Chapter 12 Section 3

Reconsideration Procedures

Revision: C-6, October 20, 2017

1.0 REQUIREMENTS FOR REQUESTING RECONSIDERATION

1.1 Must Be In Writing (To Include E-Mail)

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. 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 TRICARE Quality Management Contract (TQMC) contractor 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 TQMC contractor shall treat the request as routine correspondence, and add the request to the claim file. The contractor or the TQMC contractor shall advise the proper appealing party in writing (see Addendum A, Figure 12.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 Addendum A, Figure 12.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 TQMC contractor's letter or by the expiration of the appeal filing deadline, whichever is later.

1.3 Must Include An Appealable Issue

1.3.1 Appealable Issues

1.3.1.1 A TRICARE 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 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 (POS) 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. 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 POS 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 reporting 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. One example involving an allowable charge issue would be the contractor's decision to pay benefits under the POS 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 11, Section 7.

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 (TPM), Chapter 10, Section 1.1.

1.3.2.3 Provider Or Entity Sanction

If the decision to disqualify or exclude a provider or entity because of a determination against that provider or entity resulting from abuse or fraudulent practices or procedures under another federal or federally-funded program is not appealable, the provider or entity is limited to exhausting administrative appeal rights offered under the federal or federally-funded program that made the initial determination. A determination to sanction a provider or entity because of abuse or fraudulent practices or procedures under TRICARE is an initial determination which is appealable under 32 CFR 199. See Chapter 13. A sanction imposed pursuant to 32 CFR 199.15(m) is appealable as described in 32 CFR 199.15(m)(3).

1.3.2.4 Network Provider Or Entity/Contractor Disputes

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

Note: Network pharmacies are not subject to hold harmless provisions, and, therefore, beneficiary liability and appeal rights arise from a denial issued at a network pharmacy. The beneficiary may appeal such a denial.

1.3.2.5 Provider Not Authorized

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

1.3.2.6 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.

1.3.2.7 Denial Of Services By A PCM

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 11, Section 8, 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.

1.3.2.8 Designation Of Providers

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

1.3.2.9 Point Of Service (POS)

The decision by the contractor to cost-share services under the POS 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 TQMC contractor 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 in a timely manner, 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 (USPS) (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 TQMC contractor 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 TQMC contractor 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 TQMC contractor 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 TQMC contractor 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 before 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 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 Or Physical Incapacity Of The Beneficiary

Mental or physical incapacity of the beneficiary causing an inability to communicate when the beneficiary is the appealing party.

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 TQMC contractor 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 TQMC contractor 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 tracking time lines 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.

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 and the Health Insurance Portability and Accountability Act (HIPAA) is not disclosed. Electronic mail and facsimile may be used to respond to the appealing party, provided the contractor first obtains written permission from the appealing party to use electronic mail or facsimile for

communicating information regarding his or her appeal.

3.4 Timeliness Standards

Sections 4, 5, and 6 include standards relating to timely issuance of reconsideration determinations and timely submission of appeals case files to the TQMC contractor 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 TQMC contractor 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 TQMC contractor of the request for reconsideration is counted as day one of the timeliness requirement.

4.0 RECONSIDERATION REVIEWER QUALIFICATIONS AND ADMINISTRATIVE REQUIREMENTS

4.1 Reviewer Qualifications

If the reconsideration determination is based on lack of medical necessity or other reason relative to reasonableness, necessity, or appropriateness, the reconsideration reviewer must be someone who is:

4.1.1 Qualified under Chapter 7, Section 1, paragraph 3.0 to make an initial determination;

4.1.2 Not the individual who made the initial denial determination; and

4.1.3 A peer of the provider of services under review.

Exception: A reconsideration determination fully overturning the initial denial determination can be made by the reviewer who issued the initial denial determination.

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 (Addendum A, Figure 12.A-2). If the appeal file is forwarded to Defense Health Agency (DHA), a completed "Professional Qualifications" form (Addendum A, Figure 12.A-3) must be included in the file for each reviewer.

4.3 Additional Documentation

The contractor and the TQMC contractor 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 (LOS) may require obtaining the entire hospital record. Whenever records are required, the contractor or the TQMC contractor 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 TQMC contractor may make the determination on the information available in its records. Improperly developed or incomplete appeal files received by DHA may be returned to the contractor or the TQMC contractor 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 Section 4.

4.4 File Documentation (In Other Than Provider Termination Cases)

The contractor and the TQMC contractor 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 TPM, the TRICARE Reimbursement Manual (TRM) and all other relevant guidelines and instructions issued by DHA. 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 TQMC contractor 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 TQMC contractor or DHA must be complete, including the Appeal Summary Log (Addendum A, Figure 12.A-2) and the Professional Qualifications form (Addendum A, Figure 12.A-3). Likewise, the copy of the appeal file provided by the TQMC contractor to DHA must be complete and include the file received by the TQMC contractor from the contractor. In addition, the TQMC contractor must complete and include its portion of the Appeal Summary Log.

4.5.2 The contractor and the TQMC contractor 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 TQMC contractor or DHA. Irrespective of the method, the contractor and the TQMC contractor 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 TQMC contractor the professional qualifications of the medical reviewers referenced in paragraph 4.5.3.

4.5.3 Appeal Case File

4.5.3.1 Case files shall be assembled and forwarded to the office conducting the next level of appeal in the format described herein. Failure to comply may result in return of the case file for assembly consistent with this paragraph. A table of contents shall be the first page of the case file and will describe the contents of each tabbed section and subsection. All documents within sections shall be arranged in chronological order based on document date, not date of receipt. Summary Explanations of Benefits (EOBs) shall be redacted to remove information not associated with the

beneficiary relevant to the appeal. However, all other documents shall be complete and legible. Documents in landscape orientation shall be assembled with the heading on the left. Except as detailed in the following note, the case file shall not contain duplicate copies of documents.

Note: It may be necessary to copy documents to ensure each section contains a complete set of relevant documents. For example, at times, documents such as claims or EOBs contain handwritten notes. A copy or copies should be made of such documents, originals returned to the appropriate sections (such as the claims or EOB sections), and the copy or copies placed in the section(s) appropriate for the notes. Likewise if a document contains an attachment or enclosure, if the attachment or enclosure falls within the category of documents under a separately tabbed section or sections, the document shall be copied and the copies placed in the appropriate sections, ensuring originals remain with the document to which they were attached or enclosed.

4.5.3.2 Documents within the appeal case file shall be organized by the following tabbed sections, as applicable:

4.5.3.2.1 Appeal Summary Log.

4.5.3.2.2 Determinations. Include requests for preadmission/preprocedure authorization, if any. Include requests for reconsideration and the envelope in which they were delivered. Include acknowledgments of requests for reconsideration.

- Initial.
- Reconsideration.
- TQMC contractor reconsideration.

4.5.3.2.3 Peer reviews. Signed peer review opinions as referenced in paragraph 4.2. Include requests for peer review. Attach the professional qualifications of each peer reviewer (see Addendum A, Figure 12.A-3).

- Initial.
- Reconsideration.
- TQMC contractor reconsideration.

4.5.3.2.4 Documentation. Do not add claims, EOB forms, or medical records to this section. Documents appropriate for this section include, but are not limited to, records of telephone contacts, requests for medical and/or other documentation received or obtained prior to rendering the initial or reconsideration determination, other documentation received or obtained prior to rendering the initial or reconsideration determination, requests for additional evidence/information from the appealing party, and additional evidence/information submitted by the appealing party.

4.5.3.2.5 Claims related to the episode of care, with attachments (in chronological order with no duplicates).

4.5.3.2.6 EOB forms (in chronological order with no duplicates).

4.5.3.2.7 Medical records (in chronological order with no duplicates).

4.6 File Documentation For A Provider Termination Case

For file documentation requirements in provider termination cases, see Chapter 13, Section 5, paragraph 9.6.

5.0 APPEAL SUMMARY LOG

The contractor and the TQMC contractor (when appropriate) shall complete the Appeal Summary Log (Addendum A, Figure 12.A-2).

6.0 NOTICE TO APPEALING PARTY OF RESULTS OF RECONSIDERATION

6.1 The contractor and the TQMC contractor 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 Sections 4 and 5. The reconsideration determination shall be typewritten or computer-printed in its entirety. At the request of the appealing party, a reconsideration determination may be sent by facsimile transmission or by electronic mail, followed by mailing a hardcopy. 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 what plan the beneficiary is covered under).
- The sponsor.
- The last four digits of sponsor's Social Security Number (SSN).
- The type of care (e.g., Residential Treatment Center (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.
- The providers (identifying each provider as network or non-network participating, or non-network nonparticipating).

6.2 The notice shall include the following headings:

6.2.1 Statement Of Issues

The contractor and the TQMC contractor 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.

6.2.2 Applicable Authority

The contractor and the TQMC contractor 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 shall 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).

6.2.3 Discussion

The contractor and the TQMC contractor 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 TQMC contractor shall include a discussion of any secondary issues raised by the appealing party or which may have been discovered during the reconsideration process.

6.2.4 Decision

The contractor and the TQMC contractor 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 TQMC contractor shall state the amount in dispute remaining as a result of the decision and how the amount in dispute was determined (calculated). The contractor and the TQMC contractor shall also state whether payments are to be recouped.

6.2.5 Waiver Of Liability

Waiver of Liability provisions are only applicable to denials as described in Section 4. For applicable cases, the contractor and the TQMC contractor shall include a statement explaining waiver of liability determination as applied to 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 (EOC) will not be offered further appeal rights. Refer to the TPM, Chapter 1, Section 4.1 for information relating to waiver of liability.

6.2.6 Hold Harmless

6.2.6.1 Hold harmless provisions are applied only to care provided by a network provider. In applicable cases, the contractor and the TQMC contractor 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 3.5.)

6.2.6.2 Suggested wording for inclusion in a reconsideration determination when the provider is a network provider is provided at Addendum A, Figure 12.A-11.

6.2.7 Point Of Service (POS)

6.2.7.1 The POS 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 PCM nor referred by the PCM, nor authorized by the contractor. The contractor and the TQMC contractor shall provide beneficiaries who enroll in TRICARE Prime full and fair disclosure of any restrictions on freedom of choice that may be applicable to beneficiaries, including the POS option. Therefore, the contractor and the TQMC contractor 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 TRM, Chapter 2, Section 3).

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

> "Should you, as a TRICARE Prime beneficiary, 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."

6.2.8 Appeal Rights

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

6.2.8.1 Contractor Medical Necessity Reconsideration Determinations

If the contractor reconsideration determination is less than fully favorable, and $50 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 request an appeal to the TQMC contractor for a second reconsideration. Time frames to file an appeal of the contractor reconsideration determination are as follows:

6.2.8.1.1 Expedited Preadmission/Preprocedure Reconsiderations

The beneficiary shall file the appeal request with the TQMC contractor within three calendar days after the date of receipt of the initial reconsideration determination. The date of receipt of the appeal request by the TQMC contractor 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 TQMC contractor 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.

6.2.8.1.2 Nonexpedited Reconsiderations

The beneficiary or non-network participating provider shall file the appeal request with

the TQMC contractor within 90 calendar days after the date of the initial reconsideration determination.

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

6.2.8.2 Factual Reconsideration Determination Based on Statute or Regulation

6.2.8.2.1 If the reconsideration determination upholds the denial based on a statutory or regulatory exclusion, further appeal shall not be offered to challenge the statutory or regulatory exclusion. Further appeal is available, however, to challenge whether the exclusion was appropriately applied. For other adverse determinations, 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 DHA. A request for formal review must be postmarked or received by DHA within 60 days from the date of the notice of the reconsideration determination issued by the contractor.

6.2.8.2.2 The following wording is for the appeal rights section of reconsideration determinations upholding denials based on statutory or regulatory exclusions:

> "An administrative reconsideration review is available under the TRICARE appeal process when a denial is based on a requirement of law or regulation. However, because disputes challenging a requirement of law or regulation do not present an appealable issue, they are ineligible for appeal to a formal review or hearing. Since the disputed care in this case is excluded by law or regulation, further appeal is not authorized. This reconsideration determination completes the administrative appeal process under 32 CFR 199.10, and no further administrative appeal is available.
>
> Although disputes challenging a requirement of law or regulation are not appealable to a formal review or hearing, further appeal to a formal review or hearing is available to dispute whether the law or regulation was properly applied if other requirements are satisfied, such as the requisite amount in dispute. For example, services and supplies related to treating obesity are excluded by law and regulation when obesity is the only or the major condition being treated. If a service or supply was provided to treat hypertension, but the obesity exclusion was erroneously applied, an appeal may be filed to challenge the erroneous application of the obesity exclusion. As a further example, if law or regulation excludes durable medical equipment, but the actual service provided was for a prosthetic device, an appeal may be filed on the grounds that the durable medical equipment exclusion was incorrectly applied to the prosthetic device coverage determination."

6.2.8.3 Reconsideration Determinations Issued By The TQMC Contractor

If the reconsideration determination issued by the TQMC contractor 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 DHA. A request for hearing must be postmarked or received by DHA within 60 calendar

days from the date of the notice on the reconsideration determination issued by the TQMC contractor. Refer to paragraph 7.2 regarding hearings in preadmission/preprocedure cases in which the requested service(s) have not commenced.

6.2.8.4 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 Section 2, paragraph 4.0 for required amount in dispute):

6.2.8.4.1 Non-Expedited Reconsideration Determination

Suggested wording for a nonexpedited reconsideration can be found at Addendum A, Figure 12.A-12.

6.2.8.4.2 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 TQMC 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 non-expedited 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."

6.2.8.5 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 Section 2, paragraph 4.0 for Required Amount in Dispute), the contractor or the TQMC contractor 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 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 TQMC contractor's second reconsideration) decision is reopened and revised by the contractor or the TQMC contractor, 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 TQMC contractor's second reconsideration) is reopened and revised by the contractor or the TQMC contractor, 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 TQMC contractor 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 TQMC contractor's second reconsideration) is reopened and revised by the contractor or the TQMC contractor 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 TQMC contractor'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 a TQMC contractor reconsideration determination to DHA 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 a TQMC contractor reconsideration determination to DHA 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 Section 4, 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 DHA REVIEW

At the discretion of DHA, 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 EOC; 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, DHA, in doing normal development associated with the appeal process, may obtain information that resolves the issues without further review by DHA. 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 9, Section 2, paragraph 1.18.

9.2 The record of reconsideration shall be assembled and maintained in the format prescribed by paragraph 4.5.3.

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 DHA to be considered in the adjudication of the appeal. DHA 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 DHA within 10 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 DHA 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. DHA will notify the contractor when a request for hearing is received by requesting the contractor's appeal file. The contractor shall advise DHA, within 10 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 DHA that it intends to appear at the hearing as a witness, DHA will advise the contractor of the time and place of the hearing.

10.3 If, after receiving notice from DHA that a formal review or hearing request has been submitted, the contractor and the TQMC contractor receive additional claims or documentation related to the formal review or hearing, the contractor and the TQMC contractor shall notify DHA of the receipt of the

additional claims or documentation and submit copies of the claims or documentation to DHA, as well as copies of any written response the contractor or the TQMC contractor may have issued resulting from the receipt of additional claims or documentation.

- END -