

Chapter 13

Section 2

Controls, Education, and Conflicts of Interest

Revision: C-58, September 20, 2019

1.0 CONTROLS

1.1 Controls for the Prevention And Detection Of Fraudulent Or Abusive Practices

The contractor shall establish procedures and utilize controls for the prevention and detection of fraudulent or abusive patterns and trends in billings by providers, pharmacies, entities, and beneficiaries on a pre- and postpayment basis. Controls shall include the following (and be made available to the Defense Health Agency (DHA) Program Integrity Office (PI)):

- Eligibility verifications for beneficiaries and providers/pharmacies.
- Coordination of benefits.
- Prepayment edits (e.g., applied to program exclusions and limitations).
- Utilization of discretionary or coordinated placement of providers/beneficiaries on prepayment review.
- Postpayment utilization review to detect fraud and/or abuse by either beneficiaries, pharmacies, or providers and to establish dollar loss to the Government.
- Application of security measures to protect against embezzlement or other dishonest acts by employees.
- Incorporate anti-fraud attestation language whenever/wherever practical (e.g., claim forms, network agreements, electronic claims submission agreements).
- Utilization of Fraudlines/Hotlines.
- Prepayment duplicate screening.
- Postpayment duplicate screening.
- Verification of provider status (e.g., credentials, licensure) to include appropriate termination action when findings/recommendations of boards, etc. results in loss or suspension of licensure or certification.

- Program Integrity (PI) targeted measures (e.g., prepay anti-fraud review; use of post payment fraud detection software; routine anti-fraud data mining; investigative anti-fraud auditing; select provider/beneficiary education).
- Specific to pharmacy, controls include comparing reversal rates; excessive partial fill submissions; high use patients; review of outliers; codes with medication therapy for high ingredient costs; claims with high average ingredient cost; review of brand/generic fill rates; top pharmacies per generic code rate; controlled substance prescription rates; and ability to conduct on-site audits of pharmacies who meet these indicators and ability to review/perform on-site of top one percent of providers who meet these indicators.

1.2 Claim/Encounter Review Procedures And Controls

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

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

1.3 Beneficiary And Provider Flags

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

2.0 EDUCATION

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

2.2 The contractor shall establish a public education program addressed to beneficiaries, providers, and pharmacies. The program shall provide information about identified fraudulent or abusive practices and how individuals may identify and report such practices. This shall be accomplished by including information in the provider quarterly newsletters, e-mail, World Wide Web (WWW), and other social media and by periodic notices on the electronic explanation of benefits. Upon request, newsletters and notices shall be provided to DHA PI.

2.3 Cost-Share/Copayment Collection Questionable

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

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

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

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

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

2.4 Violation of Participation Agreement or Reimbursement Limitation

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

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

2.4.3 A breach of a participation agreement/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). If a violation of network agreement warrants a referral to DHA PI, see [Section 3](#). Also, refer to the TRM, [Chapter 3, Section 1](#).

2.5 Balance Billing Limitations

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

2.6 Contractor Development of Violation of Participation Agreement or Balance Billing Limitation

2.6.1 The contractor is responsible for ensuring that providers adhere to their participation and non-participation agreements and the associated reimbursement limitation. Corrective action is required for a provider who submits participating or non-participating claims, but does not comply with the agreement to accept as the allowable charge as full payment for the service, as determined by the contractor, or who violates the 115% reimbursement limitations. Beneficiary complaints about breach of the allowable charge participating agreement or reimbursement limitation shall be resolved by the contractor staff, e.g., explaining to the provider the commitment made in accepting participation or regarding the Appropriations Act.

2.6.2 Institutional violation letters must be sent by name to the hospital administrator. The contractor shall obtain assurance that the provider will identify and refund any money inappropriately collected and refrain from billing beneficiaries for the reductions on participating claims or in violation of the 115% reimbursement limitation in the future. A letter to a non-institutional provider must be addressed to the name of the person who has the authority to resolve the administrative matter. This could be the Chief Executive Officer (CEO), the billing manager, or the provider of services. The provider shall be advised that violating the participation agreement or reimbursement limitation subjects the provider to sanction action. The contractor shall obtain a copy of the zero balance statement to verify that the issue has been resolved. In a violation of a participation agreement or a balance billing limitation case, the contractor shall advise the provider to cease billing the beneficiary for amounts in excess of the appropriate amount and calculate the overpayment for the provider to refund to the beneficiary. (See [Addendum A](#), [Figure 13.A-1](#), [Figure 13.A-2](#), [Figure 13.A-3](#), and [Figure 13.A-4](#)).

2.6.3 If after two notices a provider refuses to make refunds, continues to violate participation agreements or reimbursement limitations, or brings suit against a beneficiary who refuses to pay the amount of the reduction, the contractor shall bring the matter to the immediate attention of DHA PI. The contractor shall also submit a copy of all supporting documents. This includes claims, Explanations of Benefits (EOBs), educational letters to the provider, patient's canceled check copy or provider's billing statement.

2.6.4 The contractor shall follow the same procedures listed above for those providers signing special TRICARE participating provider agreements (Residential Treatment Centers (RTCs), Partial Hospitalization Programs (PHPs), Substance User Disorder Rehabilitation Facilities (SUDRFs), and Marriage and Family Counseling Centers (MFCCs)).

2.7 Waiver of CHAMPUS Maximum Allowable Charge (CMAC)

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

3.0 CONFLICT OF INTEREST

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

3.1 Federal Employees And Active Duty Military

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

3.2 Exceptions

3.2.1 National Health Service Corps

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.

3.2.2 Emergency Rooms

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

3.2.3 Reserves Generally Exempt

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

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

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

3.2.5 Referrals From Uniformed Services Facilities

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

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