

## Management

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### 1.0 UTILIZATION MANAGEMENT (UM) PROGRAM PLAN

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

**1.2** The contractor shall fully describe in a written UM Plan all processes, procedures, criteria, staff and staff qualifications, and information and data collection activities and requirements the contractor shall use in conducting UM activities.

### 2.0 NOTIFICATION OF REVIEW REQUIREMENTS

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

### 3.0 REVIEWER QUALIFICATIONS AND PARTICIPATION

#### 3.1 Peer Review By Physicians

**3.1.1** Except as provided in [paragraph 3.1.2](#), each person who makes an initial denial determination about services furnished or proposed to be furnished by a licensed doctor of medicine or osteopathy or by a doctor of dentistry must be respectively another licensed doctor of medicine or osteopathy or of dentistry with an active clinical practice in the PRO area, if the initial determination is based on lack of medical necessity or other reason relative to reasonableness, necessity or appropriateness.

**3.1.2** If a PRO determines that peers are not available to make initial denial determinations, a doctor of medicine or osteopathy may make denial determinations for services ordered or performed by a doctor in any of the three specialties.

### **3.2 Peer Review By Health Care Practitioners Other Than Physicians**

Health care practitioners other than physicians may review services furnished by other practitioners in the same professional field.

### **3.3 Diagnosis Related Group (DRG) Validation Review**

Decisions about procedural and diagnostic information must be made by physicians. Technical coding issues must be reviewed by individuals with training and experience in International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM) coding (for outpatient services with dates of service or inpatient services with dates of discharge provided **on or before September 30, 2014**) and in International Classification of Diseases, 10th Revision, Clinical Modification (ICD-10-CM) coding (for outpatient services with dates of service or inpatient services with dates of discharge provided on or after **October 1, 2014**, or International Classification of Diseases, 10th Revision, Procedure Coding System (ICD-10-PCS) for inpatient services with dates of discharge provided on or after **October 1, 2014**).

### **3.4 Persons Excluded From Review**

**3.4.1** A person may not review health care services or make initial denial determinations or changes as a result of DRG validations if he or she, or a member of his or her family:

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

**3.4.2** A member of a reviewer's family is a spouse (other than a spouse who is legally separated under a decree of divorce or separate maintenance), child (including a legally adopted child), grandchild, parent, or grandparent.

### **3.5 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).

## **4.0 WRITTEN AGREEMENTS WITH INSTITUTIONAL PROVIDERS**

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

- Institutional providers will cooperate with the contractor in the assumption and conduct of review activities.
- Institutional providers will allocate adequate space for the conduct of on site review.

- Institutional providers will photocopy and deliver to the contractor all required information within 30 calendar days of a request for off-site review.
- Institutional providers will provide all beneficiaries, in writing, their rights and responsibilities (e.g., "An Important Message from TRICARE" ([Addendum A](#)), "Hospital Issued Notice of Noncoverage" ([Addendum B](#)).
- Institutional providers will inform the contractor within three working days if they issue a notice that the beneficiary no longer requires inpatient care.
- Institutional providers will assure that each case subject to preadmission/preprocedure review has been reviewed and approved by the contractor.
- Institutional providers will agree, when they fail to obtain certification as required, they will accept full financial liability for any admission subject to preadmission review that was not reviewed and is subsequently found to be medically unnecessary or provided at an inappropriate level ([32 CFR 199.15\(g\)](#)).
- The contractor shall reimburse the provider for the costs of photocopying and postage using the same reimbursement as Medicare.
- The contractor shall provide detailed information on the review process and criteria used, including financial liability incurred by failing to obtain preauthorization.

## **5.0 BENEFIT POLICY DECISIONS**

TRICARE Versus Local Policy. TRICARE policies have precedence over any local or internal policy of the contractor or the medical community of the region. However, the contractor shall notify TRICARE Management Activity (TMA) promptly of any conflicts between TRICARE policy and local policy. Variations from policy which expand, reduce, or adjust benefit coverage shall be referred to TMA for approval before being implemented.

## **6.0 CONCURRENT REVIEW REQUIREMENTS**

The contractor shall conduct concurrent review for continuation of inpatient mental health services within 72 hours of emergency admissions (see [32 CFR 199.4\(b\)\(6\)\(iv\)](#)), and authorize, as appropriate, additional days.

## **7.0 RETROSPECTIVE REVIEWS RELATED TO DRG VALIDATION**

**7.1** The contractor shall conduct quarterly focused reviews of a 1% sample of medical records to assure that reimbursed services are supported by documentation in the patient's medical record. This review must determine if the diagnostic and procedural information and discharge status of the patient as reported by the hospital matches the attending physician's description of care and services documented in the patient's record. In order to accomplish this, the contractor shall conduct the following review activities:

**7.2** Review of claim adjustments submitted by hospitals which result in the assignment of a higher weighted DRG (see [Addendum C](#)).

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

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

"Notice to Physicians: TRICARE payment to hospitals is based in part on each patient's principal and secondary diagnoses and the major procedures performed on the patient, as attested to by the patient's attending physician by virtue of his or her signature in the medical record. Anyone who misrepresents, falsifies, or conceals essential information required for payment of Federal funds may be subject to fine, imprisonment, or civil penalty under applicable Federal laws."

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

#### **7.6 Outlier Review**

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

#### **7.7 Procedures Regarding Certain Services Not Covered By The DRG-Based Payment System**

In implementing the quality and utilization review for services not covered by the DRG-based payment system, the requirements of this section shall pertain, with the exception that ICD-9-CM (for dates of discharge **on or before September 30, 2014**) and Current Procedural Terminology, 4th Edition (CPT-4) codes will provide the basis for determining whether diagnostic and procedural information is correct and matches information contained in the medical records. The ICD-10-CM and ICD-10-PCS codes will be used to provide basis of correct information for dates of discharge beginning on or after **October 1, 2014**.

#### **8.0 RETROSPECTIVE REVIEW REQUIREMENTS FOR OTHER THAN DRG VALIDATION**

The contractor shall conduct and report quarterly focused reviews of a statistically valid sample or 30 records, whichever is greater of medical records to determine the medical necessity and quality of care provided, validate the review determinations made by review staff, and determine if the diagnostic and procedural information and/or discharge status of the patient as reported on the hospital and/or professional provider's claim matches the attending physician's description of care and services documented in the medical record. The specific types of records to be sampled shall be determined separately by each Regional Director (RD) who will provide the contractor with the sampling criteria (DRG, diagnosis, procedure, Length-Of-Stay (LOS), provider, incident or occurrence as reported on claim forms) and the time frame from which the sample is to be drawn 60 calendar days prior to each quarter. For all cases selected for retrospective review, the

following review activities shall occur:

### **8.1 Admission Review**

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

### **8.2 Invasive Procedure Review**

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

### **8.3 Discharge Review**

Records shall be reviewed using appropriate criteria for questionable discharges or other potential quality problems.

### **8.4 Mental Health Review**

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

## **9.0 REVIEW RESULTS**

### **9.1 Actions As A Result Of Retrospective Review Related To Individual Claims**

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

- Deny payment for or recoup (in whole or in part) any amount claimed or paid for the inpatient hospital and professional services related to such determination;
- Require the hospital to take other corrective action necessary to prevent or correct the inappropriate practice;
- Advise the provider and beneficiary of appeal rights, as required by [Chapter 12, Section 4, paragraph 2.0](#).

### **9.2 Findings Related To A Pattern Of Inappropriate Practices**

The contractor shall notify TMA of the hospital and practice involved in all cases where a pattern of inappropriate admissions and/or billing practices, that have the effect of circumventing

the TRICARE DRG-based payment system, is identified.

### **9.3 Revision Of Coding Relating To DRG Validation**

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

- If the diagnostic and procedural information attested to by the attending physician is found to be inconsistent with the hospital's coding or DRG assignment, the hospital's coding on the TRICARE claim shall be appropriately changed and payments recalculated on the basis of the appropriate DRG assignment.
- If the information attested to by the physician as stipulated in [paragraph 7.3](#) is found not to be correct, the contractor shall change the coding and assign the appropriate DRG on the basis of the changed coding in accordance with the paragraph above.

### **9.4 Notice Of Changes As A Result Of A DRG Validation**

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

- The corrected DRG assignment;
- The reason for the change resulting from the DRG validation;
- A statement addressing who is liable for payment of denied services (e.g., a beneficiary will be liable if the change in DRG assignment results in noncoverage of a furnished service);
- A statement informing each party (or his or her representative) of the right to request a review of a change resulting from DRG validation in accordance with the provisions in [paragraph 9.5](#);
- The locations for filing a request for review and the time period within which a request must be filed; and
- A statement concerning the duties and functions of the multi-function PRO.

### **9.5 Review Of DRG Coding Change**

**9.5.1** A provider dissatisfied with a change to the diagnostic or procedural coding information made by the contractor as a result of DRG validation is entitled to a review of that change if the change caused an assignment of a different DRG and resulted in a lower payment. A beneficiary may obtain a review of the contractor's DRG coding change only if that change results in noncoverage of a furnished service (see 42 CFR 478.15(a)(2)).

**9.5.2** The contractor shall issue written notification of the results of the DRG validation review within 60 calendar days of receipt of the request for review. In the notification, the contractor shall

summarize the issue under review and discuss the additional information relevant to such issue. The notification shall state the contractor's decision and fully state the reasons that were the basis for the decision with clear and complete rationale. The notification shall include a statement that the decision is final and no further reviews are available.

### **10.0 PREPAYMENT REVIEW**

**10.1** The contractor shall establish procedures and conduct prepayment utilization review to address those cases involving diagnoses requiring prospective review, where such review was not obtained, to focus on program exclusions and limitations and to assist in the detection of and/or control of fraud and abuse. The contractor shall not be excused from claims processing cycle time standards because of this requirement.

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

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

### **11.0 CASE MANAGEMENT**

Case management shall not be accomplished for beneficiaries eligible for Medicare Part A and Enrolled in Medicare Part B unless it is specifically contracted for inside an individual MTF or if the individual is part of the Individual Case Management Program for Persons with Extraordinary Conditions (ICMP-PEC).

### **12.0 CONFIDENTIALITY APPLICABLE TO ALL UM ACTIVITIES, INCLUDING RECOMMENDATIONS AND FINDINGS**

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

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

**12.2** Release of Information - If an inquiry is made by the beneficiary, including an eligible family member (child) regardless of age, the reply should be addressed to the beneficiary, not the beneficiary's parent or guardian. The only exceptions are when a parent writes on behalf of a minor child or a guardian writes on behalf of a physically or mentally incompetent beneficiary. The

contractor must not provide information to parents/guardians of minors or incompetents when the services are related to the following diagnoses:

- Abortion
- Alcoholism
- Substance Abuse
- Venereal Disease
- **Acquired Immune Deficiency Syndrome (AIDS)**

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

**12.4** If a beneficiary has been legally declared an emancipated minor, they are to be considered as an adult. If the beneficiary is under 18 years of age and is (or was) a spouse of an Active Duty Service Member (ADSM) or retiree, they are considered to be an emancipated minor.

### **13.0 DOCUMENTATION**

The contractor shall develop and implement a program for providing beneficiaries and providers with the written results of all review activities affecting benefit determinations. All notifications to beneficiaries and providers shall be completed and mailed within the time limits established for the completion of reviews in this section. Notifications of denials shall include: patient’s name, sponsor’s name and last four digits of their Social Security Number (SSN), the clinical rationale for denial of payment for specific services (form letters are unacceptable as the clinical rationale shall provide a complete explanation, referencing any and all appropriate documentation, for the cause of the denial), all applicable appeal and grievance procedures, and the name and telephone number of an individual from whom additional information may be obtained.

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