary could have a direct effect on payments made by another contractor. This shall occur during the initial stages of case development. The contractor PI unit who initiates the case shall contact the other contractor PI unit for exposure. The initiating contractor PI unit shall provide the other contractor PI unit with the fraud/abuse scheme, name of provider (s) to include practice name, Tax Identification Numbers (TINs), National Provider Identifier (NPI), or National Council for Prescription Drug Programs (NCPDP) provider Identification and date range so research may be conducted. DHA PI shall be informed in the case report of these contacts and findings if suspected practice is a pattern among

national or regional chains. Findings of potential fraud or abuse by another contractor shall be reported to the **DHA** PI by the contractor which initiated the investigation.

3.1.2 In any situation which could lead to duplicate investigative efforts, the contractors involved must notify **DHA** PI for the proper coordination. **Joint case referrals shall be submitted by the contractor that initiated the case first. Each contractor with exposure shall conduct an independent audit; however, all findings shall be submitted by the initiating contractor PI unit.**

3.1.3 Those issues that cannot be resolved at the operational level between the contractors shall be elevated to **DHA** PI for resolution.

3.2 Contractor Coordination And Support With DOJ, USAO, And Investigative Agencies

3.2.1 Requests for health care fraud and abuse information by DOJ and DCIS must be referred to **DHA** PI. Contractor contact by any investigative agency, e.g., FBI, MCIOs, etc., shall also be reported immediately to **DHA** PI. The contractor may not release any documents or copies of documents, conduct audits, etc., at the request of any individual or agency without direction from **DHA** PI. (This includes requests from all other entities, including anti-fraud associations.) 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.

3.2.2 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 **DHA** PI. All requests for claims histories, medical and other records, regulatory/manual provisions, correspondence, audits and other documentation (e.g., newsletters, claims, checks, etc.) 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.

- END -

Controls, Education, And Conflict Of Interest

1.0 CONTROLS

1.1 Controls For The Prevention And Detection Of Fraudulent Or Abusive Practices

The contractor shall establish procedures and utilize controls 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. Controls shall include the following (and be made available to Defense Health Agency (DHA) Program Integrity Office (PI)):

- Eligibility verifications for beneficiaries and providers/pharmacies;
- Coordination of benefits;
- Prepayment edits (e.g., applied to program exclusions and limitations); (See also, Section 3, paragraph 7.4.2.)
- Utilization of discretionary or coordinated placement of providers/beneficiaries on prepayment review;
- 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;
- Incorporate anti-fraud attestation language whenever/wherever practical (e.g., claim forms, network agreements, electronic claims submission agreements);
- Utilization of Fraudlines/hotlines;
- Prepayment duplicate screening;
- Postpayment duplicate screening;
- Verification of provider status (e.g., credentials, licensure) to include appropriate termination action when findings/recommendations of boards, etc. results in loss or suspension of licensure or certification;
- Program integrity targeted measures (e.g., prepay anti-fraud review; use of post payment fraud detection software; routine anti-fraud data mining; investigative anti-fraud auditing; select provider/beneficiary education);

- Specific to pharmacy, controls include comparing reversal rates; excessive partial fill submissions; high use patients; review of outliers; codes with medication therapy for high ingredient costs; claims with high average ingredient cost; review of brand/generic fill rates; top pharmacies per generic code rate; controlled substance prescription rates; and ability to conduct on-site audits of pharmacies who meet these indicators and ability to review/perform on-site audits of top one percent of providers who meet these indicators.

1.2 Claim/Encounter Review Procedures And Controls

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

1.2.2 Utilizing information derived on a monthly basis by the contractor from the Defense Manpower Data Center (DMDC) Claims Reprocessing Report, the contractor shall identify beneficiaries accessing care after their eligibility was terminated. The contractor shall initiate action to recoup funds paid for services to beneficiaries who were not eligible and report those actions on the Quarterly Eligibility Status Report to DHA PI. The contractor shall refer only those individual beneficiary cases that involve more than the threshold as stated in Section C of the contract.

1.3 Beneficiary And Provider Flags

The contractor must have the capability for automated flagging of specific providers of care, pharmacies, and TRICARE beneficiaries for prepayment or postpayment review when fraud, overutilization or other abuses are known or suspected.

2.0 EDUCATION

2.1 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 DHA PI. The contractor shall provide desk procedures to the staff which include methods for control of claims/encounters exhibiting unusual patterns of care, over or under utilization of services, or other practices which may indicate fraud or abuse and shall include specific criteria for referral of cases to professional or supervisory review concerning issues with patterns of care, abnormal utilization practices, or suspect billing practices. Copies of desk procedures (along with revisions/changes) shall be made available to DHA PI.

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

2.3 Cost-Share/Copayment Collection Questionable

2.3.1 32 CFR 199.4 sets forth the financial liability of the TRICARE beneficiary for cost-shares and deductibles. This regulatory requirement is derived from the statutory requirements of 10 United States Code (USC) 1079 and 1086.

2.3.2 The contractor shall establish procedures for detecting providers (to include network providers) who waive cost-shares. Possible methods for detection of the waiver of cost-shares/copayments 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.

2.3.3 When the contractor identifies a provider who waived a cost-share/copayment, the contractor shall send written notice educating the provider that: such action is not allowed and explain the law governing the collection of cost-shares/copayments; payments may be reduced if reasonable efforts are not made to collect the cost-share; and he/she may be suspended as an authorized TRICARE provider if corrective action is not taken. See [Section 3](#) for referral protocols, if referral is warranted.

2.3.4 Refer to the TRICARE Reimbursement Manual (TRM), [Chapter 2, Section 1](#) for exceptions to the cost-share collection requirement and/or deductibles. In addition, the collection of cost sharing amounts is optional under the TRICARE Hospice Benefit (TRM, [Chapter 11, Section 4](#)).

2.4 Violation Of Participation Agreement Of Reimbursement Limitation

2.4.1 Network providers must participate (accept assignment) on all claims. Non-network providers are not required to participate in TRICARE, or on a claim submitted to TRICARE by the provider or beneficiary, shall be subject to Federal law covering reimbursement limitations.

2.4.2 Non-network providers may agree to participate on a claim by claim basis; however, once a provider elects to participate (e.g., accept assignment) they may not change such election on that claim and may not collect from a beneficiary more than the TRICARE maximum allowable charge, less co-payment, or cost share. Attempts to collect more than the TRICARE allowable amount would be considered a violation of the participation agreement election.

2.4.3 A breach of a participation agreement and/or billing in excess of the reimbursement limitation amount as provided by Congress as part of the Department of Defense (DoD) Appropriations Act, 1993, is considered abuse and/or fraud under authority of 10 USC 1079(h)(4). If a violation of network agreement warrants a referral to DHA PI, see [Section 3](#). Also, refer to the TRM, [Chapter 3, Section 1](#).

2.5 Balance Billing Limitations

Non-participating providers may not collect an amount which exceeds the balance billing limit of 115% the TRICARE allowed charge. Balance billing is defined as billing a beneficiary the difference between 115% of TRICARE allowed amount and the billed charges on a claim, less the copay or cost share. Billing in excess of this reimbursement limitation amount as provided by Congress as part of the DoD Appropriations Act, 1993, is considered abuse and/or fraud under 10 USC 1079(h)(4). If a violation warrants a referral to DHA PI, see [Section 3](#).

2.6 Contractor Development Of Violation Of Participation Agreement Or Balance Billing Limitation

2.6.1 The contractor is responsible for ensuring that providers adhere to their participation and non-participation agreements and the associated reimbursement limitation. Corrective action is required for a provider who submits participating or non-participating claims but does not comply with the agreement to accept the allowable charge as full payment for the service, as determined by the contractor, or who violates the 115% reimbursement limitations. 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.

2.6.2 Institutional violation letters must be sent by name to the hospital administrator. The contractor shall obtain 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. A letter to a non-institutional provider must 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 contractor shall obtain a copy of the zero balance statement to verify that the issue has been resolved. In a violation of a participation agreement or a 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. (See [Addendum A, Figure 13.A-1, Figure 13.A-2, Figure 13.A-3, and Figure 13.A-4](#)).

2.6.3 If after two notices a provider refuses to make refunds, continues to violate participation agreements or reimbursement limitations, or brings suit against a beneficiary who refuses to pay the amount of the reduction, the contractor shall bring the matter to the immediate attention of DHA 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.

2.6.4 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)).

2.7 Waiver of CHAMPUS Maximum Allowable Charge (CMAC)

As outlined in 32 CFR 199.7(a), the Director, TRICARE, or a designee, is responsible for ensuring that the benefits under TRICARE are paid to the extent described. The balance billing limit may be waived by the Director or a designee, on a case-by-case basis if requested by a TRICARE beneficiary in advance. Providers may not make this request. Any request submitted by a beneficiary must be prior to the date of service, identify the name of the provider, date of service, the specific procedure being performed, and an itemized cost of the service(s). A decision by the Director, or a designee, to waive or not waive the limit in a particular case is not subject to the appeal and hearing procedures of 32 CFR 199.10.

3.0 CONFLICT OF INTEREST

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

3.1 Federal Employees And Active Duty Military

32 CFR 199.6 prohibits active duty members of the Uniformed Services or employees (including part-time or intermittent), appointed in the civil service of the U.S. Government, from authorized TRICARE provider status. This prohibition applies to TRICARE payments for care furnished to TRICARE beneficiaries by active duty members of the Uniformed Services or civilian employees of the government. The prohibition does not apply to individuals under contract to the Uniformed Services or the Government.

3.2 Exceptions

3.2.1 National Health Service Corps (NHSC)

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

3.2.2 Emergency Rooms

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

3.2.3 Reserves Generally Exempt

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

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

Refer to [Chapter 4, Section 1, paragraph 3.0](#).

3.2.5 Referrals From Uniformed Services Facilities

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

- END -

Case Development And Action

1.0 INITIAL IDENTIFICATION

The contractor shall have an operational procedure for identifying and developing reported cases of potential fraud or abuse. Cases of potential fraud or abuse are identified both proactively and from reports made by external sources.

1.1 Proactive identification measures include:

- Processing Edits
- PrePay Review
- PostPay Review
- Proactive Research
- Information Sharing
- Anti-Fraud Data Mining

1.2 External identification sources include:

- Beneficiary Complaints/Tips
- Provider Complaints/Tips
- Concerned Individual Complaints/Tips
- Leads
- Law Enforcement Referrals
- Contractor Hotline
- **Defense Health Agency (DHA)** (e.g., initiated by **DHA** Program Integrity Office (PI))

2.0 INITIAL ANALYSIS

The contractor shall have an operational procedure for analyzing cases of potential fraud or abuse which includes, at a minimum, the following actions.

- When an allegation of fraud or abuse **is received** or when a potentially fraudulent situation is first identified, review the **allegation/issues** to eliminate obvious billing or claims/encounter processing errors.
- **Review** shall be restricted to an examination of the internal processing of the claims/encounter to identify possible sources of any **administrative** error.
- **The Contract Data Requirements List (CDRL) "Defense Health Agency (DHA)/Military Treatment Facility (MTF) Fraud and Abuse Referral Cover Sheet"** shall be completed to establish a case file.

- If it is established that a complaint received from any source was due to a claims processing error or administrative error, the error shall be corrected. The contractor shall then close out the allegation/issue and notify the complainant, subject to disclosure of information guidelines (Privacy Act, Health Insurance Portability and Accountability Act (HIPAA)), of their findings (in compliance with the privacy requirements covered in Chapter 1, Section 5 and Chapter 19, Section 3), and clearly document the reason for the closure.
- After possible internal processing errors have been ruled out, track the allegation/issue on a management reporting system and proceed to develop the allegation/issue. Identify when the aberrant billings started (such as, when the claims were initially denied as noncovered). Review prior educational efforts, warnings, recoupments, case referrals and sanctions in regards to the case.
- In suspected cases of fraud/abuse being developed for referral, do not initiate administrative action.
- For purposes of this and other sections of this chapter, a provider meets the definition under 32 CFR 199.2.

3.0 CASE DEVELOPMENT AUDITS

3.1 General

3.1.1 Audits are performed to examine and verify the accuracy of claims. The type of audit appropriate for the particular circumstances of any individual case will vary.

3.1.2 Medical Necessity Audits for Medical or mental Health Claims

Medical necessity audits must be performed by a Registered Nurse (RN), or equally qualified medically trained professional, who can make medical judgments based on professional education and experience. This means RNs or qualified Physician's Assistants (PAs) for medical claims. A qualified Licensed Vocational Nurse (LVN), working directly under the close supervision of an RN or PA, may be used, if the contractor submits the LVN's full resume and a detailed scope of authority and responsibility to the Contracting Officer's Representative (COR) for approval before the LVN assumes a medical review role. **For mental health claims, a clinical psychologist, psychiatric nurse practitioner, a psychiatrist or an equally qualified professional shall perform the audit.**

3.1.3 These personnel must have a thorough knowledge of **TRICARE regulatory provisions, policy, and standards.** The reviewer shall document, in detail, the rationale for the audit findings. The review must be dated and include the clinical specialty **and qualifications** of the reviewer and the signature (not initials) and the legibly printed name of the reviewer. Claims that the reviewer cannot make a determination on shall be referred to the contractor's medical staff or an external consultant. Use of medical staff and/or consultants is expected and required not only for initial reviews but postpayment analyses and audit requests from **DHA PI.** Whenever the case is complex, physicians **or** consultants with a specialty appropriate to the case, shall be involved in the review. Other types of audits shall be performed to suit the allegations or aberrant billing practices such as probe, non-invasive, Episode Of Care (EOC), or calendar **and are left up to the determination of the**

contractor. This shall include also utilizing other investigative techniques such as license verification and Internet research.

3.1.4 Prescription Records Audit For Pharmacy Claims/Pharmacy Claims Audit

Audits must be performed by a qualified trained professional, who can make judgments based on professional education and experience such as a certified pharmacy technician, a pharmacist, Doctor of Pharmacy or an equally qualified trained professional. These personnel must have a thorough knowledge of TRICARE regulatory provisions, applicable contract policy and standards. The reviewer shall document, in detail, the rationale for the audit findings. The review must be dated and include the clinical specialty and qualifications of the reviewer and the signature (not initials) and the legibly printed name of the reviewer. Claims that the reviewer cannot make a determination on shall be referred to the contractor's pharmacy staff (or if available, medical staff) or an external consultant. Use of pharmacy staff and/or consultants is expected and required not only for initial reviews but postpayment analyses and audit requests from DHA PI. Other types of audits shall be performed to suit the allegations or aberrant billing practices such as probe, non-invasive, etc. This shall also include utilizing other investigative techniques such as performing purchase verification, license verification, and Internet research.

3.1.5 Dental Necessity Audits For Dental Claims.

Dental necessity audits must be performed by a qualified trained professional, who can make judgments based on professional education and experience such as a certified dental technician, a dentist, or an equally qualified trained professional. These personnel must have a thorough knowledge of TRICARE regulatory provisions, applicable contract policy and standards. The reviewer shall document, in detail, the rationale for the audit findings. The review must be dated and include the clinical specialty and qualifications of the reviewer and the signature (not initials) and the legibly printed name of the reviewer. Claims that the reviewer cannot make a determination on shall be referred to the contractor's dental staff or an external consultant. Use of dental staff and/or consultants is expected and required not only for initial reviews but postpayment analyses and audit requests from DHA PI. Other types of audits shall be performed to suit the allegations or aberrant billing practices such as probe, non-invasive, EOC, etc. This shall also include utilizing other investigative techniques such as license verification, and Internet research.

3.2 Common Audit Methodologies

3.2.1 Probe Sample 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 probe sample audit are not statistically valid and therefore they may not be extrapolated to the rest of the claims universe, so probe audits should be used sparingly. The results of the probe sample audit may trigger the need for the contractor to perform a Statistically Valid Random Sample (SVRS) audit or a 100% audit.

3.2.2 Statistically Valid Random Sample (SVRS)

3.2.2.1 Once the claims universe has been focused and analyzed to determine the sampling plan and methodology to be performed, a SVRS (or samples of multiple strata) may be required. The selection of each SVRS utilizes a 90% confidence level, plus or minus 10% with a 50% occurrence

rate and shall be randomly selected from the claims history arrayed in claim 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, Figure 13.A-5 provides guidance concerning selection of samples, calculating overpayments, testing the validity of the sample(s) by calculation of the standard deviation of the sample(s) and standard error of the mean(s). 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. Prior to the selection of the SVRS, the claims universe shall also be properly focused and analyzed to determine the sampling plan and methodology. Focusing the universe is performed by targeting specific claims which match the approach and/or allegations of the case, and removing unnecessary low dollar claims. The overall sampling plan and methodology may include a stratified sampling approach consisting of one or more SVRS and/or 100% claims audit(s).

3.2.2.2 In a stratified sample, stratification of the claims universe will divide the universe into multiple strata (which may include 2, 3, 4, or even more separate groups of claims). Stratification is typically required when the claims universe includes multiple categories of claims (such as Medical and Surgical claims) and/or if the claim paid amounts are spread across a large dollar range. Each of the strata may be audited as a SVRS or as a 100% audit, depending on the specifics of each stratum. For assistance with stratification, consult with DHA PI and/or a qualified statistician. 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

A 100% claims audit may need to be performed in a number of circumstances. Situations may include a small stratum of high dollar claims which should be audited at 100% as part of stratified sampling approach. Alternatively, even lower dollar claims may need to be audited at 100% if the claims are not similar (in terms of procedure, paid amount, and/or other characteristics) to a large group of other claims in the universe.

Note: In the vast majority of cases, the unit to be statistically sampled is the entire claim (which includes all paid line-items). Occasionally, circumstances dictate that each sampled beneficiary's entire EOC should be reviewed as part of the audit. In this case, there are ways of auditing the beneficiary's EOC while still using the claim as the sampling unit, and specifics of this approach shall be discussed with DHA PI prior to selecting the sample(s). In other unusual circumstances, a probe sample audit may be required (i.e., an audit that is not statistically valid). A statistically valid sample may or may not follow the probe sample audit.

3.2.4 External Audit

A secondary method of determining probable fraudulent practices is to **conduct a verification of services with** beneficiaries. This may be used to supplement a claims audit method, and shall address 100% of the beneficiaries who received services from a provider within a recent period of no more than one year. If the provider is seeing more than 50 beneficiaries for which claims have been submitted, a systematic sample may be used (e.g., an interval of every fifth, 10th, etc., claim). Generally, no less than 50 verification letters shall be sent. In cases where the beneficiary has altered a bill, an external audit to the provider shall be conducted. A suspense period for responses to the verification letters should be 30 days, with a follow-up either written, or by phone on 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 findings shall include the DHA PI Random Sample Audit Worksheet for each statistically valid random sample performed. The corresponding CDRL, DD Form 1423 provides details on the contents and submission of this report. The supporting 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 audit worksheet(s) (e.g., overpayment summary by claim line/audit summary report, extrapolation/sample verification spreadsheet, etc.). Individual file folders, labeled with identifying information, shall be generated as appropriate and must contain all applicable documentation/data required to support the audit finding, which will include but not be limited to: claim copy, explanation of benefits, individual audit sheets, evaluation and management score sheet, medical record documentation reviewed by the auditor, etc.

4.0 CASE DEVELOPMENT/ACTION

4.1 The contractor shall develop the case to determine the probable method of fraud/abuse and potential dollar value of the case.

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

4.3 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 shall be conducted, if necessary, by the appropriate Government investigative agency. However, the contractor may contact beneficiaries and/or providers to obtain information during the course of their case development. For example, when performing a beneficiary inquiry (survey), the contractor may contact the beneficiary to confirm receipt or clarify response(s). When contacting a provider's office during the audit process to confirm receipt of the medical records request, the contractor may ask for clarification of the forms utilized or clarify the types of medical records being requested. Providers/beneficiaries may be contacted for standard business purposes (e.g., prior authorizations, etc.).

5.0 DHA 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 DHA PI.

5.2 The contractor has up to 180 days, after identification of potential fraud and/or abuse, to develop a case for referral (administrative errors have been ruled out). The 180 day clock starts at the point where an investigation in which alleged fraud/abuse has been substantiated to such an extent it appears to be a candidate for referral to DHA PI. 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 DHA PI Chief of Investigations Oversight or designee.

5.3 The contractor PI unit bears the responsibility for documenting in the referral the start of the 180 day clock.

5.4 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 DHA PI in accordance with the procedures in this chapter.

5.5 The contractor shall refer to DHA cases determined on review to support allegations of fraud/abuse that meet 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.

5.6 Cases determined on review to support allegations of fraud/abuse that fall below the threshold as stated in Section C of the contract without patient harm should not be referred to DHA PI. See paragraph 7.0 for further guidance.

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.

6.0 FRAUD AND ABUSE CASE REFERRAL CONTENT

6.1 General

DHA PI will evaluate each referred case in accordance with DHA PI criteria as outlined on the Case Referral Evaluation form. Each case referred to DHA PI by the contractor shall be submitted in duplicate. The contractor shall provide complete copies of any case files DHA 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:

- Allegations citing all the applicable TRICARE regulatory provisions that have been violated in regards to each allegation.
- 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.

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- 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 **clear summary** of 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.
- All action taken during developmental stage, to include contacts made, information obtained, potential problematic issues, etc.
- Estimate the number of claims or encounters, the length of time the suspicious behavior has occurred and the government's and contractor's loss.
- 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.
- 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.
- Previous and/or ongoing administrative measures (educational efforts, prepay review, etc.).
- 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.
- 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 (DHA PI has the option to request supporting documentation in either paper or electronic media):

- A completed DHA/MTF Fraud and Abuse Referral Cover Sheet; the corresponding CDRL, DD Form 1423 provides details on the contents and submission of this report.
- Applicable TRICARE regulatory provisions violated or if applicable, contractual requirements violated;

- 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;
- A history covering the most recent 24 month period (or the identified period of time, if longer than 24 months) in a DHA PI approved format (paper or electronic media). Electronic media shall be in a format approved by DHA PI and will be provided on two CD ROMs;
- Any relevant documents, 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;
- Contractor audits on the suspected provider, pharmacy or beneficiary. Audits shall include a summary spreadsheet that clearly identifies the audit parameters, the findings for each beneficiary audited (or claim, depending on how the audit is set up), and totals all applicable columns. Each beneficiary's claim(s) and supporting documentation shall be filed in a separate folder which clearly identifies, by last name, the beneficiary and sponsor's SSN. Each folder shall contain the contractor's individual audit sheet for those claims.
- Relevant procedure codes, revenue codes, etc;
- Supporting documents shall be provided/translated in English should the case referral be from a foreign country.

7.0 CONTRACTOR ADMINISTRATIVE ACTIONS

7.1 The contractor shall take administrative action under the following circumstances:

- The total number of claims/encounters involved is less than 25 and the total potential loss to the contractor or government for the claims is less than the threshold as stated in Section C of the contract without patient harm. The time period for the claims involved is 12 or more months.
- Case does not meet referral threshold as stated in Section C of the contract without patient harm;
- The contractor has received a written declination from the government for the case.
- Referring a case to local/state authorities if declined by DCIS, other federal law enforcement entities, returned by DHA PI, or is below the threshold as stated in Section C of the contract without patient harm.

7.2 The contractor's required administrative actions for cases shall routinely include:

- Removal from the preferred provider network;
- Educating the beneficiary/provider;

- Placing the beneficiary or provider on prepayment review;
- Placing the beneficiary or provider on postpayment review;
- Initiating recoupment action on actual damages determined as a result of billing errors identified in a statistically random sample audit.

A record of the action taken by the contractor must be completed and retained by the contractor and be made available to DHA PI upon request.

7.3 The contractor shall not **unilaterally** take administrative action (including quality interventions) **and must obtain DHA PI** approval under the following circumstances:

- The case has been identified for referral to **DHA PI**;
- The case has been referred to **DHA PI**;
- The case is under active law enforcement investigation (federal, state or local);
- The case is being prosecuted criminally or civilly **litigated**.

7.4 Administrative Measures Routinely Implemented

7.4.1 Educational Efforts

Beneficiaries and providers may be **issued** education letters when inappropriate behavior is identified. Education letters provide guidance on how to bill correctly and warn of the penalty for filing false claims and describing the inappropriate behavior (for example, an education letter advising a provider that a billing agency may not include its administrative costs when submitting claims to TRICARE). If the inappropriate behavior continues after education efforts are made the mere fact that education was provided strengthens a potential case for future referral to an investigative agency.

7.4.2 Prepayment Review

Providers/beneficiaries with atypical **or aberrant** billing patterns or with a particular problem (e.g., errors in billing of a specific type of service, **personal information compromised, etc.**) in submitting correct claims may be placed on prepayment review. Once on prepayment review their claims are subjected to review along with any medical and dental records and other supporting documentation to verify that the claims are free of billing problems. When medical records are requested, the provider must submit them within the specified time frame or the claim(s) will be denied. Generally, once a provider/beneficiary has been placed on prepay review monitoring they typically remain on prepay review monitoring for a period of one year. If the provider/beneficiary ceases the aberrant practices the provider/beneficiary is removed from prepayment review. However, if aberrant practices continue the provider/beneficiary shall remain on prepayment monitoring **for a longer period of time**. If a provider or beneficiary is placed on prepayment review before the contractor determines the case is appropriate for **DHA PI** referral the provider/beneficiary should not be removed from prepayment review. However, in the case referral summary the contractor shall indicate that the provider/beneficiary has been placed on prepay

review and when that administrative measure was initiated.

7.4.3 Recoupment Action/Offsets

Recoupment action/offsets should be taken on any monies paid in error. Recoupment action/offset should be taken in accordance with [Chapter 10](#). Re-evaluate the providers in six months to a year to determine if the aberrant billing practices have been discontinued. If they have not, take action in accordance with this Chapter. See [32 CFR 199.11](#).

7.4.4 Postpayment Review

Postpayment review of claims is a review of claims after payment has been made. This type of review allows the contractor the opportunity to assess if an overpayment was made due to administrative error or inappropriate billing.

7.5 Claims Processing Suspension

Only at the direction of the Director, DHA PI, with the concurrence of the DHA OGC, will a provider's, pharmacy's, dental practice's, or beneficiary's claims be indefinitely suspended/pended from payment due to potential **aberrant billing practices**. In this case, formal notification to the provider, pharmacy, dental practice, or beneficiary by the contractor will occur (see [Addendum A](#), [Figure 13.A-6](#) and [Figure 13.A-7](#)). For those cases where a beneficiary submits a claim, or one is submitted on his or her behalf, which includes services involving a suspended provider or network pharmacy, the contractor, under the guidance of the DHA PI, shall send a special and specific notice to the beneficiary *per* [Addendum A](#), [Figure 13.A-8](#).

7.6 Termination Of Network Agreement

If a network provider, Primary Care Manager (PCM), or pharmacy is determined to be engaged in potential aberrant practices, at its discretion, the contractor may terminate the network agreement in accordance with the terms of the agreement. DHA PI shall be notified if such action will be taken. The contractor shall reassign the beneficiaries to another PCM. The contractor shall take appropriate action with regards to beneficiaries affected by any termination action.

8.0 SPECIAL INTEREST CASES

8.1 Patient Harm

Cases involving patient harm are time sensitive and shall be expeditiously referred to DHA PI. DHA PI has responsibility in coordinating patient harm cases in which a fraudulent or abusive act resulted in patient harm. Patient harm must first be established by a qualified medical provider, dentist, or pharmacist (if applicable), and provided to DHA PI in writing. This written opinion must accompany the Fraud/Abuse Patient Harm Initial Notification Checklist, which is completed by the MCSC/Dental/PBM Program Integrity Office, and is submitted to DHA PI. The corresponding CDRL, DD Form 1423 provides details on the contents and submission of this report. The Fraud/Abuse Patient Harm Initial Notification Checklist is the minimum amount of information needed by DHA PI. DHA PI coordinates patient harm case referrals with the DHA Clinical Support Division, TRICARE Regional Office Clinical Quality Management Offices, and Law Enforcement. In cases involving actual patient harm, the contractor(s) at DHA's request shall individually notify those patients (or

their parents or guardians if under the age of 18 or incapacitated) who are affected.

8.2 TRICARE Beneficiary Eligibility

8.2.1 If there is reason to question the eligibility of a beneficiary and fraud is suspected, e.g., through correspondence, DEERS response, or contractor file data which raises some question about the eligibility of a beneficiary, the contractor shall immediately investigate internally to eliminate obvious clerical errors. If the internal investigation does not resolve the possibility of fraud, the contractor shall contact DMDC.

8.2.2 Additionally, on information derived on a monthly basis by the contractor from the DMDC-Claims Reprocessing Report, the contractor shall identify beneficiaries accessing care after their eligibility was terminated. The contractor shall initiate action to recoup funds paid for services to beneficiaries who were not eligible and report those actions on the Quarterly Eligibility Recoupment Status Report to DHA PI. See [Section 4](#). The contractor shall refer those individual beneficiary cases that meet the threshold as stated in Section C of the contract.

8.2.3 In cases where loss of eligibility is identified, the contractor shall ensure no care shall be approved for services on/after the date eligibility reportedly ended and shall flag the beneficiary file to suspend all claims for services provided on/after the date eligibility reportedly ended.

8.2.4 Handle administratively those cases that involve less than the threshold as stated in section C of the contract.

8.3 Identity Theft

Cases involving identity theft are time sensitive and shall be expeditiously referred to DHA PI. Upon notification of beneficiary identity theft the contractor shall immediately flag the beneficiary's 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. Identity theft cases shall be developed to determine if health care fraud/abuse has occurred.

8.4 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. The contractor shall request the payee 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. This shall be accomplished as follows.

8.4.1 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.

8.4.2 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.

8.4.3 Cooperating In Investigation/Prosecution

The forgery of a contractor check is a violation of state and federal law. 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 DHA OGC.

8.4.4 Reporting

Cases involving forgery and other unusual circumstances shall be reported immediately to DHA PI. Such circumstances might include a suspicion that the forgery involves contractor employee fraud or a pattern of forgery suggesting an organized effort.

8.4.5 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.

- END -

Chapter 13

Section 4

Reports

1.0 FRAUD AND ABUSE SUMMARY REPORT

1.1 The **Fraud and Abuse Workload Summary** will be compiled and submitted to the **Defense Health Agency (DHA) Program Integrity Office (PI)** within 30 calendar days following the last day of each calendar quarter. The corresponding **Contract Data Requirements List (CDRL), DD Form 1423** provides details on the contents and submission of this report.

1.2 PI Cost Avoidance and Recovery/Recoupments

The contractor shall report to DHA PI the cost avoidance and recoveries/recoupments achieved as a result of the activities/intervention of the anti-fraud investigative unit and other units contributing to health care fraud detection/prevention. This report shall be submitted to DHA PI within 30 calendar days following the last day of the quarter.

1.2.1 The PI Cost Avoidance and Recovery/Recoupments shall provide information detailing:

- Cost Avoidance, Recoveries, and Recoupments; along with the cost associated with all program integrity activities.
- Return on Investment (ROI) calculated by utilizing the DHA PI ROI tables provided on the quarterly report.
- Information from the Defense Manpower Data Center (DMDC) Claims Reprocessing Report which results in eligibility reviews, recoupments initiated, collected, or transferred to DHA.

1.2.2 Include in the fourth quarter report, an addendum which identifies potential fraud cases as a result of the use of anti-fraud software. A list of referred cases shall also be included as an addendum to the fourth quarter report.

2.0 THREATS

The contractor shall immediately report all threats (e.g., beneficiary, provider, etc.) to the local police authorities. A written report shall be completed by the individual receiving the threat and sent to the DHA PI Chief of Investigations Oversight for information referral to the Defense Criminal Investigation Service (DCIS) office having jurisdiction over the area where the threat was initiated or act was stated to occur. This includes all threats against person or property. The contractor shall provide a report of the threat to DHA PI giving as much information as possible, within five working days of the threat. The corresponding CDRL, DD Form 1423 provides details on the contents and submission of this report.

3.0 ELIGIBILITY RECOUPMENT STATUS QUARTERLY REPORT

Information from the DMDC Claims Reprocessing Report which results in eligibility reviews, recoupments initiated, collected, or transferred to **DHA** shall be submitted to **DHA** PI within 30 calendar days following the last day of each calendar quarter. The contractor shall submit this status report with the Quarterly Fraud and Abuse Summary Report also known as the PI Cost Avoidance and Recovery/Recoupments Report.

4.0 NON-DISCLOSURE STATEMENT

All reports generated as a result of this section or any other section of [Chapter 13](#), shall include the following statement at the bottom of each page.

The recipients of this report are hereby advised that it contains information that is "Law Enforcement Sensitive" or "For Official Use Only". Disclosure to unauthorized sources is strictly prohibited.

- END -

Provider Exclusions, Terminations, And Suspension Of Claims Processing

1.0 SCOPE AND PURPOSE

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 **Defense Health Agency (DHA)** 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. **This section also outlines procedures and protocol for the suspension of claims processing.**

2.0 DHA AUTHORITY FOR SUSPENSION OF CLAIMS PROCESSING

2.1 DHA may suspend claims processing based on [32 CFR 199.9](#) provisions.

2.2 The Director, DHA, or designee may suspend claims processing without notifying the provider or beneficiary of the intent to suspend payments. A written notice will advise the beneficiary or provider, within 30 days of the claims suspension, that a temporary suspension has been ordered and a statement of the basis of the decision to suspend payment.

2.3 A suspension of claims processing shall be for a temporary period pending the completion of investigation and any ensuing legal or administrative proceedings, unless sooner terminated by the Director, DHA, or designee. See [32 CFR 199.9](#) for additional guidance.

2.4 DHA Program Integrity (PI) is responsible for advising the contractor of any suspension of claims processing. The contractor shall then issue special notifications. ([Addendum A](#), [Figure 13.A-6](#), [Figure 13.A-7](#), and [Figure 13.A-8](#))

3.0 DHA AUTHORITY FOR EXCLUSIONS AND TERMINATIONS

3.1 DHA may exclude any individual or entity based on [32 CFR 199.9](#) provisions.

3.2 Effective March 28, 2013, third party billing agents or entities became subject to TRICARE sanction authority.

3.3 The contractor shall provide written notice to DHA PI of any situation involving a TRICARE provider, pharmacy, or entity whose actions warrant exclusion under DHA authority.

3.4 The Director, DHA, or designee, has the authority to exclude an authorized TRICARE provider, pharmacy, or entity. The period of exclusion is at the discretion of DHA. (See 32 CFR 199.9.)

3.5 DHA PI is responsible for coordinating and for issuing notification of exclusion action. DHA PI will send written notice of the proposed exclusion, and the potential effect thereof. The individual or entity may submit evidence and written argument regarding the proposed exclusion.

3.6 DHA PI 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 DHA PI will consider a request for reinstatement, the requirements for reinstatement, and appeal rights available. DHA PI will notify appropriate agencies, to include contractors, of all DHA exclusion actions taken. DHA PI will be responsible for initiating action based on reversed or vacated decisions. Exclusion of a provider, pharmacy, or entity shall be effective 15 calendar days from the date of the Initial Determination.

3.7 The Director, DHA, or designee has sole authority for approval of any request for reinstatement.

4.0 CONTRACTOR ACTIONS UNDER TRICARE EXCLUSION AUTHORITY - 32 CFR 199.9

4.1 When the contractor recommends exclusion to DHA PI of an authorized provider, pharmacy, or entity, supporting documentation shall be submitted (e.g., provider, pharmacy, or entity poses unreasonable potential for fraud).

4.2 The contractor will be notified immediately of an exclusion action taken by DHA PI and 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 DHA 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 DHA 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, pharmacy, or entity of the exclusion action. However, notice of exclusion action taken by DHA shall be given to all Beneficiary Counseling and Assistance Coordinators (BCACs) 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 exclusion action taken. TRICARE Area Offices (TAOs) for the region in which the provider's practice is located shall also be given notice of exclusion action taken.
- Ensuring that an excluded provider, pharmacy, or entity is not included in the network. If a network agreement is canceled, the contractor shall ensure that the affected network provider, pharmacy, or entity clearly understands his/her status. This shall be accomplished by providing notice, by certified mail, return receipt requested, stating the network agreement has been canceled (a copy to be provided to DHA PI).
- Issuing a special notice to any beneficiary who submits a claim or for whom a claim is submitted, which includes services involving an excluded provider, pharmacy or entity.

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.

- Contractors shall ensure the enforcement of all exclusion action taken, and notify appropriate parties of the application of exclusions. 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.

5.0 DHHS/OIG APPLICATION OF SANCTION AUTHORITY

5.1 DHHS/OIG may exclude individuals or entities from participation in any federal health care program to include the Department of Defense (DoD) military health system. Authority and exclusion categories can be found on the DHHS/OIG website.

5.2 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.

5.3 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.

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

5.5 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](#).

6.0 CONTRACTOR ACTIONS UNDER DHHS/OIG EXCLUSION AUTHORITY

6.1 The contractor will be provided the monthly issuance of DHHS/OIG exclusion and reinstatement actions.

6.2 The contractor shall ensure that no payment is made to an excluded provider, network pharmacy, or entity for care provided on or after the date of the DHHS/OIG action. Neither the provider, entity, nor the patient will be entitled to TRICARE cost-sharing once the exclusion is effective. The contractor must notify DHA 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, network pharmacy, or entity.

6.3 The contractor shall ensure that an excluded 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 canceled 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 canceled.

7.0 CONTRACTOR APPLICATION OF SANCTION AUTHORITY

The contractor 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.

8.0 PROVIDER, NETWORK PHARMACY, OR ENTITY TERMINATION OF AUTHORIZED PROVIDER STATUS

The contractor shall terminate the authorized provider status of any provider, network pharmacy, or entity determined not to meet program requirements. The request for reinstatement will be processed under the procedures established for initial requests for authorized provider or network pharmacy status. See Section 6 for further information.

8.1 Other Listings

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.

9.0 CONTRACTOR REQUIREMENTS FOR TERMINATION

When status as an authorized provider, authorized network pharmacy or authorized entity is ended, the contractor shall initiate termination action based on a finding that the provider, pharmacy, or entity does not meet the qualifications to be an authorized provider, etc. Separate termination action by the contractor will not be required for a provider, pharmacy, or entity sanctioned under the exclusion authority granted DHHS/OIG.

9.1 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.

9.2 The contractor shall notify the provider, pharmacy, or entity in writing of the proposed action to terminate. The contractor shall specifically notify the provider, pharmacy, or entity of the proposed action to terminate their status as an authorized TRICARE provider when the provider, pharmacy, or entity falls within the contractor's certifying responsibility and the provider, pharmacy, or entity fails to meet the requirements of 32 CFR 199.6 (Addendum A, Figure 13.A-9). The provider, pharmacy, or entity is not to be terminated when he/she fails to return certification packets. Such providers, pharmacies, or entities will be flagged as "inactive." Do not send a copy of the proposed notice to DHA PI. The notice will be sent to the provider's, pharmacy's, or entity's last 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-9).

9.2.1 The notice shall state that the provider, pharmacy, or entity will be terminated as of the effective date of the termination notice. 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.

9.2.2 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.

9.2.3 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.

9.2.4 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, pharmacy, or entity 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.

9.2.5 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.

9.2.6 If the provider being terminated is a 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.

9.3 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. The Initial Determination shall include:

- 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-10;

- A statement of the action being invoked and the effective date of the action. The effective date shall be the date the provider, pharmacy, or entity no longer met 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, pharmacy, or entity 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;
- A statement of the facts, circumstances, and/or actions that form the basis for the termination and a discussion of any information submitted by the provider, pharmacy, or entity relevant to the termination;
- A statement of the provider's, pharmacy's, or entity's right to appeal;
- The requirements and procedures for reinstatement;
- A copy of the Initial Determination along with supporting documentation.

9.4 Providers Failing To Return Recertification Documentation

Providers, pharmacies, or entities 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, pharmacy, or entity shall be advised that such action will be taken. Refer to [Section 3](#) regarding development of possible fraud/abuse cases.

9.5 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) or entity 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 DHA Finance and Accounting Office (F&AO). Refer to [Chapter 3](#).

9.6 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:

- Initial Determination of Termination Action as well as Proposed Notice to Terminate;
- Provider/entity certification file (i.e., the documentation upon which the original certification of the provider/entity was based), or network pharmacy agreement;
- All correspondence and documentation relating to the termination. Copies of the enclosures must be attached to the copy of the original correspondence;

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

9.7 Special Action/Notice Requirements When An Institution Is Terminated

When a DHA 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.

9.7.1 Provider And Beneficiary Notification

The contractor shall:

- 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;
- When the termination effective date is after the date of the initial determination, notify by certified mail any beneficiary (or his/her 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 his/her parent, guardian, or other representative) of his/her 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.);
- 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.);
- In addition, notify any beneficiary (or his/her 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;
- 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.

9.7.2 Cost-Sharing Actions

9.7.2.1 The contractor shall deny cost-sharing;

- For any new patient admitted after the effective date of the termination;
- For any beneficiary admitted during a grace period granted to an institution involved in a minor violation;

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- For any beneficiary already in an institution involved in a major violation beginning with the effective date of the termination.

9.7.2.2 The contractor shall cost-share covered care for those beneficiaries admitted prior to a grace period.

- END -

Provider Reinstatements

1.0 PROVIDERS, PHARMACIES, OR ENTITIES SANCTIONED BY TRICARE

32 CFR 199.9 provides that the Director, Defense Health Agency (DHA), or a designee, shall have the authority to reinstate providers, pharmacies or entities previously excluded or terminated, under TRICARE. For providers sanctioned by Department of Health and Human Services (DHHS), see paragraph 3.0.

1.1 DHHS/Office of Inspector General (OIG) will advise on the monthly listing if and when a previously excluded provider, pharmacy, or entity is reinstated. Before initiating reinstatement action, the contractor must first verify that the provider, pharmacy, or entity meets TRICARE requirements as an authorized provider, pharmacy, or entity under 32 CFR 199.6.

1.2 If no funds have been paid for services by the provider, pharmacy, or entity while excluded or are otherwise owed the government for claims paid prior to the exclusion, the contractor shall certify the provider, pharmacy, or entity as an authorized provider, and determine the effective date of the reinstatement.

1.3 The contractor shall advise the provider, pharmacy, or entity in writing of the reinstatement date.

2.0 CONTRACTOR RESPONSIBILITIES FOLLOWING REQUESTS FOR REINSTATEMENT FROM PROVIDERS EXCLUDED OR TERMINATED BY DHA

2.1 The contractor shall send a provider certification package to the provider to ensure that the provider meets the requirements to be an authorized TRICARE provider. The exclusion or suspension remains in effect until the provider completes and returns the certification package and is determined by the contractor to meet the requirements.

2.2 If the provider is determined to meet the requirements of an authorized provider, the contractor shall advise the provider of the reinstatement date as determined by the DHA or designee.

2.3 If the provider doesn't meet the requirements of an authorized provider, the contractor shall advise the provider as to why he/she doesn't meet them and offer appeal rights. A copy of the letter shall be provided to the DHA PI.

2.4 The contractor shall advise the same Beneficiary Counseling and Assistance Coordinators (BCACs) located within the provider's service area that were initially advised of the exclusion or suspension.

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Provider Reinstatements

2.5 For **pharmacies**, the contractor verifies that the pharmacy has all required state licenses necessary to operate as a pharmacy. The exclusion or suspension remains in effect until the contractor has determined that the pharmacy has obtained the required state licenses.

2.6 If the pharmacy has met the state licensing requirements, the contractor shall advise the pharmacy of the date it is eligible to negotiate a new network agreement with the contractor, as determined by the **DHA**.

2.7 If the pharmacy does not have the required state licenses, the contractor shall advise the pharmacy as to why it is not eligible to be a network pharmacy and offer appeal rights. A copy of the letter shall be provided to the **DHA PI**.

3.0 CONTRACTOR RESPONSIBILITIES FOLLOWING REQUESTS FOR REINSTATEMENT FROM PROVIDERS EXCLUDED BY DHHS

3.1 DHHS/OIG will advise on the monthly listing if and when a previously excluded provider, pharmacy, or entity is reinstated. Before initiating reinstatement action, the contractor shall first verify that the provider, pharmacy, or entity meets TRICARE requirements as an authorized provider, pharmacy or entity under [32 CFR 199.6](#).

3.2 If no funds have been paid for services by the provider, pharmacy, or entity while excluded or are otherwise owed the government for claims paid prior to the exclusion, the contractor shall certify the provider, pharmacy, or entity as an authorized provider, and determine the effective date of the reinstatement.

3.3 The contractor shall advise the provider, pharmacy, or entity in writing of the reinstatement date.

- END -

Figures

FIGURE 13.A-1 VIOLATION OF THE PARTICIPATION AGREEMENT (SAMPLE)

(Provider Address)

Dear _____:

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

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

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

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

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

FIGURE 13.A-1 VIOLATION OF THE PARTICIPATION AGREEMENT (SAMPLE) (CONTINUED)

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

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

Sincerely,

Name, Title and Office

cc:
Beneficiary

NOTE TO CONTRACTOR

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

FIGURE 13.A-2 VIOLATION OF THE PARTICIPATION AGREEMENT - FOLLOW-UP (SAMPLE)

(Provider Address)

Dear _____:

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

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

Cease all collection action for amounts over the TRICARE-determined allowable amount, tell **(Name of Patient)** you are stopping all collection action; and provide a copy of your letter to us within 15 days of the date of this letter. If we don't hear from you, we will refer this matter to the Defense Health Agency (DHA), Program Integrity Office.

Sincerely,

Name, Title and Office

cc:
Beneficiary

**FIGURE 13.A-3 VIOLATION OF REIMBURSEMENT LIMITATION (BALANCE BILLING)
(SAMPLE)**

(Provider Address)

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

Dear _____:

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

Within 30 days of the date of this letter, you are to:

- **Refund the beneficiary the amount over the 115% of the CMAC, or**
- If no overpayment was made by the beneficiary, then credit the account **and stop billing the beneficiary over 115% of the CMAC.** The enclosed Explanation of Benefits (EOB) contains the procedure code(s) for each service, the date(s) of service, and the CMAC for each procedure. The 115% of the CMAC can be easily calculated from the information provided on the EOB (1.15 x CMAC = Balance Billed Amount.)
- **As background, the DoD put provisions in place as noted** in a final rule published in the **Federal Register** on October 1, 1993, **effective** November 1, 1993. **These provisions apply** to all services provided on or after that date. Failure by a nonparticipating provider to comply with this requirement is a basis for exclusion from TRICARE as an authorized provider.

If you have questions, please contact (**List Appropriate Point of Contact List** Telephone Number).

Sincerely,

Name, Title and Office

cc:
Beneficiary

NOTE TO CONTRACTOR

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

**FIGURE 13.A-4 VIOLATION OF REIMBURSEMENT LIMITATION (BALANCE BILLING)
FOLLOW-UP (SAMPLE)**

(Provider Address)

RE: Patient:

Sponsor:

Sponsor SSN (last four):

Dear _____:

In a letter dated **(Date of Initial Letter)**, copy enclosed, you were advised of an incorrect billing practice, and advised to refund to the beneficiary (or credit the account) any amount billed in excess of 115% of the CHAMPUS Maximum Allowable Charge (CMAC). To date, we have not heard from you. **Within 15 days of the date of this letter, write us of your intent to correct this error and follow public law. TRICARE's 115% limit is based on a similar Medicare law. Because TRICARE is a much smaller federal program, not all providers are as familiar with the TRICARE requirements as they are with Medicare requirements.**

If you **need** additional information or you disagree with **analysis**, please contact our Service Department at **(List Appropriate Point of Contact List Telephone Number)**.

Sincerely,

Name, Title and Office

cc:

Beneficiary

FIGURE 13.A-5 STATISTICAL SAMPLING FOR OVERPAYMENT DETERMINATIONS AND IDENTIFICATION OF PROBABLE FALSE CLAIMS

Prior to the selection of the statistically valid random sample, the claims universe shall also be properly focused and analyzed to determine the sampling plan and methodology. Focusing the universe is performed by targeting specific claims which match the approach and/or allegations of the case, and removing unnecessary low dollar claims. The overall sampling plan and methodology may include a stratified sampling approach consisting of one or more statistically valid random sample(s) and/or 100% claims audit(s).

In order to determine the probable scope and extent of overpayments, regardless of how the overpayment was incurred, a statistically valid random sample shall be drawn from each identified stratum (or the entire universe of claims in some cases). Denied claims or claims where TRICARE paid zero dollars shall always be removed from the Universe prior to stratification and sampling. Only netted records shall be used.

This primary sample shall be selected using a random number generator with a known seed number. Using a known non-zero seed number is critical, as it will provide for the reproduction of the same set of random numbers with the same sample and universe.

The sample size shall be calculated using the following parameters:

- 90% confidence level
- 10% precision level
- 50% occurrence rate (if there is no established rate of occurrence) or an estimate of the occurrence rate from a previously documented statistically valid analysis (by a Federal health care entitlement program) of the units of audit (e.g., same provider, same procedures, same time period) of the possible fraudulent.

An oversample of 20% shall always be randomly selected from the entire universe and audited with the primary sample at the beginning of an audit.

In all claim audits using statistical techniques to extrapolate findings of a sample to a **specific stratum or a** universe of claims, the audit addresses the average overpayment per claim as the single unit of measurement. The claim and the explanation of benefits are the evidentiary documents which demonstrate the billed services submitted by a provider or beneficiary and the payments made to a provider or beneficiary. The claim is compared to the contents of the medical record to validate whether a service was provided, whether it was provided at the level billed, whether it was provided by the authorized provider shown on the claim, or any other information which may be relevant to identify a dollar loss to the Government. This information shall be recorded on a summary spreadsheet generated by Microsoft® Excel, or compatible software, with a .xls file extension for compatibility with other widely used spreadsheet software (**typically, the DHA Random Sample Audit Worksheet shall be included for each statistically valid random sample**).

Each claim in the sample shall be listed on the summary spreadsheet and the overpayment totaled. When no overpayment exists, the claim shall appear on the summary spreadsheet with zero listed as the overpayment.

Each claim of the audited oversample shall also be included with the case, either as part of the summary spreadsheet or as part of a separate spreadsheet.

FIGURE 13.A-5 STATISTICAL SAMPLING FOR OVERPAYMENT DETERMINATIONS AND IDENTIFICATION OF PROBABLE FALSE CLAIMS (CONTINUED)

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

DETERMINING EXTRAPOLATION AMOUNT AND VALIDATING THE AUDIT FINDINGS

It is necessary to calculate the standard deviation, standard error of the mean, and sampling error. The contractor shall have the electronic capability to accomplish these calculations according to the methodology provided in the following paragraphs.

In the sample technique discussed in the previous section, if the sample has been properly designed and selected, and the **stratum or** universe approximates a normal distribution appropriately, there are 90 chances in 100 that the claim overpayments will fall within the range of the arithmetical mean plus or minus 1.645 times the calculated standard deviation. Additional values shall be calculated as well, to determine the validity of the overpayment estimates.

Calculating the standard deviation of the sample: The standard deviation, which is expressed in dollars and cents, shall be determined using the following steps:

1. Calculate the difference between each claim observation and the average mean overpayment.
2. Square each of the calculated differences.
3. Sum the Squares of the differences for all of the claim observations.
4. Divide the Sum of the Squares by the number of observations in the sample.
(Note: When the sample size is less than 40, Divide the Sum of the Squares by the number of observations minus one.)
5. Take the Square Root of the Divided Sum of the Squares.

Calculating the standard error of the mean: The standard error of the mean shall be calculated by dividing the standard deviation by the square root of the sample size.

Calculating the sampling error and overpayment estimate range: The sampling error shall be calculated by multiplying the standard error of the mean by the "Z" score (for a 90% confidence level the "Z" score is 1.645. The "Z" score changes as the confidence level changes).

Calculating the precision value: The precision value, expressed in dollars and cents, shall be calculated by multiplying the sampling error by the number of claims in the **stratum or** universe.

Calculating the overpayment estimates: The overpayment point estimate was calculated above by multiplying the average mean of overpayment per claim by the number of claims in the **specific stratum or** universe. The high and low (plus or minus) estimates of overpayments shall be calculated respectively by adding and by subtracting the precision value from the overpayment point estimate. The overpayment estimates shall be expressed in dollars and cents.

Calculating the sample precision percentage: The sample precision percentage shall be calculated by dividing the precision value by the overpayment point estimate. The desired precision percentage is 10% or less for tight precision, with approximately 20% or more representing low precision.

FIGURE 13.A-5 STATISTICAL SAMPLING FOR OVERPAYMENT DETERMINATIONS AND IDENTIFICATION OF PROBABLE FALSE CLAIMS (CONTINUED)

Testing the validity of the sample and the overpayment estimates:

1. If the standard deviation is greater than two times the arithmetic mean, this is an indicator that the sample does not demonstrate the confidence level required for validity.
2. If the high estimate of overpayments is greater than the **specific stratum** or universe amount or the low estimate of overpayments is less than zero, then the computed overpayment amount shall not be used.
3. When high precision is not achieved, the lower overpayment estimate shall be used as the amount of overpayment demanded, as opposed to the point estimate. This procedure yields a conservative demand amount for recovery that is very likely less than the true amount of overpayment, and it allows a reasonable recovery without requiring the tight precision that might be needed to support a demand for the point estimate.

ALTERNATE SAMPLING METHODS

If the tests for the validity of the sample and overpayment estimates are not met, it may be an indicator that the universe should **have been** stratified **appropriately**, or other techniques should be used. If this is the case, consult with **DHA PI**. **For example** if there are services subjected to audit where there are large differences in payments (e.g., surgical and medical), there will likely be a need to stratify the universe into two or more separate categories for separate sample selection. When stratification is necessary and after consulting with **DHA PI**, please seek consultation for such sample techniques from a qualified statistician.

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

FIGURE 13.A-6 SPECIAL NOTICE TO PROVIDER/PHARMACY WHEN THE PROVIDER'S OR NETWORK PHARMACY'S CLAIMS ARE SUSPENDED (SAMPLE)

(Provider Address)

Dear _____:

This letter serves as notice that as of **(Date)** we are suspending payment for claims for you or your organization's services for an indefinite period of time. This action (in accordance with 32 CFR 199.9) is a result of the government's investigation of your/your organization's medical and/or financial records.

Any participation agreements with patients remain in full force and effect, and you cannot reject the terms of the agreement as a result of the delay in claims processing. You are also prohibited from assessing a finance charge, either to the beneficiary or the Government, on these suspended claims.

Within 30 days of the date of this notice, you may present to the Director, Program Integrity Office, **DHA**:

1. Written information (including documentary evidence) and arguments against your suspension as long as the additional specific information raises a genuine dispute over the material facts, or

2. A written request to personally present your case to the Director, **DHA**, or a designee. All such presentations shall be made at **DHA**, 16401 East Centretch Parkway, Aurora, Colorado 80011-9066 at your expense.

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

(Contractor's Address)

Sincerely,

Name, Title and Office

NOTE TO CONTRACTOR

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

FIGURE 13.A-7 SPECIAL NOTICE TO BENEFICIARY WHEN THE BENEFICIARY'S CLAIMS ARE SUSPENDED (SAMPLE)

(Beneficiary Address)

Dear _____:

We are letting you know that as of **(Date)** we have suspended payment on your claims for an indefinite period of time. They are being reviewed by the government (in accordance with 32 CFR 199.9).

Within 30 days of the date of this notice, you may present to the Director, Program Integrity Office, **DHA**:

- 1. Written** information (including documentary evidence) and argument **against this action, as long as** the additional specific information raises a genuine dispute over the material facts; or
- 2. A written request to personally** present evidence to the Director, **DHA**, or a designee. **Your** presentations shall be made at **your expense and conducted at: DHA**, 16401 East Centretch Parkway, Aurora, Colorado 80011-9066.

If you have any questions or comments **on** this action, we suggest you **write** to:

(Contractor's Address)

Sincerely,

Name, Title and Office

NOTE TO CONTRACTOR

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

FIGURE 13.A-8 SPECIAL NOTICE TO A BENEFICIARY WHEN A BENEFICIARY'S CLAIM IS SUSPENDED (PHARMACY/PROVIDER) (SAMPLE)

(Beneficiary Address)

Dear _____:

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

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

(Contractor's Address)

Sincerely,

Name, Title and Office

NOTE TO CONTRACTOR

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

FIGURE 13.A-9 NOTICE OF PROPOSED ACTION TERMINATING A PROVIDER/PHARMACY (SAMPLE)

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

(Provider Address)

Dear _____:

We are proposing to terminate you as a TRICARE authorized TRICARE provider, effective (**Date and provide one of the following statements: The date on which you did not met these requirements, or June 10, 1977, the effective date of the Regulation, WHICHEVER DATE IS LATER**). Your termination ends only after you successfully meet established qualification criteria and are reinstated as a TRICARE authorized provider.

Based on submitted documents, you don't qualify to be a TRICARE authorized provider (in accordance with 32 CFR 199.6) (NOTE: The contractor shall give the reasons and supporting facts for the proposed termination.)

Authority for this termination can be found in the 32 CFR 199.9, which provides administrative remedies for fraud, abuse and conflict of interest, and for termination when the provider has not met or satisfied the criteria for TRICARE authorized provider status. **Since we lack evidence you meet all the criteria, you are now considered to have lost or given up (“forfeited or waived”) any right to bill TRICARE beneficiaries. If you do bill a beneficiary, payment back to the beneficiary may be required by the Director, Defense Health Agency (DHA), or a designee, as a condition of reinstatement. (NOTE: If beneficiaries choose to continue to see you as a non-authorized provider, TRICARE will deny their claims.)**

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

We will treat any claims for dates of service on or after your termination date as erroneous payments; they are subject to collection. Further claims actions are suspended until you get reinstated as an authorized provider.

Within 30 days of the date of this letter, you may:

1. **Submit written evidence or argument on why you disagree with the facts of this decision. Submit written documents to: (Unit or Name Of Person And Address To Whom The Provider Is To Submit Certification Documentation); or**
2. **Submit a written request to present, in person, to staff at the office listed above evidence or argument against this decision. Travel to and from this location is at your expense.**

**FIGURE 13.A-9 NOTICE OF PROPOSED ACTION TERMINATING A PROVIDER/PHARMACY
(SAMPLE) (CONTINUED)**

Documents postmarked within 30 days of the date of this letter will be accepted. If you have a good reason as to why you can't not present additional evidence within 30 days, you may submit a written request to extend the deadline to 60 days from the date of this letter. All communications with this office **must** be in writing.

Sincerely,

Name, Title and Office

NOTE TO CONTRACTOR

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

FIGURE 13.A-10 INITIAL DETERMINATION TERMINATING A PROVIDER/PHARMACY (SAMPLE)

(Provider Address)

} Initial Determination
} Contractor Name
} Case File YY-“#”

Dear _____:

On **(Date of Proposed Action Notice)**, we sent notice we proposed terminating you as a TRICARE authorized **(Provider/Pharmacy Type)** under TRICARE. You were told you could submit, within 30 days, either:

1. Written evidence you meet TRICARE's authorization requirements as a **(Provider Type)** and written argument against the action; or
2. A written request to present, in person, at your expense, evidence or arguments supporting you meet qualification criteria as an authorized provider.

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

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

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

(List Specific Requirements From The Regulation)

Our position is you do not meet the requirements because **(Give specific basis for your decision; if the provider submitted any evidence or argument in writing or in person, identify that evidence or argument here and discuss its relevance to this decision.)**

**FIGURE 13.A-10 INITIAL DETERMINATION TERMINATING A PROVIDER/PHARMACY
(SAMPLE) (CONTINUED)**

The period of your termination as an authorized (**Provider/Pharmacy Type**) under TRICARE is indefinite under the provisions of the [32 CFR 199.9](#). The period of termination will end only upon receipt of documentation that you have successfully met the established qualifications and receipt of your request for reinstatement as an authorized provider under the procedures established by the [32 CFR 199.9](#). All requests for reinstatement of terminated providers must be submitted to: **Contractor Program Integrity Office.**

Regulation ([32 CFR 199.10](#)) sets forth policies and procedures for providers to appeal a termination decision as long as there is an appealable issue, such as a question on factual matters of the case. If you question the fact(s) serving as the basis for your termination, you may file an appeal. (**NOTE: The appeal process may not be used to challenge any provision of law or regulation.**) You must mail a written request for a hearing within 60 days from the date of this letter to: Chief, Office of Appeals and Hearings, **DHA**, 16401 East Centretech Parkway, Aurora, Colorado 80011-9066. **Include** a copy of this letter **and** any additional documentation/evidence you **want** considered **as part of your hearing package.**

Sincerely,

Name, Title and Office

cc:
Program Integrity Office
DHA

NOTE TO CONTRACTOR

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

- END -

General

1.0 INTRODUCTION

The TRICARE Prime Remote (TPR) program provides health care to Service members (including Reserve Component (RC) members activated for more than 30 days) who meet the eligibility criteria specified in [32 CFR 199.16\(e\)\(2\)](#) and are enrolled in the program. This chapter applies to operations of the TPR program in remote locations of the United States and the District of Columbia (DC) while the TRICARE Operations Manual (TOM), [Chapter 24, Section 18](#) applies to operations of the TPR program outside of the United States.

2.0 ELIGIBILITY

Contractors have no responsibility for determining eligibility or for deciding in which region a Service member shall enroll. Regional Directors (RDs) will furnish contractors with enrollment information (refer to [paragraph 3.0](#)). If a contractor receives a claim for care provided to a Service member who is not enrolled in TPR or who is not enrolled in TRICARE Prime at a Military Treatment Facility (MTF), the contractor shall process the claim according to the applicable guidelines of the Supplemental Health Care Program (SHCP) ([Chapter 17](#)).

Note: Service member astronauts assigned to the Johnson Space Center in Houston, Texas must and shall be enrolled in TPR.

3.0 TPR PROGRAM UNITS

The RD will supply the contractor with an electronic directory, updated as needed, that lists, by region, the designated TPR zip codes for the contractor's region(s). The RD will also provide unit listings to the contractor so that the contractor can mail educational materials to the units. In some instances, individual member listings (as opposed to units) may be provided.

4.0 BENEFITS

4.1 Remote Service members enrolled in the TPR program shall receive the benefits of TRICARE Prime, even in areas without contractor networks. Some covered benefits (see [Section 2, paragraph 5.3](#)) require review by Specified Authorization Staff (SAS) (identified in Addendum A, [paragraph 1.0](#)) so they may identify fitness-for-duty issues. If the contractor determines that a requested or claimed service, supply, or equipment is not covered by TRICARE (including [Chapter 17, Section 3, paragraph 2.2.4](#)) and no **Defense Health Agency (DHA)**-approved waiver is provided, the contractor shall decline to file an authorization and shall deny any received claims accordingly. The contractor shall notify the civilian provider and the remote Service member/non-enrolled Service member of the declined authorization with explanation of the reason. The notification to a civilian provider and the remote Service member/non-enrolled Service member shall explain the waiver process and provide contact information for the applicable Uniformed Services Headquarters Service

Project Officers as listed in [Chapter 17, Addendum A, paragraph 2.0](#). No notification to the SAS is required. The contractor shall not make claims payments to sanctioned or suspended providers (see [Chapter 13, Section 5](#)). The claim shall be denied if a sanctioned or suspended provider bills for services. SAS do not have the authority to overturn DHA or Department of Health and Human Services (DHHS) provider exclusions. See [Section 2](#) for referral and authorization requirements. Services that would not have ordinarily been covered under TRICARE policy (including limitations and exclusions) may be authorized for Service members only in accordance with the terms of a waiver approved by the Director, DHA, at the request of an authorized official of the Uniformed Service concerned. (Reference HA Policy 12-002 "Use of Supplemental Health Care Program Funds for Non-Covered TRICARE Health Care Services and the Waiver Process for Active Duty Service Members").

4.2 A SAS authorization shall be deemed to constitute referral, authorization, and direction to bypass edits as appropriate to ensure payment of SAS-approved claims. Contractors shall implement appropriate measures to recognize SAS authorization in order to expedite claims processing.

5.0 SAS

Certain Uniformed Service controls and rules apply to Service members due to unique military readiness requirements. SAS (identified in Addendum A, [paragraph 1.0](#)) serves as liaison among the Service member, the Service member's Uniformed Service, and the contractor for managing the Service member's health care services. The SAS review referrals for proposed care as well as information about care already received in order to determine impact on an individual's fitness for duty (see [Section 2, paragraph 5.3](#) and [Addendum B](#) for referral and review/authorization procedures). SAS, the PCM (if assigned) and the contractor shall work together in making arrangements for the Service member's required examinations. The SAS will provide the protocol, procedures, and required documentation through the contractor to the provider for these examinations. For required care that may not be obtainable in the civilian community, SAS will refer the Service member to an MTF. Refer to [Addendum A](#) for the addresses and telephone numbers of the SASs.

6.0 APPEAL PROCESS

6.1 If the contractor, at the direction of the SAS, denies authorization of, or authorization for reimbursement, for a TPR enrollee's health care services, the contractor shall, on the Explanation of Benefits (EOB) or other appropriate document, furnish the enrollee with clear guidance for requesting a reconsideration from or filing an appeal with the SAS (see [paragraph 6.2](#)). The SAS will handle only those issues that involve SAS denials of authorization or authorization for reimbursement. The contractor will handle allowable charge issues, grievances, etc.

6.2 If the TPR enrollee disagrees with a denial rendered by the SAS, the first level of appeal will be through the SAS who will coordinate the appeal as appropriate. The enrollee may initiate the appeal by contacting his/her SAS. If the SAS upholds the denial, the SAS will notify the enrollee of further appeal rights with the appropriate Surgeon General's office.

6.3 If the denial is overturned at any level, the SAS will notify the contractor and the Service member.

completed. The contractor shall use the same best business practices as used for other Prime enrollees in determining EOC when claims are received with lines of care that contain both referred and non-referred lines. Laboratory tests, radiology tests, echocardiogram, holter monitors, pulmonary function tests, and routine treadmills logically associated with the original EOC may be considered part of the originally requested services and do not need to come back to the PCM (if assigned) or Primary Care Provider (PCP) for approval.

5.3.1.2 If the SAS determines that the Service member may receive the care from a civilian source, the SAS will enter the appropriate code into the authorization/referral system. The contractor shall notify the Service member of approved referrals. The Service member may receive the specialty care from a Military Treatment Facility (MTF), a network provider, or a non-network provider according to TRICARE access standards, where possible. In areas where providers are not available within TRICARE access standards, community norms shall apply. (A Service member may always choose to receive care at an MTF even when the SAS has authorized a civilian source of care and even if the care at the MTF cannot be arranged within the Prime access standards subject to the member's unit commander [or supervisor] approval.) If the appointment is with a non-network provider, the contractor shall instruct the provider on payment requirements for Service members (e.g., no deductible or cost-share) and on other issues affecting claim payment (e.g., the balance billing prohibition). The contractor shall follow Chapter 8, Section 5 when there are additional requests by a MTF for Civilian Health Care (CHC) needs. The contractor shall adjudicate claims for additional MTF requested civilian care in accordance with Chapter 8, Sections 2 and 5.

5.3.1.3 If the contractor does not receive the SAS's response or request for an extension within two work days, the contractor shall, within one work day after the end of the two work day waiting period, enter the contractor's authorization code into the contractor's claims processing system. The contractor shall document in the contractor's system each step of the effort to obtain a review decision from the SAS. The first choice for civilian care is with a network provider; if a network provider is not available within Prime access standards, the contractor may authorize the care with a TRICARE-authorized provider. The contractor shall help the Service member locate an authorized provider.

5.3.1.4 If the SAS directs the care to a military source, the SAS will manage the EOC. If the Service member disagrees with a SAS determination that the care must be provided by a military source, the Service member may appeal only through the SAS who will coordinate the appeal as appropriate; the contractor shall refer all appeals and inquiries concerning the SAS's fitness-for-duty determination to the SAS.

5.3.1.5 If the Service member's PCM determines that a specialty referral or test is required on an urgent basis (less than 48 hours from the time of the PCM office visit) the PCM shall contact the contractor for a referral and send required information to the SAS for a fitness for duty review. The Service member shall receive the care as needed without waiting for the SAS determination, and the contractor shall adjudicate the claim according to TRICARE Prime provisions. If further specialty care is warranted, the PCM shall request a referral to specialty care. The contractor shall contact the SAS with a request for an additional SAS review for the specialty care.

5.3.2 Care Received With No Authorization or Referral

5.3.2.1 The contractor may receive claims for care that require referral, authorization, and SAS review, that have not been authorized or reviewed. If the claim involves care covered under

TRICARE policy, the contractor shall pend the claim and supply the required information ([Addendum B](#)) to the SAS for review. If the SAS does not notify the contractor of the review determination or ask for an extension for further review within two workdays after submitting the request for coverage determination, the contractor shall then authorize the care. The contractor shall then release the claim for payment, and apply any overrides necessary to ensure that the claim is paid with no fees assessed to the active duty member. However, the contractor shall not make claims payments to sanctioned or suspended providers (see [Chapter 13, Section 5](#)).

Note: Claims for care provided under the National DoD/DVA MOA for Payment for Processing Disability Compensation and Pension Examinations (DCPE) in the Integrated Disability Evaluation System (IDES) shall follow the requirements specified in [Chapter 17, Section 2, paragraph 3.2.5](#).

5.3.2.2 If the contractor determines that the requested service, supply, or equipment is not covered by TRICARE policy (including [Chapter 17, Section 3, paragraph 2.2.4](#)) and no Defense Health Agency (DHA) approved waiver is provided, the contractor shall decline to file an authorization and shall deny any received claims accordingly. The contractor shall notify the civilian provider and the remote Service member/non-enrolled Service member of the declined authorization with explanation of the reason. The notification to a civilian provider and the remote Service member/non-enrolled Service member shall explain the waiver process and provide contact information for the applicable Uniformed Services Headquarters Point of Contact (POC)/ Service Project Officers as listed in [Chapter 17, Addendum A, paragraph 2.0](#). No notification to the SAS is required.

Note: If the SAS retroactively determines that the payment should not have been made, the contractor shall initiate recoupment actions according to [Chapter 10, Section 4](#).

6.0 ADDITIONAL INSTRUCTIONS

6.1 Comprehensive Health Promotion and Disease Prevention Examinations

The contractor shall reimburse charges for comprehensive health promotion and disease prevention examinations covered under TRICARE Prime (see the TRICARE Policy Manual (TPM), [Chapter 7, Section 2.2](#)) without SAS review.

6.2 Vision And Hearing Examinations

The Service member may directly contact the contractor for assistance in arranging for vision and hearing examinations. The contractor shall refer Service members to SAS for information on how to obtain eyeglasses, hearing aids, and contact lenses as well as examinations for them.

6.3 No PCM Assigned

Service members who work and reside in areas where a PCM is not available may directly access the contractor for assistance in arranging for routine primary care and for urgent specialty or inpatient care with a TRICARE-authorized provider. Since a non-network provider is not required to know the fitness-for-duty review process, it is important that the Service member coordinate all requests for specialty and inpatient care through the contractor. The contractor shall contact the SAS as required for reviews and other assistance as needed.

1.2.2.5 Criteria Not Met

If none of the conditions stated above are met, the claim may be returned uncontrolled to the submitting party in accordance with established procedures.

1.2.3 For outpatient active duty, TDRL, non-TRICARE eligible patients, eligible members enrolled in the Federal Recovery Coordination Program (FRCP), and for all SHCP inpatients, there will be no application by the contractor of the DEERS Catastrophic Cap and Deductible Data (CCDD) file, Third Party Liability (TPL), or Other Health Insurance (OHI) processing procedures, for supplemental health care claims. Normal TRICARE rules will apply for all TRICARE eligible outpatients' claims. Outpatient claims for non-enrolled Medicare eligibles will be returned to the submitting party for filing with the Medicare claims processor.

1.3 TPL

TPL processing requirements ([Chapter 10](#)) shall be applied to all claims covered by this chapter. However, adjudication action on claims will not be delayed awaiting completion of the requisite questionnaire and compilation of documentation. Instead, the claim will be processed to completion and the TPL documentation will be forwarded to the appropriate Uniformed Service claims office when complete.

1.4 Types Of Care

Contractor staff shall receive and accept calls directly from Service members requesting authorization for care which has not been MTF referred. If the caller is requesting after hours authorization for care while physically present in the Prime Service Area (PSA) of the MTF to which he/she is enrolled, the care shall be authorized in accordance with the contractor-MTF Memoranda of Understanding (MOU) established between the contractor and the local MTF. If the caller is traveling away from his/her duty station, the care shall be authorized if a prudent person would consider the care to be urgent or emergent. Callers seeking authorization for routine care shall be referred back to their MTF for instructions. The contractor shall send daily notifications to the Service members' enrolled MTF for all care authorized after hours according to locally established business rules.

2.0 COVERAGE

Except as authorized by this section, services that would not have ordinarily been covered under TRICARE policy (including limitations and exclusions) may be authorized for Service members only in accordance with the terms of a waiver approved by the Director, DHA, at the request of an authorized official of the Uniformed Service concerned, or by DHA-GL. (Reference HA Policy 12-002 "Use of Supplemental Health Care Program Funds for Non-Covered TRICARE Health Care Services and the Waiver Process for Active Duty Service Members.") TRICARE coverage limits continue to apply to services to non-active duty TRICARE-eligible covered beneficiaries provided under the SHCP.

2.1 On occasion, under the SHCP, care may be referred or authorized for services from a provider of a type which is not TRICARE authorized. This is limited to emergent cases, care under the DoD/VA MOA, or with a DHA waiver. The contractor shall not make claims payments to sanctioned or suspended providers. (See [Chapter 13, Section 5](#).) The claim shall be denied if a sanctioned or

suspended provider bills for services. MTFs do not have the authority to overturn DHA or Department of Health and Human Services (DHHS) provider exclusions. TRICARE utilization review and utilization management requirements will not apply.

- On occasion Service members may be referred or authorized for emergency services from a facility which is not TRICARE authorized (see the TRICARE Reimbursement Manual (TRM), Chapter 1, Section 29, paragraph 2.1). The Service member must be transferred to an authorized facility when a bed becomes available and it is safe (as determined by the Service member's current provider and accepting provider) to transfer the Service member. There is no time standard. Continued stay at an unauthorized facility beyond the emergent requirement requires a waiver under the SHCP. The Service member will be held harmless during this process.

2.1.1 In determining whether a given service or supply would not have ordinarily been covered under TRICARE policy, the contractor shall:

2.1.1.1 Deny health care services and supplies that are specifically excluded from coverage, as reflected in the TRICARE Manuals and on the No Government Pay List (NGPL);

2.1.1.2 Ensure application of any published frequency limitations, coverage criteria, and/or other TRICARE published criteria; and

2.1.1.3 Allow coverage for care provided under current Demonstration authority.

2.1.2 In making the determination required by paragraph 2.0, the contractor is not required to determine medical necessity. A referral from an MTF or an authorization from a SAS shall be deemed authorization for coverage of the private sector care.

2.1.3 Similarly, an MTF referral or SAS authorization for private sector care that is not specifically excluded from coverage, including the off-label use of an Food and Drug Administration (FDA) approved drug, device, or medical procedure for which no published exclusion exists, shall constitute authorization to process the claim for payment. MTF, SAS, or civilian provider requests for authorization for care that is considered by the Managed Care Support Contractor (MCSC) to be unproven per the TRICARE Policy Manual (TPM), Chapter 1 will be processed unless the request is for a specific published exclusion or all-inclusive limitation.

2.2 Upon receipt of an MTF referral/civilian provider referral (for remote Service members/non-enrolled Service members), the contractor shall perform a coverage review. A referral from an MTF or an authorization from a SAS shall be deemed to constitute member eligibility verification, as well as direction to bypass provider certification and Non-Availability Statement (NAS) rules. The contractor shall take measures as appropriate to enable them to distinguish between an MTF referral and a SAS authorization.

2.2.1 If the contractor determines that the service, supply, or equipment requested by an MTF referral is covered under TRICARE policy (including paragraph 2.2.4), the contractor shall file an authorization in its system and pay received claims in accordance with the filed authorization. If the contractor determines that the service, supply, or equipment requested by civilian provider referral (for remote Service members/non-enrolled Service members) is covered under TRICARE policy, the contractor shall forward the appropriate documentation to the SAS for authorization. Upon receipt

denied charges rendered by an approved demonstration provider unless the beneficiary was notified in writing that the care provided was not a covered benefit prior to receiving the care. Beneficiary-submitted claims for services provided by an approved demonstration provider in an approved demonstration area shall be denied unless it is submitted with proof of payment showing that the beneficiary has paid for the service(s).

4.5 Active Duty Service Members (ADSMs) are not eligible for TRICARE Standard and therefore are not included in this demonstration, regardless of their residence address or enrollment status. ADSMs not enrolled in TOP who are on Temporary Additional Duty/Temporary Duty (TAD/TDY), deployed, deployed on liberty, or in an authorized leave status in the Philippines shall follow referral/authorization guidelines for TOP Prime Remote enrollees (see [Chapter 24, Section 26](#)).

4.6 This demonstration is not applicable to beneficiaries enrolled in TOP Prime, TOP Prime Remote, TRICARE Prime, TRICARE Prime Remote (TPR), TRICARE Prime Remote for Active Duty Family Members (TPRADFMs), or TYA (Prime option). Additionally, this demonstration is not applicable to TRICARE Standard beneficiaries whose home address (as determined by the claim) indicates a residence other than the Philippines. The demonstration is also not applicable to TRICARE Standard beneficiaries who reside in the Philippines (as determined by the claim) when they receive care from a provider who renders care in a location that is not included in the demonstration.

4.7 All TOP requirements regarding utilization management, case management, quality management, and preauthorizations are applicable to demonstration participants. The TOP contractor is not required to enroll participants into the demonstration or to provide referral/authorization services to demonstration participants unless the requested service requires preauthorization (per [Chapter 7, Section 2](#) and TPM, [Chapter 1, Section 7.1](#)). The TOP contractor shall conduct a covered benefit review upon beneficiary or provider request; however, an authorization letter will not be generated except for those services which require preauthorization.

4.8 TRICARE Standard beneficiaries who reside in the Philippines may request a waiver if they elect to receive care from non-approved providers or facilities in a demonstration area. Beneficiary waiver requests should be submitted in writing to the TOP contractor and will be considered on a case-by-case basis. Except for emergency care (which never requires prior approval), beneficiaries are encouraged to submit waiver requests prior to receiving care. However, the TOP contractor will also consider waiver requests that are submitted after care has been rendered. The Director, TRICARE Area Office (TAO)-Pacific will make the final determination if the beneficiary disagrees with the TOP contractor's decision. In such cases, the TOP contractor shall forward all supporting documentation and rationale regarding the waiver denial determination to the Director, TAO-Pacific to assist in the final determination. Some examples of potential beneficiary waiver situations include (this list is not all-inclusive):

- Beneficiaries who were engaged in an ongoing episode of care with a non-approved provider when the demonstration began, and who wish to continue care with their established provider.
- Beneficiaries who are unable to obtain an appointment with an approved provider within the appropriate time frame (based on TRICARE access standards for urgent, routine, and specialty care).

Note: Waivers for emergency care rendered by non-approved providers or facilities shall be approved on a retrospective basis based on TRICARE policy. Emergency care never requires preauthorization.

4.9 Since provider participation in this demonstration is voluntary, there may be situations where the TOP contractor is unable to recruit a sufficient number and mix of approved providers in all specialties in designated demonstration areas. In these situations, the TOP contractor may request a specialty waiver so that beneficiaries can receive care from non-approved (certified) providers in accordance with normal TRICARE Standard reimbursement policy. The TOP contractor is responsible for identifying any anticipated or actual gaps in coverage by approved providers in demonstration area(s), and submitting a specialty waiver request in writing to the Director, TAO-Pacific. The waiver request shall include a description of the contractor's efforts to recruit approved providers in that particular specialty, as well as any perceived or known barriers to participation in the demonstration. If the Government approves the specialty waiver, the contractor shall implement processes to ensure that claims for that specialty (in the designated demonstration area) are processed under normal TRICARE Standard rules. This specialty waiver process will ensure that TRICARE Standard beneficiaries will not be liable for 100% of the charges (as described in [paragraph 4.4](#)) if the TOP contractor is unable to recruit approved providers in a particular specialty.

4.10 A provider may be removed from the list for administrative reasons or may be removed for cause by the TOP contractor. The Government may also direct the TOP contractor to remove providers from the list for cause. A provider removed from the approved list may submit a written request to the TOP contractor for reconsideration. If the TOP contractor upholds the removal, the provider shall be given the right to appeal to the Director, TAO-Pacific. If the appeal decision is upheld by the Director, TAO-Pacific, there is no right to further appeal.

Note: The appeal process does not apply to certified providers who are not selected by the TOP contractor to participate in the demonstration as approved providers. Recruiting and retaining a sufficient number and mix of approved providers in demonstration area(s) is the responsibility of the TOP contractor. The TOP contractor is not required to offer approved provider status to every current certified provider in demonstration area(s).

4.11 Claims for a provider removed from the list will be processed in accordance with [Chapter 13, Section 5](#). The list will be updated on the contractor's web site on the first of the month following the provider being removed from the list.

5.0 DHA AND TOP CONTRACTOR RESPONSIBILITIES

5.1 The DHA Deputy Director (or his or her designee) shall:

5.1.1 Determine the geographical area(s) for the demonstration and the phased implementation approach and timeline (if applicable) and communicate this information in writing to the TOP contractor no later than 240 calendar days prior to the start of health care delivery under the demonstration.

5.1.2 Establish a process to allow a provider to appeal his/her removal from the approved list (see [paragraph 4.10](#)).

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