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TRICARE
MANAGEMENT ACTIVITY

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CHANGE 61
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**PUBLICATIONS SYSTEM CHANGE TRANSMITTAL
FOR
TRICARE OPERATIONS MANUAL (TOM), FEBRUARY 2008**

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

CHANGE TITLE: DENTAL PROGRAM REQUIREMENTS

CONREQ: 15446

PAGE CHANGE(S): See page 2.

SUMMARY OF CHANGE(S): This change moves requirements that are currently attachments to the Active Duty Dental Program (ADDP) and TRICARE Dental Program (TDP) contracts, and publishes them in the TRICARE Operations Manual (TOM) and TRICARE System Manual (TSM).

EFFECTIVE AND IMPLEMENTATION DATE: Upon direction of the Contracting Officer.

This change is made in conjunction with Feb 2008 TSM, Change No. 30.

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Director, Operations Division

ATTACHMENT(S): 63 PAGES
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REMOVE PAGE(S)

CHAPTER 13

Section 1, pages 1 through 5

Section 2, pages 1 through 14

Section 3, pages 1 through 9

Section 4, pages 1 and 2

Section 5, page 1

Addendum A, pages 25 through 28

APPENDIX A

pages 7 - 31

INSERT PAGE(S)

Section 1, pages 1 through 6

Section 2, pages 1 through 14

Section 3, pages 1 through 10

Section 4, pages 1 and 2

Section 5, page 1

Addendum A, pages 25 through 29

pages 7 - 31

General

1.0 CONTRACTOR'S PROGRAM INTEGRITY RESPONSIBILITY

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

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

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

1.4 The contractor shall conduct the following functional activities:

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

referred to TMA. This is in addition to cases being developed under other methods, i.e., receipt of beneficiary complaints, law enforcement inquiries, other private plan referrals, etc. Finally, utilizing all methods of identifying fraud/abuse cases, this shall result in referring a minimum of 10 cases (meeting the criteria outlined in [Section 2](#)) to TMA each year. The list of cases and their disposition shall be included as an addendum to the fourth quarter Fraud and Abuse Summary Report. This [paragraph 1.4.1](#) is not applicable to the TRICARE Dual Eligibility Fiscal Intermediary Contract (TDEFIC).

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

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

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

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

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

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

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

1.4.7 Develop and maintain standard operating procedures (e.g., desk procedures). A copy, in electronic read-only format, shall be provided to TMA PI at the start of the contract with updates provided as changes occur.

1.4.8 In relation to TRICARE dual eligibles, the contractor shall follow the provisions outlined in this chapter.

2.0 ROLES AND RESPONSIBILITIES OF COOPERATING COMPONENTS

2.1 TMA

The Director, TMA, and designees administer the TRICARE program in accordance with TRICARE law, 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 TMA PI

The TMA PI is the centralized administrative hub for anti-fraud and abuse activities worldwide. The Office is responsible for developing policies and procedures regarding prevention, detection, investigation and control of TRICARE fraud, waste and program abuse, monitoring contractor program integrity activities, coordinating with Department of Defense (DoD) and external investigative agencies and initiating administrative remedies as required.

2.3 TMA OGC

The TMA OGC is responsible for providing legal counsel and legal services to TMA. It is the principal point of contact on all legal matters involving the Department of Justice (DOJ) and its Federal Bureau of Investigation (FBI). This office serves as DOJ's primary contact point in civil litigation involving benefit funds, and in preparing for litigation or pursuant to litigation, may make direct requests to TMA offices, principally the TMA PI, and contractors for information and records. The TMA OGC is responsible for actions pursued under the Program Fraud Civil Remedies Act (PFCRA) and, in developing or pursuing a PFCRA case, may request information, data, and records from TMA offices and contractors. Settlements that affect the agency (e.g., civil settlement involving a monetary compromise, a provider's or pharmacy's TRICARE status, compromise of waiver of any sanction) must be coordinated with and approved by TMA, OGC, or designee.

2.4 Department Of Defense Inspector General (DoDIG)

The DoDIG has the responsibility to conduct, supervise, monitor, and initiate investigations relating to fraud within the DoD. This authority specifically includes TMA, its employees, contractors and subcontractors. This authority is not limited by the type of contract which has been entered into by the Director, TMA. 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

The 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 TMA), and any other fraud investigation deemed appropriate by the DoDIG or designated representative.

The DCIS has primary investigative jurisdiction for cases concerning alleged fraud/abuse. This includes cases that may involve the use of facilities by medical providers on military installations, alleged fraud by retired service members and their family members, 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 who have received health care services.

2.7 Defense Contract Audit Agency (DCAA)

Upon request, the DCAA provides audit assistance to TMA 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.

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. For example, cases involving drug seeking beneficiaries should be coordinated with the MCSCs, dental contractor(s), TDEFIC contractor, and pharmacy contractor. Another example would be where the suspected provider is part of a national or regional chain and the suspected fraudulent or abusive practice may be part of a pattern repeated by other members of the chain. The TMA PI shall be informed in the case report of these contacts and findings. Findings of potential fraud or abuse by another contractor shall be reported to the TMA PI by the contractor which initiated the investigation.

3.1.2 In any situation which could lead to duplicate investigative efforts that could compromise an investigation, the contractors involved must notify the TMA PI for the proper coordination.

3.1.3 During the development of a TMA fraud referral, coordination is required when one TRICARE contractor must contact a provider that has a contractual relationship (network agreement) with another TRICARE contractor. In such instance, the contractor without the contractual relationship shall contact the TMA PI, and that office will coordinate the necessary activities between the contractors.

3.1.4 Those issues that cannot be resolved at the operational level between the contractors shall be elevated to TMA PI for resolution.

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

3.2.1 DOJ has jurisdiction for criminal and civil action. Requests for information related to criminal and/or civil action must be referred to the TMA PI.

3.2.2 The DoDIG has jurisdiction over all cases involving suspected fraud or other criminal activity under TRICARE. Requests for information by the criminal investigative arm of the DoDIG, DCIS, shall be referred to the TMA PI. Contractor contact by any other investigative agency, e.g., FBI, MCIOs, etc., shall also be reported immediately to the TMA 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 the TMA PI.

3.2.3 The contractor shall provide investigative and prosecutive support, at the direction of the TMA PI or OGC, by downloading claims data in no less than dBase IV+ or Microsoft® (MS) Excel spreadsheet (Version 2000 or later) format 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. Other documentation or data to be provided may include, but it 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 equipment available to meet the timeliness requirement of 10 calendar days for retrieval, transmission, and/or mailing of the information.

3.2.4 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.

3.2.5 The contractor must identify and provide for expert or program witnesses at Grand Jury hearings, criminal trials and civil and administrative cases at TMA PI request. An expert witness is an individual having acquired a special skill or knowledge through training or experience on a subject being discussed. This could be a professional person (medical doctor, dentist, etc.) or a technical person (lab/x-ray technician, ADP person, etc.) 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.

3.2.6 The contractor must provide technical and professional consultation concerning the operations and benefits of TRICARE as well as case specific information or other relevant data to investigative agencies, DOJ or USAO for both criminal and civil cases.

3.3 Contacts By Suspects Or Their Legal Representative

The contractor shall refer all contacts with the contractor by the suspect or his/her legal representative (personal, letter, or telephone) to the TMA OGC. A copy shall also be provided to TMA PI.

3.4 Coordination With Private Business And Other Government Contractors

Contractors shall implement procedures for and coordinate potential fraud or abuse cases with the program integrity units of their private business and other Government contractors, such as Medicare or Medicaid, subject to any federal restrictions (e.g., Privacy Act, Health Insurance Portability and Accountability Act of 1996 (HIPAA)). Procedures shall be shared with TMA PI upon request. Coordination is limited to providing summary data only (e.g., do not release protected health information).

- 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
- 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, encounter is defined as the personal contact between the patient and a **provider (e.g., professional health care giver, pharmacist, or dentist), to include instances** in a managed care program in which a fee-for-service claim is not submitted.

2.1 Claims processing error identified: If it is established that a complaint received directly from a beneficiary, provider, pharmacy, **dental practice**, 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. **For pharmacy or dental claims, trained professional pharmacists or dental reviewers shall be used who can make judgments based on professional education and experience.** 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, **pharmacy, or dental** 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, **pharmacy, or dental** 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, **pharmaceutical, or dental** 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, **pharmacist, or dentist** 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, dental, 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 (\$10,000 for Pharmacy, Dental, and Dual Eligible Cases)

4.2.1 Cases determined on review to support allegations of fraud but are under \$25,000, (\$10,000 for pharmacy, dental, 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 (or dental) condition to suffer actual physical injury or psychological injury or acceleration of an underlying condition. The determination that patient harm has occurred must be based on the opinion of a qualified medical or dental provider or pharmacist in the case of pharmacy claims.

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

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

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

4.2.4 Exception, if clear and convincing evidence of fraud/abuse is identified, circumstances may warrant referral of a case less than \$25,000, (\$10,000 for pharmacy, dental, 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, Dental, 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, dental, 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, pharmacy, or dental practice is billing for services not rendered, the provider is not providing or referring the beneficiary for appropriate care which is medically necessary per medical standards (or in the case of dental, necessary per dental standards), or provider, pharmacy, or dental practice is falsifying medical records.

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

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

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

4.4 Special Interest Cases

4.4.1 Unbundling

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

4.4.2 Problem Provider Cases

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

4.4.3 Pharmacy Fraud

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

4.4.4 Conflict of Interest; Federal Employees and Active Duty Military

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

4.4.5 Eligibility Fraud

Cases of beneficiary eligibility fraud require the Social Security Number (SSN) or DoD Benefits Number (DBN) to be flagged to prevent further claims from being processed or providing services by a network provider or network pharmacy. Develop and refer to TMA only those cases that involve more than a \$25,000 loss to the government (less than \$10,000 for pharmacy, dental, and dual eligible). Handle administratively those cases that involve less than a \$25,000 loss to the government (less than \$10,000 for pharmacy, dental, 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, dental practice's, or beneficiary's claims be indefinitely suspended from payment due to potential fraud. In this case, formal notification to the provider, pharmacy, dental practice, 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), the Health Benefits Advisors (HBAs), and the Beneficiary Counseling and Assistance Coordinators (BCACs) in close proximity to the provider. For pharmacies, upon written request from the TMA PI, the contractor shall notify in writing the COR, HBAs, and BCACs 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 and/or dental claims for potential overutilization and substance abuse. If a potential drug abuse situation is identified by a private physician, a physician reviewer in the course of business for the contractor, a dentist, pharmacist, or a physician in a hospital setting, as representing an addictive state in the beneficiary, the beneficiary shall be placed on 100% prepayment review. The [32 CFR 199.4](#) precludes government cost-sharing of benefits to support or maintain potential drug abuse situations. This is true, whether or not the drugs are obtained by legal means and are otherwise eligible for benefit consideration under other circumstances. The contractor shall:

- Pend all claims for the beneficiary;

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

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

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

4.4.8 Possible Forgery of Check Endorsement

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

4.4.8.1 Affidavit Required

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

4.4.8.2 Request for Credit

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

4.4.8.3 Issuing a Replacement Check

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

4.4.8.4 Cooperating in Investigation/Prosecution

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

4.4.8.5 Reporting

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

4.4.8.6 Time Limits

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

5.0 TMA REFERRALS

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

5.2 In suspected cases of fraud/abuse, the contractor shall not send an educational letter or attempt recoupment unless an exception is specifically permitted elsewhere in this chapter (e.g., violation of participation agreement in reimbursement limitation, potential loss is less than \$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 has up to 180 days, after identification of potential fraud and/or abuse, to develop a case for referral (clerical and/or processing errors have been ruled out) in accordance with [paragraph 5.0](#). Identification means the contractor has been made aware of allegations of

fraud/abuse by a beneficiary, provider, law enforcement, other source, or proactive measures. Once developed, the case shall be referred within 30 days of development completion. Exception to the above must be requested in writing and approved by the Director, TMA PI or designee.

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

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

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

6.0 FRAUD AND ABUSE CASE REFERRAL CONTENT

6.1 General

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 or DBN, beneficiary's relationship to sponsor, provider's specialty (e.g., General Practitioner, Dental Surgeon, or Pharmacy) and identification number, address, telephone number, etc.

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

6.3 Copies of Supporting Documents

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

- A completed TRICARE Fraud and Abuse Report (TMA Form 435, [Addendum A, Figure 13.A-1](#)).
- Copies of the applicable TRICARE regulatory provisions violated.

TRICARE Operations Manual 6010.56-M, February 1, 2008

Chapter 13, Section 2

Case Development And Action

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

7.1.2 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 USC 3729, applies to this contract provision.

7.1.3 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, dental, 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.

7.1.4 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.

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.

7.1.5 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.

7.1.6 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 and dental 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/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. 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/beneficiary 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, F&AO, 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

Only at the direction of the Director, TMA PI, with the concurrence of the TMA OGC, will a provider's, pharmacy's, **dental practice's**, or beneficiary's claims be indefinitely suspended/pended from payment due to potential fraud. In this case, formal notification to the provider, pharmacy, **dental practice**, 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 **RD**, **HBA's**, and **BCAC's** in close proximity to the provider or **network dentist**. For pharmacies, upon written request from the TMA PI, the contractor shall notify in writing the **COR**, **HBA's**, and **BCAC's** 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 -

Prevention And Detection

1.0 FRAUD AND ABUSE

1.1 Abuse is defined in [32 CFR 199.2](#) as:

"...any practice that is inconsistent with accepted sound fiscal, business, or professional practice which results in a TRICARE claim, unnecessary costs, or TRICARE payment for services or supplies that are: (1) not within the concepts of medically necessary and appropriate care as defined in this Regulation, or (2) that fail to meet professionally recognized standards for health care providers. The term "abuse" includes deception or misrepresentation by a provider, or any person or entity acting on behalf of a provider in relation to a TRICARE claim."

1.2 Fraud is defined in the Regulation as:

"...1) a deception or misrepresentation by a provider, beneficiary, sponsor, or any person acting on behalf of a provider, sponsor, or beneficiary with the knowledge (or who had reason to know or should have known) that the deception or misrepresentation could result in some unauthorized TRICARE benefit to self or some other person, or some unauthorized TRICARE payments, or 2) a claim that is false or fictitious, or includes or is supported by any written statement which asserts a material fact which is false or fictitious, or includes or is supported by any written statement that (a) omits a material fact and (b) is false or fictitious as a result of such omission and (c) is a statement in which the person making, presenting, or submitting such statement has a duty to include such material fact. It is presumed that, if a deception or misrepresentation is established and a TRICARE claim is filed, the person responsible for the claim had the requisite knowledge. This presumption is rebuttable only by substantial evidence. It is further presumed that the provider of the services is responsible for the actions of all individuals who file a claim on behalf of the provider (for example, billing clerks); this presumption may only be rebutted by clear and convincing evidence."

2.0 CONTROLS, EDUCATION, TRAINING

2.1 Prevention And Detection Of Fraudulent Or Abusive Practices

The contractor shall establish procedures for the prevention and detection of fraudulent or abusive patterns and trends in billings by providers, pharmacies, and beneficiaries on a pre- and postpayment basis. (These procedures shall be made available to the TRICARE Management Activity (TMA) Program Integrity Office (PI).) The key functions include, but are not limited to:

- Eligibility verifications for beneficiaries and providers/pharmacies.

- Duplicate payment prevention. On a quarterly basis each fiscal year, the contractors shall generate and utilize reports from the automated TRICARE Duplicate Claims System (DCS) to identify the reasons for actual duplicate payments. The automated TRICARE DCS contains pre-formatted reports which will assist in identifying the reasons for actual duplicate payments (see [Chapter 9](#) for report formats). Based on review of these reports, contractors shall develop and implement corrective actions to improve prepayment duplicate detection and reduce actual duplicate payments.

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

- Coordination of benefits.
- Prepayment utilization control as applied to program exclusions and limitations and detection and/or control of fraud and abuse. This shall include utilization of discretionary or coordinated placement of providers/beneficiaries on prepayment review. (See also, [Section 2.](#))
- Application of utilization review and quality assurance standards, norms and criteria.
- Postpayment utilization review to detect fraud and/or abuse by either beneficiaries, pharmacies, or providers and to establish dollar loss to the government.
- Application of security measures to protect against embezzlement or other dishonest acts by employees.
- Enforcement of conflict of interest provisions and dual compensation prohibitions.

2.2 Internal Management Control Reviews

2.2.1 The contractor shall perform internal management control reviews as described in [Chapter 1, Section 4, paragraph 3.0](#).

2.2.2 In accordance with the Financial Manager's Integrity Act, an Annual Letter of Assurance (ALA) will be issued by the contractor on October 1 of each year. The period covered by the ALA will be for the just completed government fiscal year (i.e., October 1st through September 30th). In the letter, the contractor shall certify that there is a corporate commitment to having controls in place to prevent and detect fraudulent and abusive practices and that the contractor understands and will comply with its contractual obligations in that respect ([Addendum A, Figure 13.A-7](#)).

2.3 Fraud And Abuse Education

2.3.1 The contractor shall establish and maintain a formal training program for all contractor personnel in the detection of potential fraud or abuse situations. This may be included as a specific segment of the contractor's regular training programs. (See [Chapter 1, Section 4, paragraph 5.0](#).) Training program material shall be made available to TMA PI. The contractor shall provide desk procedures to the staff which include methods for control of claims/encounters exhibiting unusual patterns of care, over or under utilization of services, or other practices which may indicate fraud or

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 TMA PI (see [Section 1, paragraph 1.4.7](#)).

2.3.2 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 TMA PI at the same time distribution is made to providers/beneficiaries. Electronic versions are acceptable.

2.4 Claim/Encounter Review Procedures And Controls

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. [Section 2](#) provisions shall be followed as necessary.

2.5 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. If a network Primary Care Manager (PCM) or pharmacy is determined to be engaged in potential fraudulent practices, the contractor at its discretion, may terminate the network agreement. The contractors shall reassign the beneficiaries to another PCM. The contractor's actions shall be in a manner so as to not jeopardize the Government's investigation.

2.6 Gag Clauses

The contractor shall ensure there are no gag clauses in their contracts or policies with providers. Gag clauses are provisions that prevent providers, explicitly or implicitly, from giving patients information about treatment options that may be taken or from referring very ill patients outside the network to authorized providers with rare expertise in the types of care needed. The American Medical Association's (AMA's) Code of Ethics has declared gag clauses an unethical interference in the physician-patient relationship.

3.0 EXAMPLES OF FRAUD AND ABUSE SITUATIONS

3.1 Managed Care Fraud

3.1.1 Misrepresenting actual provider of service when the services were provided by a lower level provider or a provider not authorized to provide the service by virtue of failing to meet regulatory requirements.

3.1.2 Misrepresenting patient encounters, treatment outcomes and/or diagnoses to disguise undertreatment or to artificially inflate the amounts of future capitation payments. In some cases it may be necessary to look at the financial arrangements (contract) with the provider to determine the financial incentive of the provider.

3.1.3 Referral patterns that indicate kickbacks or result in additional expenses.

3.1.4 Frequent changes in contracts or agreements with supplier groups (Durable Medical Equipment (DME) and supplier companies) in an effort to preclude payment to them at the discounted amount.

3.1.5 Failure to document verbal referrals in writing resulting in claims denial for lack of authorization.

3.1.6 Inclusion of gag clauses in managed care provider contracts/agreements or that which prevents providers from providing information to their patients regarding benefits, risks and costs or appropriate treatment alternatives.

3.1.7 Where the provider or the providers' employee has an investment and/or financial interest, the patient shall be informed prior to the referral and provided information regarding alternative referral sources whenever such alternatives exist. Failure to inform the patient constitutes a potential fraudulent/abusive situation.

3.2 TRICARE Beneficiary Eligibility Questionable

3.2.1 If there is reason to question the eligibility of a beneficiary and fraud is suspected, e.g., through correspondence, Defense Enrollment Eligibility Reporting System (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 the Defense Manpower Data Center (DMDC), 400 Gigling Road, Seaside, California 93955.

3.2.2 In cases where eligibility fraud is evident, the contractor shall take the following action:

3.2.2.1 Prime Enrollees

No care shall be approved for services on/after the date eligibility reportedly ended.

3.2.2.2 Non-Enrollees and Pharmacy Claims

Flag the beneficiary file to suspend all claims for services provided on/after the date eligibility reportedly ended. The beneficiary is not to be contacted or informed of the investigation. If the participating provider inquires about the claim he/she can be advised that the claim is under review and requested to send in a copy of the Identification (ID) card, both sides, if the provider has one on file. Upon receipt, a "good faith" payment may be considered. See [Chapter 10, Section 3, paragraph 6.0](#). The contractor shall retain a copy of the Explanation Of Benefits (EOB) and cancelled check in the case file. If the beneficiary inquires about the claim(s), he or she will be informed that the claim requires review and he or she will be advised when processing is complete. The contractor shall establish procedures for control of these claims and for keeping them in a suspense

status until the eligibility status has been established.

3.2.3 If the DEERS response indicates that the beneficiary is not eligible, the contractor shall research claims/encounter history for other erroneous claims from the date TRICARE eligibility ended. If the contractor's history does not date back far enough, request a history printout from TMA PI. The contractor shall report the circumstances to TMA PI in accordance with the procedures for case referrals.

3.3 Provider Authorized Status Questionable

3.3.1 The contractor shall attempt to verify the provider's status in such a way that the provider is not alerted to a possible investigation. Credentials or licensure shall be verified with the appropriate credentialing or licensing agency. School accreditation and required education shall be verified with the appropriate school.

3.3.2 The contractor shall review reports of findings or recommendations of state licensure boards, boards of quality assurance, other regulatory agencies, state medical societies, peer review organizations, or other professional associations for possible fraud or abuse issues. The contractor shall terminate a provider when the finding or recommendation results in loss of licensure or certification. Licensure/certification must be at full clinical practice level. Refer to the TRICARE Policy Manual (TPM), [Chapter 11, Section 3.2](#). The reports may be used to also cancel a network provider's contract since a non-authorized provider cannot be a network provider. The contractor shall submit a copy of the report to the TMA PI.

3.4 Conflict Of Interest; Federal Employees And Active Duty Military

3.4.1 Conflict of Interest

3.4.1.1 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, TMA, or a designee, may refer the case to the Uniformed Service concerned for review and action.

3.4.1.2 If such a referral is made, a report of the results of findings and action taken shall be submitted to the Director, TMA, within 90 days of receiving the referral, by the Regional Director (RD) having jurisdiction. For pharmacies, the Contracting Officer's Representative (COR) shall submit the report. TRICARE cost-sharing shall be denied on any claim in which a conflict of interest situation is found to exist. This denial of cost-sharing applies whether the claim is submitted by the individual who provided the care, the institutional provider in which the care was furnished, or the beneficiary.

3.4.2 Federal Employees And Active Duty Military

The Regulation 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.

3.4.3 Exceptions

3.4.3.1 National Health Service Corps

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

3.4.3.2 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.

3.4.3.3 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 TMA. Reservists on active duty are not exempt during the period of their active duty commitment.

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

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

3.4.3.5 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 TMA PI for investigation.

3.5 Cover-Ups In Coordination Of Benefits

Coordination of benefits is a standard part of TRICARE claims processing requirements. Listed below are frequently overlooked common clues to the existence of another health plan.

- "Benefits Assigned" notation
- Large bills filed late
- Large credits
- Bills or statements that appear to have been altered
- Odd partial payments
- Other Carrier inquiries

3.6 Cost-Share/Copayment Collection Questionable

The [32 CFR 199.4](#), sets forth the financial liability of the TRICARE beneficiary for a cost-share and deductible. This regulatory requirement is derived from the statutory requirements of 10 United States Code (USC) 1079 and 1086. Claim payments are subject to the provision that reasonable efforts are to be made by the provider to collect the cost-share. A provider's failure to make a reasonable effort to collect the cost-share may result in reduction of payment or may result in a suspension of authorized provider status under TRICARE. Reasonable efforts would include several documented attempts to collect and set procedures by the provider to refer cases to a collection agency. Under managed care programs, cost-share amounts may also apply, which must be collected from the beneficiary. The pharmacy contractor shall ensure that network pharmacies collect copayments before dispensing any prescription.

3.6.1 The contractor shall establish procedures for detecting providers who waive cost-shares. Possible methods for detection of the waiver of cost-shares include:

- Itemized receipts attached to non-assigned claims which reflect an annotation that such amounts have been waived.
- Changes in charging practices or erratic charge practices for the same procedure.
- Complaints or notices from beneficiaries, other providers or interested third parties.
- Advertisements of such practices by providers.

3.6.2 The contractor shall establish procedures for detecting network providers/pharmacies who waive the copayment amounts.

3.6.3 When the contractor identifies a provider who has waived a cost-share/copayment, the contractor shall notify the provider in writing that such action is not allowed and explain the law governing the collection of cost-shares/copayments and that payments to the provider may be reduced if reasonable efforts are not made to collect the cost-share. The contractor shall also explain that the provider may be suspended as an authorized TRICARE provider if corrective action is not taken. See [Section 2](#) for referral protocols, if referral is warranted.

Note 1: Certain heart and lung hospitals are exempt from the cost-share collection requirement.

Note 2: Refer to the TRICARE Reimbursement Manual (TRM), [Chapter 2, Section 1](#), for waiver of cost-shares and/or deductibles for medical services provided to family members of active duty personnel from August 2, 1990, until the date the "Persian Gulf Conflict" ends as prescribed by Presidential proclamation or by law.

Note 3: The hospice benefit is exempt from the cost-sharing and deductible provisions normally associated with standard TRICARE reimbursement with the exception of small cost-sharing amounts for biological and inpatient respite care. The collection of these cost-sharing amounts is optional under the TRICARE Hospice Benefit (TRM, [Chapter 11, Section 4](#)).

3.7 Procedure Code Unbundling

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

3.7.2 Following the referral to TMA of the 10 most egregious providers, who continue to submit unbundled billings, the contractor shall conduct a review of those providers to determine if they are engaging in other aberrant billing practices. If warranted, follow the requirements for referring a case to TMA with a statement that the provider has already been referred for continuing to submit unbundled billings.

3.7.3 The contractor shall not initiate recoupment or take any adverse action against the providers being referred to the TMA PI. The contractor shall keep a record of the providers selected to be sent to the TMA so that no provider is referred more than once (except as stipulated in [paragraph 3.7.2](#)) even if the provider continues to be identified for unbundling.

3.8 Automated TRICARE DCS

On a quarterly basis each fiscal year, contractors shall generate and utilize reports from the automated TRICARE DCS to assist in detecting fraud and abuse. The automated TRICARE DCS contains pre-formatted reports which will assist in detecting duplicate billings and inappropriate Current Procedural Terminology, 4th Edition (CPT-4) coding modifications by providers (see the TRM, [Chapters 3 and 4](#) for report formats).

3.9 Violation Of Participation Agreement Or Reimbursement Limitation

Breach of a participation agreement/or billing in excess of the reimbursement limitation amount as provided by Congress as part of the Department of Defense (DoD) Appropriations Act, 1993, are considered abuse and/or fraud under authority of 10 USC 1079(h)(4). See [Section 2](#) if a case referral is warranted. The contractor shall take action as stated in [Section 6, paragraph 5.2](#). Also, refer to the TRM, [Chapter 3, Section 1](#).

3.10 Failure To File TRICARE Claims

Failure by a provider to comply with the claim submittal requirements is considered abuse (see [Section 6, paragraph 5.4](#) and [Chapter 8, Section 1, paragraph 2.1](#)).

3.11 Pharmacy Fraud

3.11.1 Comparing reversal rates. Pharmacies with low reversal rates should be targeted for further evaluation.

3.11.2 Examination of pharmacy claims for excessive partial fill submissions or pharmacies with no partial fill submissions. If appropriate, compare the percentage and/or number of partial fills to the overall average across the entire pharmacy program.

3.11.3 Screening for high use patients (e.g., high number of prescriptions per patient) by measuring the total number of new prescriptions generated for individual patients over a given time period.

3.11.4 Review of copayments or dispensing fees, which should be appropriate for the drug category and conditions.

3.11.5 Coordination with other contractors for double billing from both the medical benefit and pharmacy benefit. Applies to medications routinely administered under a medical benefit but obtained in the retail pharmacy network.

3.11.6 Screening for gross errors in quantity dispensed and for high dollar claims. A review of outliers would then be conducted.

3.11.7 Reconcile diagnostic codes with medication therapy for high cost agents.

3.11.8 Review of pharmacy claims with high average ingredient cost.

3.11.9 Review of brand/generic fill rates.

3.11.10 Review of top pharmacies per generic code rate.

3.11.11 Review of controlled substance prescription rates.

3.11.12 Ability to conduct on-site audits to facilitate prevention, identification and referral of cases involving any of the above listed items.

Note: At a minimum, the contractor shall perform on-site audits of the top one percent of providers who meet the indicators above.

3.12 Dental Fraud

3.12.1 Billing for services that were never rendered.

3.12.2 Intentional misreporting of the procedure provided, the service date, the identity of the provider, or the identity of the patient.

3.12.3 Deliberate performance of dentally unnecessary services for financial gain.

3.12.4 Alteration of patient records and/or claim forms.

- END -

Evaluation

Note: This section is not applicable to pharmacy.

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

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

2.0 POSTPAYMENT

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

Note: High volume beneficiaries are those beneficiaries whose charges exceed \$25,000 during a 12 month reporting period. High volume providers are institutional providers whose payments exceeded \$750,000; individual providers whose payments exceeded \$50,000, Groups/Clinics whose payments exceeded \$100,000 (over \$25,000 average per professional provider within the group.)

3.0 SIGNATURE RELAXATION PROGRAM AUDIT

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

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

4.0 PROVIDER SIGNATURE AUTHORIZATION-ON-FILE IRREGULARITIES

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

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

5.0 PROBLEM PROVIDER CASES

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

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

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

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

Reporting

1.0 FRAUD AND ABUSE SUMMARY REPORT

The information from the case reports will be compiled and submitted to the TRICARE Management Activity (TMA) Program Integrity Office (PI) within 30 calendar days following the last day of each calendar quarter.

2.0 AUTOMATED TRICARE DUPLICATE CLAIMS SYSTEM (DCS)

On a fiscal year, quarterly basis, the contractors shall generate and utilize reports from the automated TRICARE DCS to assist in detecting fraud and abuse. The automated TRICARE DCS contains preformatted reports which will assist in detecting duplicate billings and inappropriate Current Procedural Terminology, 4th Edition (CPT-4) coding modifications by providers (see [Chapter 9](#) for report formats).

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

3.0 UTILIZATION MANAGEMENT (UM) REPORT

A copy of the UM reports for TRICARE Prime, TRICARE Extra, and TRICARE Standard shall be sent to the TMA PI on a quarterly basis.

4.0 SAVINGS REPORT

The contractor shall report to the TMA PI the potential dollar amounts saved as a result of the activities/intervention of the anti-fraud/investigative units.

5.0 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 -

FIGURE 13.A-17 CONTROLLED PRESCRIPTION DRUGS (CONTINUED)

3.0 UTILIZATION REVIEW RECOMMENDED CRITERIA AND PROCEDURES

Prescription drug claims should be developed for medical necessity prior to payment if the claim contains at least one controlled drug and exceeds one or more of the prepayment utilization review screening criteria developed by the contractor.

3.1 Claims For Controlled Drugs

Claims for controlled drugs that fail any prepayment screening criterion should be subjected to review. Subsequent drug claims should be suspended pending completion of the review.

3.2 Claims History

The claims history, particularly claims for services performed by the prescribing physician, should be reviewed. This review may demonstrate that the drugs are medically necessary and that drug abuse is unlikely, particularly in terminal patients. In that event, the drug claim(s) may be paid. If the claim history review does not resolve the question of possible abuse, recommend that the contractor submit the case to professional review.

3.3 Medical Review

If medical review determines that care is appropriate, the claim may be paid. If drug abuse is confirmed, the abused drugs will be denied. The beneficiary is to be notified that no payment will be made and that the decision is based on lack of medical necessity. If appropriate, the prescribing physician shall be notified. If there is a documented diagnosis of a morbid addictive state (rather than abuse), all narcotics shall be denied. The beneficiary is to be offered appropriate appeal rights and informed that his/her attending physician may discuss the case with the contractor's medical advisor or pharmacy consultant. For a period of six months, all drug claims for this beneficiary should be reviewed by a professional advisor before payment. The professional advisor may extend the period of review.

FIGURE 13.A-18 CASE REFERRAL EVALUATION (SAMPLE)

**CASE REFERRAL EVALUATION
TRICARE, PROGRAM INTEGRITY OFFICE**

Case Name: _____
 Contractor: _____
 Date TMA PI Received: _____
 Case Referral Number: _____

Determine the following:

1. What are the allegations (What part of 32 CFR 199.9, section (b) or (c) has been violated.)?

2. Does the case referral identify a pattern of **fraud/abuse**?

Did the contractor summarize those findings in order to determine probable method of fraud/abuse? _____

Were any special analytical tools involved to single out the perpetrators, i.e., regression analysis? _____

(NOTE: Patient harm by itself is a **utilization review/malpractice issue** and not fraud.)

Check One

- | | | |
|--------------------------|---|---|
| <input type="checkbox"/> | Pattern & findings summarized | 5 |
| <input type="checkbox"/> | Pattern & findings not summarized | 3 |
| <input type="checkbox"/> | Failed to develop case beyond a single indicator of fraud (Or failed to document that development only resulted in single indicator of fraud) | 1 |
| <input type="checkbox"/> | Case does not establish an egregious pattern of fraud (e.g., one level of E & M upcoding, excessive ultrasounds, etc.) | 0 |

Rationale for rating:

3. Have the allegations been substantiated in the referral?

(NOTE: If no, then no points are awarded)

How? _____

Check One

- | | | |
|--------------------------|--|---|
| <input type="checkbox"/> | Statistically valid random audit using accepted PI criteria | 5 |
| <input type="checkbox"/> | Alternate method of substantiating fraudulent pattern (e.g., 100% audit) | 5 |
| <input type="checkbox"/> | Audit (e.g., calendar, beneficiary survey) | 3 |
| <input type="checkbox"/> | Sample Claims (e.g., probe audit) | 1 |

Date: _____ Case Name: _____

TRICARE Operations Manual 6010.56-M, February 1, 2008

Chapter 13, Addendum A

Figures

FIGURE 13.A-18 CASE REFERRAL EVALUATION (SAMPLE) (CONTINUED)

[Form subject to change]

From Date: January 1, 2008

Rationale for rating:

4. How has TRICARE been affected (monetarily, patient harm, etc.)?

Check One

- | | | |
|--------------------------|--|---|
| <input type="checkbox"/> | Actual Patient Harm w/ fraud component | 5 |
| Dollar Damages: | | |
| <input type="checkbox"/> | >\$75,000 | 5 |
| <input type="checkbox"/> | \$40,000 - \$75,000 | 3 |
| <input type="checkbox"/> | <\$40,000 | 1 |

Note: Maximum score for this section is 5 points.

Provide actual dollar loss and extrapolated loss, if applicable:

(Actual)

(Extrapolated)

5. Were all applicable TRICARE regulatory provisions cited in the referral in regards to each substantiated allegation and were copies included with the referral?

Did referral reference applicable professional standards such as JCAHO, AMA, state provisions, code of ethics, etc.?

Check One

- | | | |
|--------------------------|--|---|
| <input type="checkbox"/> | Yes | 5 |
| <input type="checkbox"/> | Not all applicable provisions cited or incorrect provisions provided | 3 |
| <input type="checkbox"/> | No | 0 |

If not, print the applicable policy and/or regulation to include with the referral.

Rationale for rating:

Date: _____

Case Name: _____

TRICARE Operations Manual 6010.56-M, February 1, 2008

Chapter 13, Addendum A

Figures

FIGURE 13.A-18 CASE REFERRAL EVALUATION (SAMPLE) (CONTINUED)

[Form subject to change]

From Date: January 1, 2008

6. Is this case referral complete in accordance with the Fraud and Abuse Chapter of the TRICARE Operations Manual requirements (the fraud/abuse is thoroughly documented, the pattern of fraud/abuse is supported by evidence, all supporting documentation is included and well organized), and ready to send to DCIS?

Check One

- | | | |
|--------------------------|---|---|
| <input type="checkbox"/> | Yes | 5 |
| <input type="checkbox"/> | Needs minimal work that can be completed by TMA Program Integrity | 3 |
| <input type="checkbox"/> | Needs work by contractor | 1 |
| <input type="checkbox"/> | Referral did not meet criteria | 0 |

Note: If items from #5 were missing deduct points in that section, do NOT deduct points in this section.

Rationale for rating:

7. Does referral comprehensively document all action taken to identify and capture total TRICARE exposure (e.g., all provider TIN's identified, necessary coordination made with other contractors and your commercial line of business for additional billings information, etc.)?

Check One

- | | | |
|--------------------------|--|---|
| <input type="checkbox"/> | Yes | 5 |
| <input type="checkbox"/> | Not all exposure captured (e.g., captured TDEFIC exposure and failed to coordinate with other contractor in neighboring state) | 3 |
| <input type="checkbox"/> | No | 0 |

Rationale for rating:

Date: _____

Case Name: _____

TRICARE Operations Manual 6010.56-M, February 1, 2008

Chapter 13, Addendum A

Figures

FIGURE 13.A-18 CASE REFERRAL EVALUATION (SAMPLE) (CONTINUED)

[Form subject to change]

From Date: January 1, 2008

8. Total Points: 0 Case Rating: _____
30 5
29-27 4
26-24 3
23-18 2
17-1 1

NOTE: Cases are rated on a scale of 1-5 with a score of 5 representing the best case referrals.

Rated by: _____
Title: _____
Reviewed By: _____
Date: _____

Rationale for rating:

Date: _____

Case Name: _____

[Form subject to change]

From Date: January 1, 2008

- END -

TRICARE Operations Manual 6010.56-M, February 1, 2008

Appendix A

Acronyms And Abbreviations

CPR	CAC PIN Reset
CPT	Chest Physiotherapy Current Procedural Terminology
CPT-4	Current Procedural Terminology, 4th Edition
CQM	Clinical Quality Management
CQMP	Clinical Quality Management Program
CQMP AR	Clinical Quality Management Program Annual Report
CQS	Clinical Quality Studies
CRM	Contract Resource Management (Directorate)
CRNA	Certified Registered Nurse Anesthetist
CRS	Cytoreductive Surgery
CRT	Computer Remote Terminal
CSA	Clinical Support Agreement
CSE	Communications Security Establishment (of the Government of Canada)
CSP	Corporate Service Provider Critical Security Parameter
CST	Central Standard Time
CSU	Channel Sending Unit
CSV	Comma-Separated Value
CSW	Clinical Social Worker
CT	Central Time Computerized Tomography
CTA	Computerized Tomography Angiography
CTC	Computed Tomographic Colonography
CTCL	Cutaneous T-Cell Lymphoma
CTEP	Cancer Therapy Evaluation Program
CUC	Chronic Ulcerative Colitis
CVAC	CHAMPVA Center
CVS	Contractor Verification System
CY	Calendar Year
DAA	Designated Approving Authority
DAO	Defense Attache Offices
DBA	Doing Business As
DBN	DoD Benefits Number
DC	Direct Care
DCAA	Defense Contract Audit Agency
DCAO	Debt Collection Assistance Officer
DCID	Director of Central Intelligence Directive
DCII	Defense Clearance and Investigation Index
DCIS	Defense Criminal Investigating Service Ductal Carcinoma In Situ
DCN	Document Control Number
DCP	Data Collection Period

TRICARE Operations Manual 6010.56-M, February 1, 2008

Appendix A

Acronyms And Abbreviations

DCPE	Disability Compensation and Pension Examination
DCR	Developed Character Reference
DCS	Duplicate Claims System
DCSI	Defense Central Security Index
DCWS	DEERS Claims Web Service
DD (Form)	Department of Defense (Form)
DDAS	DCII Disclosure Accounting System
DDP	Dependent Dental Plan
DDS	DEERS Dependent Suffix
DE	Durable Equipment
DECC	Defense Enterprise Computing Center
DED	Dedicated Emergency Department
DEERS	Defense Enrollment Eligibility Reporting System
DELM	Digital Epiluminescence Microscopy
DENC	Detailed Explanation of Non-Concurrence
DepSecDef	Deputy Secretary of Defense
DES	Data Encryption Standard Disability Evaluation System
DFAS	Defense Finance and Accounting Service
DG	Diagnostic Group
DGH	Denver General Hospital
DHHS	Department of Health and Human Services
DHP	Defense Health Program
DIA	Defense Intelligence Agency
DIACAP	DoD Information Assurance Certification And Accreditation Process
DII	Defense Information Infrastructure
DIS	Defense Investigative Service
DISA	Defense Information System Agency
DISCO	Defense Industrial Security Clearance Office
DISN	Defense Information Systems Network
DISP	Defense Industrial Security Program
DITSCAP	DoD Information Technology Security Certification and Accreditation Process
DLAR	Defense Logistics Agency Regulation
DLE	Dialyzable Leukocyte Extract
DLI	Donor Lymphocyte Infusion
DM	Disease Management
DMDC	Defense Manpower Data Center
DME	Durable Medical Equipment
DMEPOS	Durable medical equipment, prosthetics, orthotics, and supplies
DMI	DMDC Medical Interface
DMIS	Defense Medical Information System
DMIS-ID	Defense Medical Information System Identification (Code)

TRICARE Operations Manual 6010.56-M, February 1, 2008

Appendix A

Acronyms And Abbreviations

DMLSS	Defense Medical Logistics Support System
DMZ	Demilitarized Zone
DNA	Deoxyribonucleic Acid
DNA-HLA	Deoxyribonucleic Acid - Human Leucocyte Antigen
DNACI	DoD National Agency Check Plus Written Inquiries
DO	Doctor of Osteopathy Operations Directorate
DOB	Date of Birth
DOC	Dynamic Orthotic Cranioplasty (Band)
DoD	Department of Defense
DoD AI	Department of Defense Administrative Instruction
DoDD	Department of Defense Directive
DoDI	Department of Defense Instruction
DoDIG	Department of Defense Inspector General
DoD P&T	Department of Defense Pharmacy and Therapeutics (Committee)
DOE	Department of Energy
DOEBA	Date of Earliest Billing Action
DOES	DEERS Online Enrollment System
DOHA	Defense Office of Hearings and Appeals
DOJ	Department of Justice
DOLBA	Date of Latest Billing Action
DOS	Date Of Service
DP	Designated Provider
DPA	Differential Power Analysis
DPI	Designated Providers Integrator
DPO	DEERS Program Office
DPPO	Designated Provider Program Office
DRA	Deficit Reduction Act
DREZ	Dorsal Root Entry Zone
DRG	Diagnosis Related Group
DRPO	DEERS RAPIDS Program Office
DRS	Decompression Reduction Stabilization
DSAA	Defense Security Assistance Agency
DSC	DMDC Support Center
DSCC	Data and Study Coordinating Center
DS Logon	DoD Self-Service Logon
DSM	Diagnostic and Statistical Manual of Mental Disorders
DSM-III	Diagnostic and Statistical Manual of Mental Disorders, Third Edition
DSM-IV	Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition
DSMC	Data and Safety Monitoring Committee
DSMO	Designated Standards Maintenance Organization
DSMT	Diabetes Self-Management Training

TRICARE Operations Manual 6010.56-M, February 1, 2008

Appendix A

Acronyms And Abbreviations

DSO	DMDC Support Office
DSPOC	Dental Service Point of Contact
DSU	Data Sending Unit
DTF	Dental Treatment Facility
DTM	Directive-Type Memorandum
DTR	Derived Test Requirements
DTRO	Director, TRICARE Regional Office
DUA	Data Use Agreement
DVA	Department of Veterans Affairs
DVAHCF	Department of Veterans Affairs Health Care Finder
DVD	Digital Video Disc
DWR	DSO Web Request
Dx	Diagnosis
DXA	Dual Energy X-Ray Absorptiometry
E-ID	Early Identification
E-NAS	Electronic Non-Availability Statement
e-QIP	Electronic Questionnaires for Investigations Processing
E&M	Evaluation & Management
E2R	Enrollment Eligibility Reconciliation
EAL	Common Criteria Evaluation Assurance Level
EAP	Employee-Assistance Program Ethandamine phosphate
EBC	Enrollment Based Capitation
ECA	External Certification Authority
ECAS	European Cardiac Arrhythmia Society
ECG	Electrocardiogram
ECHO	Extended Care Health Option
ECT	Electroconvulsive Therapy
ED	Emergency Department
EDC	Error Detection Code
EDI	Electronic Data Information Electronic Data Interchange
EDIPI	Electronic Data Interchange Person Identifier
EDIPN	Electronic Data Interchange Person Number
EDI_PN	Electronic Data Interchange Patient Number
EEG	Electroencephalogram
EEPROM	Erasable Programmable Read-Only Memory
EFM	Electronic Fetal Monitoring
EFMP	Exceptional Family Member Program
EFP	Environmental Failure Protection
EFT	Electronic Funds Transfer Environmental Failure Testing
EGHP	Employer Group Health Plan

TRICARE Operations Manual 6010.56-M, February 1, 2008

Appendix A

Acronyms And Abbreviations

E/HPC	Enrollment/Health Plan Code
EHHC	ECHO Home Health Care Extended Care Health Option Home Health Care
EHP	Employee Health Program
EHRA	European Heart Rhythm Association
EIA	Educational Interventions for Autism Spectrum Disorders
EID	Enrollment Information for Dental
EIDS	Executive Information and Decision Support
EIN	Employer Identification Number
EIP	External Infusion Pump
EKG	Electrocardiogram
ELN	Element Locator Number
ELISA	Enzyme-Linked Immunoabsorbent Assay
E/M	Evaluation and Management
EMC	Electronic Media Claim Enrollment Management Contractor
EMDR	Eye Movement Desensitization and Reprocessing
EMG	Electromyogram
EMTALA	Emergency Medical Treatment & Active Labor Act
ENTNAC	Entrance National Agency Check
EOB	Explanation of Benefits
EOBs	Explanations of Benefits
EOC	Episode of Care
EOE	Evoked Otoacoustic Emission
EOG	Electro-oculogram
EOMB	Explanation of Medicare Benefits
ePHI	electronic Protected Health Information
EPO	Erythropoietin Exclusive Provider Organization
EPR	EIA Program Report
EPROM	Erasable Programmable Read-Only Memory
ER	Emergency Room
ERISA	Employee Retirement Income and Security Act of 1974
ESRD	End Stage Renal Disease
EST	Eastern Standard Time
ESWT	Extracorporeal Shock Wave Therapy
ET	Eastern Time
ETIN	Electronic Transmitter Identification Number
EWPS	Enterprise Wide Provider System
EWRAS	Enterprise Wide Referral and Authorization System
F&AO	Finance and Accounting Office(r)
FAI	Femoroacetabular Impingement
FAP	Familial Adenomatous Polyposis

TRICARE Operations Manual 6010.56-M, February 1, 2008

Appendix A

Acronyms And Abbreviations

FAR	Federal Acquisition Regulations
FASB	Federal Accounting Standards Board
FBI	Federal Bureau of Investigation
FCC	Federal Communications Commission
FCCA	Federal Claims Collection Act
FDA	Food and Drug Administration
FDB	First Data Bank
FDL	Fixed Dollar Loss
Fed	Federal Reserve Bank
FEHBP	Federal Employee Health Benefit Program
FEL	Familial Erythrophagocytic Lymphohistiocytosis
FEV ₁	Forced Expiratory Volume
FFM	Foreign Force Member
FHL	Familial Hemophagocytic Lymphohistiocytosis
FI	Fiscal Intermediary
FIPS	Federal Information Processing Standards (or System)
FIPS PUB	FIPS Publication
FISH	Fluorescence In Situ Hybridization
FISMA	Federal Information Security Management Act
FL	Form Locator
FMCRA	Federal Medical Care Recovery Act
FMRI	Functional Magnetic Resonance Imaging
FOBT	Fecal Occult Blood Testing
FOC	Full Operational Capability
FOIA	Freedom of Information Act
FPO	Fleet Post Office
FQHC	Federally Qualified Health Center
FR	Federal Register Frozen Records
FRC	Federal Records Center
FSO	Facility Security Officer
FTE	Full Time Equivalent
FTP	File Transfer Protocol
FX	Foreign Exchange (lines)
FY	Fiscal Year
GAAP	Generally Accepted Accounting Principles
GAO	General Accounting Office
GBL	Government Bill of Lading
GDC	Guglielmi Detachable Coil
GFE	Government Furnished Equipment
GHP	Group Health Plan
GHz	Gigahertz

TRICARE Operations Manual 6010.56-M, February 1, 2008

Appendix A

Acronyms And Abbreviations

GIFT	Gamete Intrafallopian Transfer
GIQD	Government Inquiry of DEERS
GP	General Practitioner
GPCI	Geographic Practice Cost Index
H/E	Health and Environment
HAC	Health Administration Center Hospital Acquired Condition
HAVEN	Home Assessment Validation and Entry
HBA	Health Benefits Advisor
HBO	Hyperbaric Oxygen Therapy
HCC	Health Care Coverage
HCDP	Health Care Delivery Program
HCF	Health Care Finder
HCFA	Health Care Financing Administration
HCG	Human Chorionic Gonadotropin
HCIL	Health Care Information Line
HCM	Hypertrophic Cardiomyopathy
HCO	Healthcare Operations Division
HCP	Health Care Provider
HCPC	Healthcare Common Procedure Code (formerly HCFA Common Procedure Code)
HCPCS	Healthcare Common Procedure Coding System (formerly Healthcare Common Procedure Coding System)
HCPR	Health Care Provider Record
HCSR	Health Care Service Record
HDC	High Dose Chemotherapy
HDC/SCR	High Dose Chemotherapy with Stem Cell Rescue
HDGC	Hereditary Diffuse Gastric Cancer
HDL	Hardware Description Language
HEAR	Health Enrollment Assessment Review
HEDIS	Health Plan Employer Data and Information Set
HepB-Hib	Hepatitis B and Hemophilus influenza B
HHA	Home Health Agency
HHA PPS	Home Health Agency Prospective Payment System
HHC	Home Health Care
HHC/CM	Home Health Care/Case Management
HHRG	Home Health Resource Group
HHS	Health and Human Services
HI	Health Insurance
HIAA	Health Insurance Association of America
HIC	Health Insurance Carrier
HICN	Health Insurance Claim Number
HINN	Hospital-Issued Notice Of Noncoverage

TRICARE Operations Manual 6010.56-M, February 1, 2008

Appendix A

Acronyms And Abbreviations

HINT	Hearing in Noise Test
HIPAA	Health Insurance Portability and Accountability Act (of 1996)
HIPEC	Hyperthermic Intraperitoneal Chemotherapy
HIPPS	Health Insurance Prospective Payment System
HIQH	Health Insurance Query for Health Agency
HIV	Human Immunodeficiency Virus
HL7	Health Level 7
HLA	Human Leukocyte Antigen
HMAC	Hash-Based Message Authentication Code
HMO	Health Maintenance Organization
HNPCC	Hereditary Non-Polyposis Colorectal Cancer
HOPD	Hospital Outpatient Department
HPA&E	Health Program Analysis & Evaluation
HPSA	Health Professional Shortage Area
HPV	Human Papilloma Virus
HRA	Health Reimbursement Arrangement
HRG	Health Resource Group
HRS	Heart Rhythm Society
HRT	Heidelberg Retina Tomograph Hormone Replacement Therapy
HSCRC	Health Services Cost Review Commission
HTML	HyperText Markup Language
HTTP	HyperText Transfer (Transport) Protocol
HTTPS	Hypertext Transfer (Transport) Protocol Secure
HUAM	Home Uterine Activity Monitoring
HUD	Humanitarian Use Device
HUS	Hemolytic Uremic Syndrome
HVPT	Hyperventilation Provocation Test
IA	Information Assurance
IATO	Interim Approval to Operate
IAVA	Information Assurance Vulnerability Alert
IAVB	Information Assurance Vulnerability Bulletin
IAVM	Information Assurance Vulnerability Management
IAW	In accordance with
IBD	Inflammatory Bowel Disease
IC	Individual Consideration Integrated Circuit
ICASS	International Cooperative Administrative Support Services
ICD	Implantable Cardioverter Defibrillator
ICD-9-CM	International Classification of Diseases, 9th Revision, Clinical Modification
ICF	Intermediate Care Facility
ICMP	Individual Case Management Program

TRICARE Operations Manual 6010.56-M, February 1, 2008

Appendix A

Acronyms And Abbreviations

ICMP-PEC	Individual Case Management Program For Persons With Extraordinary Conditions
ICN	Internal Control Number
ICSP	Individual Corporate Services Provider
ID	Identification Identifier
IDB	Intradiscal Biacuplasty
IDD	Internal or Intervertebral Disc Decompression
IDE	Investigational Device Exemption Investigational Device
IDEA	Individuals with Disabilities Education Act
IDES	Integrated Disability Evaluation System
IDET	Intradiscal Electrothermal Therapy
IDME	Indirect Medical Education
IdP	Identity Protection
IDTA	Intradiscal Thermal Annuloplasty
IE	Interface Engine Internet Explorer
IEA	Intradiscal Electrothermal Annuloplasty
IEP	Individualized Educational Program
IFSP	Individualized Family Service Plan
IG	Implementation Guidance
IgA	Immunoglobulin A
IGCE	Independent Government Cost Estimate
IHI	Institute for Healthcare Improvement
IHS	Indian Health Service
IIHI	Individually Identifiable Health Information
IIP	Implantable Infusion Pump
IM	Information Management Instant Message/Messaging Intramuscular
IMRT	Intensity Modulated Radiation Therapy
IND	Investigational New Drugs
INR	International Normalized Ratio Intramuscular International Normalized Ratio
INS	Immigration and Naturalization Service
IOC	Initial Operational Capability
IOD	Interface Operational Description
IOLs	Intraocular Lenses
IOM	Internet Only Manual
IORT	Intra-Operative Radiation Therapy
IP	Inpatient
IPC	Information Processing Center (outdated term, see SMC)
IPHC	Intraperitoneal Hyperthermic Chemotherapy

TRICARE Operations Manual 6010.56-M, February 1, 2008

Appendix A

Acronyms And Abbreviations

IPN	Intraperitoneal Nutrition
IPP	In-Person Proofing
IPPS	Inpatient Prospective Payment System
IPS	Individual Pricing Summary
IPSEC	Secure Internet Protocol
IQ	Intelligence Quotient
IQM	Internal Quality Management
IRB	Institutional Review Board
IRR	Individual Ready Reserve
IRS	Internal Revenue Service
IRTS	Integration and Runtime Specification
IS	Information System
ISN	Investigation Schedule Notice
ISO	International Standard Organization
ISP	Internet Service Provider
IT	Information Technology
ITSEC	Information Technology Security Evaluation Criteria
IV	Initialization Vector Intravenous
IVF	In Vitro Fertilization
JC	Joint Commission (formerly Joint Commission on Accreditation of Healthcare Organizations (JCAHO))
JCAHO	Joint Commission on Accreditation of Healthcare Organizations
JCOS	Joint Chiefs of Staff
JFTR	Joint Federal Travel Regulations
JNI	Japanese National Insurance
JTF-GNO	Joint Task Force for Global Network Operations
JUSDAC	Joint Uniformed Services Dental Advisory Committee
JUSMAC	Joint Uniformed Services Medical Advisory Committee
JUSPAC	Joint Uniformed Services Personnel Advisory Committee
KB	Knowledge Base
KO	Contracting Officer
LAA	Limited Access Authorization
LAC	Local Agency Check
LAK	Lymphokine-Activated Killer
LAN	Local Area Network
LASER	Light Amplification by Stimulated Emission of Radiation
LCF	Long-term Care Facility
LCIS	Lobular Carcinoma In Situ
LDL	Low Density Lipoprotein
LDLT	Living Donor Liver Transplantation
LDR	Low Dose Rate

TRICARE Operations Manual 6010.56-M, February 1, 2008

Appendix A

Acronyms And Abbreviations

LLLT	Low Level Laser Therapy
LNT	Lexical Neighborhood Test
LOC	Letter of Consent
LOD	Letter of Denial/Revocation Line of Duty
LOI	Letter of Intent
LOS	Length-of-Stay
LOT	Life Orientation Test
LPN	Licensed Practical Nurse
LSIL	Low-grade Squamous Intraepithelial Lesion
LSN	Location Storage Number
LTC	Long-Term Care
LUPA	Low Utilization Payment Adjustment
LV	Left Ventricle [Ventricular]
LVEF	Left Ventricular Ejection Fraction
LVN	Licensed Vocational Nurse
LVRS	Lung Volume Reduction Surgery
MAC	Maximum Allowable Charge Maximum Allowable Cost
MAC III	Mission Assurance Category III
MAID	Maximum Allowable Inpatient Day
MB&RB	Medical Benefits and Reimbursement Branch
MBI	Molecular Breast Imaging
MCIO	Military Criminal Investigation Organization
MCS	Managed Care Support
MCSC	Managed Care Support Contractor
MCSS	Managed Care Support Services
MCTDP	Myelomeningocele Clinical Trial Demonstration Protocol
MD	Doctor of Medicine
MDI	Mental Developmental Index Multiple Daily Injection
MDR	MHS Data Repository
MDS	Minimum Data Set
MEB	Medical Evaluation Board
MEC	Marketing and Education Committee
MEI	Medicare Economic Index
MEPS	Military Entrance Processing Station
MEPRS	Medical Expense Performance Reporting System
MET	Microcurrent Electrical Therapy
MFCC	Marriage and Family Counseling Center
MGCRB	Medicare Geographic Classification Review Board
MGIB	Montgomery GI Bill
MH	Mental Health

TRICARE Operations Manual 6010.56-M, February 1, 2008

Appendix A

Acronyms And Abbreviations

MHO	Medical Holdover
MHS	Military Health System
MHSO	Managing Health Services Organization
MHSS	Military Health Services System
MI	Myocardial Infarction
MI&L	Manpower, Installations, and Logistics
MIA	Missing In Action
MIDCAB	Minimally Invasive Direct Coronary Artery Bypass
MIRE	Monochromatic Infrared Energy
MLNT	Multisyllabic Lexical Neighborhood Test
MMA	Medicare Modernization Act
MMP	Medical Management Program
MMSO	Military Medical Support Office
MMWR	Morbidity and Mortality Weekly Report
MNR	Medical Necessity Report
MOA	Memorandum of Agreement
MOMS	Management of Myelomeningocele Study
MOP	Mail Order Pharmacy
MOU	Memorandum of Understanding
MPI	Master Patient Index
MR	Magnetic Resonance Medical Review Mentally Retarded
MRA	Magnetic Resonance Angiography
MRHFP	Medicare Rural Hospital Flexibility Program
MRI	Magnetic Resonance Imaging
MRPU	Medical Retention Processing Unit
MS	Microsoft®
MSA	Metropolitan Statistical Area
MSC	Military Sealift Command
MSIE	Microsoft® Internet Explorer
MSP	Medicare Secondary Payer
MST	Mountain Standard Time
MSUD	Maple Syrup Urine Disease
MSW	Masters of Social Work Medical Social Worker
MT	Mountain Time
MTF	Military Treatment Facility
MUE	Medically Unlikely Edits
MV	Multivisceral (transplant)
MVS	Multiple Virtual Storage
MWR	Morale, Welfare, and Recreation
N/A	Not Applicable

TRICARE Operations Manual 6010.56-M, February 1, 2008

Appendix A

Acronyms And Abbreviations

N/D	No Default
NAC	National Agency Check
NACI	National Agency Check Plus Written Inquiries
NACLC	National Agency Check with Law Enforcement and Credit
NADFM	Non-Active Duty Family Member
NARA	National Archives and Records Administration
NAS	Naval Air Station
	Non-Availability Statement
NATO	North Atlantic Treaty Organization
NAVMED	Naval Medical (Form)
NBCC	National Board of Certified Counselors
NCCI	National Correct Coding Initiatives
NCF	National Conversion Factor
NCI	National Cancer Institute
NCPAP	Nasal Continuous Positive Airway Pressure
NCPDP	National Council of Prescription Drug Program
NCQA	National Committee for Quality Assurance
NCVHS	National Committee on Vital and Health Statistics
NDAA	National Defense Authorization Act
NDC	National Drug Code
NDMS	National Disaster Medical System
NED	National Enrollment Database
NETT	National Emphysema Treatment Trial
NF	Nursing Facility
NGPL	No Government Pay List
NHLBI	National Heart, Lung and Blood Institute
NHSC	National Health Service Corps
NICHD	National Institute of Child Health and Human Development
NIH	National Institutes of Health
NII	Networks and Information Integration
NIPRNET	Nonsecure Internet Protocol Router Network
NIS	Naval Investigative Service
NISPOM	National Industrial Security Program Operating Manual
NIST	National Institute of Standards and Technology
NLT	No Later Than
NMES	Neuromuscular Electrical Stimulation
NMOP	National Mail Order Pharmacy
NMR	Nuclear Magnetic Resonance
NMT	Nurse Massage Therapist
NOAA	National Oceanic and Atmospheric Administration
NoPP	Notice of Private Practices
NOSCASTC	National Operating Standard Cost as a Share of Total Costs

TRICARE Operations Manual 6010.56-M, February 1, 2008

Appendix A

Acronyms And Abbreviations

NP	Nurse Practitioner
NPDB	National Practitioner Data Bank
NPI	National Provider Identifier
NPPES	National Plan and Provider Enumeration System
NPR	Notice of Program Reimbursement
NPS	Naval Postgraduate School
NPWT	Negative Pressure Wound Therapy
NQF	National Quality Forum
NRC	Nuclear Regulatory Commission
NRS	Non-Routine [Medical] Supply
NSDSMEP	National Standards for Diabetes Self-Management Education Programs
NTIS	National Technical Information Service
NUBC	National Uniform Billing Committee
NUCC	National Uniform Claims Committee
O/ATIC	Operations/Advanced Technology Integration Center
OA	Office of Administration
OASD(HA)	Office of the Assistant Secretary of Defense (Health Affairs)
OASD (H&E)	Office of the Assistant Secretary of Defense (Health and Environment)
OASD (MI&L)	Office of the Assistant Secretary of Defense (Manpower, Installations, and Logistics)
OASIS	Outcome and Assessment Information Set
OB/GYN	Obstetrician/Gynecologist
OBRA	Omnibus Budget Reconciliation Act
OCE	Outpatient Code Editor
OCHAMPUS	Office of Civilian Health and Medical Program of the Uniformed Services
OCMO	Office of the Chief Medical Officer
OCONUS	Outside of the Continental United States
OCR	Office of Civil Rights
OCSP	Organizational Corporate Services Provider
OCT	Optical Coherence Tomograph
OD	Optical Disk
OF	Optional Form
OGC	Office of General Counsel
OGC-AC	Office of General Counsel-Appeals, Hearings & Claims Collection Division
OGP	Other Government Program
OHI	Other Health Insurance
OHS	Office of Homeland Security
OIG	Office of Inspector General
OMB	Office of Management and Budget
OP/NSP	Operation/Non-Surgical Procedure
OPD	Outpatient Department
OPM	Office of Personnel Management

TRICARE Operations Manual 6010.56-M, February 1, 2008

Appendix A

Acronyms And Abbreviations

OPPS	Outpatient Prospective Payment System
OR	Operating Room
OSA	Obstructive Sleep Apnea
OSAS	Obstructive Sleep Apnea Syndrome
OSD	Office of the Secretary of Defense
OSHA	Occupational Safety and Health Act
OSS	Office of Strategic Services
OT	Occupational Therapy (Therapist)
OTC	Over-The-Counter
OUSD	Office of the Undersecretary of Defense
OUSD (P&R)	Office of the Undersecretary of Defense (Personnel and Readiness)
P/O	Prosthetic and Orthotics
P&T	Pharmacy And Therapeutics (Committee)
PA	Physician Assistant
PACAB	Port Access Coronary Artery Bypass
PACO ₂	Partial Pressure of Carbon Dioxide
PAO ₂	Partial Pressure of Oxygen
PAK	Pancreas After Kidney (transplant)
PAP	Papanicolaou
PAT	Performance Assessment Tracking
PatID	Patient Identifier
PAVM	Pulmonary Arteriovenous Malformation
PBM	Pharmacy Benefit Manager
PC	Peritoneal Carcinomatosis Personal Computer Professional Component
PCA	Patient Controlled Analgesia
PCDIS	Purchased Care Detail Information System
PCI	Percutaneous Coronary Intervention
PCM	Primary Care Manager
PCMBN	PCM By Name
PCMRA	PCM Research Application
PCMRS	PCM Panel Reassignment (Application) PCM Reassignment System
PCO	Procurement (Procuring) Contracting Officer
PCP	Primary Care Physician Primary Care Provider
PCS	Permanent Change of Station
PD	Passport Division
PDA	Patent Ductus Arteriosus Personal Digital Assistant
PDD	Percutaneous (or Plasma) Disc Decompression
PDDBI	Pervasive Developmental Disorders Behavior Inventory

TRICARE Operations Manual 6010.56-M, February 1, 2008

Appendix A

Acronyms And Abbreviations

PDDNOS	Pervasive Developmental Disorder Not Otherwise Specified
PDF	Portable Document Format
PDI	Potentially Disqualifying Information
PDQ	Physicians's Data Query
PDR	Person Data Repository
PDS	Person Demographics Service
PDTS	Pharmacy Data Transaction System
PDX	Principal Diagnosis
PE	Physical Examination
PEC	Pharmacoeconomic Center
PEP	Partial Episode Payment
PEPR	Patient Encounter Processing and Reporting
PERMS	Provider Education and Relations Management System
PET	Positron Emission Tomography
PFCRA	Program Fraud Civil Remedies Act
PFP	Partnership For Peace
PFPWD	Program for Persons with Disabilities
Phen-Fen	Pondimin and Redux
PHI	Protected Health Information
PHIMT	Protected Health Information Management Tool
PHP	Partial Hospitalization Program
PHS	Public Health Service
PI	Program Integrity (Office)
PIA	Privacy Impact Assessment (Online)
PIC	Personnel Investigation Center
PIE	Pulsed Irrigation Evacuation
PIN	Personnel Identification Number
PIP	Personal Injury Protection Personnel Identity Protection
PIRFT	Percutaneous Intradiscal Radiofrequency Thermocoagulation (PIRFT)
PIT	PCM Information Transfer
PIV	Personal Identity Verification
PK	Public Key
PKE	Public Key Enabling
PKI	Public Key Infrastructure
PKU	Phenylketonuria
PLS	Preschool Language Scales
PM-DRG	Pediatric Modified-Diagnosis Related Group
PMPM	Per Member Per Month
PMR	Percutaneous Myocardial Laser Revascularization
PNET	Primitive Neuroectodermal Tumors
PNT	Policy Notification Transaction

TRICARE Operations Manual 6010.56-M, February 1, 2008

Appendix A

Acronyms And Abbreviations

POA	Power of Attorney Present On Admission
POA&M	Plan of Action and Milestones
POC	Pharmacy Operations Center Plan of Care Point of Contact
POL	May 1996 TRICARE/CHAMPUS Policy Manual 6010.47-M
POS	Point of Sale (Pharmacy only) Point of Service Public Official's Statement
POV	Privately Owned Vehicle
PPACA	Patient Protection and Affordable Care Act
PPD	Per Patient Day
PPN	Preferred Provider Network
PPO	Preferred Provider Organization
PPP	Purchasing Power Parity
PPS	Prospective Payment System Ports, Protocols and Services
PPSM	Ports, Protocols, and Service Management
PPV	Pneumococcal Polysaccharide Vaccine
PQI	Potential Quality Indicator Potential Quality Issue
PR	Periodic Reinvestigation
PRC	Program Review Committee
PRFA	Percutaneous Radiofrequency Ablation
PRG	Peer Review Group
PRO	Peer Review Organization
ProDUR	Prospective Drug Utilization Review
PROM	Programmable Read-Only Memory
PRP	Personnel Reliability Program
PRPP	Pharmacy Redesign Pilot Project
PSA	Prime Service Area Physician Scarcity Area
PSAB	Personnel Security Appeals Board
PSCT	Peripheral Stem Cell Transplantation
PSD	Personnel Security Division
PSG	Polysomnography
PSI	Personnel Security Investigation
PST	Pacific Standard Time
PT	Pacific Time Physical Therapist Physical Therapy Prothrombin Time

TRICARE Operations Manual 6010.56-M, February 1, 2008

Appendix A

Acronyms And Abbreviations

PTA	Pancreas Transplant Alone Percutaneous Transluminal Angioplasty
PTC	Processed To Completion
PTCA	Percutaneous Transluminal Coronary Angioplasty
PTK	Phototherapeutic Keratectomy
PTNS	Posterior Tibial Nerve Stimulation
PTSD	Post-Traumatic Stress Disorder
PVCs	Premature Ventricular Contractions
QA	Quality Assurance
QC	Quality Control
QI	Quality Improvement Quality Issue
QII	Quality Improvement Initiative
QIO	Quality Improvement Organization
QIP	Quality Improvement Program
QLE	Qualifying Life Event
QM	Quality Management
QUIG	Quality Indicator Group
RA	Radiofrequency Annuloplasty Remittance Advice
RADDP	Remote Active Duty Dental Program
RAM	Random Access Memory
RAP	Request for Anticipated Payment
RAPIDS	Real-Time Automated Personnel Identification System
RC	Reserve Component
RCC	Recurring Credit/Debit Charge
RCN	Recoupment Case Number Refund Control Number
RCS	Report Control Symbol
RD	Regional Director Registered Dietitian
RDBMS	Relational Database Management System
RDDDB	Reportable Disease Database
REM	Rapid Eye Movement
RF	Radiofrequency
RFA	Radiofrequency Ablation
RFI	Request For Information
RFP	Request For Proposal
RHC	Rural Health Clinic
RHHI	Regional Home Health Intermediary
RhoGAM	RRho (D) Immune Globulin
RN	Registered Nurse
RNG	Random Number Generator

TRICARE Operations Manual 6010.56-M, February 1, 2008

Appendix A

Acronyms And Abbreviations

RO	Regional Office
ROC	Resumption of Care
ROFR	Right of First Refusal
ROM	Read-Only Memory Rough Order of Magnitude
ROT	Read-Only Table
ROTC	Reserved Officer Training Corps
ROVER	RHHI OASIS Verification
RPM	Record Processing Mode
RRA	Regional Review Authority
RTC	Residential Treatment Center
rTMS	Repetitive Transcranial Magnetic Stimulation
RUG	Resource Utilization Group
RV	Residual Volume Right Ventricle [Ventricular]
RVU	Relative Value Unit
SAAR	System Authorization Access Request
SAD	Seasonal Affective Disorder
SADMERC	Statistical Analysis Durable Medical Equipment Regional Carrier
SAFE	Sexual Assault Forensic Examination
SAO	Security Assistant Organizations
SAP	Special Access Program
SAPR	Sexual Assault Prevention and Response
SAS	Sensory Afferent Stimulation
SAT	Service Assist Team
SBCC	Service Branch Classification Code
SBI	Special Background Investigation
SCA	Service Contract Act
SCH	Sole Community Hospital
SCHIP	State Children's Health Insurance Program
SCI	Sensitive Compartmented Information Spinal Cord Injury
SCIC	Significant Change in Condition
SCOO	Special Contracts and Operations Office
SCR	Stem Cell Rescue
S/D	Security Division
SD (Form)	Secretary of Defense (Form)
SEP	Sensory Evoked Potentials
SES	Senior Executive Service
SelRes	Selected Reserve
SF	Standard Form
SGDs	Speech Generating Devices
SHCP	Supplemental Health Care Program

TRICARE Operations Manual 6010.56-M, February 1, 2008

Appendix A

Acronyms And Abbreviations

SI	Sensitive Information Small Intestine (transplant) Special Indicator (code) Status Indicator
SIDS	Sudden Infant Death Syndrome
SIF	Source Input Format
SII	Special Investigative Inquiry
SI/L	Small Intestine-Live (transplant)
SIOP-ESI	Single Integrated Operational plan-Extremely Sensitive Information
SIP	System Identification Profile
SIT	Standard Insurance Table
SMC	System Management Center
SNF	Skilled Nursing Facility
SNS	Sacral Nerve Root Stimulation
SOC	Start of Care
SOFA	Status Of Forces Agreement
SOIC	Senior Officer of the Intelligence Community
SON	Submitting Office Number
SOR	Statement of Reasons
SPA	Simple Power Analysis
SPECT	Single Photon Emission Computed Tomography
SPK	Simultaneous Pancreas Kidney (transplant)
SPOC	Service Point of Contact
SPR	SECRET Periodic Reinvestigation
SQL	Structured Query Language
SRE	Serious Reportable Event
SSA	Social Security Act Social Security Administration
SSAA	Social Security Authorization Agreement
SSAN	Social Security Administration Number
SSBI	Single-Scope Background Investigation
SSDI	Social Security Disability Insurance
SSL	Secure Socket Layer
SSM	Site Security Manager
SSN	Social Security Number
SSO	Short-Stay Outlier
ST	Speech Therapy
STF	Specialized Treatment Facility
STS	Specialized Treatment Services
STSF	Specialized Treatment Service Facility
SUBID	Sub-Identifier
SUDRF	Substance Use Disorder Rehabilitation Facility
SVO	SIT Validation Office

TRICARE Operations Manual 6010.56-M, February 1, 2008

Appendix A

Acronyms And Abbreviations

SVT	Supraventricular Tachycardia
SWLS	Satisfaction With Life Scale
TAD	Temporary Additional Duty
TAFIM	Technical Architecture Framework for Information Management
TAMP	Transitional Assistance Management Program
TAO	TRICARE Alaska Office TRICARE Area Office
TAR	Total Ankle Replacement
TARO	TRICARE Alaska Regional Office
TB	Tuberculosis
TBD	To Be Determined
TBE	Tick Borne Encephalitis
TBI	Traumatic Brain Injury
TC	Technical Component
TCP/IP	Transmission Control Protocol/Internet Protocol
TCSRC	Transitional Care for Service-Related Conditions
TDD	Targeted Disc Decompression
TDEFIC	TRICARE Dual Eligible Fiscal Intermediary Contract
TDP	TRICARE Dental Program/Plan
TDY	Temporary Duty
TED	TRICARE Encounter Data
TEE	Transesophageal Echocardiograph [Echocardiography]
TEFRA	Tax Equity and Fiscal Responsibility Act
TEOB	TRICARE Explanation of Benefits
TEPRC	TRICARE Encounter Pricing (Record)
TEPRV	TRICARE Encounter Provider (Record)
TET	Tubal Embryo Transfer
TF	Transfer Factor
TFL	TRICARE For Life
TFMDP	TRICARE (Active Duty) Family Member Dental Plan
TGRO	TRICARE Global Remote Overseas
TGROHC	TGRO Host Country
TIFF	Tagged Imaged File Format
TIL	Tumor-Infiltrating Lymphocytes
TIMPO	Tri-Service Information Management Program Office
TIN	Taxpayer Identification Number
TIP	Thermal Intradiscal Procedure
TIPS	Transjugular Intrahepatic Portosystemic Shunt
TIS	TRICARE Information Service
TLAC	TRICARE Latin America/Canada
TLC	Total Lung Capacity
TMA	TRICARE Management Activity

TRICARE Operations Manual 6010.56-M, February 1, 2008

Appendix A

Acronyms And Abbreviations

TMA-A	TRICARE Management Activity - Aurora
TMAC	TRICARE Maximum Allowable Charge
TMCPA	Temporary Military Contingency Payment Adjustment
TMH	Telemental Health
TMI&S	Technology Management Integration & Standards
TMOP	TRICARE Mail Order Pharmacy
TMR	Transmyocardial Revascularization
TMS	Transcranial Magnetic Stimulation
TNEX	TRICARE Next Generation (MHS Systems)
TNP	Topical Negative Pressure
TOB	Type of Bill
TOE	Target of Evaluation
TOL	TRICARE Online
TOM	August 2002 TRICARE Operations Manual 6010.51-M February 2008 TRICARE Operations Manual 6010.56-M
TOP	TRICARE Overseas Program
TOPO	TRICARE Overseas Program Office
TPA	Third Party Administrator
TPC	Third Party Collections
TPharm	TRICARE Pharmacy
TPL	Third Party Liability
TPM	August 2002 TRICARE Policy Manual 6010.54-M February 2008 TRICARE Policy Manual 6010.57-M
TPN	Total Parenteral Nutrition
TPOCS	Third Party Outpatient Collections System
TPR	TRICARE Prime Remote
TPRADFM	TRICARE Prime Remote Active Duty Family Member
TPRADSM	TRICARE Prime Remote Active Duty Service Member
TPRC	TRICARE Puerto Rico Contract(or)
TQMC	TRICARE Quality Monitoring Contractor
TRDP	TRICARE Retiree Dental Program
TRI	TED Record Indicator
TRIAP	TRICARE Assistance Program
TRM	August 2002 TRICARE Reimbursement Manual 6010.55-M February 2008 TRICARE Reimbursement Manual 6010.58-M
TRO	TRICARE Regional Office
TRO-N	TRICARE Regional Office-North
TRO-S	TRICARE Regional Office-South
TRO-W	TRICARE Regional Office-West
TRPB	TRICARE Retail Pharmacy Benefits
TRR	TRICARE Retired Reserve
TRRx	TRICARE Retail Pharmacy
TRS	TRICARE Reserve Select

TRICARE Operations Manual 6010.56-M, February 1, 2008

Appendix A

Acronyms And Abbreviations

TRSA	TRICARE Reserve Select Application
TSC	TRICARE Service Center
TSF	Target of Evaluation Security Functions
TSM	August 2002 TRICARE Systems Manual 7950.1-M February 2008 TRICARE Systems Manual 7950.2-M
TSP	Target of Evaluation Security Policy
TSR	TRICARE Select Reserve
TSRDP	TRICARE Select Reserve Dental Program
TSRx	TRICARE Senior Pharmacy
TSS	TRICARE Senior Supplement
TSSD	TRICARE Senior Supplement Demonstration
TTPA	Temporary Transitional Payment Adjustment
TTY	Teletypewriter
TUNA	Transurethral Needle Ablation
TYA	TRICARE Young Adult
UAE	Uterine Artery Embolization
UARS	Upper Airway Resistance Syndrome
UB	Uniform Bill
UBO	Uniform Business Office
UCBT	Umbilical Cord Blood Stem Cell Transplantation
UCC	Uniform Commercial Code Urgent Care Center
UCCI	United Concordia Companies, Inc.
UCSF	University of California San Francisco
UIC	Unit Identification Code
UIN	Unit Identifier Number
UM	Utilization Management
UMO	Utilization Management Organization
UMP	User Maintenance Portal
UPIN	Unique Physician Identification Number
UPPP	Uvulopalatopharyngoplasty
URFS	Unremarried Former Spouse
URL	Universal Resource Locator
US	Ultrasound United States
USA	United States of America
USACID	United States Army Criminal Investigation Division
USAF	United States Air Force
USAO	United States Attorneys' Office
USC	United States Code
USCG	United States Coast Guard
USCO	Uniformed Services Claim Office
USD	Undersecretary of Defense

TRICARE Operations Manual 6010.56-M, February 1, 2008

Appendix A

Acronyms And Abbreviations

USD (P&R)	Undersecretary of Defense (Personnel and Readiness)
USDI	Undersecretary of Defense for Intelligence
USFHP	Uniformed Services Family Health Plan
USHBP	Uniformed Services Health Benefit Plan
USMC	United States Marine Corps
USMTF	Uniformed Services Medical Treatment Facility
USN	United States Navy
USPDI	United States Pharmacopoeia Drug Information
USPHS	United States Public Health Service
USPS	United States Postal Service
USPSTF	U.S. Preventive Services Task Force
USS	United Seaman's Service
USTF	Uniformed Services Treatment Facility
UV	Ultraviolet
VA	Veterans Affairs (hospital) Veterans Administration
VAC	Vacuum-Assisted Closure
VAD	Ventricular Assist Device
VAMC	VA Medical Center
VATS	Video-Assisted Thoroscopic Surgery
VAX-D	Vertebral Axial Decompression
VD	Venereal Disease
VO	Verifying Office (Official)
VPN	Virtual Private Network
VPOC	Verification Point of Contact
VRDX	Reason Visit Diagnosis
VSAM	Virtual Storage Access Method
VSD	Ventricular Septal Defect
WAC	Wholesale Acquisition Cost
WAN	Wide Area Network
WATS	Wide Area Telephone Service
WC	Worker's Compensation
WebDOES	DEERS Online Enrollment System Web (application)
WEDI	Workgroup for Electronic Data Interchange
WIC	Women, Infants, and Children (Program)
WII	Wounded, Ill, and Injured
WLAN	Wireless Local Area Network
WORM	Write Once Read Many
WRAMC	Walter Reed Army Medical Center
WTC	World Trade Center
WTRR	Wire Transfer Reconciliation Report
WTU	Warrior Transition Unit

TRICARE Operations Manual 6010.56-M, February 1, 2008

Appendix A

Acronyms And Abbreviations

X-Linked SCID	X-Linked Severe Combined Immunodeficiency Syndrome
XML	eXtensible Markup Language
ZIFT	Zygote Intrafallopian Transfer
2D	Two Dimensional
3D	Three Dimensional

- END -

