Addendum A Figures

Figure 2-7-A-1 TRICARE Fraud & Abuse Report, TMA Form 435

TRICARE FRAUD AND ABUSE REPORT				ACTION OFFICER
KEYWORD (Region #)	CONTRACTOR CODE	STATE (USPS CODE	DATE REFERRED TO TMA	
SUBJECT	NAME (Last, First, MI) CROSS REFERENCE (Last, First, MI)		SSAN/EIN/TIN	ADDRESS (City, State)

SECTION (A) **POTENTIAL FRAUD OR ABUSE ISSUE** **(NO MORE THAN 4 SELECTIONS)**	**POTENTIAL ABUSE** (257) ___ OVERUTILIZATION (273) ___ QUALITY OF CARE (282) ___ SERVICES NOT MEDICALLY NECESSARY (298) ___ WAIVER OF BENEFICIARY COST-SHARE (299) ___ IMPROPER BILLING PRACTICES (385) ___ OTHER (Abuse)___________________	**POTENTIAL FRAUD** (200) ___ MISREPRESENTATION OF CREDENTIALS (206) ___ ALTERING BILLS / RECEIPTS (389) ___ BALANCE BILLING LIMITATION (209) ___ BREACH OF PROVIDER PARTICIPATION AGREEMENT (211) ___ BILLING FOR SERVICES NOT RENDERED (230) ___ ELIGIBILITY (231) ___ EMBEZZLEMENT (235) ___ FALSIFYING RECORDS / DOCUMENTS (237) ___ FORGERY OF CHECK (244) ___ KICKBACKS / REBATES (248) ___ MISREPRESENTING SERVICES / DIAGNOSES (256) ___ FAILURE TO DISCLOSE OTHER HEALTH INSURANCE (386) ___ MISREPRESENTATION OF PATIENT (387) ___ MISREPRESENTATION OF PROVIDER (384) ___ OTHER (Fraud)___________________________
SECTION (B) **CLASSIFICA-TION OF SUBJECT** **(Check One)**	(101) ___ BENEFICIARY (105) ___ CONTRACTOR EMPLOYEE **PHYSICIAN** (102) ___ GENERAL PRACTICE (103) ___ SURGEON (104) ___ PSYCHIATRIST (105) ___ OBSTETRICIAN (106) ___ INTERNAL MEDICINE (108) ___ DENTIST (112) ___ ANESTHESIOLOGY (133) ___ OTHER (Physician) (Specify)_____________ **HOSPITAL** (110) ___ ACUTE GENERAL (111) ___ PSYCHIATRIC (113) ___ RESIDENTIAL TREATMENT CENTER (114) ___ SPECIALIZED TREATMENT FACILITY	(107) ___ PSYCHOLOGIST (109) ___ PODIATRIST (115) ___ CLINIC, GROUP PRACTICE (116) ___ LABORATORY (117) ___ MEDICAL SUPPLIER (118) ___ AMBULANCE SERVICE (119) ___ PHARMACY (121) ___ CLINICAL SOCIAL WORKER (122) ___ MARRIAGE & FAMILY COUNSELOR (129) ___ MENTAL HEALTH COUNSELOR (130) ___ OTHER (Specify)____________________________ (131) ___ OTHER (Hospital) (Specify)_______________________ (134) ___ REGISTERED NURSE (135) ___ OCCUPATION / PHYSICAL THERAPIST (140) ___ PARTNERSHIP PHYSICIAN (141) ___ OTHER (Specify)____________________________
SECTION (C) **REFERRAL SOURCE** **(Check One)**	(01) ___ BENEFICIARY / SPONSOR (02) ___ CONTRACTOR (03) ___ LEAD AGENT (Region_____________) (05) ___ HEALTH BENEFITS ADVISOR (06) ___ PROVIDER OF CARE (08) ___ MEDIA	(09) ___ DEFENSE ELIGIBILITY ENROLLMENT REPORTING SYSTEM (10) ___ TMA PROGRAM INTEGRITY BRANCH (12) ___ OTHER (Specify) ___________________ (13) ___ OTHER GOVERNMENT SOURCE (Specify)____________ (14) ___ QUI TAM (15) ___ DEFENSE CRIMINAL INVESTIGATIVE SERVICE (DCIS)
SECTION (D) **CASE DISPOSITION** **(Check One)**	(PR) ___ PLACED ON PREPAYMENT REVIEW (PC) ___ PROVIDER CONSULTATION (MR) ___ REFERRED TO MEDICAL REVIEW (IG) ___ REFERRED TO DoD IG (CD) ___ CASE DISMISSED (RL) ___ REFERRED TO LICENSING BOARD (TR) ___ TRANSFERRED	(DI) ___ REFERRED TO TMA PROGRAM INTEGRITY (DP) ___ DENIED PAYMENT (RF) ___ RECOUPED FUNDS (FR) ___ REFERRED TO CONTRACTORS RECOUPMENT SECTION (LT) ___ REFERRED TO TMA RECOUPMENT SECTION (NC) ___ NOT CHASED (Conviction, but for hardship reason no recoupment) (PS) ___ PROVIDER SANCTIONED (Terminated or Excluded)

SECTION (E) **DOLLAR IMPACT**	(01) DOLLARS CURRENT CASE	(02) DOLLARS IDENTIFIED FOR RECOUPMENT	(03) DOLLARS RECOUPED

TMA FORM 435
March 1998

PREVIOUS EDITIONS OF THIS FORM ARE OBSOLETE

Figure 2-7-A-1 TRICARE Fraud & Abuse Report, TMA Form 435 (Continued)

INSTRUCTIONS

This form is to be completed for each potential fraud or abuse case opened.

A. *Fraud or Abuse Issue: May select up to four issues. If more than one applies, rate them from most to least important.*

B. *Classification of Subject: Self-explanatory. Check the category which most appropriately identified the subject. When one individual provider within a clinic or group is involved, use the individual provider classification.*

C. *Referral Source: Select the one which most appropriately identifies the referral of this case.*

D. *Case Disposition: Select the one which most appropriately identifies the disposition of this case. Do not complete if referred to TMA, Program Integrity Branch.*

E. *Dollar Impact: Complete (01) Dollars Current Case, i.e., erroneous or overpayment amount, when referred to TMA, Program Integrity Branch.*

Figure 2-7-A-2 Sample Letter to Beneficiary in External Audit Cases

(BENEFICIARY ADDRESS)

Dear________:

We are pleased that we were recently of service to you. Now we ask your participation in this survey to help us improve service to you and all other TRICARE beneficiaries. We are requesting that you review the following information to determine whether our records are correct. Our records show that you received the following services:

Provider: ***(Name of physician, hospital or other supplier)***

Date of Service: ***(List by each date of service. Do not use range dates.)***

Place of Service:

Type of Service: ***(List by narrative description, not by procedure code.)***

Amount Billed to Patient:

Amount Paid by Patient, Sponsor, or Parent/Guardian:

Cost-share Amount or Other Health Insurance Amount:

If the "amount paid by patient" was not actually paid to the provider of care by the patient, sponsor, or parent/guardian, explain below or on the reverse side of this letter.

Please circle any of the above items which appear to be wrong and explain on the reverse side of this letter. In addition, please provide the following information:

Did you sign a claim form or an authorization form supplied by the provider of care for the services shown above? YES ___, NO _____.

Did you sign a "benefit assignment" form which stated you were responsible for the full charges over and above what your insurance (or TRICARE) would pay? YES_______ NO _______.

Your work phone number: *Home phone number:*

________________________ ________________,

*We appreciate your assistance in responding to this request and have enclosed a self-addressed stamped envelope for your convenience. If you have any questions, please call (**TELEPHONE NUMBER**). Thank you for your cooperation.*

Sincerely,

Name, Title and Office

Enclosure:
Self-Addressed Stamped Envelope

Figure 2-7-A-3 Sample Letter to Provider in External Audit Cases

(PROVIDER ADDRESS)

Dear_______:

Recently, we received a claim filed by a beneficiary who reported services and/or supplies furnished by you. Now we ask your assistance in this survey to help us improve service and benefits to all TRICARE beneficiaries and providers. Please review the following information in your records to determine whether our information is correct.

Patient Name:

Sponsor SSN:

Date of Service:

Place of Service:

Type of Service:

Total Amount Billed Patient:

Please circle any of the above items which appear to be in error, provide the correct information next to it, and return this letter in the enclosed self-addressed, stamped envelope. If the information is correct, write the word "correct" on this letter and return it.

In addition, please provide the following information:

1. Procedure, diagnosis or additional description of services provided this patient:
2. Your telephone number:

Thank you for your attention to this matter. Your assistance in responding to this survey is appreciated.

Sincerely,

Name, Title and Office

Enclosure:
Self-Addressed Stamped Envelope

Figure 2-7-A-4 Special Notice to Provider When the Provider's Claims are Suspended (Sample)

(PROVIDER ADDRESS)

Dear__________:

This is to inform you that we have been notified by the TRICARE Management Activity (TMA) to suspend payment for present and future claims for services provided by you or your organization. This action is being taken immediately under the provisions of the 32 Code of Federal Regulations 199.9 because of further investigation by the Government of your organization's medical and/or financial records. This suspension is for an indefinite period of time as determined by TMA.

Please note that any participation agreement with your patients remains in full force and effect and you cannot repudiate the agreement as a result of the delay in final disposition of the claims. The assessment of a finance charge, either to the beneficiary or the Government, on these suspended claims is also prohibited.

Within thirty (30) days of the date of this notice, you may present to the Chief, Program Integrity Branch, TMA, in writing, information (including documentary evidence) and argument in opposition to the suspension, provided the additional specific information raises a genuine dispute over the material facts, or you may submit a written request to present in person, evidence to the Director, TMA, or a designee. All such presentations shall be made at TMA, 16401 East Centretech Parkway, Aurora, Colorado 80011-9043 at your expense.

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

*(**Contractor's Address**)*

Sincerely,

Name, Title and Office

NOTE TO CONTRACTOR

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

Figure 2-7-A-5 Special Notice to Beneficiary When the Beneficiary's Claims are Suspended Due to Possible Beneficiary Fraud (Sample)

(BENEFICIARY ADDRESS)

Dear_________:

*This is to inform you that your claims have been suspended pending review by the TRICARE Management Activity (TMA), effective (**DATE**) for an indefinite period of time. This action is being taken by the TMA under the provisions of the 32 Code of Federal Regulation 199.9, because of further investigation by the Government of your claims.*

Within thirty (30) days of the date of this notice, you may present to the Chief, Program Integrity Branch, TMA, in writing, information (including documentary evidence) and argument in opposition to the suspension, provided the additional specific information raises a genuine dispute over the material facts or you may submit a written request to present, in person, evidence to the Director, TMA, or a designee. All such presentations shall be made at TMA, 16401 East Centretech Parkway, Aurora, Colorado, 80011-9043,at your expense.

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

*(**CONTRACTOR'S ADDRESS**)*

Sincerely,

Name, Title and Office

NOTE TO CONTRACTOR

The TMA, Program Integrity Branch will be the sole authority for the direction of issuance of a notice of the suspension of a beneficiary's claims from processing. Instructions will be provided on an individual case-by-case basis. The contractor shall state the reason for the claims processing suspension as provided by the TMA.

Figure 2-7-A-6 Special Notice to Beneficiary When A Beneficiary's Claims Are Suspended Due To Possible Provider Fraud (Sample)

(BENEFICIARY ADDRESS)

Dear_________:

*This is to inform you that your claim(s) for services provided by (**PROVIDER'S NAME AND ADDRESS**) has been suspended pending review by the TRICARE Management Activity (TMA), for an indefinite period of time. This action is being taken by the TMA under the provisions of the 32 Code of Federal Regulations 199.9, because of further review by the Government of services/supplies provided by (**NAME OF PROVIDER**).*

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

*(**CONTRACTOR'S ADDRESS**)*

Sincerely,

Name, Title and Office

NOTE TO CONTRACTOR

The TMA, Program Integrity Branch will be the sole authority for the direction of issuance of a notice of the suspension of a beneficiary's claims from processing. Instructions will be provided on an individual case-by-case basis. The contractor shall state the reason for the claims processing suspension as provided by TMA.

Figure 2-7-A-7 Annual Letter of Assurance (Sample)

XXXXXXXXXXXX
Director
TRICARE Management Activity (TMA)
16401 East Centretech Parkway
Aurora, CO 80011-9043

Dear ___________

An evaluation of the system of internal accounting and administrative control of (name of contractor) in effect during the fiscal year ended (date) was performed in accordance with Guidelines for the Evaluation and Improvement of and Reporting on Internal Control Systems in the Federal Government, issued by the Director of the Office of Management and Budget, in consultation with the Comptroller General, as required by the Federal Managers' Financial Integrity Act of 1982, and accordingly included an evaluation of whether the system of internal accounting and administrative control of (name of contractor) was in compliance with the standards prescribed by the Comptroller General.

The objectives of the system of internal accounting and administrative control of (name of contractor) are to provide reasonable assurance that:

1. *Obligations and costs are in compliance with applicable law;*
2. *Funds, property, and other assets are safeguarded against waste, loss, unauthorized use, or misappropriation; and*
3. *Revenues and expenditures applicable to agency operations are properly recorded and accounted for to permit the preparation of accounts and reliable financial statistical reports and to maintain accountability over the assets.*

The concept of reasonable assurance recognizes that the cost of internal control should not exceed the benefits expected to derive therefrom, and that the benefits consist of reductions in the risks of failing to achieve the stated objectives. Estimates and judgements are required to assess the expected benefits and related costs of control procedures. Furthermore, errors or irregularities may occur and not be detected because of inherent limitations in any system of internal accounting and administrative control, including those limitations resulting from resource constraints, Congressional restrictions, and other factors. Finally, projection of any evaluation of the system to future periods is subject to the risk that procedures may be inadequate because of changes in conditions or that the degree of compliance with the procedures may deteriorate.

The results of the evaluation described in the first paragraph, assurances given by appropriate (name of contractor) officials, and other information provided, indicate that the system of internal accounting and administrative control of (name of contractor) in effect during the fiscal year ended (date), taken as a whole, complies with the requirement to provide reasonable assurance that the above-mentioned objectives were achieved within the limits described in the preceding paragraph. Controls are in place to prevent and detect fraudulent and abusive practices, and comply with contractual requirements in that respect. The evaluation, however, did disclose the following weaknesses: (1)

(LIST THE MATERIAL WEAKNESSES (2))

Figure 2-7-A-7 Annual Letter of Assurance (Sample) (Continued)

Attachment A to this statement contains the (name of contractor) plans and schedules for correcting such weaknesses (1), and the status of actions taken to correct weaknesses identified in prior years' reports. (3)

Sincerely,

Name, Title and Office

Enclosure(s)
(if any)

NOTE TO CONTRACTOR

(1) *If there are no material weaknesses, this sentence should be deleted, and there would be no list or Attachment A containing plans and schedules for correcting such weaknesses.*

(2) *If material weaknesses in systems subject to these guidelines are found, this sample letter constitutes the statement and report required by the Federal Managers' Financial Integrity Act. If material weaknesses are not found, this sample, as adjusted, constitutes the statement required by the Act.*

(3) *If there were no actions taken during the past year to correct weaknesses, or no identified weaknesses for which corrective actions remain to be taken, this phrase would be deleted.*

Figure 2-7-A-8 TRICARE Fraud & Abuse Summary Report (By Calendar Quarter)

Reporting Period Ended _______________,

The TRICARE Fraud and Abuse Case Report, TMA Form 435, will be completed on every case opened for initial investigation of potential fraud or abuse. The following information, which is essentially the same as on Form 435, will be submitted to the Program Integrity Branch, TRICARE Management Activity (TMA), within forty- five (45) days of the last day of each calendar quarter.

A. Case Workload Report

Number of open pending cases beginning of quarter	
Add-number of new cases opened during quarter (Opened Case: A case requiring special review for possible fraud or abuse)	+
Less-number of cases closed during quarter (Closed Case: A case for which the potential fraud or abuse issue has been resolved and final action has been taken)	-
Equals number of cases pending end of quarter	
Number of cases referred to the TMA Program Integrity Branch during quarter	
Total number of pending cases at the TMA Program Integrity Branch	

B. Categorical Information on Cases Closed During this Quarter

CLASSIFICATION OF SUBJECT	NUMBER OF CASES
Beneficiary	
Physician	
General Practice	
Surgeon	
Psychiatrist	
Obstetrician	
Internal Medicine	
Anesthesiologist	
Dentist	
Other (Specify)	
Psychologist	
Podiatrist	

Figure 2-7-A-8 TRICARE Fraud & Abuse Summary Report (By Calendar Quarter) (Continued)

Reporting Period Ended ______________,	
Hospital	
Acute General	
Psychiatric	
Other (Specify)	
Skilled Nursing Facility	
Residential Treatment Center	
Specialized Treatment Facility	
Clinic, Group Practice	
Laboratory	
Medical Supplier	
Ambulance Service	
Pharmacy	
Registered Nurse	
Clinical Social Worker	
Marriage, Family and Pastoral Counselor	
Mental Health Counselor	
Chiropractor	
Partnership/Resource Sharing	
Occupational Therapist	
Physical Therapist	
Others	
Total	

Figure 2-7-A-8 TRICARE Fraud & Abuse Summary Report (By Calendar Quarter) (Continued)

Reporting Period Ended ______________,		
POTENTIAL FRAUD OR ABUSE ISSUES -- Report Managed Care and TRICARE separately, as follows		
ISSUE - POTENTIAL ABUSE	NUMBER OF CASES	TOTAL DOLLAR AMOUNT BY ISSUE
Waiver of beneficiary cost-shares		$
Improper billing practices		$
Services Not Medically Necessary		$
Overutilization		$
Failure to File Claims (Provider)		$
Billing Administrative Charge for Filing Claims		$
Quality of Care		$
Other (Specify)		$
ISSUE -- POTENTIAL FRAUD -- Report as follows	NUMBER OF CASES	TOTAL DOLLAR AMOUNT BY ISSUE
Billing for Services Not Rendered		$
Misrepresenting Services/Diagnosis		$
Altering Bill/Receipt		$
Falsifying Records/Documents		$
Kickbacks/Rebates		$
Eligibility		$
Embezzlement		$
Forgery of Check		$
Other Health Insurance		$
Misrepresentation of Credentials		$
Breach of Provider Participation Agreement		$

Figure 2-7-A-8 TRICARE Fraud & Abuse Summary Report (By Calendar Quarter) (Continued)

Reporting Period Ended _______________,		
Balance Billing Limitation		$
Misrepresenting Patient		$
Misrepresenting Provider		$
Other (Specify)		$
Total		$
FRAUD OR ABUSE REFERRAL SOURCE -- Report as follows	**NUMBER OF CASES**	
Beneficiary/Sponsor		
Clerical Identification		
Prepayment Review		
Postpayment Review		
Health Benefits Advisor		
Provider of Care		
Medical Review (Third Level)		
Media		
DEERS		
TMA		
DCIS		
Other Contractor		
OHI		
Public/anonymous		
Other (Specify)		
DISPOSITION OF FRAUD AND ABUSE CASES -- Report as follows	**NUMBER OF CASES**	
Place on Prepayment Review		
Provider Consultation		
Referred for Medical Review		
Referred to the TMA Program Integrity Branch		

Figure 2-7-A-8 TRICARE Fraud & Abuse Summary Report (By Calendar Quarter) (Continued)

Reporting Period Ended _______________,	
Case dismissed (no issue)	
Referred to Licensing Board	
Denied Payment	
Recouped Funds	
Referred to Contractor Recoupment Section	
Referred to the TMA Recoupment Section	
Provider Sanctioned (terminated or excluded)	
Other (specify)	
DOLLAR AMOUNT REPORT	**DOLLAR AMOUNT**
Actual monies saved this quarter:	$
Recoupments	$
Claim Denials (Partial and Full)	$

Figure 2-7-A-8 TRICARE Fraud & Abuse Summary Report (By Calendar Quarter) (Continued)

Reporting Period Ended ______________,				
Recoupment Action				
BENEFICIARY/ PROVIDER NAME	SSN/EIN	REQUESTED RECOUPMENT	RECEIVED THIS QUARTER	RECEIVED TO DATE
		$	$	$
		$	$	$
		$	$	$
		$	$	$

Figure 2-7-A-9 Notice to Provider Excluded or Suspended Under the Social Security Act (Sample)

(PROVIDER'S ADDRESS)

Dear ___________

*The Department of Defense, TRICARE Management Activity (TMA), has been advised by the Department of Health and Human Services (DHHS) that you have been (**EXCLUDED** or **SUSPENDED**) from Medicare participation under the provisions of the Social Security Act. This (**EXCLUSION** or **SUSPENSION**) for the period (**INSERT TERMS OF SANCTION, I.E., ONE YEAR, TWO YEARS, ETC.**), was effective fifteen (15) days from the date of DHHS' notice of (**INSERT DATE OF DHHS' NOTICE**) and will remain in effect for the period of time determined by the Secretary of the Department of Health and Human Services.*

Based on the provisions of the regulation governing the operations of TRICARE, 32 CFR 199.9, payments under TRICARE will also be denied for services or supplies furnished fifteen (15) days after the date of this letter. As the actions taken by TRICARE are based on a DHHS determination, no administrative appeal rights are available under 32 CFR 199.10 which specifically provides that:

> *"Any sanction, including the period of the sanction, imposed under Chapter 9 of this Regulation which is based solely on a provider's exclusion or suspension by another agency of the Federal Government, a state, or a local licensing authority is not appealable under this chapter. The provider must exhaust administrative appeal rights offered by the other agency that made the initial determination to exclude or suspend the provider."*

If you wish to provide services under TRICARE after you are reinstated by DHHS, you must apply for reinstatement to the Chief, Program Integrity Branch, TMA, 16401 East Centretech Parkway, Aurora, CO 80011-9043. Include a copy of your DHHS reinstatement letter and documentation sufficient to establish that you meet the qualifications under the Regulation to be an authorized provider.

Sincerely,

Name, Title and Office

cc:
Program Integrity Branch
TMA

NOTE TO CONTRACTOR

Letter is to be sent by Return Receipt Requested or any other method requiring a signature documenting receipt.

Figure 2-7-A-10 Notice to Beneficiary When Provider Is Excluded or Suspended Under the Social Security Act (Sample)

(BENEFICIARY'S ADDRESS)

Dear______:

*This is to inform you that (**NAME OF PROVIDER**) has been (**EXCLUDED** or **SUSPENDED**) as an authorized provider under the TRICARE Management Activity (TMA) effective (**GIVE ACTUAL TRICARE EFFECTIVE DATE**). This action is being taken by the TMA based upon a Department of Health and Human Services (**EXCLUSION** or **SUSPENSION**) under the provisions of the Social Security Act and the 32 Code of Federal Regulations 199.9. Therefore, we will not pay for any services provided to you by (**NAME OF PROVIDER**), on or after (**ACTUAL TMA EFFECTIVE DATE**) for a period of time determined by TMA. The provider has been notified by the Department of Health and Human Services and TMA of this action.*

*If you need assistance in selecting an alternative facility or professional provider, please contact your Health Benefits Advisor or call (**GIVE APPROPRIATE CONTRACTOR TELEPHONE NUMBER**).*

Sincerely,

Name, Title and Office

Figure 2-7-A-11 Notice of Proposed Action Terminating a Provider (Sample)

(PROVIDER'S ADDRESS)

Dear__________:

*This is to notify you of our proposed action to terminate you as an authorized TRICARE provider. This decision is based on the fact that you do not meet the qualifications as an authorized TRICARE provider as established by the 32 Code of Federal Regulations 199.6, based on the documentation submitted to us. (**NOTE: The contractor shall give the reasons and supporting facts for the proposed termination.**)*

*The effective date of this termination is retroactive to (**INSERT DATE and PROVIDE ONE OF THE FOLLOWING STATEMENTS: the date on which you did not meet these requirements, or June 10, 1977, the effective date of the Regulation, WHICHEVER DATE IS LATER**). The period of termination is indefinite and will end only after you have successfully met the established qualifications for authorized provider status under TRICARE and have been reinstated as an authorized TRICARE provider.*

Authority for this termination can be found in the 32 Code of Federal Regulations 199.9, which provides administrative remedies for fraud, abuse and conflict of interest, and for termination when the provider has not met or satisfied the criteria for TRICARE authorized provider status. This Regulation applies whether you are a participating or a nonparticipating provider. Since a provider is expected to know the TRICARE requirements for qualification as an authorized provider, and we have no evidence that you meet the qualification requirements, you are considered to have forfeited or waived any right or entitlement to bill the beneficiary for the care involved in the TRICARE claims. If you do bill the beneficiary, restitution to the beneficiary may be required by the Director, TMA, or a designee, as a condition for consideration of reinstatement as a TRICARE authorized provider. Beneficiaries who choose to continue to use the services of an unauthorized TRICARE provider shall not be reimbursed by TRICARE.

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

Any claims cost-shared or paid under TRICARE for services or supplies furnished by the provider on or after the effective date of termination, even when the effective date is retroactive, shall be deemed an erroneous payment. All erroneous payments are subject to collection. Any further claims processing will be suspended unless you provide documentation that you meet the requirements as an authorized provider.

*We will consider any documentary evidence or written argument regarding the proposed action submitted within thirty (30) days of the date of this letter. You may also submit within thirty (30) days a written request to present in person, evidence or argument to (**INSERT UNIT OR NAME OF PERSON AND ADDRESS TO WHOM THE PROVIDER IS TO SUBMIT CERTIFICATION DOCUMENTATION**). All such presentations shall be made at the above mentioned office at your expense.*

Figure 2-7-A-11 Notice of Proposed Action Terminating a Provider (Sample) (Continued)

*Any requests or submittals to (**INSERT UNIT OR PERSON'S NAME MENTIONED ABOVE**), must be received within thirty (30) days of the date of this letter or, if received after thirty (30) days, must be postmarked within thirty (30) days of the date of this letter. If you cannot present additional information within thirty (30) days, upon written request and for good cause shown, you may request that additional information be submitted within sixty (60) days from the date of this letter. All communications with this office should be in writing.*

Sincerely,

Name, Title and Office

NOTE TO CONTRACTOR

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

Figure 2-7-A-12 Initial Determination Terminating a Provider (Sample)

(PROVIDER'S ADDRESS)

} Initial Determination
} Contractor Name
} Case File YY-"#"

Dear_________:

*By letter dated (**DATE OF PROPOSED ACTION NOTICE**), you were given notice of a proposed action to terminate you as an authorized (**PROVIDER TYPE**) under TRICARE. By that notice, you were offered the opportunity to submit, within thirty (30) days, either documentary evidence supporting your contention that you meet the requirements for authorization as a (**PROVIDER TYPE**) and written argument contesting the proposed action or a written request to present in person, and at your sole expense, evidence or argument supporting your contention that you meet the requirements for authorization as a (**PROVIDER TYPE**).*

(STATE WHAT THE PROVIDER DID: I.E., BY LETTER DATED ___, YOU SUBMITTED ADDITIONAL INFORMATION, OR ON {DATE} YOU PERSONALLY APPEARED BEFORE {STATE NAME AND POSITION OF THE INFORMAL REVIEW OFFICIAL}, OR YOU FAILED TO TAKE ADVANTAGE OF THE OPPORTUNITY TO SUBMIT ANY DOCUMENTATION OR ARGUMENT CONTESTING THE PROPOSED ACTION.)

*After reviewing all available information, this initial determination is issued terminating your status as an authorized TRICARE provider effective (**INSERT EITHER JUNE 10, 1977, THE EFFECTIVE DATE OF THE CHAMPUS REGULATION OR THE DATE ON WHICH THE PROVIDER WAS FIRST APPROVED OR LOST THEIR LICENSE, WHICHEVER IS LATER**), the date on which you first failed to meet the requirements as a (**PROVIDER TYPE**) under the 32 Code of Federal Regulations 199.6. This termination action is being taken under authority of the 32 Code of Federal Regulations 199.9. The retroactive date of termination is not limited due to the passage of time, erroneous payments of claims, or any other event which may be cited as a basis for TRICARE recognition of a provider notwithstanding the fact that the provider does not meet program qualifications. Termination under TRICARE shall continue even if you obtain a license to practice in a second jurisdiction during the period of exclusion or revocation of your license by the original licensing jurisdiction. Any claims previously cost-shared or paid under TRICARE for services or supplies furnished on or after the effective date of termination shall be deemed an erroneous payment and shall be subject to collection action under appropriate law and regulation*

*Under the 32 Code of Federal Regulations 199.6, to be an authorized (**PROVIDER TYPE**), an individual must be licensed or certified by the state and meet the following requirements:*

(LIST SPECIFIC REQUIREMENTS FROM THE REGULATION)

Figure 2-7-A-12 Initial Determination Terminating a Provider (Sample) (Continued)

*Records available for review indicate that you do not meet the requirements for authorization as a (**PROVIDER TYPE**) under TRICARE because (**GIVE SPECIFIC BASIS FOR YOUR DECISION; IF THE PROVIDER SUBMITTED ANY EVIDENCE OR ARGUMENT IN WRITING OR IN PERSON, IDENTIFY THAT EVIDENCE OR ARGUMENT HERE AND DISCUSS ITS RELEVANCE TO THIS DECISION.**)*

*The period of your termination as an authorized (**PROVIDER TYPE**) under TRICARE is indefinite under the provisions of the 32 Code of Federal Regulations 199.9. The period of termination will end only upon receipt of documentation that you have successfully met the established qualifications and receipt of your request for reinstatement as an authorized provider under the procedures established by the 32 Code of Federal Regulations 199.9. All requests for reinstatement of terminated providers must be submitted to the Chief, Program Integrity Branch, TRICARE Management Activity (TMA), 16401 East Centretech Parkway, Aurora, CO 80011-9043.*

*The 32 Code of Federal Regulations 199.10, sets forth policies and procedures for appealing decisions that affect the rights and liabilities of providers whose status as an authorized provider under TRICARE has been terminated. In order to appeal, however, there must be an appealable issue, that is, there must be a disputed question of fact which, if resolved in your favor, would result in your approval as a TRICARE authorized provider. The administrative appeal process may not be used to challenge the propriety, equity, or legality of any provision of law or regulation. If you disagree with this initial determination and you believe a disputed question of fact exists, you may appeal. Your written request for a hearing must be mailed within sixty (60) days from the date of this letter to the Chief, Office of Appeals and Hearings, TMA, 16401 East Centretech Parkway, Aurora, CO 80011-9043. A copy of this letter should be included with your request for a hearing. You should also include any additional documentation or evidence you wish considered in support of your contention that you meet the TRICARE criteria for authorization as a (**PROVIDER TYPE**).*

Sincerely,

Name, Title and Office

cc:
Program Integrity Branch
TMA

NOTE TO CONTRACTOR

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

Figure 2-7-A-13 ***Reserved***

Figure 2-7-A-14 Violation of the Participation Agreement (Sample)

(PROVIDER'S ADDRESS)

Dear_________:

*We have been notified that you are in breach of the participation agreement. (**NAME OF PATIENT**) advised us that (**HE/SHE**) has been billed for amounts in excess of (**HIS/HER**) cost-share for services provided on (**DATES**), which is a violation of your participation agreement.*

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

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

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

*To preclude any adverse action against your authorized provider status, please notify (**NAME OF PATIENT**) in writing that all attempts to collect amounts in excess of (**HIS/HER**) deductible and cost-share have ceased.*

Figure 2-7-A-14 Violation of the Participation Agreement (Sample) (Continued)

*The total billed amount is (**PUT IN AMOUNT**) and the correct TRICARE allowable is (**PUT IN ALLOWABLE AMOUNT**). (**NAME OF PATIENT**) cost-share amount is (**PUT IN APPROPRIATE PERCENTAGE**), of (**PUT IN DOLLAR AMOUNT**). The total payment amount to you is (**PUT IN GOVERNMENT'S COST-SHARE PLUS PATIENT'S DEDUCTIBLE AND COST-SHARE AMOUNT**). (**NAME OF PATIENT**) is only responsible for (**HIS/HER**) cost-share amount (**PUT IN AMOUNT**). Any amounts billed to the patient in excess the patient's cost-share and deducible amount (**PUT IN DEDUCTIBLE AMOUNT, IF ANY**), is a violation of your participation agreement.*

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

Sincerely,

Name, Title and Office

cc:
Beneficiary

NOTE TO CONTRACTOR

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

Figure 2-7-A-15 Violation of the Participation Agreement - Follow-up (Sample)

(PROVIDER'S ADDRESS)

Dear_______:

*By letter dated (**DATE**), you were advised that you were in violation of your participation agreement for a TRICARE beneficiary. You were requested to write to (**NAME OF PATIENT**) and advise (**HIM/HER**) that attempts to collect amounts in excess of the deductible and cost-share amount are cancelled and to provide a copy of the letter to us within fifteen (15) days of the date of our letter. To date, we have not heard from you*

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

*Please cease collection action for amounts in excess of the TRICARE-determined allowable amount and advise (**NAME OF PATIENT**) of this action; provide a copy of your letter to us within fifteen (15) days of the date of this letter. We will refer this matter to the TRICARE Management Activity (TMA), Program Integrity Branch, 16401 East Centretech Parkway, Aurora, CO 80011-9043 if we do not hear from you.*

Sincerely,

Name, Title and Office

cc:
Beneficiary

Figure 2-7-A-16 Violation of Reimbursement Limitation (Balance Billing) {Sample}

(PROVIDER'S ADDRESS)

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

Dear______:

*We have been advised that you have billed (**NAME OF PATIENT**) for an amount greater than 115 per cent of the CHAMPUS Maximum Allowable Charge (CMAC). Please be advised that, as part of the Department of Defense Appropriation's Act, 1993, Public Law 102-396, Section 9011, Congress limited the amount that a nonparticipating provider may bill a beneficiary in excess of the CMAC to the same percentage as that used by Medicare.*

Provisions of the law were implemented by the DoD in a final rule published in the Federal Register on October 1, 1993. The effective date of the rule is November 1, 1993, and applies to all services provided on or after that date. Failure by a nonparticipating provider to comply with this requirement is a basis for exclusion from TRICARE as an authorized provider.

Please provide a refund to the beneficiary within thirty (30) days of the date of this letter. If no overpayment was made by the beneficiary, then credit the account within thirty (30) days of the date of this letter and cease billing efforts for the amount in excess of the 115 percent of the CMAC. The enclosed Explanation of Benefits (EOB) contains the procedure code(s) for each service rendered, the date(s) of service, and the CMAC for each procedure. The 115 percent of the CMAC can be easily calculated from the information provided on the EOB (1.15 x CMAC = Balance Billed Amount.)

*If you have any further questions regarding this matter, please contact our Service Department at (**TELEPHONE NUMBER**) or your Provider Relations Representative.*

Sincerely,

Name, Title and Office

cc:
Beneficiary

NOTE TO CONTRACTOR

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

Figure 2-7-A-17 Violation of Reimbursement Limitation (Balance Billing) Follow-up (Sample)

(PROVIDER'S ADDRESS)

RE: Patient:
Sponsor:
Sponsor SSN:

Dear___________:

*In a letter dated (**DATE OF INITIAL LETTER**), copy enclosed, you were advised of an incorrect billing practice, and advised to refund to the beneficiary (or credit the account) any amount billed in excess of 115 percent of the CHAMPUS Maximum Allowable Charge (CMAC). To date, we have not heard from you. Please respond to our letter, within fifteen (15) days of the date of this letter, of your intention to correct this practice to conform with the public law. Failure to provide a refund to the beneficiary and/or to cease billing for amounts in excess of 115 percent of the CMAC may result in your suspension as an authorized TRICARE provider.*

*Please contact our Service Department at (**TELEPHONE NUMBER**) or your Provider Relations Representative if you have any questions concerning this matter.*

Sincerely,

Name, Title and Office

cc:
Beneficiary