CASE DEVELOPMENT AND ACTION

1.0. INITIAL REVIEW

The contractor shall have an operational procedure for developing 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 14-A-1).

NOTE: (1) Definition of case development is a unit of work. (2) For purposes of this chapter, encounter is defined as the personal contact between the patient and a professional health care giver in a managed care program in which a fee-for-service claim is not submitted.

1.1. Claims processing error identified: If it is established that a complaint received directly from a beneficiary or provider 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), of their findings. The contractor shall clearly document the reason for the case closure.

1.2. 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).

2.0. INTERNAL INVESTIGATION

2.1. All Abuse Cases And Fraud Cases Under $10,000

The contractor's required actions will normally include: education, warning of the penalty for filing false claims, recoupment, and prepayment monitoring. A record of the action taken by the contractor must be completed and retained. For recoupment procedures, see Chapter 11, "Claims Adjustments and Recoupments." All monies paid by previous TRICARE contractors and recouped by the current contractor will be refunded to the TMA Chief, Finance and Accounting Office. Cases determined on review to support allegations of fraud but are under $10,000, should not be referred to TMA. The contractor shall send providers 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. 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 the referral is the educational letter with the signed receipt.

2.2. All Abuse Cases And Fraud Cases Of $10,000 Or More

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

2.2.1. 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 is billing for services not rendered, the provider is not providing or referring the beneficiary for appropriate care which is medically necessary per medical standards, or provider is falsifying medical records. The contractor's review shall include all the provider numbers used by that provider. An audit shall be accomplished if there is evidence of possible fraud, e.g., repetitive occurrences of a pattern of abnormal billing.

2.2.1.1. If the case involves more than 50 claims/encounters within the most recent 24 months, a sample audit which is statistically valid, at a 90 percent confidence level, plus or minus ten percent with a 50% occurrence rate shall be randomly selected from a claims/encounter history arrayed in claim/encounter internal control number ascending order. The contractor must have the capacity to electronically generate sample sizes and random numbers using a Government approved system. Chapter 14, 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 where no "claim" exists.

2.2.1.2. The 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.

2.2.1.3. If the case involves less than 50 claims/encounters within the most recent 24 months, audit the entire universe.

2.2.1.4. 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, tenth, 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 (Figure 14-A-2, Sample Letter to Beneficiary in External Audit Cases). In cases where the beneficiary has altered a bill, an external audit to

the provider shall be conducted (Figure 14-A-3, Sample Letter to Provider in External Audit Cases). 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.

2.2.1.5. Medical necessity audits must be performed by registered nurses, or equally qualified medically trained staff, who can make medical judgments based on professional education and experience. This means RNs or qualified physician's assistants (PAs) for medical claims. For mental health claims, a clinical psychologist, psychiatric nurse practitioner or a psychiatrist shall be used. A qualified 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 for approval before the LVN assumes a medical review role. These personnel must have a thorough knowledge of medical policy, standards and TRICARE criteria. The reviewer shall document the rationale for the audit findings. The review must be dated and include the clinical specialty of the reviewer and the signature (not initials) and the legibly printed name of the reviewer. Claims that the reviewer cannot make a determination on shall be referred to the contractor's medical staff or an external consultant. Use of medical staff and/or consultants is expected and required not only for initial reviews but postpayment analyses and audit requests from TMA. Whenever the case is complex, physician consultants, with a specialty appropriate to the case, shall be involved in the review. In the case of mental health claims, a staff or consultant physician shall be involved in complex cases. The physician shall review the claims and document the rationale for the audit findings. The review must be dated and include the clinical specialty of the reviewer, the signature (not initials), and the legibly printed name of the reviewer.

2.2.2. Cases of beneficiary eligibility fraud require the SSN to be flagged to prevent further claims from being processed or providing services by a network provider. Develop and refer to TMA only those cases that involve more than a $25,000 loss to the government. Handle administratively those cases that involve less than a $25,000 loss to the government. Only at the direction of the Chief, TMA Program Integrity Office, with the concurrence of the TMA Office of General Counsel, will a provider's or beneficiary's claims be indefinitely suspended from payment due to potential fraud. In this case, formal notification to the provider or beneficiary by the contractor will occur (Figure 14-A-4, Special Notice to Provider When Provider's Claims are Suspended, and Figure 14-A-5, Special Notice to Beneficiary When Beneficiary's Claims are Suspended). The contractor, upon written request from the TMA Program Integrity Office, shall notify in writing the Regional Director and the Health Benefits Advisors in close proximity to the provider. 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, the contractor, under the guidance of the TMA Program Integrity Office, shall send a special and specific notice to the beneficiary (Figure 14-A-6).

3.0. REFUND OR PAYMENT ACTIONS: TMA DIRECTION

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, except for eligibility cases where the loss is less than $25,000. The contractor shall obtain written instructions from the TMA Program Integrity Office 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.

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

4.0. FRAUD AND ABUSE CASE REFERRALS TO TMA

4.1. 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 Program Integrity Office quarterly with the fraud and abuse summary report.

4.2. The contractor shall refer all initially developed (i.e., clerical and/or processing errors have been ruled out and the case exceeds the exception provided in paragraph 6.0.) allegations of potential fraud to the TMA Program Integrity Office within 30 calendar days of its determination of potential fraud and abuse, in accordance with paragraph 6.0. The contractor shall not report fraud and abuse cases which are suspected of violating Federal law directly to the DCIS, MCIOs, FBI or any other investigative organization. All cases shall be reported to TMA Program Integrity Office in accordance with the procedures in this chapter.

4.3. The contractor shall not initiate recoupment action or take any other administrative action on a potential fraud and abuse case except as expressly provided in this chapter. Refer to the NOTE under paragraph 5.9. and to paragraph 6.0. These potential fraud and abuse cases shall be referred to TMA.

4.4. The contractor shall not respond to direct requests for documentation from investigative agencies. The contractor shall promptly notify the TMA Program Integrity Office of any requests made directly to the contractor. If the contractor responds directly to a request for documentation from an investigative agency, the costs of responding shall not be charged to the contract.

4.5. It is DoD policy that all employees, contractors and subcontractors shall cooperate fully with investigative agencies of the United States upon the direction of the TMA Program Integrity Office. All written requests for claims histories, medical and other records, correspondence, audits and other documentation shall be provided by the contractor. Requests for witnesses and technical support will be completed by the contractor.

5.0. FRAUD AND ABUSE CASE REFERRAL CONTENT

The contractor shall submit the following information in duplicate when referring cases of potential fraud or program abuse. The case will contain a completed TRICARE Fraud and Abuse Report (TMA Form 435, Figure 14-A-1).

5.1. Summarize the behavior which is suspected to be in violation of Federal law, regulation or policy; for example, billing for services 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.

5.2. Describe 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 social security number, beneficiary's relationship to sponsor, provider's specialty and identification number, address, telephone number, etc.

5.3. Describe how the alleged violation of Federal law, regulation or policy occurred, e.g., 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, altering medical records, etc. Enclose copies of the claims, explanation of benefits forms, medical records, provider certification file and other documents demonstrating the suspicious behavior. Enclose a history covering the most recent 24 month period in electronic media in dBase format, no less than version 2.4 or hard copy. Hard copy histories are acceptable only for histories of less than 100 claims/encounters.

5.4. Describe how the suspicious behavior was uncovered, e.g., audit, prepayment screen, beneficiary or provider complaint or tip, DoD Hotline, investigator notification, etc.

5.5. Estimate the number of claims or encounters, the length of time the suspicious behavior has occurred and of the Government's and Contractor's loss.

5.6. Describe the current status of claims or other requests submitted by the suspected provider or beneficiary, i.e., regular development, processing and payment or denial, claims suspension, prepayment review, etc.

5.7. Describe and enclose a copy of any documents, such as any correspondence with the provider or beneficiary and telephone conversation records. Provide a copy of all contractor audits on the suspected provider or beneficiary. Describe any other facts that may establish a pattern of practice or indicate that the provider or beneficiary intended to defraud the Government or the contractor. Include a copy of the supporting document(s).

5.8. Conduct, prepare and include a random sample validation audit of the most recent 24 month period that is statistically valid, of the claims/encounters against the medical or clinical records to determine the harm to the Government by identifying the method of the fraudulent action and the average overpayment per claim/encounter, extrapolated to the universe of claims/encounters from which the random sample was selected. A random audit should not be conducted if there is clear evidence of fraud and the individual would be alerted of an investigation by requests for records. If there is significant harm to the

Government or the case develops into a significant fraud investigation, then there may be a need to do a statistical audit that covers more than a two year period.

5.9. 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 Social Security Number. Each folder shall contain the contractor's individual audit sheet for those claims.

NOTE: In suspected cases of fraud/abuse, do 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 $10,000). Administrative remedies can adversely impact civil or criminal prosecution of a case and are inappropriate if fraud is suspected.

6.0. CONTRACTOR ADMINISTRATIVE ACTION

6.1. Fraudulent and abusive practices are violations of the 32 CFR 199 or may constitute violations of the U.S. Criminal Code (Title 18).

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

6.2. The contractor shall take administrative action under the following circumstances:

- The total number of claims/encounters involved is less than 25 and the total potential loss to the contractor or Government for the claims is less than $10,000.00. 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 the TMA Program Integrity Office to ensure the case is not under active investigation.

- The contractor has received a written declination from the Government for the case.

6.3. Administrative action may include:

- Referring the case to local or state investigations for referral to the district attorney or state attorney general.

- Initiating recoupment action.

- Placing the beneficiary or provider on prepayment review.

6.4. The TMA and the contractor will provide assistance to the local or state authorities in their investigation and prosecution of the case.