CHAPTER 7
SECTION 1

UTILIZATION MANAGEMENT

This section establishes requirements applicable to utilization and quality review of all health care services delivered to beneficiaries living in the Regions, to all beneficiaries receiving care in the Regions regardless of their place of residence, and to all providers delivering care within the Regions. Additional requirements for enrollees (such as authorizations for specialty care) and network providers (such as qualifications to be network providers) are further identified in Chapter 5. All providers shall be subject to the same review standards and criteria. The contractor shall be considered a multi-function Peer Review Organization under this contract.

1.0. UTILIZATION MANAGEMENT PROGRAM STRUCTURAL REQUIREMENTS

1.1. Utilization Management Program Plan

The contractor shall fully describe in a written Utilization Management Plan all processes, procedures, criteria, staff and staff qualifications, and information and data collection activities and requirements the contractor shall use in conducting utilization management activities including utilization reviews, discharge planning, disease management programs, demand management programs or other techniques employed by the contractor to exercise clinical oversight.

1.1.1. The contractor shall specifically describe how the utilization management requirements of the contract shall be accomplished.

1.1.2. The Utilization Management Program Plan shall be approved by the Contracting Officer. The finalized plan shall be submitted through the appropriate Lead Agent to the Contracting Officer for approval. The Contracting Officer will provide the contractor with written approval within 30 calendar days of receipt of the plan.

1.1.3. The contractor shall establish and document in the Utilization Management Program Plan specific, measurable goals for the evaluation of the overall effectiveness of the Utilization Management Program. Additionally, the contractor shall establish goals and thresholds for the internal monitoring and improvement of the Utilization Management Program as well as program components for measuring the improvements.

1.1.4. The contractor, Lead Agent, and Contracting Officer shall review the plan annually. Revisions to the plan, if any, shall be submitted for approval through the Lead Agent to the Contracting Officer prior to the start of each option period. The contractor shall submit any revised plan to the Lead Agent at least 90 calendar days prior to the beginning of each option period.

1.1.5. The contractor's utilization management plan shall delineate the organizational structure, responsibilities and authorities of personnel involved in the performance of utilization management activities.

1.2. Notification Of Review Requirements

The contractor is responsible for education and training to providers and beneficiaries on the requirements of the utilization management programs. The contractor shall describe fully the process for notification in a timely manner (but not less than 30 calendar days prior to commencement of review) of all providers, both network and nonnetwork, of all review requirements such as preauthorization, concurrent review, retrospective review (including the fiscal penalties for failing to obtain review authorizations), review criteria to be used, and requirements for case management.

1.3. Written Agreements With Institutional Providers

The contractor shall establish written agreements with each institutional provider over which the contractor has review authority. These agreements shall be in place before the start of health care delivery. Agreements must specify that:

1.3.1. Institutional providers will cooperate with the contractor in the assumption and conduct of review activities.

1.3.2. Institutional providers will allocate adequate space for the conduct of on site review.

1.3.3. Institutional providers will photocopy and deliver to the contractor all required information within 30 calendar days of a request for off-site review.

1.3.4. Institutional providers will provide all beneficiaries, in writing, their rights and responsibilities (e.g., "An Important Message from TRICARE" (Chapter 7, Addendum A), "Hospital Issued Notice of Noncoverage" (Chapter 7, Addendum B).

1.3.5. Institutional providers will inform the contractor within three working days if they issue a notice that the beneficiary no longer requires inpatient care.

1.3.6. Institutional providers will assure that each case subject to preadmission/ preprocedure review has been reviewed and approved by the contractor.

1.3.7. Institutional providers will agree, when they fail to obtain certification as required, they will accept full financial liability for any admission subject to preadmission review that was not reviewed and is subsequently found to be medically unnecessary or provided at an inappropriate level. (32 CFR 199.15(g))

1.3.8. The contractor shall reimburse the hospital under the diagnosis related group reimbursement system for the costs of photocopying and postage as established by TMA. Reimbursement is currently set at $.07 a page plus postage up to first class.

1.3.9. The contractor shall provide detailed information on the review process and criteria used, including financial liability incurred by failing to obtain preauthorization (see paragraph 5.2.)

1.4. Review Staff Qualifications

The contractor's utilization review staff shall meet the requirements for TRICARE authorized providers (see 32 CFR 199.6 and Policy Manual, Chapter 10).

2.0. MEDICAL REVIEW

2.1. Requirements For Compliance

The Public Law 89-614 and amendments governing the operation of TMA; Chapter 55, Title 10 of the United States Code, require reimbursement of eligible TRICARE beneficiaries and providers for covered services that are medically necessary.

2.2. Benefit Policy Decisions

2.2.1. TRICARE Versus Local Policy

TRICARE policies have precedence over any local or internal policy of the contractor or the medical community of the region where non-Prime enrollees are involved. However, the contractor shall notify TMA promptly of any conflicts between TRICARE policy and local policy. For TRICARE Prime enrollees, variations from policy which simply expand coverage may be implemented without prior approval, but TMA must be notified of enhanced coverage at least thirty days prior to implementation. If benefits are being reduced or adjusted, the change shall be referred to TMA for approval before being implemented.

2.2.2. TRICARE Policy Silent

When TRICARE is silent on an issue, the matter shall be referred to TMA for a benefit policy determination. Until a policy is published by TMA covering the specific issue, all claims involving the policy issue must be denied. The policy issuance from TMA will include specific instructions for handling claims when a retroactive determination is made. If the policy determination affects procedures for claims processing, an Operations Manual change will also be issued.

2.3. Reviewers

2.3.1. First Level Reviewers

The contractor shall use licensed physicians, licensed registered nurses (RNs), or certified physician's assistants (PAs) to conduct first level medical and surgical reviews based on approved criteria. The contractor shall use licensed psychiatrists, licensed registered psychiatric nurses, licensed clinical psychologists, or licensed clinical social workers to conduct first level reviews of mental health services. First level reviewers may issue denial determinations based on coverage limitations contained in 32 CFR 199, the Policy Manual, and other TRICARE guidance (these are considered factual determinations) or refer the case to second level review.

2.3.2. Second Level Reviewers

2.3.2.1. The contractor shall use licensed, board certified (by a board recognized by the American Board of Medical Specialties) physicians, who did not participate in the first level review of the care under consideration, to conduct second level medical necessity reviews of all medical and surgical cases not initially approved during the first level review process. Second level physician reviewers must meet the Utilization Review Accreditation Committee (URAC) Utilization Management (UM) Standards. The contractor shall use licensed, board certified psychiatrists, who did not participate in the first level review of the care under consideration, to conduct second level medical necessity reviews of all mental health care not initially approved during the first level review process. In addition, second level psychiatrist reviewers must meet the URAC UM Standards.

2.3.2.2. Physician specialists (e.g., anesthesiologists, pathologists, radiologists) shall be used in consultation in reviewing the services rendered by a like specialist.

2.3.2.3. The contractor shall make every effort for the reviewing physician who is a psychiatrist to consult with a peer who is in the same discipline as the attending / treating provider (e.g. psychologist, social worker, etc.) if the attending / treating clinician is other than a psychiatrist. All consultations shall be fully documented in the case file. When the requirement cannot be met, the contractor shall document the reasons in the case file.

2.3.2.4. The contractor shall designate a Registered Records Administrator or Accredited Records Technician (ART) as the individual responsible for the overall DRG validation process and shall utilize individuals trained and experienced in ICD-9-CM coding to perform the DRG validation function, as described in paragraph 3.6.

2.3.2.5. The contractor shall not allow a person to review health care services or make denial determinations or changes as a result of DRG validations if he or she or a member of his or her family (e.g., spouse, other than a spouse who is legally separated under a decree of divorce or separate maintenance; child, including a legally adopted child; grandchild; or parent)

- Participated in developing or executing the beneficiary's treatment plans;
- Is a member of the beneficiary's family; or
- Is a governing body member, officer, partner, five percent (5%) or more owner, or managing employee in the health care facility where the services were or are to be furnished.

2.3.3. Reconsideration Reviewers

2.3.3.1. The contractor shall ensure that reconsideration reviewers meet the requirements in the Policy Manual, Chapter 10, as well as those listed below, and shall NOT be the reviewer who made the initial denial determination or have admitting privileges in the facility involved in the reconsideration. Reconsideration reviewers shall meet the qualifications of a physician reviewer authorized to make initial denial determinations.

2.3.3.2. The contractor shall designate licensed doctors of medicine, osteopathy, or dentistry with active staff privileges in one or more hospitals in the contractor's area to perform reconsideration reviews.

2.3.3.3. The reviewer shall be a board-certified (by a board recognized by the American Board of Medical Specialties) specialist in the specialty of the attending physician or the type of services under review. If the services subject to review were rendered by a qualified health care provider other than a physician, every effort will be made for the reviewing physician to consult with a peer who is a similarly qualified health care practitioner. All consultations shall be fully documented in the case file. When this requirement cannot be met, the contractor shall document the reasons in the case file.

2.3.3.4. If possible, the reviewer will practice in a setting (urban/rural) similar to the physician whose services are being reviewed unless meeting this requirement would compromise the effectiveness or efficiency of the review process. When matching reviewers of similar practice settings is not possible, the contractor shall fully document the reasons in the case file.

2.3.3.5. For reconsiderations regarding "knowledge" determinations (i.e., whether the liable party knew or should have known that services would be determined medically unnecessary), the reconsideration reviewers shall be physicians who are knowledgeable in applying the requirements in 32 CFR 199.4(h); Chapter 13, Section 4, paragraph 4.0.; and the *TRICARE Reimbursement* Manual, *Chapter 2, Section 3*.

2.4. Contractor Levels Of Claims Review

The contractor shall establish review procedures that contain the following levels of review:

2.4.1. First Level Claims Review

First level review shall be a screening process using approved criteria to render decisions as to the medical necessity and appropriateness of the level of care under review. Second level review is required for all cases not meeting the first level screening criteria. Denial determinations based on coverage limitations contained in 32 CFR 199, the TRICARE/CHAMPUS Policy Manual, and other TRICARE guidances, are considered factual determinations. The first level reviewer may approve care, or deny the care, in those cases where they can make a factual determination (i.e., the type of care provided is specifically excluded from the TRICARE Program) and there is no need for a medical necessity determination, or refer the case to second level review if a medical necessity determination is required. At the first level review, basic prepayment screens (automated and manual), are applied to each claim submitted. Such prepayment screens shall include, but not be limited to, the following:

2.4.1.1. Screening of the claim against the series of diagnoses and related procedure codes which are specific exclusions or limitations of the Program.

2.4.1.2. Screening of the claim for possible duplicate care and billings.

2.4.1.3. Screening of the claim for unusual dollar amounts for a claimed service or supply.

2.4.1.4. Screening of the claim for excessive utilization of services, supplies, or pharmaceuticals.

2.4.2. Second Level Review

Second level review shall be conducted to render medical necessity determinations based on the medical expertise of the reviewer and must be carried out 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 handling of mental health claims, an RN or PA with mental health training, or a qualified MSW or clinical psychologist. A qualified, graduate pharmacist may be used for prescription drug claims. 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 contractor shall make documented guidelines available to reviewers for all coverage parameters and medical necessity criteria. The reviewer shall document the rationale for the approval or denial of coverage; i.e., fully state the evidence and the reasons that were the basis for approval or denial. The review must be dated and include the clinical specialty of the reviewer (e.g., RN, LPN) and the signature and legibly printed name of the reviewer (not initials). Contractors with fully documented guidelines may desire to standardize phraseology for common procedures and recurring types of cases. This is acceptable if the record supports the conclusions that were made. If the initial review personnel cannot make a determination, the claim(s) shall be referred to Medical Review. Either contractor medical staff or an external consultant shall do the review. Use of medical staff and / or consultants is expected and required for not only initial claims processing, but also in appeals or in postpayment analyses. Whenever the case is complex, physician consultants, with a specialty appropriate to the case, should be involved in the review. In the case of mental health claims, a staff or consultant physician must be involved in complex cases and in all mental health case appeals. The physician consultant will carefully review the case and document the rationale for the decision; i.e., fully state the evidence and the reasons that were the basis for approval of denial. The review must be dated and include the clinical specialty of the reviewer (e.g., MD, DO) and signature and legibly printed name of the reviewer. The physician reviewer must document his or her rationale for the approval or denial of coverage in a brief written opinion in the case file. The opinion must be signed (not initialed) by the reviewer.

2.4.2.1. Telephone Consultations

To expedite non-network claims processing and to make more effective use of physician medical advisors, telephone consultations with the advisor may be used if the following provisions are met:

- The consultation must be handled by a supervisory level registered nurse medical reviewer or by a physician member of the contractor's advisory staff.
- There must be great care taken to prevent misunderstanding of the circumstances of the case and the medical advisor's recommendations.

- The matters discussed and the recommendation must be thoroughly documented, including the date, the rationale for the decision / recommendation, the name of the caller and the name of the medical advisor.

- The medical advisor who was contacted must review the actual case file and countersign the written decision within ten workdays of the call. The case shall not be delayed for the signature.

- The use of telephone calls must not be used to replace in-person medical advisor reviews, but to supplement them and to increase the ability to speed processing and to increase involvement of appropriate specialists in effective review of complex cases.

3.0. REQUIREMENTS FOR UTILIZATION REVIEWS

3.1. Medical Review Of Rebundled Procedures

Procedures are to be subjected to the rebundling edits prior to determining if medical review is necessary. The requirement for medical review is to be determined based on the rebundled, comprehensive procedure, not a fragmented procedure. Rebundling rules do not allow reimbursement of fragmented procedures.

3.2. Review Criteria

3.2.1. Medical And Surgical Reviews

The contractor shall use review criteria published by InterQual, Inc., of Marlborough, Massachusetts, in their most current version as the criteria for screening medical and surgical inpatient care for first level review. The contractor may use additional criteria for areas such as procedures, admissions, or determining length of stay only when they are not addressed by InterQual. Any additional criteria shall be provided as part of the Utilization Management Plan required in paragraph 1.1.

3.2.2. Mental Health Review Criteria

The contractor shall use only the review criteria specified in the contract for first level screening review. The contractor shall not use any additional criteria for the first level of review.

3.3. Prospective Review Requirements

The contractor shall establish and conduct prospective review procedures to allow for benefit determination, evaluation of proposed treatment, determination of medical necessity, assessment of level of care required, assignment of expected length of stay for those types of care and for facilities not reimbursed on a DRG basis, and appropriate placement prior to the delivery of care. Assignment of expected length of stay is not required for facilities reimbursed on a DRG, fixed, or capitated basis. This review shall not eliminate the requirement for a Nonavailability Statement (NAS) for non enrollees requesting inpatient care.

3.3.1. Preauthorization review shall be performed for all care and procedures listed in Chapter 7, Addendum D. The offeror may propose additional authorization reviews. The admissions / procedures are subject to change over time based upon the Government's assessment of the efficacy of the review. The changes will include adding and / or removing admissions / procedures.

3.3.2. The contractor shall prospectively review all care for which an inpatient nonavailability statement (NAS) is required utilizing the criteria prescribed in paragraph 3.2. The prospective review determination shall be provided to the MTF Commander to allow the issuance of an NAS, if appropriate, and for advising the beneficiary and provider of the MTF Commander's decision regarding the issuance of an NAS. If the care is preauthorized and an NAS is approved, the contractor, when asked to make an appointment, shall confirm with the patient, within one workday, an appointment for the authorized care. If an NAS is denied based on a medical necessity or a factual determination, the beneficiary and / or civilian participating provider has the right to reconsideration as described in Chapter 13, Section 4 and 5. If a NAS is denied based on MTF capacity, the beneficiary may appeal as described in Chapter 13.

3.3.3. If the review does not occur prior to the admission / procedure, (e.g. the admission / surgery was an emergency), the contractor shall conduct the review within 24 hours of notification of the admission / procedure. Where the provider does not obtain preauthorization as required, the contractor shall conduct prepayment review in accordance with paragraph 5.2.

3.3.4. The contractor shall preauthorize all outpatient mental health care beyond the eighth visit in an enrollment period. For nonenrollees, all outpatient mental health care beyond the eighth visit in a fiscal year shall be preauthorized. Network providers shall notify TRICARE Prime beneficiaries' PCM of all care provided upon obtaining written authorization from the beneficiary.

3.3.5. The preauthorization shall have an effective date and an expiration date.

3.3.6. The contractor shall issue determinations on at least 90% of all requests for medical-surgical preauthorization within one working day following receipt of the request and all required information. The contractor shall issue determinations on 100% of such requests within five working days following receipt of the request and all required information.

3.3.7. In the case of mental health care, the contractor shall issue a determination on 90% of all requests within one working day following the request for preauthorization and the receipt of all required information. The contractor shall issue a determination on 100% within five working days. The contractor shall not issue an authorization for acute, inpatient mental health care for more than seven calendar days at a time.

3.3.8. *Inpatient mental health requires preauthorization, and, if necessary, reviewing of waivers of the day limits (care in excess of 30 days) for beneficiaries eligible for Medicare Part A and enrolled in Medicare Part B. As second payer, TRICARE will rely on and not replicate Medicare's determination of medical necessity and appropriateness in all other circumstances where Medicare is primary. In the event that inpatient mental health services were not preauthorized, the contractor shall obtain the*

necessary information and complete a retrospective review. Penalties for failing to obtain preauthorization apply.

3.4. Concurrent Review Requirements

*Except for beneficiaries eligible for Medicare Part A and enrolled in Medicare Part B, t*he contractor shall establish and conduct concurrent review procedures to validate the appropriateness of admission, level of care, medical necessity of treatment and/or procedures, quality of care rendered, and information provided during any previous review. Also, the contractor's concurrent review procedures shall include provisions for identification of beneficiaries for whom case management services would be appropriate according to paragraph 6.0.

3.4.1. The contractor shall conduct concurrent review for continuation of inpatient mental health services within 72 hours of emergency admissions (see 32 CFR 199.4(b)(6)(iv)), and authorize, as appropriate, additional days. The contractor shall conduct subsequent concurrent reviews 48 hours prior to expiration of the previous authorization.

3.4.2. For all nonmental health care provided in non-DRG reimbursed facilities, the contractor shall conduct concurrent review 48 hours prior to expiration of the previous authorization.

3.4.3. For all nonmental health care provided in a DRG, fixed, or capitation-based reimbursed facility, the contractor shall require the facility to request continued stay review no later than day ten if the inpatient stay is expected to extend beyond ten calendar days.

3.4.4. The contractor shall evaluate the potential need for case management at the time of each continued stay review.

3.4.5. The contractor shall review all episodes of outpatient mental health care in accordance with the 32 CFR 199 and review all care provided after every eight sessions.

3.5. Retrospective Review Requirements For Other Than DRG Validation

The contractor shall conduct quarterly focused reviews of a one percent sample of medical records to assess the accuracy of information provided during the prospective review process, determine the medical necessity and quality of care provided, validate the review determinations made by review staff, and determine if the diagnostic and procedural information and/or discharge status of the patient as reported on the hospital and/or professional provider's claim matches the attending physician's description of care and services documented in the medical record. The specific types of records to be sampled shall be determined separately by each Lead Agent who will provide the contractor with the sampling criteria (DRG, diagnosis, procedure, length of stay, provider, incident or occurrence as reported on claim forms) 60 calendar days prior to the quarter from which the review sample is drawn. Within the parameters provided by each Lead Agent, the contractor shall ensure that each sample is statistically valid. For all cases selected for retrospective review, the following review activities shall occur:

3.5.1. Admission Review

The medical record must indicate that inpatient hospital care was medically necessary and provided at the appropriate level of care.

3.5.2. Invasive Procedure Review

The performance of unnecessary procedures may represent a quality and/or utilization problem. In addition, the presence of codes of procedures often affects DRG classification. Therefore, for every case under review, the medical record must support the medical necessity of the procedure performed. For this purpose, invasive procedures are defined as all surgical and any other procedures which affect DRG assignment.

3.5.3. Discharge Review

Records shall be reviewed using appropriate criteria identified in paragraph 3.2., and the initial reviewer identifies for second level (physician) review, potential problems with premature discharges (i.e., where, in the opinion of the physician reviewer, the patient was not medically stable and/or where discharge was not consistent with the patient's need for continuing acute inpatient hospital care), as well as other potential quality problems.

3.5.4. Mental Health Review

The contractor shall review all mental health claims in accordance with the provisions in 32 CFR 199.4(a)(11) and (a)(12).

3.6. Retrospective Reviews Related To DRG Validation

The contractor shall assure that reimbursed services are supported by documentation in the patient's medical record. This review must determine if the diagnostic and procedural information and discharge status of the patient as reported by the hospital matches the attending physician's description of care and services documented in the patient's record. In order to accomplish this, the contractor shall conduct the following review activities:

3.6.1. Review of claim adjustments submitted by hospitals which result in the assignment of a higher weighted DRG (see Chapter 7, Addendum C).

3.6.2. Review for physician certification as to the major diagnosis and procedures and the physician's acknowledgment of a penalty statement on file.

3.6.2.1. When the claim is submitted, the hospital must have on file a signed and dated acknowledgment from the attending physician that the physician has received the following notice:

> "Notice to Physicians: TRICARE payment to hospitals is based in part on each patient's principal and secondary diagnoses and the major procedures performed on the patient, as attested to by the patient's attending physician by virtue of his or her signature in the medical record. Anyone who misrepresents, falsifies, or conceals essential

information required for payment of Federal funds may be subject to fine, imprisonment, or civil penalty under applicable Federal laws."

3.6.2.2. The acknowledgment must be completed by the physician at the time that the physician is granted admitting privileges at the hospital, or before, or at the time the physician admits his or her first patient. Existing acknowledgments signed by physicians already on staff remain in effect as long as the physician has admitting privileges at the hospital.

3.6.3. Outlier Review

Claims which qualify for additional payment as a long-stay outlier or as a cost-outlier shall be subject to review to ensure that the additional days or costs were medically necessary and appropriate and met all other requirements for payment. In addition, claims which qualify as short-stay outliers shall be reviewed to ensure that the admission was medically necessary and appropriate and that the discharge was not premature.

3.6.4. Procedures Regarding Certain Services Not Covered By The DRG-Based Payment System

In implementing the quality and utilization review for services not covered by the DRG-based payment system, the requirements of this section shall pertain except that ICD-9 and CPT-4 codes will provide the basis for determining whether diagnostic and procedural information is correct and matches information contained in the medical records.

4.0. REVIEW RESULTS

4.1. Actions As A Result Of Retrospective Review Related To Individual Claims

If it is determined, based upon information obtained during reviews, that a hospital has misrepresented admission, discharge, or billing information, or is found to have quality of care defects, or has taken an action that results in the unnecessary admission of an individual entitled to benefits, unnecessary multiple admission of an individual, or other inappropriate medical or other practices with respect to beneficiaries or billing for services furnished to beneficiaries, the contractor shall, as appropriate:

4.1.1. Deny payment for or recoup (in whole or in part) any amount claimed or paid for the inpatient hospital and professional services related to such determination;

4.1.2. Require the hospital to take other corrective action necessary to prevent or correct the inappropriate practice;

4.1.3. Advise the provider and beneficiary of appeal rights, as required by Chapter 13, Section 4, paragraph 2.0.

4.2. Findings Related To A Pattern Of Inappropriate Practices

The contractor shall notify TMA of the hospital and practice involved in all cases where a pattern of inappropriate admissions and billing practices that have the effect of circumventing the TRICARE DRG-based payment system is identified.

4.3. Revision Of Coding Relating To DRG Validation

The contractor shall ensure the application of the following provisions in connection with the DRG validation process.

4.3.1. If the diagnostic and procedural information attested to by the attending physician is found to be inconsistent with the hospital's coding or DRG assignment, the hospital's coding on the TRICARE claim shall be appropriately changed and payments recalculated on the basis of the appropriate DRG assignment.

4.3.2. If the information attested to by the physician as stipulated in paragraph 3.6.2. is found not to be correct, the contractor shall change the coding and assign the appropriate DRG on the basis of the changed coding in accordance with the paragraph above.

4.4. Notice Of Changes As A Result Of A DRG Validation

The contractor shall notify the provider and practitioner of changes to procedural and diagnostic information that result in a change of DRG assignment within 30 calendar days of the contractor's decision. The notice must be understandable and written in English and shall contain:

4.4.1. The corrected DRG assignment;

4.4.2. The reason for the change resulting from the DRG validation;

4.4.3. For day outliers in hospitals, the date on which the stay or services in the facility will be approved as being reasonable and medically necessary or appropriate to the patients' health care needs;

4.4.4. A statement addressing who is liable for payment of denied services (e.g., a beneficiary will be liable if the change in DRG assignment results in noncoverage of a furnished service);

4.4.5. A statement informing each party (or his or her representative) of the right to request a review of a change resulting from DRG validation in accordance with the provisions in paragraph 4.6.;

4.4.6. The locations for filing a request for review and the time period within which a request must be filed;

4.4.7. A statement concerning the duties and functions of the multi-function PRO; and

4.4.8. A notice to payers. The contractor shall provide written notice of changes as a result of DRG validation to the claims processor within the same time periods as the notices to other parties.

4.5. Record Of Changes As A Result Of DRG Validation

The contractor shall document and preserve a record of all changes as a result of DRG validation for six years from the date the services in question were provided. The documentary record must include:

4.5.1. The detailed basis for the changes as a result of a DRG validation, and

4.5.2. A copy of the change in the DRG notices sent to all parties and the date on which the notices were mailed or delivered.

4.6. The Contractor Shall Review Changes Resulting from DRG Validation

4.6.1. A provider or practitioner dissatisfied with a change to the diagnostic or procedural coding information made by the contractor as a result of DRG validation is entitled to a review of that change if the change caused an assignment of a different DRG and resulted in a lower payment.

4.6.2. A beneficiary may obtain a review of the contractor's DRG coding change only if that change results in noncoverage of a furnished service (see 42 CFR 473.15(a)(2)).

4.6.3. The individual who reviews changes in DRG procedural or diagnostic information shall be a physician, and the individual who reviews changes in DRG coding must be qualified through training and experience with ICD-9-CM coding.

4.6.4. Procedures described for reconsideration or reopening also apply to the contractor's review of a DRG coding change. (See Chapter 13, Section 5, paragraph 5.3. for additional information relating to the appeals process of DRG cases.)

4.6.5. Finality of review. An initial change as a result of the DRG validation is final and binding unless that change is reviewed and revised in accordance with the procedures in Chapter 13, Section 5, paragraph 5.3. No additional review or appeal for matters is available (see 42 CFR 473.15(c)).

5.0. OTHER TYPES OF REVIEWS

5.1. Quarterly Monitoring Reviews

The contractor shall define in the Utilization Management Plan procedures for and shall conduct a quarterly review of care to determine deviations from statistical utilization norms. Any deviation shall be investigated to determine if quality or access problems were the cause of the deviation or if opportunities exist to more effectively manage care. Additionally, the contractor shall monitor and evaluate the cost of care in accordance with Chapter 7, Addendum E.

5.2. Prepayment Review

The contractor shall establish procedures and conduct prepayment utilization review to address those cases involving diagnoses requiring prospective review, where such review was not obtained, to focus on program exclusions and limitations and to assist in the

detection of and/or control of fraud and abuse. The contractor shall not be excused from claims processing cycle time standards because of this requirement.

5.2.1. The contractor shall perform prepayment review of all cases involving diagnoses requiring preauthorization where review was not obtained. No otherwise covered care shall be denied solely on the basis that authorization was not requested in advance, except for care provided by a network provider.

5.2.2. The contractor shall perform prepayment review of all DRG claim adjustments submitted by a provider which result in higher weighted DRGs.

5.2.3. Payment reduction for noncompliance with required utilization review procedures shall apply to any case in which a provider was required to obtain preauthorization or continued stay (in connection with required concurrent review procedures) approval; the provider failed to obtain the necessary approval, and the health care services were not disallowed on the basis of necessity or appropriateness. In a case described in this section, reimbursement will be reduced unless such reduction is waived by the contractor based on special circumstances. The amount of the reduction for TRICARE Standard providers will be ten percent of the amount otherwise allowable for services for which preauthorization (including preauthorization for continued stays in connection with concurrent review requirements) approval should have been obtained but was not obtained. The amount of this reduction for TRICARE Prime and Extra providers shall be in accordance with the provider's contract with the contractor but not less than ten percent.

5.2.3.1. The amount of this reduction for a non-network attending physician shall be ten percent of the amount otherwise allowable for services for which preauthorization (including preauthorization for continued stays in connection with concurrent review requirements) approval should have been obtained but was not obtained. Payment reduction for network providers will be subject to the provisions of their respective contracts.

5.2.3.2. In the case of hospital admissions reimbursed under the DRG-based payment system, the reduction shall be taken against the percentage (between zero and 100 percent) of the total reimbursement equal to the number of days of care provided without preauthorization approval divided by the total length of stay for the admission.

5.2.3.3. In the case of institutional payments based on per diem payments, the reduction shall be taken only against the days of care provided without preauthorization approval.

5.2.3.4. For care for which payment is on a per service basis, the reduction shall be taken only against the amount that relates to the services provided without preauthorization approval.

5.2.3.5. Unless otherwise specifically provided under procedures issued by the Director, TMA, the effective date of any preauthorization approval shall be the date on which a properly submitted request was received by the review organization designated for that purpose.

5.2.3.6. The payment reduction set forth in this section may be waived by the contractor when the provider could not reasonably have been expected to know of the preauthorization

requirement or some other special circumstances where the provider may not have known the requirements and that the contractor believes justifies the waiver.

5.2.3.7. Services for which payment is disallowed may not be billed to the patient or the patient's family.

6.0. CASE MANAGEMENT

The contractor shall establish an individual case management program for inpatient and outpatient care. The case management program shall be available to all beneficiaries in the MHS region, both enrolled and nonenrolled. The contractor shall grant exceptions to benefit limitations only if it is determined and documented that care provided as an exception is clinically appropriate, cost-effective, and significantly contributes to quality of life.

6.0.1. Beneficiaries Eligible for Medicare Part A and Enrolled in Medicare Part B

Case management shall not be accomplished for these beneficiaries unless it is specifically contracted for inside an individual MTF or if the individual is part of the Individual Case Management Program for Persons with Extraordinary Conditions (ICM-PEC).

6.1. Contractor Management

The contractor shall manage all cases identified for case management to ensure that a beneficiary's clinical needs are fulfilled at the most cost-effective, clinically appropriate setting. This shall include reducing length of stay, identifying and using less expensive care sites when clinically appropriate, decreasing readmissions, and locating and using all alternative sources of available funding.

6.2. Identification of Candidates for Case Management

6.2.1. The contractor shall identify through all review processes all cases involving a diagnosis listed in Chapter 7, Addendum F as well as any cases with the potential to benefit from case management. The contractor shall initiate an evaluation for potential case management services within one work day of identification. All case management evaluations shall be completed within five working days and the beneficiary and provider notified when case management services are determined to be beneficial and cost-effective.

6.2.2. Within 15 calendar days of the last day of each preceding quarter, the contractor shall conduct a quarterly review of all claims processed during the preceding 12 months and identify those individuals whose frequency of services or cost of services make them candidates for case management. The contractor shall evaluate cases within five workdays following identification.

6.2.3. The contractor shall require institutional providers to provide notification within 24 hours of admission of MHS beneficiaries with diagnoses listed in Chapter 7, Addendum F and shall initiate evaluation for case management services within 24 hours of notification. The contractor shall accept and evaluate referrals from any source for case management of patients for whom improved health status and quality of care may be enhanced over the long term. For beneficiaries who do not meet criteria for case management, the case manager shall

make available to those beneficiaries information concerning other sources of needed services within the community.

6.3. Case Manager Qualifications

The contractor's case managers shall be licensed RNs and / or licensed social workers who have a minimum of two years of case management experience.

6.4. Coordination Of MTF/Contractor Resources For Case Management

The contractor shall establish direct communications regarding cases managed with the appropriate MTF and the appropriate Lead Agent to ensure that MTF resources and DoD programs are fully utilized. The timing and extent of such communications shall be defined in the MOU with each MTF Commander and each Lead Agent as identified in Chapter 16, Section 1.

6.5. Case Management Treatment Plan

The contractor shall ensure the establishment of a multidisciplinary care plan for each beneficiary accepted into case management. The care plan shall include the specific services to be delivered, the frequency of services, the expected duration, community resources, military resources, all funding options, the goals, and an assessment of the patient's environment. The care plan must be approved by the attending physician and the patient or the patient's legal guardian. The care plan shall be updated at least monthly and modified where appropriate. The appropriate Lead Agent and Contracting Officer reserve the right to review and approve individual case management plans.

7.0. DISCHARGE PLANNING

The contractor shall ensure its utilization management program incorporates a mechanism to ensure that planning for beneficiary discharge from inpatient settings is initiated as soon as possible in the course of treatment. Discharge planning shall commence during the prospective review process except for emergency cases. Discharge planning for emergency cases shall begin with the contractor's first review of the case.

7.1. The contractor shall specify how the discharge process will relate to the case management component of the utilization management program.

7.2. The contractor shall coordinate with the appropriate MTF Commander to establish a mechanism to facilitate discharge planning of beneficiaries from military facilities.

7.3. The contractor shall require institutional providers to provide notification within 24 hours of admission of MHS beneficiaries with diagnoses listed in Chapter 7, Addendum F and shall initiate evaluation for case management services within 24 hours of notification. The contractor shall accept and evaluate referrals from any source for case management of patients for whom improved health status and quality of care may be enhanced over the long term. For beneficiaries who do not meet criteria for case management, the case manager shall make available to those beneficiaries information concerning other sources of needed services within the community.

8.0. CONFIDENTIALITY APPLICABLE TO ALL UTILIZATION MANAGEMENT ACTIVITIES, INCLUDING RECOMMENDATIONS AND FINDINGS

8.1. The contractor shall develop and implement procedures, processes, and policies that meet the confidentiality and disclosure requirements set forth in Title 10, U.S.C., Chapter 55, Section 1102; the Social Security Act, Section 1160, and implementing regulations at 42 CFR 476, the Alcohol, Drug Abuse and Mental Health Administration (ADAMHA) Reorganization Act (42 U.S.C. 290dd-2), the Privacy Act (5 U.S.C.552a), 32 CFR 199.15(j) and (l). Additionally, the contractor shall display the following message on all quality assurance documents:

> "Quality Assurance document under 10 U.S.C. 1102. Copies of this document, enclosures thereto, and information therefrom will not be further released under penalties of law. Unauthorized disclosure carries a possible $3,000 fine."

8.2. Release of Information - If an inquiry is made by the beneficiary, including an eligible family member (child) regardless of age, the reply should be addressed to the beneficiary, not the beneficiary's parent or guardian. The only exceptions are when a parent writes on behalf of a minor child or a guardian writes on behalf of a physically or mentally incompetent beneficiary. In responding to a parent of a minor or the guardian of a incompetent beneficiary, the Privacy Act precludes disclosure of sensitive information (e.g., abortion, alcohol and drug abuse, venereal disease) or information which, if released, could have an adverse affect on the beneficiary. The contractor must not provide information to parents/guardians of minors or incompetents when the services are related to the following diagnostic codes:

Abortion:	ICD-9-CM 634-639.9; 779.6
Alcoholism:	ICD-9-CM 291.9; 303-303.9; 305
Drug Abuse:	ICD-9-CM 292-292.9; 304-304.9; 305.2-305.9
Venereal Disease:	ICD-9-CM 090-099.9; 294.1
AIDS	ICD-9-CM 079.53; 042

8.3. The term "minor" means any person who has not attained the age of 18 years. Generally, the parent of a minor beneficiary and the legally appointed guardian of an incompetent beneficiary shall be presumed to have been appointed the representative without specific designation by the beneficiary. Therefore, for beneficiaries who are under the age of 18 years or who are incompetent, a notice issued to the parent or guardian, under established TRICARE procedures, constitutes notice to the beneficiary.

8.4. If a beneficiary has been legally declared an emancipated minor, they are to be considered as an adult. If the beneficiary is under18 years of age and is (or was) a spouse of an active duty service member or retiree, they are considered to be an emancipated minor.

9.0. DOCUMENTATION

The contractor shall develop and implement a program for providing beneficiaries and providers with the written results of all review activities which affect benefit determinations.

9.1. All notifications to beneficiaries and providers shall be completed and mailed within the time limits established for the completion of reviews in this section.

9.2. Notifications of denials shall include: patient's name, sponsor's name and social security number, the clinical rationale for denial of payment for specific services (form letters are unacceptable as the clinical rationale shall provide a complete explanation, referencing any and all appropriate documentation, for the cause of the denial), all applicable appeal and grievance procedures, and the name and telephone number of an individual from whom additional information may be obtained.