

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.

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