CHAPTER 14
SECTION 3

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."

The Regulation goes on to state that a pattern of inappropriate practice will normally be required to find that abuse has occurred unless a specific action is deemed gross and flagrant. Any practice or action that constitutes fraud as defined below would also be abuse.

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 and beneficiaries on a pre and postpayment basis. The key functions include, but are not limited to:

- Eligibility verifications for beneficiaries and providers.
- Duplicate payment prevention. On a quarterly basis each fiscal year, contractors shall generate and utilize reports from the automated TRICARE Duplicate Claims System to identify the reasons for actual duplicate payments. The automated TRICARE Duplicate Claims System contains pre-formatted reports which will assist in identifying the reasons for actual duplicate payments (see ADP Manual, Chapter 11, Addendum E 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.
- Coordination of benefits.
- Prepayment utilization control as applied to program exclusions and limitations and detection and/or control of fraud and abuse.
- Application of utilization review and quality assurance standards, norms and criteria.
- Postpayment utilization review to detect fraud and/or abuse by either beneficiaries 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. As part of the Annual Letter of Assurance to be issued on October 1, of each year, the contractor shall certify that it has controls in place to prevent and detect fraudulent and abusive practices, understands and will comply with its contractual obligations in that respect (Chapter 14, Addendum A, Figure 14-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.) 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.

2.3.2. The contractor shall establish a public education program addressed to beneficiaries and providers 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.

2.4. Claim/Encounter Review Procedures And Controls

The contractor shall subject all TRICARE claims/encounters to appropriate review 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.

2.5. Beneficiary And Provider Flags

The contractor must have the capability for automated flagging of specific providers of care and TRICARE beneficiaries for prepayment review when fraud, overutilization or other abuses are known or suspected. If a network primary care manager is determined to be engaged in potential fraudulent practices, the contractor at its discretion, may terminate the provider's network agreement and reassign the beneficiaries to another primary care manager. The contractor's actions shall be in a manner so as to not jeopardize the Government's investigation.

2.6. Prepayment Authorization

The contractor shall follow the procedures for verifying authorization for the Program for Persons with Disabilities and Psychiatric Residential Treatment Centers for Children and Adolescents contained in the Policy Manual, Chapter 8, Section 1.3.

2.7. 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 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 the 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 (pharmacies, Durable Medical Equipment 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, 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, a TRICARE Form 88-R (Verification of Eligibility) shall be sent to the DEERS Support Office, 2100 Garden Road, Monterey, CA 93940.

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. See Chapter 6, Section 2, paragraph 1.0. and the Policy Manual, Chapter 9, Section 3.1 for additional information.

3.2.2.2. Non-Enrollees

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 ID card, both sides, if the provider has one on file. Upon receipt, a "good faith" payment may be consider. See Chapter 11, Section 3, paragraph 2.3.2. The contractor shall retain a copy of the 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 Program Integrity Office. The contractor shall report the circumstances to TMA Program Integrity Office 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 Policy Manual, Chapter 10, Section 2.2. 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 Program Integrity Office.

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 Veterans Administration) of the United States 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 Lead Agent having jurisdiction. 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 United States 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 United States Government

Refer to Chapter 4, Section 3, paragraph 4.0.

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 Program Integrity Office for investigation. Referrals made through the Health Care Finder should be in accord with Chapter 7, Section 2.

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 U.S.C., 1079-1086. 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.

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 who waive the copayment amounts.

3.6.3. When the contractor identifies a provider who has waived a cost-share/copayment, the contractor shall contact the provider and explain the policy 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.

NOTE: 1) Certain heart and lung hospitals are exempt from the cost-share collection requirement. 2) Refer to the *TRICARE Reimbursement* Manual, *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. 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 outpatient drugs/biological and inpatient respite care. The collection of these cost-sharing amounts is optional under the TRICARE Hospice Benefit (*TRICARE Reimbursement* Manual, *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 (Chapter 8, Section 9, paragraph 3.0.). From those providers referred to the contractor's program integrity staff, the contractor shall select the ten 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 Program Integrity Office based on the following criteria. The reports will be submitted 45 days following the first full calendar quarter after implementation of this requirement and following each subsequent calendar quarter.

- There is currently no open case on the provider in the contractor's program integrity unit for other types of fraud or abuse.
- Claims were submitted primarily on a participating provider basis.
- The provider received payments in the amount of $25,000 or more during the most recent 12 month period.
- The contractor's program integrity unit received no requests from the TMA Program Integrity Office for data on the provider to be sent to the DCIS.
- The contractor's program integrity staff has taken no action against the provider (e.g., no prepayment reviews initiated, no recoupment actions taken, etc.) other than to educate the provider regarding unbundling.

3.7.2. The contractor shall include the following information when referring a provider to the TMA Program Integrity Office:

- Provider name and specialty.

- All EINs/TINs, including subidentifier, for this provider.
- Provider's office addresses and billing addresses, if different.
- Copies of letters, sample EOBs, telephone or personal visit contact records supporting educational efforts in advising providers that unbundled billings are in violation of acceptable billing practices in accordance with 32 CFR 199.9.
- Billing history to include the procedure codes that failed the rebundling edits, number of times they failed, dates of service range, total billed amount, total allowable amount for the unbundled procedures billed, rebundled procedure codes and total amount allowed and paid as a result of rebundling.

3.7.3. The contractor shall not initiate recoupment or take any adverse action against the providers being referred to the TMA Program Integrity Office. 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 even if the provider continues to be identified for unbundling.

3.8. Automated TRICARE Duplicate Claims System

On a quarterly basis each fiscal year, contractors shall generate and utilize reports from the automated TRICARE Duplicate Claims System to assist in detecting fraud and abuse. The automated TRICARE Duplicate Claims System contains pre-formatted reports which will assist in detecting duplicate billings and inappropriate CPT-4 coding modifications by providers (see the ADP Manual, Chapter 11, Addendum E 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 the Congress as part of the DoD Appropriations Act, 1993, are considered abuse and/or fraud. The contractor shall take action as stated in Chapter 14, Section 6, paragraph 5.2. Also, refer to *TRICARE Reimbursement* Manual, *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 Chapter 14, Section 6, paragraph 5.3. and Chapter 8, Section 1, paragraph 2.2.).