

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
- TRICARE Management Activity (TMA) (e.g., initiated by TMA 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 a contractor receives an allegation of fraud or abuse or when a potentially fraudulent situation is first identified by contractor staff, the contractor shall initially review the case to eliminate obvious billing or claims/encounter processing errors. This review shall be restricted to an examination of the internal processing of the claims/encounter to identify possible sources of any error. A TRICARE Fraud and Abuse Report will be completed to establish a case file ([Addendum A, Figure 13.A-1](#)).

Note 1: Definition of case development is a unit of work.

Note 2: For purposes of this chapter, for Managed Care Support Contractors (MCSCs), encounter is defined as the personal contact between the patient and a professional health care giver in a managed care program in which a fee-for-service claim is not submitted.

TRICARE Operations Manual 6010.56-M, February 1, 2008

Chapter 13, Section 2

Case Development And Action

2.1 Claims processing error identified: If it is established that a complaint received directly from a beneficiary, provider, pharmacy, or other source was due to a claims processing error, the error shall be corrected. The contractor may then close out the case and notify the complainant, subject to disclosure of information guidelines (Privacy Act, Health Insurance Portability and Accountability Act (HIPAA)), of their findings. The contractor shall clearly document the reason for the case closure.

2.2 Inability to Determine Error - Possibility of Fraud or Abuse: After possible internal processing errors have been ruled out, the contractor shall control the case on a management reporting system for fraud and abuse cases and proceed to develop the case. The contractor, shall identify when the aberrant billings started (such as, when the claims were initially denied as noncovered). The contractor shall review prior educational efforts, warnings, recoupments, case referrals and sanctions in regards to the case.

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 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. For mental health claims, a clinical psychologist, psychiatric nurse practitioner or a psychiatrist shall be used. 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. These personnel must have a thorough knowledge of medical policy, standards and TRICARE criteria. The reviewer shall document, in detail, the rationale for the audit findings. The review must be dated and include the clinical specialty 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 TMA. Whenever the case is complex, physician consultants, with a specialty appropriate to the case, shall be involved in the review. In the case of mental health claims, a staff or consultant physician shall be involved in complex cases. The physician shall review the claims and document the rationale for the audit findings. The review must be dated and include the clinical specialty of the reviewer, the signature (not initials), and the legibly printed name of the reviewer.

3.1.3 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. See [Section 1, paragraph 1.4](#) for additional information.

3.2 Common Audits

3.2.1 Probe Audit

A probe audit is a sample of limited number of claims that are identified systematically to

determine if claims are being billed inappropriately. The results of a sample audit may trigger the need for the contractor to perform a statistically valid random sample of 100% audit sample.

3.2.2 Statistically Valid Random Sample

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

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

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

3.2.3 One-Hundred Percent (100%) Claims Audit

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

3.2.4 External Audit

A secondary method of determining probable fraudulent practices is an external audit to beneficiaries for confirmation of services. This may be used to supplement a claims audit method. These audits shall address 100% of the beneficiaries who received services from a provider within a recent period of no more than one year. If the case involves a provider seeing more than 50 beneficiaries for whom a claim has been submitted, a systematic sample (a sample selection using an interval such as every fifth, 10th, etc., claim) may be used to select beneficiaries for external audit validation of services. Generally, no less than 50 external audit letters shall be sent ([Addendum A, Figure 13.A-2](#)). In cases where the beneficiary has altered a bill, an external audit to the provider shall be conducted ([Addendum A, Figure 13.A-3](#)). The suspense period for receipt of the response to the letters is 30 days with a follow-up, either written or by phone, at the 30th day.

3.3 Reporting Audit Findings

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

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

4.0 CASE DISPOSITION

4.1 General

Contractors shall refer to TMA only those cases that involve more than a \$25,000 loss to the government (more than \$10,000 for pharmacy and dual eligible) or cases with any loss where patient harm has occurred. Contractor shall handle administratively, those cases that involve less than a \$25,000 loss to the government (less than \$10,000 for pharmacy and dual eligible).

4.2 Potential Fraud and Abuse Exposure Cases Under \$25,000 Loss without Patient Harm

4.2.1 Cases determined on review to support allegations of fraud but are under \$25,000, (\$10,000 for pharmacy and dual eligible cases) without patient harm the case should not be referred to TMA.

Note: For purposes of this chapter, patient harm refers to a fraudulent or abusive practice directly causing a patient who is undergoing treatment for a disease, injury, or medical 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 provider.

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

4.2.3 Recoupment action should be taken on any monies paid in error. Re-evaluate the providers in six months to a year to determine if the aberrant billing practices have been discontinued. If they have not, follow the procedures for referring the case to TMA. A critical piece of evidence to include in the referral is the educational letter with the signed receipt.

4.2.4 Exception, if clear and convincing evidence of fraud/abuse is identified, circumstances may warrant referral of a case less than \$25,000, (\$10,000 for pharmacy and dual eligible), and will require the contractor to contact TMA PI to discuss allegations and findings.

4.3 Potential Fraud and Abuse Exposure Cases Over \$25,000 Loss (\$10,000 for Pharmacy and Dual Eligible Cases) or Any Loss with Patient Harm

4.3.1 Cases determined on review to support allegations of fraud that are over \$25,000, (\$10,000 for pharmacy and dual eligible cases) or cases of any loss with patient harm shall be developed for potential referral to TMA for forwarding to the Department of Justice (DOJ), United States Attorney's Office (USAO).

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

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

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

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

4.4 Special Interest Cases

4.4.1 Unbundling

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

4.4.2 Problem Provider Cases

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

4.4.3 Pharmacy Fraud

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

4.4.4 Conflict of Interest; Federal Employees and Active Duty Military

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

4.4.5 Eligibility Fraud

Cases of beneficiary eligibility fraud require the Social Security Number (SSN) to be flagged to prevent further claims from being processed or providing services by a network provider or network pharmacy. Develop and refer to TMA only those cases that involve more than a \$25,000 loss to the government (less than \$10,000 for pharmacy and dual eligible). Handle administratively those cases that involve less than a \$25,000 loss to the government (less than \$10,000 for pharmacy and dual eligible). Only at the direction of the Chief, TMA PI, with the concurrence of the TMA Office of General Counsel (OGC), will a provider's, pharmacy's, or beneficiary's claims be indefinitely suspended from payment due to potential fraud. In this case, formal notification to the provider, pharmacy, or beneficiary by the contractor will occur ([Addendum A, Figure 13.A-4](#) and [Figure 13.A-5](#)). The contractor, upon written request from the TMA PI, shall notify in writing the Regional Director (RD) and the Health Benefits Advisors (HBAs) in close proximity to the provider. For pharmacies, upon written request from the TMA PI, the contractor shall notify in writing the COR and HBAs in close proximity to the network pharmacy. 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 TMA PI, shall send a special and specific notice to the beneficiary ([Addendum A, Figure 13.A-6](#)). See also [Section 3, paragraph 3.2](#).

4.4.6 Identification Theft

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

4.4.7 Drug Seeking Beneficiaries

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

- Pend all claims for the beneficiary;
- Establish the necessity for the drugs and their appropriateness on the basis of diagnosis or definitive symptoms;
- Deny all related claims if a drug abuse situation does exist including office visits or emergency room visits if the purpose of the visit was to obtain drugs; and

- Reopen prior claims (most recent 12 months) for the beneficiary and review those claims to determine whether or not drug abuse existed at the time the earlier claims were paid. If drug abuse is ascertained for prior claims, recoupment action shall be taken for the erroneous payments.

4.4.7.2 The contractor shall request the beneficiary to select a physician, who will act as the primary care physician coordinating all care and making referrals when appropriate. For Prime enrollees, the contractor shall take action to manage the beneficiary's treatment as appropriate. The contractor shall not submit these cases to the TMA PI unless potential fraud is identified, such as altered prescriptions or drug receipts, or aberrant prescribing patterns by the physician. When appropriate, the contractor shall develop the case as stated in [paragraph 4.3](#). The contractor shall also coordinate efforts with other TRICARE contractors as needed to ensure medical, dental, and pharmacy benefits are not being abused and to ensure the beneficiary's care is appropriately managed.

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

4.4.8 Possible Forgery of Check Endorsement

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

4.4.8.1 Affidavit Required

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

4.4.8.2 Request for Credit

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

4.4.8.3 Issuing a Replacement Check

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

4.4.8.4 Cooperating in Investigation/Prosecution

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

4.4.8.5 Reporting

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

4.4.8.6 Time Limits

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

5.0 TMA REFERRALS

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

5.2 In suspected cases of fraud/abuse, the contractor shall not send an educational letter or attempt recoupment unless an exception is specifically permitted elsewhere in this chapter (e.g., violation of participation agreement in reimbursement limitation, potential loss is less than \$25,000). Administrative remedies can adversely impact civil or criminal prosecution of a case and are inappropriate if fraud is suspected.

5.3 The contractor shall refer all developed (i.e., clerical and/or processing errors have been ruled out and the case exceeds the exception provided in [paragraph 5.0](#)) allegations of potential fraud to the TMA PI within 180 calendar days of identification of potential fraud and abuse, in accordance with [paragraph 5.0](#). Identification means the contractor has been made aware of allegations of fraud/abuse by a beneficiary, provider, law enforcement, other source, or proactive measures. The contractor shall not report fraud and abuse cases which are suspected of violating Federal law directly to the Defense Criminal Investigating Service (DCIS), Military Criminal Investigation

Organizations (MCIOs), Federal Bureau of Investigation (FBI) or any other investigative organization. All cases shall be reported to TMA PI in accordance with the procedures in this chapter.

Note: Up to 180 days is allowed to develop a case. Once a case is developed the case should be referred within 30 days of development completion. Exception to the 180 day referral must be requested in writing and approved by the Director, TMA PI or designee.

5.4 The contractor shall not respond to direct requests for documentation from investigative agencies, private payer plans, anti-fraud associations, or other entities. The contractor shall promptly notify the TMA PI of any requests made directly to the contractor. If the contractor responds directly to a request for documentation from an investigative agency or other entity, the costs of responding shall not be charged to the contract.

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

6.0 FRAUD AND ABUSE CASE REFERRAL CONTENT

6.1 General

[Addendum A, Figure 13.A-18](#) will be used by TMA to evaluate each referred case. Each case referred to TMA PI by the contractor shall be submitted in duplicate. The contractor is required to provide complete copies of any case files TMA PI requests (i.e., utilization reviews, patterns of practice, etc.) at no cost to the government.

6.2 Case Summary

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

- The allegations citing all the applicable TRICARE regulatory provisions that have been violated in regards to each allegation.
- A description of the individual or institution suspected of committing or attempting to commit the alleged wrongful behavior, including all appropriate information, such as the beneficiary's name, sponsor's status and SSN, beneficiary's relationship to sponsor, provider's specialty (e.g., General Practitioner or Pharmacy) and identification number, address, telephone number, etc.
- A description how the suspicious behavior was uncovered, e.g., audit, prepayment screen, beneficiary, pharmacy, provider complaint, tip, DoD Hotline, investigator notification, etc. In addition, indicate the date the allegations were identified.

- A description clearly summarizing the behavior which is suspected to be in violation of Federal law, regulation or policy; for example, billing for services, pharmaceuticals or supplies that were not provided, altering receipts or claim forms, duplicate billing, providing incorrect information when seeking preauthorization, etc. This shall include identifying specific facts that illustrate the pattern or summary conclusions. For example: submitted probable false claims to the contractor through the U.S. Post Office or via electronic mail, altered checks, misrepresented the description and coding of services, falsified the name of the actual provider of care, falsified the name of the actual pharmacy dispensing the prescription, altering medical records, etc.
- A description of all action taken during developmental stage, to include contacts made, information obtained, potential problematic issues, etc.
- A description of the estimate the number of claims or encounters, the length of time the suspicious behavior has occurred and the government's and contractor's loss.
- A description of the current status of claims or other requests submitted by the suspected provider, pharmacy or beneficiary, i.e., regular development, processing and payment or denial, claims suspension, prepayment review, etc.
- A description of any relevant documents provided, such as any correspondence with the provider, pharmacy or beneficiary, telephone conversation records, provider certification files, requests for medical records, educational letters, recoupment letters, etc.
- A description of previous and/or ongoing administrative measures (educational efforts, prepay review, etc.).
- A description of all actions taken to identify and determine the total TRICARE exposure, including coordination with other contractors. The Case Summary shall indicate the total monetary exposure to TRICARE and if actual patient harm has occurred.
- A description of any other facts that may establish a pattern of practice or indicate that the provider, pharmacy or beneficiary intended to defraud the government or the contractor.

6.3 Copies of Supporting Documents

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

- A completed TRICARE Fraud and Abuse Report (TMA Form 435, [Addendum A, Figure 13.A-1](#)).
- Copies of the applicable TRICARE regulatory provisions violated.
- Enclose copies of each claim, explanation of benefits forms, medical records, pharmacy records, provider certification file and other documents demonstrating the suspicious behavior in individually labeled file folders.

TRICARE Operations Manual 6010.56-M, February 1, 2008

Chapter 13, Section 2

Case Development And Action

- Enclose a history covering the most recent 24 month period (or the identified period of time, if longer than 24 months) in electronic media in dBase IV, or MS/EXCEL spreadsheet (Version 2000 or later) to electronic media and have the capability to compress the data using WIN-Zip self extracting software, with no less than version 2.4 or provide the data on a CD-ROM. Hard copy histories are acceptable only for histories of less than 100 claims/encounters.
- Enclose a copy of 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.
- Provide a copy of all contractor audits on the suspected provider, pharmacy or beneficiary. All audits will include a summary spreadsheet that clearly identifies the audit parameters, the findings for each patient audited (or claim, depending on how the audit is set up), and totals all applicable columns. Each patient's claim(s) and supporting documentation shall be filed in a separate manila folder which clearly identifies, by last name, the patient and sponsor's SSN. Each folder shall contain the contractor's individual audit sheet for those claims.
- Provide copies of relevant procedure codes, revenue codes, etc.

7.0 CONTRACTOR ADMINISTRATIVE ACTIONS

7.1 General

7.1.1 Fraudulent and abusive practices are violations of the 32 CFR 199 may constitute violations of the US Criminal Code (title 18).

Investigations, criminal, civil or administrative, are matters within the jurisdiction of the Federal Government. The US reserves the right(s) to resolve any disputes with third parties over the submittal of false claims under TRICARE or claims that potentially may be false claims. The definition of "false claims" in the False Claims Act, 31 U.S.C. 3729, applies to this contract provision.

7.1.2 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 \$25,000.00 (\$10,000 for pharmacy and dual eligible) without patient harm. The time period for the claims involved is 12 or more months.
- The government has not provided written declination or taken any action on a case for 12 months after receipt from the contractor. The contractor shall contact TMA PI first to ensure the case is not under active investigation.
- The contractor has received a written declination from the government for the case.

7.1.3 The contractor shall not take administrative action (including quality interventions) without TMA approval under the following circumstances:

- The case has been identified for referral to TMA PI.
- The case has been referred to TMA PI and the government has not provided a declination or taken action for a period of less than 12 months.
- The case is under active law enforcement investigation (federal, state or local).
- The case is being prosecuted criminally or civilly.

7.1.3.1 Exception, if the contractor determines that circumstances warrant initiation of administrative actions, the contractor must contact TMA PI to seek approval before initiating administrative measures.

7.1.4 Administrative actions may include:

- Referring case to local or state investigations for referral to district attorney or state attorney general. If this course of action is taken no other administrative actions should be initiated unless a declination is received from the investigative body the case was referred to. TMA and the contractor will provide assistance to local or state authorities in their investigation and prosecution of a case administratively referred.
- Removal from the preferred provider network.

7.1.5 Administrative actions routinely include:

- Educating the beneficiary/provider.
- Placing the beneficiary or provider on prepayment or postpayment review.
- Initiating recoupment action. This should include initiating recoupment action on extrapolated damages determined as a result of billing errors identified in a statistically random sample audit.

7.2 Administrative Measures Routinely Implemented

7.2.1 Educational Efforts

Beneficiaries and providers may be certified mailed 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.

7.2.2 Prepayment Review

Providers/beneficiaries with atypical billing patterns or with a particular problem (e.g., errors in billing of a specific type of service) in submitting correct claims may be placed on prepayment review. Once on prepayment review their claims are subjected to review along with any claim attachments, including medical records and other supporting documentation to verify that the claims are free of billing problems. Prepayment reviews may require providers to submit medical records. 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 has been placed on prepay review monitoring they typically remain on prepay review monitoring for a period of one year. If the provider ceases the aberrant practices the provider is removed from prepayment review. However, if aberrant practices continue the provider shall remain on prepayment monitoring. If a provider or beneficiary is placed on prepayment review before the contractor determines the case is appropriate for TMA 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 has been placed on prepay review and when that administrative measure was initiated. See [Section 3, paragraph 2.0](#).

7.2.3 Recoupments/Offsets

See [32 CFR 199.11](#) and [paragraph 4.2.3](#).

7.2.4 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.

7.3 Refund of Payment Actions: TMA Direction

7.3.1 If the contractor's investigation identifies potential fraud or abuse and involves an overpayment, the contractor shall not request a refund of the overpayment or initiate offsets, except for eligibility cases where the loss is less than \$25,000. The contractor shall obtain written instructions from the TMA PI prior to taking any adverse action, to preclude such action from interfering with the government's investigation. At the TMA direction claims processing may be suspended.

7.3.2 If a suspect voluntarily remits a refund, the contractor shall deposit it in the contractor's bank account if the refund is for a service paid by the contractor. If the monies were paid by a previous contractor, the contractor shall forward the check to the TMA, Finance and Accounting Branch, along with an explanation and case identification. Photocopies of the remittance (check, money order, etc.) shall be made and placed in the case file of the suspect to maintain a complete record of all financial transactions related to the case. Such record (ADP printouts, manually developed financial transaction records, etc.) shall be retained by the contractor in the case file until the final disposition of the case. All voluntary remits shall be reported to TMA PI.

7.4 Claims Processing Suspension

7.4.1 Only at the direction of the Director, TMA PI, with the concurrence of the TMA OGC, will a provider's, pharmacy's or beneficiary's claims be indefinitely suspended/pended from payment due to potential fraud. In this case, formal notification to the provider, pharmacy, or beneficiary by the contractor will occur (see [Addendum A, Figure 13.A-4](#) and [Figure 13.A-5](#)). The contractor, upon written request from the TMA PI, shall notify in writing the Regional Director and the HBAs in close proximity to the provider. For pharmacies, upon written request from the TMA PI, the contractor shall notify in writing the COR and the HBAs in close proximity to the network pharmacy. 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 TMA PI, shall send a special and specific notice to the beneficiary (see [Addendum A, Figure 13.A-6](#)).

- END -