CHAPTER 13
SECTION 1

GENERAL

1.0. PURPOSE OF APPEAL PROCESS

An appeal under TRICARE is an administrative review of program determinations made under the provisions of law and regulation. An appeal cannot challenge the propriety, equity, or legality of any provision of law or regulation. This chapter sets forth the policies and procedures for appealing decisions made by *TRICARE* and the National Quality Monitoring Contractor (NQMC) that adversely affect the rights and liabilities of beneficiaries and participating providers, and providers denied the status of an authorized provider under TRICARE.

2.0. AUTHORITY

Title 32, Code of Federal Regulations (CFR), Part 199 authorizes the appeal process. It established the appeals and hearing process effective April 4, 1977. The procedures and principles included in this chapter are based on the requirements of 32 CFR 199.10. For additional information regarding the appeal process refer to Chapter 12, Section 6, "Provider Exclusions, Suspensions and Terminations"; and the TRICARE Policy Manual, Chapter 1, Section 4.1, "Waiver of Liability".

3.0. CONTRACTOR RESPONSIBILITIES

It is the responsibility of the contractor to ensure that the rights of appealing parties are protected at all levels of the appeal process in which the contractor participates. The contractor's responsibility begins with the initial determination and does not end until a final resolution is reached, including, where appropriate, timely payment following a reversal.

3.1. Initial Determinations

The contractor shall develop a written plan and implement a formal appeal process that incorporates the requirements for initial medical necessity and factual determinations set forth below. The contractor shall issue a dated initial determination in the form of an Explanation of Benefits (EOB) or a letter. The initial determination shall contain sufficient information to enable the beneficiary or provider to understand the basis for the denial. The initial determination shall state with specificity what services and supplies are being denied and for what reason. The contractor shall retain a legible hardcopy or microcopy of the initial determination or be able to produce a duplicate EOB from electronic records upon request. The initial determination shall include adequate notice of appeal rights and requirements. If a request for authorization for services or supplies is denied and a claim is later submitted for the services or supplies, both the denial of authorization and the claim denial are considered initial determinations and, therefore, either may be appealed. Suggested notices are at paragraph 3.6. and paragraph 3.7. below.

3.2. Medical Necessity Initial Determinations

The appeal process applicable to medical necessity initial denial determinations is addressed in Chapter 13, Section 4. A flow chart diagramming the appeal process relating to medical necessity denials is at Chapter 13, Addendum A, Figure 13-A-5.

3.3. Factual Initial Determinations

The appeal process applicable to factual initial denial determinations is addressed in Chapter 13, Section 5. A flow chart diagramming the appeal process relating to factual denials is at Chapter 13, Addendum A, Figure 13-A-6.

3.4. TRICARE/Medicare Dual Eligible - Initial Determinations

Services and supplies denied payment by Medicare will not be considered for coverage by TRICARE if the Medicare denial of payment is appealable under the Medicare appeal process. If, however, a Medicare appeal results in some payment by Medicare, the services and supplies covered by Medicare will be considered for coverage by TRICARE. Services and supplies denied payment by Medicare will be considered for coverage by TRICARE, if the Medicare denial of payment is not appealable under the Medicare appeal process. The appeal procedures set forth in this chapter are applicable to initial denial determinations by TRICARE under the TRICARE Dual Eligible Fiscal Intermediary Contract.

3.5. Written Notice Of Initial Determination (Not EOB)

Suggested wording for a nonexpedited written appeal notice (including factual determinations):

> "An appropriate appealing party (i.e., (1) the TRICARE beneficiary, (2) the non-network participating provider of care, or (3) a provider of care who has been denied approval under TRICARE or the appointed representative of an appropriate appealing party who is dissatisfied with the initial determination has the right to request a reconsideration. *To avoid a possible conflict of interest, an officer or employee of the United States, such as an employee or member of a Uniformed Service, including an employee or staff member of a Uniformed Service legal office, or a Health Benefits Advisor, subject to the exceptions in Title 18, United States Code, Section 205, is not eligible to serve as a representative. An exception usually is made for an employee or member of a Uniformed Service who represents an immediate family member.* The request must be in writing, must be signed, and must be postmarked or received by (insert name of contractor, *postal* address, *e-mail address,* and fax number), within 90 calendar days from the date of this decision and must include a copy of this decision. For purposes of TRICARE, a postmark is a cancellation mark issued by the United States Postal Service. *If the postmark on the envelope is not legible, then the date of receipt is deemed to be the date of filing.*"

"Additional documentation in support of the appeal may be submitted; however, because a request for reconsideration must be postmarked or received within 90 calendar days from the date of this decision, a request for a reconsideration should not be delayed pending the acquisition of additional documentation. If additional documentation is to be submitted at a later date, the letter requesting the reconsideration must include a statement that additional documentation will be submitted and the expected date of submission."

"Upon receiving your request, all TRICARE claims related to the entire course of treatment will be reviewed."

3.6. Suggested Modified Wording For An Appeal Of A Preadmission/Preprocedure Initial Denial Determination

"A TRICARE beneficiary, or the appointed representative of the beneficiary, who is dissatisfied with the initial determination, may request an expedited reconsideration. The request must be in writing, must be signed, must be received by (insert contractor name, *postal* address, *e-mail address,* and fax number) within three (3) calendar days after receipt of this denial determination, and must include a copy of this denial determination. A request for an expedited reconsideration which is received after the expedited reconsideration filing deadline will be addressed as a nonexpedited reconsideration. We recommend that you submit any additional documentation with the request for an expedited reconsideration. Upon receiving your request, all TRICARE claims related to the entire course of treatment will be reviewed."

3.7. Suggested Modified Wording For An Appeal Of A Concurrent Review Initial Denial Determination

"A TRICARE beneficiary, who is an inpatient in the facility, or the appointed representative of the beneficiary who is dissatisfied with the initial determination, may request a reconsideration. The request must be in writing, must be signed, and must be *sent to* (insert contractor name, *postal* address, *e-mail address,* and fax number). To ensure expedited processing of a request for reconsideration, the beneficiary must submit the request by noon of the day following the day of receipt of this denial determination; however, a request for reconsideration which is received after the reconsideration filing deadline, but which is postmarked or received within 90 *calendar* days from the date of this denial determination, will be accepted. A request for reconsideration must include a copy of the denial determination. We recommend that you submit any additional documentation with the request for reconsideration. Upon receiving your request, all TRICARE claims related to the entire course of treatment will be reviewed."

3.8. Submission Of Reconsideration Requests

The contractor shall establish unique post office boxes or addresses for submission of reconsideration requests.

4.0. WAIVER OF LIABILITY

If applicable, waiver of liability as it applies to the beneficiary and *non-network* provider for services found not to be medically necessary, at an inappropriate level, custodial care, or other reasons relative to reasonableness, necessity or appropriateness of care, shall be addressed in the initial determination. Refer to Chapter 13, Section 4, paragraph 4.0. for additional information relating to the applicability of waiver of liability.

5.0. UNDELIVERABLE INITIAL DETERMINATIONS

If the notice of initial determination is returned as undeliverable, the contractor shall follow the procedures set forth in Chapter 8, Section 8, paragraph 6.0.

6.0. NOTICE TO PROVIDER SEEKING AUTHORIZED PROVIDER STATUS

When a provider has requested approval as a TRICARE provider, the contractor shall mail the initial notice of approval or disapproval to the last known address of the provider.

7.0. FINALITY OF INITIAL DETERMINATION

The initial determination is final and binding unless the initial determination is reopened by the contractor or revised upon appeal.

8.0. PROVIDING ASSISTANCE

8.1. To Appealing Parties

The contractor shall ensure that the rights of appealing parties are protected. In discharging this responsibility, the contractor shall:

- Issue initial and reconsideration determinations which clearly explain appeal rights when an adverse decision is made.

- Explain to inquirers the procedures for requesting a reconsideration, a formal review or a hearing.

- Complete the file documentation when necessary, e.g., provide an EOB copy when an appeal is filed without a copy, or develop for additional information when the appealing party's statements indicate a need for added support or the file indicates added development is appropriate.

- When requested to do so, provide the appealing party a copy of the appeal file.

8.2. To The TRICARE Management Activity (TMA)

When an appealing party files for a formal review or hearing with TMA, the contractor shall provide a complete file record to TMA on a timely basis. (See Chapter 13, Section 6 for requirements.)

9.0. REPROCESSING OF CLAIMS AND PREADMISSION/PREPROCEDURE REQUESTS FOLLOWING ISSUANCE OF RECONSIDERATION DETERMINATIONS, FORMAL REVIEW DETERMINATIONS AND HEARING FINAL DECISIONS

TMA will provide the appropriate contractor with a copy of the formal review determination and hearing final decision. All contractor determinations reversed in whole or in part by the contractor's or the NQMC's reconsideration determination, the TMA formal review determination, or by a hearing final decision, shall be reprocessed by the contractor within *the claim processing standards* from the date of the contractor's reconsideration determination or receipt of the copy of the NQMC's reconsideration determination, the formal review determination or the hearing final decision. The contractor must return to the TMA Appeals and Hearings Division, any formal review determinations or hearing final decisions misdirected to the contractor.

10.0. QUALITY OF CONTRACTOR RECONSIDERATION CASES

The contractor shall implement a process to ensure that 90 percent of contractor reconsideration cases demonstrate accurate contractor processing of the appeal, consistent with the TOM requirements and the documentation in the case file.

11.0. TIMELINESS OF CONTRACTOR RECONSIDERATION DETERMINATIONS

Timeliness of contractor reconsideration determinations is addressed in Chapter 13, Sections 4 and 5.

12.0. SERVICES AND SUPPLIES AUTHORIZED IN ERROR

If a contractor authorizes services or supplies, and the beneficiary obtains the services or supplies in reliance on the authorization, and the services or supplies are later determined not to be a benefit under TRICARE, Government funds cannot be used to pay for the services or supplies.

13.0. DOCUMENTATION

The contractor shall deliver to TMA, Appeals and Hearings Division, one complete set of its processing guidelines, desk instructions, and reference materials covering all tasks required in Chapter 13 and Chapter 12, Section 10, no later than 60 calendar days prior to the start of health care delivery.