CHAPTER 13
SECTION 3

RECONSIDERATION PROCEDURES

1.0. REQUIREMENTS FOR REQUESTING A RECONSIDERATION

1.1. Must Be In Writing

1.2. Must Be Made By A Proper Appealing Party

A network provider is never a proper appealing party. Disputes between a network provider and the contractor concerning authorization of services are not subject to the appeal process. Network provider disputes are addressed under the provider contract provisions, the contractor's administrative procedures, or through the state courts. Because non-network, nonparticipating providers are not proper appealing parties, non-network, nonparticipating provider disputes regarding waiver of liability determinations are addressed as allowable charge reviews rather than reconsideration reviews. If the contractor or the NQMC receives a timely appeal request for reconsideration from a person who is not authorized to participate in the appeal, before the expiration of the appeal filing deadline, the contractor or the NQMC shall treat the request as routine correspondence, and add the request to the claim file. The contractor or the NQMC shall advise the proper appealing party in writing (see Chapter 13, Addendum A, Figure 13-A-4) with a copy to the improper appealing party. A blank "Appointment of Representative," form shall be enclosed with the letter to the proper appealing party (see Figure 13-A-1). The proper appealing party shall be told that an appeal must be filed within 20 calendar days of the date of the contractor's or the NQMC's letter or by the expiration of the appeal filing deadline, whichever is the later.

1.3. Must Include An Appealable Issue

1.3.1. Appealable Issues

1.3.1.1. A TRICARE Prime enrollee, a TRICARE Extra user or a TRICARE Standard beneficiary making use of the authorization process who requests authorization to receive services and such authorization is denied by the contractor, may appeal even though no care has been provided and no claim submitted. (Refer to *paragraph 7.2.* and Chapter 13, Section 4, paragraph 3.1.2., for additional information relating to preadmission/preprocedure denials).

1.3.1.2. The decision by the contractor to cost-share services under the Point-of-Service Option is not appealable; with the exception of the issue of whether services were related to an emergency and, therefore, exempt from the requirement for referral and authorization. Whether services were related to an emergency is a factual determination and is appealable. The TRICARE Prime enrollee must demonstrate that the care would qualify as an emergency under the criteria for emergency care set forth in 32 CFR 199.4. Should the beneficiary prevail in the appeal, the amount cost-shared would be the difference between the amount cost-shared under the Point of Service option and the amount that would have been cost-shared

had the beneficiary received the care from a network provider. A determination by the contractor that services received under the point-of-service option are not a TRICARE benefit would be appealable as a medical necessity or factual denial determination.

1.3.1.3. The decision by a contractor to deny a request by the Primary Care Manager (PCM) to refer a beneficiary to a specialist is an appealable issue, if the reason for the denial is a determination by the contractor that a referral is not needed.

1.3.1.4. Concurrent review authorizations granting 48 hours or less of additional services beyond the previous authorization when the provider has requested more than 48 hours of additional services. If the concurrent review authorization grants more than 48 hours of additional services beyond the previous authorization, but less than the period requested by the provider, an appeal does not exist. In such a case, the letter authorizing the additional period would inform the provider that a subsequent concurrent review will be conducted within 48 hours prior to the expiration of the newly authorized period.

1.3.2. Nonappealable Issues

The following issues are not appealable and shall not be accepted for reconsideration. They should be counted as correspondence for both workload report and processing purposes.

1.3.2.1. Allowable Charge

The amount of the TRICARE-determined allowable cost or charge for services or supplies is not appealable, since the methodology for determining allowable costs or charges is established by regulation. *One example involving an allowable charge issue would be the contractor's decision to pay benefits under the Point of Service option (absent any claim that the care was emergency in nature and was, therefore, exempt from the requirement for referral and authorization).* In cases involving contractor cutbacks or downcoding of diagnoses or procedure codes, there is no issue with respect to the medical necessity of the services provided and therefore, no appealable issue (i.e., the contractor does not determine that the services are not a benefit under TRICARE). The sole issue in these cases is the level of payment for the medically necessary services - an allowable charge issue. If, however, the contractor cutback or downcoding results in the noncoverage of a furnished service, then an appealable issue would exist. See Chapter 12, Section 9.

1.3.2.2. Eligibility

Determination of a person's eligibility as a TRICARE beneficiary is not appealable since this determination is the responsibility of the Uniformed Services. See the TRICARE Policy Manual, Chapter 10, Section 1.1.

1.3.2.3. Denial of NAS Issuance for Inpatient Mental Health Care

Determinations relating to the issuance of a Nonavailability Statement (NAS) (DD Form 1251) based on the availability of care at the MTF are not appealable since these determinations are the responsibility of the Uniformed Services. For *Standard beneficiaries*, when the issuance of an NAS is denied based on a medical necessity or a factual

determination (including a determination that the facts of the case do not demonstrate a medical emergency for which an NAS is not required), the beneficiary and/or civilian participating provider has the right to reconsideration. Refer to the TRICARE Policy Manual, Chapter 1, Section 6.1.

1.3.2.4. Provider Sanction

If the decision is to disqualify or exclude a provider because of a determination against that provider resulting from abuse or fraudulent practices or procedures under another federal or federally-funded program is not appealable, the provider is limited to exhausting administrative appeal rights offered under the federal or federally-funded program that made the initial determination. However, a determination to sanction a provider because of abuse or fraudulent practices or procedures under TRICARE is an initial determination which is made by the contractor and is appealable under 32 CFR 199. See Chapter 14. A sanction imposed pursuant to 32 CFR 199.15(m) is appealable as described in 32 CFR 199.15(m)(3).

1.3.2.5. Network Provider/Contractor Disputes

Disputes between a network provider and the contractor concerning payment for services provided by the network provider are not appealable.

1.3.2.6. Provider Not Authorized

The denial of services or supplies received from a provider not authorized to provide care under TRICARE is not appealable.

1.3.2.7. Denial Of A Treatment Plan

The denial of a treatment plan when an alternative treatment plan is selected is not appealable. Peer to peer dialogue resulting in selection and approval of another treatment option is not a denial of care.

1.3.2.8. Denial Of Services By A Primary Care Manager

The refusal of a PCM to provide services or to refer a beneficiary to a specialist is not an appealable issue. A beneficiary who has been refused services or a referral by a PCM may file a grievance under Chapter 12, Section 10, paragraph 1.0. The decision by the contractor to deny a PCM's request to refer a beneficiary to a specialist is an appealable issue and is addressed in paragraph 1.3.1.3.

1.3.2.9. Designation Of Providers

The contractor's designation of a particular network or non-network provider to perform requested services is not appealable.

1.3.2.10. *Point Of Service*

The decision by the contractor to cost-share services under the Point of Service option is not appealable, with the exception of the issue of whether the services were related to an emergency and are therefore exempt from the requirement for referral and authorization.

1.4. Must Be Filed Timely

An appeal must be filed before the expiration of the appeal filing deadline or within 20 *calendar* days of the date of the contractor's letter, referenced in paragraph 1.2. In calculating the number of days elapsed, the day following the date of the previous determination is counted as day "one" with the count progressing through actual calendar days including the date the request is filed. The contractor or NQMC shall treat an untimely request for reconsideration as routine correspondence, and add the request to the claim file.

1.4.1. By Mail

If the appeal is not filed timely, the contractor shall advise the appealing party that the appeal cannot be accepted since the time limit for filing was exceeded, based on the receipt date of the appeal request or the postmark date on the envelope. For the purposes of TRICARE, a postmark is a cancellation mark issued by the United States Postal Service (i.e., private mail carriers do not issue postmarks). If there is no postmark or the date of the postmark is illegible, the date of receipt by the contractor shall be used to determine timeliness of filing.

1.4.2. By Facsimile

A request for reconsideration submitted by facsimile transmission (fax) is considered filed on the date the fax is received by the contractor.

1.4.3. By Electronic Mail

A request for reconsideration submitted by electronic mail (e-mail) is considered filed on the date the e-mail is received by the contractor.

1.5. Must State The Issue In Dispute And Include Previous Determination

The request should state the specific issue in dispute and be accompanied by a copy of the previous denial determination notice. If a contractor or the NQMC receives a request for reconsideration which otherwise satisfies the requirements as stated above, the request shall be accepted notwithstanding the failure of the appealing party to provide a copy of the previous denial determination notice or to state the specific issue in dispute. In such cases, the contractor or the NQMC shall accept the request for reconsideration and shall supply a copy of the previous denial determination notice from its files or shall initiate communication with the appealing party to clarify the specific issue in dispute, as appropriate.

2.0. EXTENSION OF APPEAL FILING DEADLINE

If the appeal is untimely the appealing party shall be told that if it can be shown to the satisfaction of the contractor or the NQMC, that timely filing of the request was not possible due to extraordinary circumstances over which the appealing party had no practical control, an extension of the appeal filing deadline may be granted. A determination by the contractor or the NQMC that extraordinary circumstances do not exist is not appealable.

2.1. Extraordinary Circumstances Are Limited To:

2.1.1. Administrative Error

2.1.1.1. Administrative error (misrepresentation, mistake or other accountable action) of an employee of the contractor performing functions under TRICARE and acting within the scope of that individual's authority. For example, an administrative error would occur when a request for reconsideration was filed with the contractor after the expiration of the appeal filing deadline but the envelope containing the reconsideration request was misplaced by the contractor. In such a case, the misplacement of the envelope by the contractor would constitute an extraordinary circumstance over which the appealing party had no practical control, thereby permitting late filing of the appeal, unless it could be determined that:

- The appealing party used a means other than the United States Postal Service to deliver the reconsideration request to the contractor, or
- The letter requesting the reconsideration was dated after the reconsideration filing deadline, or
- Other circumstances would lead to the conclusion that the reconsideration request could not have been postmarked on or before the reconsideration filing deadline (for example, the reconsideration request was received by the contractor 30 days after the reconsideration filing deadline).

2.1.2. Mental Incompetency

Mental incompetency of the appealing party (this includes the inability to communicate as a result of physical disabilities).

2.2. Requests For Extension

There must have been a denial of an appeal, due to lack of timely filing, before an extension can be considered. Contractors and the NQMC shall return all requests for extension of the appeals filing deadline to the requesting party if an appeal has not been denied due to lack of timely filing. The contractor and the NQMC shall inform the requesting party that the request for extension may not be considered until a request for reconsideration has been received.

3.0. RECEIPT AND CONTROL OF APPEALS

3.1. Date Stamp

All reconsideration requests shall be stamped with the actual date of receipt within three workdays of receipt by the contractor.

3.2. Control

The contractor shall establish a single centralized appeals department and establish and maintain a single automated system for the control, location, and aging of appeals received. Appeals may be processed at more than one location but all appeals shall be managed and controlled by the centralized appeals department. The contractor's ability to respond to inquiries on a timely basis shall be measured from the actual date of receipt of the inquiry by the contractor, rather than from the date the inquiry was received in the appropriate responding department or from the date the inquiry was imaged by the contractor. The contractor is responsible for ensuring issuance of complete and accurate determinations on all reconsiderations within the time frames set forth in the *TRICARE Operations Manual*.

3.3. Acknowledgment Of Receipt Of Request For Reconsideration

The contractor shall provide an interim written response for all reconsiderations not processed to completion by the date required, advising the appealing party of the estimated date of issuance of the reconsideration determination. A preprinted postcard may be used if information covered by the Privacy Act is not disclosed. Electronic mail may be used to respond to the appealing party, provided the contractor first obtains written permission from the appealing party to use electronic mail for communicating information regarding his or her appeal.

3.4. Timeliness Standards

Chapter 13, Sections 4, 5, and 6 include standards relating to timely issuance of reconsideration determinations and timely submission of appeal case files to the NQMC and to the Appeals and Hearings Division. Standards are expressed in either calendar days or working days. To determine whether timeliness has been met relating to a standard expressed in working days, the first working day following receipt by the contractor or NQMC of the request for reconsideration, or request for the appeal file, is counted as day one of the timeliness requirement. To determine whether timeliness has been met relating to a standard expressed in calendar days, the first calendar day following receipt by the contractor or NQMC of the request for reconsideration is counted as day one of the timeliness requirement.

4.0. *RECONSIDERATION* REVIEW*ER QUALIFICATIONS AND ADMINISTRATIVE REQUIREMENTS*

4.1. Reviewe*r Qualifications*

A reconsideration reviewer must be someone who is, (1) qualified under Chapter 7, Section 1, paragraph 3.0. to make an initial determination, (2) not the individual who made the initial denial determination and (3) a specialist in the type of services under review.

4.2. Administrative Requirements

*Each review shall be dated and include the signature, legibly printed name, clinical specialty, and credentials of the reviewer. Each reviewer shall include rationale for his or her decision (i.e., a complete statement of the evidence and the reasons for the decision). In addition, the name and title of the individual issuing the reconsideration determination shall be included in the Appeal Summary Log (*Figure 13-A-2*). If the appeal file is forwarded to TMA, a completed "Professional Qualifications" form (*Figure 13-A-3*) must be included in the file for each reviewer.*

4.3. Additional Documentation

The contractor and the NQMC shall request and make every reasonable effort to obtain any documentation required to arrive at a proper reconsideration determination. This includes follow-up letters or documented telephone calls if requested information is not received. An appeal involving inpatient admission or length of stay may require obtaining the entire hospital record. Whenever records are required, the contractor or the NQMC shall request such records directly from the provider. Written or verbal statements made by beneficiaries regarding their medical conditions are not a substitute for medical records. If there are no extenuating circumstances alleged and no added information furnished or referenced, the contractor or the NQMC may make the determination on the information available in its records. Improperly developed or incomplete appeal files received by TMA may be returned to the contractor or the NQMC for additional development, completion, and, if appropriate, issuance of a revised reconsideration determination. Due to the time constraints involved in expedited preadmission/preprocedure appeals, fully documenting a case file may not be possible. Requirements for documenting case files for expedited preadmission/preprocedure appeals is addressed in Chapter 13, Section 4.

4.4. File Documentation (In Other Than Provider Termination Cases)

The contractor and the NQMC shall carefully review the initial determination and all pertinent evidence and documentation obtained at reconsideration in light of the applicable provisions of 32 CFR 199, the TOM, the Policy Manual, the TRICARE Reimbursement Manual and all other relevant guidelines and instructions issued by TMA. The reconsideration determination shall be based on the facts of the case as shown in the evidence and shall be supported by appropriate citations from 32 CFR 199, which shall be cited in the reconsideration determination.

4.5. File Content, Requirements, And Structure

4.5.1. The contractor and the NQMC shall document all determinations made at the reconsideration level in sufficient detail so that, if the next level of appeal is pursued, a subsequent reviewer shall be provided with a clear and complete picture of all actions taken on the case to that point. All material related to the reconsideration shall be made part of the permanent claim file. The copy of the appeal file provided by the contractor to the NQMC or TMA must be complete, including the Appeal Summary Log (Figure 13-A-2) and the Professional Qualifications form (Figure 13-A-3). Likewise, the copy of the appeal file provided by the NQMC to TMA must be complete and include the file received by the NQMC from the contractor. In addition, the NQMC must complete and include its portion of the Appeal Summary Log.

4.5.2. The contractor and the NQMC shall retain and completely document the file or files for all claims involved in the appeal. The contractor can either establish a separate appeal file containing all documents related to the appeal, or can gather all documents related to the appeal, including the completed Appeal Summary Log and Professional Qualifications Statement, into an appeal file when the file is requested by the NQMC or TMA. Irrespective of the method, the contractor and the NQMC shall be responsible for furnishing the required appeal file to the entity performing the next level of appeal within required time periods, if an appeal request is filed. The contractor is not required to submit to the NQMC, the professional qualifications of the medical reviewers referenced in paragraph 4.5.3.

4.5.3. Contractors and the NQMC shall organize the appeal file so that the claim(s) and associated EOBs shall be the last section in the file and all additional documentation shall be arranged in front of it, in order of receipt. Attachments should not be separated from the transmitting document. Examples of documents that are part of the appeal file are:

- Claim(s) with attachments, including, when appropriate, all related claims,
- Explanation of Benefits (EOB) forms,
- Request for Preadmission/Preprocedure Authorization(s),
- Preadmission/Preprocedure Authorization(s),
- Request for medical and/or other documentation received or obtained by the contractor prior to making the initial determination,
- Medical and/or other documentation received or obtained by the contractor prior to making the initial determination,
- Initial determination,
- Written request(s) for reconsideration, including the envelope in which it was mailed,
- Request for additional evidence submitted by the appealing party,

- Additional evidence submitted by the appealing party,
- Written and signed opinion of the reviewer(s) referenced in paragraph 4.1.,
- Reconsideration determination(s),
- Professional qualifications of the medical reviewer(s) (see Figure 13-A-3),
- Appeal Summary Log (see Figure 13-A-2).

4.6. File Documentation For A Provider Termination Case

For file documentation requirements in provider termination cases, see Chapter 14, Section 6, paragraph 4.4.

5.0. APPEAL SUMMARY LOG

The contractor and the NQMC (when appropriate) shall complete the Appeal Summary Log (Figure 13-A-2).

6.0. NOTICE TO APPEALING PARTY OF RESULTS OF RECONSIDERATION

The contractor and the NQMC shall inform the appealing party (or the representative if a representative has been appointed) of the reconsideration determination in writing in accordance with the timeliness standards set forth in Chapter 13, Sections 4 and 5. The reconsideration determination shall be typewritten in its entirety. Handwritten notices shall not be sent. At the request of the appealing party, a reconsideration determination may be sent by facsimile transmission (fax) or by electronic mail (e-mail), followed by mailing of the determination by means of the United States Postal Service. All claims that relate to the same incident of care or the same type of service to the beneficiary shall be addressed in a single reconsideration determination. If the appealing party is a non-network participating provider, a copy of the reconsideration determination shall be furnished to the beneficiary. Conversely, the non-network participating providers shall be furnished copies of the determination if the beneficiary filed the appeal. The notice shall include a caption identifying the beneficiary (including whether the beneficiary is Standard and Extra user, or a Prime enrollee), the beneficiary's date of birth, the sponsor, the sponsor's social security number, the type of care (e.g., RTC care, outpatient psychotherapy, mammography, substance abuse, dental, etc.), the date(s) of service, the date(s) of service in dispute, whether the appeal was processed as a preauthorization, concurrent review, or retrospective review; and the providers (identifying each provider as network or non-network participating, or non-network nonparticipating). The notice shall include the following headings:

6.1. Statement Of Issues

The contractor and the NQMC shall summarize the issue or issues under appeal and shall be clear and concise. All issues shall be addressed; for example, a reconsideration determination in all cases requiring preadmission authorization shall address the requirement for preadmission authorization of the care as well as whether the requirement was met.

6.2. Applicable Authority

The contractor and the NQMC shall briefly discuss the provision of law, regulation, TRICARE policy or TRICARE guidelines on which the determination was made. Include pertinent specific citations and quotations of applicable text. The contractor should omit authority that is not applicable to the case under review (e.g., when citing cosmetic surgery policy, the contractor need not include a listing of all procedures considered by TRICARE to constitute cosmetic surgery, but should quote only the procedure(s) applicable to the case under review).

6.3. Discussion

The contractor and the NQMC shall discuss the original and any added information relevant to the issue(s) under appeal, clearly and concisely, and shall state the patient's condition, including symptoms. Usually one or two paragraphs will suffice unless the issues are complex. The contractor and the NQMC shall include a discussion of any secondary issues raised by the appealing party or which may have been discovered during the reconsideration process.

6.4. Decision

The contractor and the NQMC shall state the decision and whether the reconsideration upholds or reverses the original decision in whole or in part, and clearly and concisely state the rationale for the decision; i.e., fully state the reasons that were the basis for the approval or denial of TRICARE benefits. If applicable TRICARE criteria must be met, the patient's medical condition must be related to each criterion and a finding made concerning whether each criterion is met. The contractor and the NQMC shall state the amount in dispute remaining as a result of the decision and how the amount in dispute was determined (calculated). Also state whether payments are to be recouped.

6.5. Waiver Of Liability

Waiver of Liability provisions are only applicable to denials as described in Chapter 13, Section 4. For applicable cases, the contractor and the NQMC shall include a statement explaining waiver of liability determination as applied t the beneficiary and to each provider, including the rationale for each decision. A beneficiary found not to be liable for the entire episode of care will not be offered further appeal rights. Refer to the TRICARE Policy Manual, Chapter 1, Section 4.1 for information relating to waiver of liability.

6.6. Hold Harmless

Hold harmless provisions are applied only to care provided by a network provider. In applicable cases, the contractor and the NQMC shall include a statement explaining hold harmless, including how the provision is waived, the beneficiary's right to a refund, the method by which a beneficiary can request a refund, and must provide information regarding from what entity a refund can be requested. (See Chapter 5, Section 1, paragraph 2.5.)

6.6.1. Suggested wording for inclusion in a reconsideration determination in which a provider is a network provider is:

"If you decide to proceed with the service or it has already been provided, and the service is provided by a network provider, you may be held harmless from financial liability despite the service having been determined to be non-covered by TRICARE. A network provider cannot bill you for non-covered care unless you are informed in advance that the care will not be covered by TRICARE and you waive your right to be held harmless by agreeing in advance (which agreement is evidenced in writing) to pay for the specific non-covered care. If the service has already been provided when your receive this letter and it was provided by a network provider, and if there was no such agreement and you have paid for the care, you can seek a refund for the amount you paid. This can be done by requesting a refund from [insert contractor name and address].

Include documentation of your payment for the care, by writing to the above address. If you have not paid for the care and have not signed such an agreement, and a network provider is seeking payment for the care, please notify the TRICARE Management Activity, Beneficiary and Provider Services Directorate, 16401 East Centretech Parkway, Aurora, CO 80011-9066.

Under hold harmless provisions, the beneficiary has no financial liability and, therefore, has no further appeal rights. If, however, you agree(d) in advance to waive your right to be held harmless, you will be financially liable and the appeal rights outlined below would apply. Similarly, the appeal rights outlined below apply if you have not yet received the care or if you received the care from a non-network provider and there is $50.00 or more in dispute."

6.7. *Point-of-Service*

The Point-of-Service option is available to TRICARE Prime beneficiaries who seek or receive non-emergency specialty or inpatient care, either within or outside the network which is neither provided by the beneficiary's Primary Care Manager or referred by the Primary Care Manager, nor authorized by the contractor. The contractor and the NQMC shall provide beneficiaries who enroll in TRICARE Prime full and fair disclosure of any restrictions on freedom of choice that may be applicable to enrollees, including the Point-of-Service (POS) option. Therefore, the contractor and the NQMC must explain the right of the beneficiary to exercise the POS option and its effect on the payment of benefits for services determined to be medically necessary (Additional information about the POS option can be found in the TRICARE Reimbursement Manual, Chapter 2, Section 3).

6.7.1. *Suggested language to be included in a reconsideration determination where the beneficiary has been identified as a TRICARE Prime enrollee is:*

"Should you, as a TRICARE Prime enrollee, elect to proceed with this service and the service is provided by a non-network provider, and provided the service is found upon appeal to have been medically necessary, benefits will be payable under the deductible and cost-share amounts for Point-of-Service claims and your out-of-pocket expenses will be higher than they would be had you received the service from a network provider. No more than 50% of the

allowable charge can be paid by the government for care provided under the Point-of-Service option."

6.8. Appeal Rights

The contractor and the NQMC shall state whether further appeal rights are available if the determination is less than fully favorable.

6.8.1. Medical Necessity Contractor Reconsideration Determinations

If the contractor reconsideration determination is less than fully favorable, the contractor shall include a statement explaining the right of the beneficiary (or representative) and the non-network participating provider to request an appeal to the NQMC for a second reconsideration. Timeframes to file an appeal of the contractor reconsideration determination are as follows:

6.8.1.1. Expedited Preadmission/Preprocedure Reconsiderations

The beneficiary shall file the appeal request with the NQMC within three calendar days after the date of receipt of the initial reconsideration determination. The date of receipt of the appeal request by the NQMC shall be considered to be five calendar days after the date of mailing, unless the receipt date is documented. A request for reconsideration filed with the NQMC by the beneficiary more than three calendar days after the date of receipt but within 90 calendar days from the date of the initial reconsideration determination will be addressed as a nonexpedited reconsideration.

6.8.1.2. Nonexpedited Reconsiderations

The beneficiary or non-network participating provider shall file the appeal request with the NQMC within 90 calendar days after the date of the initial reconsideration determination.

NOTE: Refer to Chapter 13, Section 4, paragraph 2.6.2. for the appeal process in concurrent review cases.

6.8.2. Factual Reconsideration Determination

If the reconsideration is less than fully favorable and $50 or more remains in dispute, the contractor shall include a statement explaining the rights of the beneficiary (or representative) and the non-network participating provider to request a formal review with TMA. A request for formal review must be postmarked or received by TMA within 60 calendar days from the date of the notice of the reconsideration determination issued by the contractor.

6.8.3. Reconsideration Determinations Issued By The NQMC

If the reconsideration determination issued by the NQMC is less than fully favorable and $300 or more remains in dispute, the contractor shall include a statement explaining the right of the beneficiary (or representative) and the non-network participating

provider to file a request for hearing with TMA. A request for hearing must be postmarked or received by TMA within 60 calendar days from the date of the notice on the reconsideration determination issued by the NQMC. Refer to paragraph 7.2. regarding hearings in preadmission/preprocedure cases in which the requested service(s) have not commenced.

6.8.4. When the Amount Required to File an Appeal Remains in Dispute

The following wording is suggested if the amount required to file an appeal remains in dispute. (See Chapter 13, Section 2, paragraph 4.0. for required amount in dispute):

6.8.4.1. Nonexpedited Reconsideration Determination

"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, has the right to request a (insert level of appeal). The request must be in writing, be signed, and postmarked or received by **(insert the NQMC name, postal address, e-mail address, and fax number or the Appeals and Hearings Division, TMA, 16401 East Centretech Parkway, Aurora, Colorado 80011-9066)**, within **(insert number *of calendar or working*)** days from the date of this decision and must include a copy of this reconsideration determination. For the purposes of TRICARE, a postmark is a cancellation mark issued by the United States Postal Service.

Additional documentation in support of the appeal may be submitted. However, because a request for **(insert level of appeal)** must be postmarked or received within **(insert number)** days from the date of the reconsideration determination, a request for **(insert level of appeal)** should not be delayed pending the acquisition of any additional documentation. If additional documentation is to be submitted at a later date, the letter requesting the **(insert level of appeal)** 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."

6.8.4.2. Expedited Preadmission/Preprocedure Reconsideration Determination (include in addition to the suggested wording above)

"The TRICARE beneficiary, or the appointed representative of the beneficiary, has the alternative of requesting an expedited reconsideration. The request must be in writing, be signed and must be received by **(insert the NQMC name, postal address, e-mail address, and fax number)** within three working days after the receipt of this

denial determination, and must include a copy of this denial determination. A request for an expedited reconsideration filed after the three day appeal filing deadline will be accepted as a nonexpedited request for reconsideration. It is recommended that any additional documentation you may wish to submit be submitted with the request for expedited reconsideration. Upon receiving your request, all TRICARE claims related to the entire course of treatment will be reviewed."

6.8.5. Amount In Dispute Less Than The Amount Required To File An Appeal

For those cases in which the amount in dispute is less than the amount required to file an appeal (refer to Chapter 13, Section 2, paragraph 4.0. for Required Amount in Dispute), the contractor or the NQMC shall notify the appealing party or representative that the reconsideration determination is final and no further administrative appeal is available. The following is suggested wording:

> "Because the amount in dispute is less than **(insert required amount in dispute)**, this reconsideration determination is final and there are no further appeal rights available."

7.0. EFFECT OF THE RECONSIDERATION DETERMINATION

7.1. The reconsideration determination is final and binding upon all parties unless:

7.1.1. The amount in dispute meets the jurisdictional requirements required to file an appeal (Refer to Chapter 13, Section 2, paragraphs 3.3. and 4.0. regarding requirements for an amount in dispute.), appeal rights were offered in the notice of denial at the reconsideration (or second reconsideration) level, and a request for a second reconsideration, formal review, or hearing, as applicable, is either postmarked or received by the appeal filing deadline, or

7.1.2. The contractor's reconsideration (or NQMC's second reconsideration) decision is reopened and revised by the contractor or the NQMC, either on its own motion or at the request of a party, within one year from the date of the reconsidered determination, or

7.1.3. The contractor's reconsideration (or the NQMC's second reconsideration) is reopened and revised by the contractor or the NQMC, after one year but within four years, because: new and material evidence is received; a clerical error in the reconsideration determination is discovered; the contractor or the NQMC erred in an interpretation or application of TRICARE coverage policy; or an error is apparent on the face of the evidence upon which the reconsideration (or second reconsideration) determination was based, or

7.1.4. The contractor's reconsideration (or the NQMC's second reconsideration) is reopened and revised by the contractor or the NQMC at any time, if the reconsideration (or second reconsideration) determination was obtained through fraud or an abusive practice, e.g., describing services in such a way that a wrong conclusion is reached; or

7.1.5. The contractor's reconsideration (or the NQMC's second reconsideration) is reversed upon appeal at a hearing in accordance with the provisions of 32 CFR 199.10 and 199.15.

7.1.5.1. Beneficiaries may appeal an NQMC reconsideration determination to TMA and obtain a hearing on such appeal to the extent allowed under the procedures in 32 CFR 199.10(d).

7.1.5.2. A non-network participating provider may appeal an NQMC reconsideration determination to TMA and obtain a hearing on such appeal to the extent allowed under the procedures in 32 CFR 199.10(d). The issue in a hearing requested by a provider is limited to waiver of liability (i.e., whether the provider knew or could reasonably have been expected to know that the services were excludable) (refer to paragraph 4.0.). Because waiver of liability applies only to services retrospectively determined to be potentially excludable, waiver of liability will not apply in concurrent review or preadmission/preprocedure cases (i.e., non-network participating providers may request hearings only in cases involving retrospective determinations with the issue being limited to waiver of liability.)

7.2. Further appeal of a preadmission/preprocedure denial to the hearing level is not permitted unless the requested services have commenced. An appeal to a hearing where the services have not commenced is not allowed because there would not be an adequate remedy should the hearing final decision hold in favor of the beneficiary. This is because the issue at hearing would be whether the medical documentation at the time of the request for preadmission/preprocedure demonstrated medical necessity for the services requested. A final decision issued as a result of the hearing process (which may take several months to complete) holding that the beneficiary met the requirements for preadmission/preprocedure on the date the preadmission/preprocedure request was made could not be implemented as the circumstances that warranted the services at the time of the initial request would unquestionably have changed.

8.0. CASES RETURNED WITHOUT TMA REVIEW

At the discretion of TMA, certain cases appealed may be returned to the contractor for processing without the issuance of a formal review or hearing decision. These cases will normally involve instances in which a processing error has resulted in a denial or partial denial of a claim; instances in which the contractor has failed to obtain additional documentation as required by *paragraph 4.3.*; instances in which the contractor has failed to address the entire episode of care; instances in which the contractor has erroneously identified a medical necessity issue as a factual issue and visa-versa; instances in which the contractor has failed to complete the Appeal Summary Log; and instances in which the contractor has failed to offer appropriate appeal rights. Also, TMA, in doing normal development associated with the appeal process, may obtain information that resolves the issues without further review by TMA. If the case is returned for reprocessing, for record purposes the case will be treated as a new request for reconsideration (i.e., Chapter 1, Section 3, paragraph 4.0., will apply and the returned case will be reported for workload purposes). Development for additional documentation, if necessary, will be performed as it would in any reconsideration case. The contractor shall issue a revised reconsideration determination based on the merits of the claim. If applicable, additional appeal rights shall be offered by the contractor.

9.0. RECORD OF RECONSIDERATION

The contractor shall ensure maintenance of records incorporating the following requirements:

9.1. The contractor shall maintain the record of its reconsideration determinations in accordance with the requirements of Chapter 2, Section 2, paragraph 1.20.

9.2. The record of the reconsideration shall include:

- The initial determination.
- The basis for the initial determination.
- Documentation of the date of receipt of the request for reconsideration (include the envelope in which the request for reconsideration was received if the request was made by letter posted with the United States Postal Service).
- Record(s) of telephone contacts with provider(s).
- Evidence submitted by the parties or obtained by the contractor.
- Legible dated copies of medical (Peer) reviews with accompanying "professional qualifications" forms.
- A copy of the notice of the reconsideration determination that was provided to the parties.
- Documentation of the delivery or mailing and, if appropriate, the receipt of the notice of the reconsideration determination by the parties.
- Claims and Explanations of Benefits (EOB) forms.
- Appeal Summary Log.
- Request for preauthorization.
- Response to request for preauthorization.

10.0. CONTRACTOR PARTICIPATION IN THE FORMAL REVIEW AND HEARING

10.1. Contractor participation in the formal review and hearing is limited to submission of written documentation to TMA to be considered in the adjudication of the appeal. TMA will notify the contractor, by requesting the contractor's appeal file, when a request for formal review or hearing is received. The contractor shall advise TMA within ten calendar days of receiving notification that a formal review or hearing request has been received, that it intends to participate in the formal review or hearing through submission of additional documentation. The additional documentation shall be received by TMA within 20 calendar

days following the notice to the contractor of the receipt of the formal review or hearing request.

10.2. The contractor may appear at the hearing as a witness and offer testimony in such capacity. TMA will notify the contractor when a request for hearing is received by requesting the contractor's appeal file. The contractor shall advise TMA, within ten calendar days of receiving notification that a hearing request has been received, that it intends to appear at the hearing as a witness. If the contractor has advised TMA that it intends to appear at the hearing as a witness, TMA will advise the contractor of the time and place of the hearing.

10.3. If, after receiving notice from TMA that a formal review or hearing request has been submitted, the contractor and the NQMC receive additional claims or documentation related to the formal review or hearing, the contractor and the NQMC shall notify TMA of the receipt of the additional claims or documentation and submit copies of the claims or documentation to TMA, as well as copies of any written response the contractor or NQMC may have issued resulting from the receipt of additional claims or documentation.