[Categorical Listing] [Numerical Listing]

This policy clarifies HA Policies 94-005 and 97-046

HEALTH AFFAIRS

THE ASSISTANT SECRETARY OF DEFENSE

WASHINGTON, DC 20301-1200

15 APR 1998

MEMORANDUM FOR ASSISTANT SECRETARY OF THE ARMY (M&RA)
ASSISTANT SECRETARY OF THE NAVY (M&RA)
ASSISTANT SECRETARY OF THE AIR FORCE (MRAI&E)
DIRECTOR, DEFENSE FINANCE AND ACCOUNTING SERVICE

SUBJECT: Revised Utilization Management Policy for the Direct Care System

This attached policy revision of the Utilization Management (UM) Policy for the Direct Care System of October 1994 is designed to update, clarify and simplify the guidelines for utilization management, a vital component of TRICARE, in the Military Healthcare System.

The changes in the revision represent a bridge between the old policy and the future vision under TRICARE 3.0, the contract initiatives currently being formulated as guidance for the next round of managed care support contracts. The overriding theme of the revision is one of more flexibility at the local and regional level to perform UM functions which easily and efficiently accomplish the goal of providing quality, cost-effective care in the appropriate setting to our beneficiaries.

Our point of contact is Commander John H. Varga at (703) 697-8975.

Gary A. Christopherson
Acting Assistant Secretary of Defense

Attachment:
As stated

HA Policy 98-031

DEPARTMENT OF DEFENSE
UTILIZATION MANAGEMENT POLICY
FOR THE DIRECT CARE SYSTEM

SECTION I - GENERAL POLICIES AND INFORMATION

1. ***Introduction.***

The Department of Defense (DoD) Utilization Management (UM) Policy for the Direct Care Setting provides guidance in support of a uniform resource management system based on systematic business and clinical decision processes. This policy is a framework. Regional UM and Quality Management (QM) processes and plans will be developed at the Lead Agent level. The Lead Agent will use the Request for Proposal (RFP) and the final contract (technical proposal) to establish joint plans with the Managed Care Support (MCS) Contractors, further delineated with Memoranda of Understanding (MOU). This policy gives Lead Agents and MTF Commanders the utmost flexibility to develop processes which are cost efficient, consistent with National Committee for Quality Assurance (NCQA) standards or Joint Commission on Accreditation of Health Care Organizations (JCAHO) standards, are multidisciplinary, and which improve patient care. UM and QM are important links between the delivery of health services, overall business decisions, and accomplishment of a process of quality and

performance improvement.

2.*Goals & Objectives*

2.1 Ensure that all health care services rendered are cost effective, delivered in the most appropriate setting and optimized for quality and timeliness of the care rendered.

2.2 Optimize Defense Health Plan expenditures with business decisions based on UM/QM processes.

2.3 Facilitate partnering with the Managed Care Support Contractors while sustaining quality and improving patient satisfaction.

2.4 Incorporate appropriate measurement and statistical methods to demonstrate process performance, process improvement results, and system performance.

3. *UM Overview*

Key elements of the UM program (education, utilization review, demand/referral management, case management, disease management, discharge planning, health promotion and prevention) provide a basic foundation for evaluation of care and services, and for the development of best practices such as practice guidelines (preferred practice patterns, clinical guidelines), critical pathways (clinical pathways, CareMaps^{R}, clinical protocols, algorithms), and clinical outcomes studies. Under TRICARE, UM in the Direct Care System (DCS) must be integrated with the contractor's network as well as other Military Treatment Facilities (MTF) in the region, including coordination with Specialized Treatment Services centers (STS) and Centers of Excellence. For UM to be effective, it must be comprehensive, systematic and ongoing. It should include all aspects of medical, surgical and mental health care, both inpatient and outpatient, encompassing all services and providers or practitioners who have direct impact on patient care.

4. *Confidentiality*. This policy is applicable to all Utilization Management activities, including recommendations and findings.

4.1 Lead Agents in conjunction with MTFs will develop and implement procedures, processes, and policies that meet the confidentiality and disclosure requirements set forth in Title 10, U.S.C., Chapter 55, Section 1102; the Social Security Act, Section 1160 and implementing regulations at 42 CFR 476, the Alcohol, Drug Abuse and Mental Health Administration (ADAMHA) Reorganization Act (42 U.S.C. 290dd-2), the Privacy Act (5 U.S. C.552a), DoD 6010,8-R, Chapter 15, J. and L. Additionally, Lead Agents and MTF's will ensure the following message is displayed on all quality assurance documents:

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

4.2 Release of Information - If an inquiry is made by the beneficiary, including an eligible dependent 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 guardian writes on behalf of a physically or mentally incompetent beneficiary. In responding to a parent of a minor or the guardian of an incompetent beneficiary, the Privacy Act precludes disclosure of sensitive information (e.g., abortion, alcohol and drug abuse, venereal disease) or information, which if released, could have an adverse effect on the beneficiary. Government or contract personnel, at all levels of the MHS, must *not* provide information to parents/guardians of minors or incompetents when the services are related to the following diagnostic codes:

4.2.1 Alcoholism: ICDM-9-CM 291.9; 303-303.9; 305

Abortion: ICDM-9-CM 634-639.9; 779.6

Drug Abuse: ICDM-9-CM 292-292.9; 304-304.9; 305.2-305.9

Venereal Disease: ICDM-9-CM 090-099.9; 294.1

AIDS: ICDM-9-CM 079.53; 042

4.2.2 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 will 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 constitutes notice to the beneficiary.

4.2.3 Beneficiaries who have been legally declared emancipated minors are to be considered as adults. If the beneficiary is under 18 years of age and is (or was) a spouse of an active duty service member or retiree, he or she will be considered to be an emancipated minor.

SECTION II - UM PLANS

5. *UM Plans*

Each Lead Agent, in conjunction with each MTF and in coordination with the appropriate Service Intermediate Command, will develop a written UM plan consistent with the requirements of DoD UM policy, service UM policy, JCAHO standards, NCQA standards and the region’s MCS Request For Proposals (RFP). The plan must describe fully all processes, procedures, criteria, staff, and staff qualifications. Lead Agents will define the procedures for conducting a quarterly review of care to determine deviations from statistical utilization norms. Any significant deviation will be investigated to determine if quality or access problems were the cause of the deviation or if opportunities exist to more effectively manage care. While specific diagnoses or procedures targeted may differ from those specified in this policy, DoD may request reports from Lead Agents based on standardized utilization trends. Health Affairs (TMA) will provide assist visits to Lead Agents and MTF’s on a periodic basis upon request from the MTF, Lead Agent or Service SG to document compliance with adopted UM plans (appropriate representatives from Service Intermediate Commands and SG Offices will be an integral part

of the assist teams). The Regional and MTF UM Plans must be reviewed and updated annually, as required by JCAHO and NCQA. UM plans will address the areas further described in paragraphs 6-18 that follow.

6. ***Education and Orientation***

6.1 ***Provider Education***. Education of military and civilian providers within the Direct Care System to the basic principles of managed care and to the specific goals and requirements of the MCS contract is vital to success. The investment of time, money and effort toward these education and orientation goals will be returned many fold in the form of facilitated start-up, better provider and beneficiary compliance, lower rates of appeals and complaints, as well as better clinical outcomes and quality of care.

6.2 ***Beneficiary Education*****.** Education of the TRICARE beneficiaries, as well as the Medicare eligible beneficiaries, to the improved benefits and quality within the TRICARE continuum will similarly be rewarded with a shorter learning curve, less frustration and improved compliance with requirements.

6.3 ***Lead Agents*** *and* ***MTF Commanders*** are encouraged to use all available resources within the MCS contracts and their own training budgets to accomplish education and orientation of providers, staff and beneficiaries. MTF and Region specific education and lesson plans are an ideal method of identifying needs, resources and goals.

7. ***Review Criteria***

7.1 ***Medical/Surgical Reviews***. Review criteria published by InterQual, Inc., of Marlborough, Massachusetts, in their most current version will be used as the criteria for screening medical and surgical care for first level inpatient review. Additional criteria may be used only for areas not addressed by InterQual (i.e. - Milliman and Robertson or other proprietary sources, where more specific outpatient criteria have been developed). Any additional criteria will be described as parts of the written UM plan.

7.2 ***Mental Health Reviews*****.** HA approved review criteria (currently HMSI) will be used to conduct first level screening review. For substance abuse admission to specialized substance abuse units in MTFs, review criteria developed by the American Society of Addiction Medicine (ASAM PPC-2) will be used to conduct first level screening review.

8. ***Reviewer Qualifications***

8.1 ***First Level Reviewers*** must be familiar with not only the basic criteria (InterQual or HMSI), but must be trained to screen patients with any other criteria used by the facility.

8.1.1 All medical and surgical cases will be reviewed by licensed physicians, licensed registered nurses (RNs), or certified physician assistants (PAs).

8.1.2 If directly supervised by the appropriate above licensed or certified specialist, reviewers may be paraprofessionals such as licensed practical nurses, hospital corpsmen/technicians, and medical records technicians. If paraprofessionals serve as first level reviewers, the Lead Agent will specify qualifications such as experience, length of service, rank or other similar parameters.

8.1.3 All mental health cases will be reviewed by licensed psychiatrists, licensed registered psychiatric nurses, licensed clinical psychologists, or licensed clinical social workers.

8.1.4 If directly supervised by the appropriate above licensed or certified specialist, mental health reviewers may be paraprofessionals such as licensed practical nurses or hospital corpsmen/technicians. If paraprofessionals serve as first level reviewers, the Lead Agent will specify qualifications such as experience, length of service, rank or other similar parameters. At a minimum, these paraprofessionals must have specialized formal training and experience in mental health.

8.2 ***Second Level Reviewers*** must be licensed physicians (possessing a current, valid, unrestricted license in the U.S.), meeting the definition of a "Clinical Peer" as published in the Utilization Review Accreditation Commission National Utilization Review Standards.

8.2.1 *Medical and surgical cases:* Physicians must meet the above criteria (8.2) and be board certified (by a specialty board recognized by the American Board of Medical Specialties or its osteopathic equivalent) and have their historical practice in the major clinical area (medicine, surgery, pediatrics, obstetrics/gynecology or psychiatry) being reviewed;

8.2.2 *Mental health cases:* Physicians must meet the above criteria (8.2) with board certification by the American Board of Psychiatry and Neurology

8.2.3 *Specialty Consultation.* In all cases, every effort should be made for the reviewing physician to consult with a peer who is in the same discipline as the attending/treating provider (e.g. psychologist, anesthesiologist, pathologist, podiatrist, and radiologist). All consultations will be fully documented in the case file. When the requirement cannot be met, the reason will be documented.

8.2.4 *Conflict of interests.* Reviewers may excuse themselves from reviewing a case in which they feel an objective opinion cannot be rendered but in all cases will be excluded from reviews when the claim involves a case in which the reviewer participated in developing or executing the beneficiary's treatment plans or involves the reviewer or a member of the reviewer's family (For purposes of this policy "family" is defined as spouse, other than a spouse who is legally separated under a decree of divorce or separate maintenance, child, including a legally adopted child, grandchild or parent).

8.3 ***Reconsideration Reviewers*** will only be licensed doctors of medicine, osteopathy, or oral surgeons (possessing a current, valid , unrestricted license in the U.S.), with active staff privileges and patient care responsibilities in a regional medical treatment facility. They will be board-certified (by a board recognized by the American Board of Medical Specialties or osteopathic equivalent) specialists in the specialty of the attending physician or the type of services under review. They will not be the reviewers who made the initial denial determination or be assigned as a staff physician in the facility involved in the reconsideration.

8.3.1 If the services subject to review were rendered by a qualified health care provider other than a physician, every effort will be made for the reviewing physician to consult with a peer who is a similarly qualified health care provider. All consultations shall be fully documented. When the requirement cannot be met, the reasons will be documented.

8.3.2 If possible, the reviewer will practice in a setting similar to the provider whose services are being reviewed, unless meeting this requirement would compromise the effectiveness or efficiency of the review process. When matching reviewers of similar practice settings is not possible, the reasons will be documented.

9.*Utilization Reviews*

Utilization Review (UR) is a systematic evaluation of the necessity, appropriateness, and efficiency of the use of health care services, procedures, and facilities. It includes reviews and evaluations of the following:

9.1 *Prospective Review*. Prospective review procedures will be established in coordination between the MTF, LA and Service Intermediate Commands; and will be conducted to allow for evaluation of proposed treatment, determination of medical necessity, and assessment of level of care required prior to the delivery of care.

9.1.1 If review does not occur prior to the admission/procedure, (e.g. the admission/ procedure was an emergency), a review will be conducted within twenty-four (24) hours of notification of the admission/procedure.

9.1.2 Prospective review is valid for only thirty (30) days from the date of issuance. All prospectively reviewed treatment that is not begun within thirty (30) days will require another prospective review.

9.1.3 Prospective review procedures will include provisions for identification of beneficiaries for whom case management services would be appropriate.

9.1.4 *Required Prospective Reviews*.

9.1.4.1 Inpatient - All admissions will be subject to prospective review for medical necessity and level of care determination based on the criteria below:

9.1.4.1.1 Prospective review will be performed on 100% of the following diagnoses:

- All admissions for beneficiaries in the Program for Persons with Disabilities (previously known as the Program for the Handicapped/PFTH).

9.1.4.1.2 Prospective review will be performed on adequate numbers (as defined below) of selected DRG's categories as follows (minimum numbers of reviews, more may be done):

- 3 DRG's for MTF's with average occupied beds less than 50
- 6 DRG's for MTF's with average occupied beds 50-150
- 10 DRG's for MTF's with average occupied beds greater than 150
- DRG's shall be chosen based on high cost, high frequency, problem prone, or areas targeted for improvement through objective criteria.
- Diagnoses and procedures listed in Attachment 1 should be used as initial sources for above reviews, but may be modified.
- Adequate numbers shall be 100% unless predetermined objective statistical criteria indicate that sampling

is appropriate.

9.1.4.2 Outpatient - All PCM to Specialist referrals shall be reviewed against standard pre-established criteria (such as proprietary criteria from Milliman and Robertson or InterQual or from specialty organizations).

9.1.4.2.1 Prospective review will be performed on 100% of the following, if not separately reviewed as a specialty referral:

- All mental health (subsequent to the eighth visit).
- All outpatient invasive procedures with significant risk to the patient (JCAHO definition in the current version of the Accreditation Manual). **See 9.1.4.1.2.**

9.1.4.2.2 MTF specific referrals, diagnoses, or procedures with historically proven low rates of denial under prospective review (including those required above) may be deleted from 100% review (with concurrence of the Lead Agent). In additional to those cases noted above, outpatient reviews shall be conducted on cases as noted in the formula below:

- 3 Referral categories, procedures or diagnoses for MTF's with annual outpatient visits less than 100,000
- 5 Referral categories, procedures or diagnoses for MTF's with annual outpatient visits 100,000-150,000
- 7 Referral categories, procedures or diagnoses for MTF's with annual outpatient visits 150,000-200,000
- 10 Referral categories, procedures or diagnoses for MTF's with annual outpatient visits greater than 200,000
- Review selections shall be chosen based on high cost or high frequency non-invasive procedures, problem prone, or areas targeted through objective criteria.
- Diagnoses and procedures listed in Attachment 1 should be used as initial sources for above reviews, but may be modified.
- Adequate numbers for each referral category, diagnosis or procedure shall be 100% unless predetermined objective statistical criteria indicate that sampling is appropriate.

9.1.4.3 Lead Agents and MTF Commanders may add to the above lists (paragraphs 9.1.4.1 and 9.1.4.2) of required preauthorization reviews as appropriate or necessary for the management of utilization at their facilities.

9.1.5 *Prospective Review Determinations* will be issued on at least ninety percent (90%) of all requests for prospective review within one (1) working day following receipt of the request and all required information. Determinations will be issued on one hundred percent (100%) of such requests within five (5) working days following receipt of the request and all required information. An authorization for acute, inpatient mental health care will NOT be issued for more than seven (7) calendar days at a time.

9.2 *Concurrent Review*. Concurrent review procedures will be established and conducted to allow for evaluation of care while it is being provided. These procedures will be conducted to validate the appropriateness of disposition and/or level of care, medical necessity of treatment and/or procedure, quality of care rendered and information provided during any previous review. The process will also make provisions for identification of beneficiaries for whom case management services would be appropriate.

9.2.1 *Inpatient Concurrent Review* consists of three separate components:

9.2.1.1 Admission review is conducted within twenty-four (24) hours of admission to verify the appropriateness and medical necessity of the hospitalization (Med/Surg or Mental Health admissions). All patients admitted without preadmission authorization will undergo admission review within the first 24 hours of hospitalization, following the guidelines in paragraph 9.1.4.1.2 for numbers and types. These reviews may include the same DRGs as prospective review or different DRGs, depending on the goals of the MTF and LA. Documentation in the medical record must justify the admission, and should include a supporting history and physical, a plan of care, and medical orders showing a correlation between the necessity for hospitalization and the plan of care. Practice guidelines and critical pathways are methods of review against a standard.

9.2.1.2 Continued stay review is conducted regularly throughout a patient's hospitalization to assess the patient's need for continued inpatient treatment. Concurrent review will be conducted at least every seventy two (72) hours throughout a patient's hospitalization (all mental health patients and appropriately selected medical/surgical patients) or with a change in the level of care (all patients) or additional procedures (all patients) to validate the following:

9.2.1.2.1 (subsequent to the eighth visit)Concurrent reviews will be conducted on all mental health patients forty-eight (48) hours prior to expiration of any previous authorization.

9.2.1.2.2 During all concurrent review processes, the reviewer evaluates the appropriate level of care, identifies any delays in service, determines if all tests are appropriate, notes any complications, ascertains if unrelated conditions that do not require intervention are being evaluated or treated, information provided during any previous review and assesses status of discharge planning.

9.2.1.2.3 If a frequency of review for medical/surgical or mental health cases different from those noted above in 9.2.1.2 or 9.2.1.2.1 is more desirable or efficient, it will be established by the Lead Agent, with justification forwarded to Health Affairs (TMA) for timing different from that required in the MCS contract or this plan.

9.2.1.3 Discharge review is conducted to ensure patients are discharged only when they are medically stable. Concurrent review procedures will include provisions for identification of beneficiaries for whom case management services would be appropriate.

9.2.2 *Outpatient Concurrent Review*

9.2.2.1 Mental Health Review. Concurrent review will be conducted for every eight sessions of outpatient mental health care.

9.2.2.2 Disease Management could be considered a form of outpatient medical/surgical review, and should be considered as an option, not a requirement to an overall well integrated UM/QM plan.

9.3 ***Retrospective Review Requirements*****.** Retrospective review is conducted for medical/surgical and mental health services after treatment/discharge to determine trends or patterns in either the under-utilization or over-utilization, sequencing of resources, and as a performance review of the UM process. Retrospective reviews may

be used to identify potential areas for future prospective and concurrent reviews.

9.3.1 *Retrospective Review Requirements*. Retrospective review is conducted after discharge to determine trends and/or patterns in either under-utilization or over-utilization of resources during the patient's hospitalization as well as areas for improvement in performance and quality.

9.3.1.1 Quarterly focused reviews will be conducted of at least a one percent (1%) sample of medical records which were previously prospectively or concurrently reviewed to assess the accuracy of information provided during the review, determine the medical necessity and quality of care provided, and validate the review determinations made by review staff.

9.3.1.2 For records not previously reviewed, the medical record will be evaluated to determine whether the care rendered was medically necessary, was provided at the appropriate level of care, and to identify potential quality problems, including possible premature discharges (i.e. the patient was not medically stable and/or where discharge was not consistent with the patient's need for continued care).

9.3.1.3 The specific types of records to be sampled will be determined by the Lead Agent who will determine sampling criteria (sample size, diagnosis, Diagnosis Related Group (DRG), procedure, length of stay, provider, incident or occurrence as reported on medical records). For all cases selected for retrospective review, initial reviewers will identify for second level (physician) review potential utilization and/or quality problems.

The following review activities will occur for:

9.3.1.4 Inpatient Retrospective Reviews:

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

9.3.1.4.2 Invasive Procedure Review. The medical record must support the medical necessity of the procedure performed.

9.3.1.4.3 Discharge Review. Records will be reviewed to identify possible premature discharges (i.e. the patient was not medically stable and/or where discharge was not consistent with the patient's need for continued acute inpatient hospital care), as well as other potential quality problems.

9.3.1.5 Outpatient Retrospective Reviews:

9.3.1.5.1 Noninvasive procedure review. The medical record must support the medical necessity of the procedure performed.

9.3.1.5.2 Invasive procedure review. As above.

9.3.1.5.3 Discharge review. As above.

10. ***Profiling***

10.1 Profiling is the collection, collation and analysis of clinical utilization data to develop provider specific information for resource consumption and outcomes for episodes of care. These profiles should be used to produce provider feedback reports to help the providers modify their own behavior, to determine which specialist should handle specific types of cases, to detect fraud and abuse, to help focus the utilization management system, to produce performance based incentive systems and to perform resource or economic modeling.

10.2 Profiling may be performed on a provider, clinic, MTF, network or region specific basis.

10.3 MTF Commanders and Lead Agents are encouraged to use profiling to make appropriate management decisions within the scope of Managed Care.

11. ***Case Management.***

11.1 Case management is a collaborative process which assesses, plans, implements, coordinates, monitors, and evaluates options and services to meet complex health needs through communication and available resources to promote quality, cost effective outcomes.

11.2 Critical pathways (paragraph 13) can enhance the case management process. They centralize the focus of patient care by mapping the processes, tasks, and resources required to achieve a predetermined outcome of care within a specified timeline while incorporating best practice standards, as well as practice guidelines (paragraph 12), for all key disciplines and departments involved in the management of a specific patient population. Multidisciplinary criteria will be developed to determine which cases may benefit from case management.

11.3 ***Case Manager Qualifications*****.** Case managers will be licensed RNs and/or licensed social workers who have experience in case management in the appropriate clinical specialty for those patients being case managed; regional or area case managers are encouraged, who should be certified case managers through one of the nationally recognized accrediting bodies.

11.4 ***Identification and evaluation of Candidates for Case Management***

11.4.1 Quarterly review of inpatient records (using screening criteria) processed during the preceding twelve (12) months will be conducted in order to identify those individuals whose frequency of services or cost of services make them candidates for case management. However, referrals for case management may come from any source.

11.4.2 An evaluation for potential case management services will be initiated within one (1) working day of the referral. All case management evaluations will be completed within five (5) working days of the referral. The beneficiary and provider will be notified when case management services are determined to be beneficial and cost-effective.

11.4.3 Information concerning other sources of needed services within the community will be made available to patients who do not meet criteria for case management.

11.5 ***Coordination of Lead Agent/Contractor Resources for Case Management***

Lead Agents and MTF Commanders will establish direct communications with the appropriate MCS contractor to ensure that regional resources and DoD programs are fully utilized in the delivery of case management services. The timing and extent of such communications will be defined in a memorandum of understanding (MOU) with the MCS contractor and the Lead Agent or MTF Commander, as appropriate. Each MTF Commander, in consultation with the Lead Agent, shall identify diagnoses/screening criteria to be incorporated into the case management program within their catchment area. Suggested tTypes of cases which must may be case managed include:

11.5.1 Head trauma
Spinal cord injuries
Human immunodeficiency virus (AIDS)
Neoplasms
Neonates admitted to neonatal intensive care units
Bone marrow transplant patients
Major burns
Organ transplants
Investigational protocol patients
Additional diagnoses which are encouraged, when locally feasible:
Catastrophic illness/injury
Repeat admissions
Poorly controlled chronic disease
Resource intensive
Dual medical + psychiatric diagnoses
Dual psychiatric + substance abuse diagnoses
Asthma
High risk OB

11.6 ***Case Management Treatment Plan***

The MTF Commander will ensure the establishment of a multidisciplinary care plan for each beneficiary accepted into case management. The care plan will include complete assessment of the patient's condition, environment, social setting, financial and community resources; specific treatment goals; specific services to be provided and expected duration; funding sources; and evaluation of progress toward goals. The care plan must be approved by all involved clinical providers and the patient or patient's legal guardian. Final approval rests with a physician or oral surgeon.

Progress toward established goals will be evaluated at least twice weekly for inpatients and quarterly for outpatients in order to update and/or modify the plan where appropriate.

Lead Agents will establish direct communications with the appropriate MCS contractor to ensure that regional resources and DoD programs are fully utilized in the delivery of case management services. The timing and extent of such communications will be defined in an MOU with the MCS contractor and the Lead Agent. Types of cases which must be evaluated for case management include:

- Head trauma
- Spinal cord injuries
- Human immunodeficiency virus (AIDS)
- Neoplasms
- Neonates requiring neonatal intensive care unit services
- Bone marrow transplant patients
- Major burns

11.7 ***Evaluation of Case Management Program***

Case management programs will be evaluated annually, including both clinical and financial indicators such as reduction of admissions, reduction of length of stay, use of more appropriate levels of care, and cost avoidance.

12. ***Practice Guidelines***

12.1 Practice guidelines provide practitioners with a decision making tool for determining appropriate health care for specific clinical circumstances. Guidelines offer an opportunity to improve health care delivery processes by reducing unwanted variation. As recommended by the Institute of Medicine, practice guidelines should be valid, reliable and reproducible, clinically applicable and flexible, a multidisciplinary process, reviewed on a scheduled basis and well documented.

12.2 Practice guidelines are integral parts of a well designed UM plan. Their use is encouraged throughout the MHS, with proper modification for local practice variations.

13. ***Critical Pathways***

13.1 An optimal sequencing and timing of interventions by physicians, nurses, and other disciplines for a particular diagnosis or procedure, designed to minimize delays and resource utilization and to maximize the quality of care. A critical path is the sequence of activities that can normally be expected to result in the most cost effective clinical course of treatment. The Length of the path (or episode of care) is governed by the activity or intervention that takes the most time to complete. Other definitions for critical pathways include: clinical paths, clinical pathways, clinical protocols, algorithms or CareMaps^{R}.

13.2 Critical pathways are integral parts of a well designed UM plan. Their use is encouraged throughout the MHS, with proper modification for local variations.

14. ***Discharge Planning.***

14.1 Discharge planning is a process which assesses requirements to accomplish an appropriate and timely discharge from an acute care setting or release from care in the outpatient setting. It should be designed to decrease or eliminate barriers that disrupt patients' timely release and to facilitate their smooth transition into the post-discharge/post-care environment.

14.2 In all settings, mechanisms will be incorporated into the UM process to assure discharge planning is initiated as soon as is possible in the course of treatment. In the inpatient setting discharge planning will commence prior to all planned admissions. For emergency admissions it will begin with the first review of the case. The UM plan will specify how the discharge process will relate to the case management component of the UM program.

14.3 When appropriate, the Lead Agent in conjunction with MTFs will collaborate with the MCS contractor to establish a mechanism to facilitate discharge planning of beneficiaries from militaryornon-military facilities.

15. ***Disease Management***

15.1 Disease Management is a prospective disease-specific approach to delivering health care spanning all encounter sites (inpatient, outpatient, ER, home care). It augments physician's visits with non-physician practitioners who specialize in target diseases. These non-physician care managers provide patients with additional education and help in controlling or minimizing the effects of their illnesses.

15.2 A significant component of an overall disease management approach is the adoption of Clinical Practice Guidelines (paragraph 12).

15.3 Disease Management is an integral part of a well designed UM plan. Its use is encouraged throughout the MHS, with proper modification for local variations.

16. ***Demand Management***

Demand management refers to activities of a health plan designed to reduce overall requirement for health care services by members, including advice lines, self-care and medical consumerism programs, shared decision-making programs, information technology, preventive services and health risk appraisals (Health Enrollment Assessment Review - HEAR). Lead Agents and MTF Commanders are encouraged to pursue alternative methods of Demand Management (in addition to those already provided in the MCS contracts). Recommendations for new programs should be submitted to HA (TMA) for final approval, if the new program alters or interferes with a current HA policy.

17. ***Wellness and Health Promotion***

17.1 Health Promotion is a balance of awareness, education, motivation, and intervention activities (physical, emotional, spiritual, intellectual, and social) designed to facilitate behavioral and environmental alterations in lifestyle that will optimize health and total fitness or prevent disease and injury. It includes those activities intended to support and influence individuals to manage their own health through self-care, health maintenance, and avoidance of modifiable disease and injury risks. Operationally, health promotion and disease prevention encompass clinical preventive services and lifestyle issues of tobacco use prevention and cessation, physical fitness, nutrition, stress management, alcohol and drug abuse prevention, communicable and chronic disease prevention (including cancer and cardiovascular disease prevention), and other efforts to reduce preventable illnesses and injuries.

17.2 An adequate Health Promotion plan is an integral part of a well designed UM plan. Its use is encouraged throughout the MHS, with proper modification for local variations.

18. ***Levels of Review, Denials and Appeals.*** (Review criteria and reviewer qualifications in Paragraph 7 & 8) Review procedures will contain the following levels:

18.1 ***First Level of Review.*** Ascreening process, using approved criteria, to render decisions as to the medical necessity and appropriateness of the level of care under review. First level reviewers may authorize benefits or refer the case to second level review but will never deny services or negotiate level of service. Second level review is required for all cases not meeting the first level screening criteria.

18.2 ***Second Level of Review.*** A level of reviewconducted to render medical necessity determinations based on the medical expertise of the reviewer. Only one of two determinations can be made. The care can either be approved or denied. The decision must be documented.

18.3 ***Denial.*** A determination by the second level reviewer that the health care services furnished or proposed to be furnished to a patient are not medically necessary, are not reasonable, or are not at the appropriate level of care, is an initial denial determination and is appealable as described under Third Level Review (Reconsideration) and Fourth Level Review (NQMC Review) in Sections 18.4 and 18.5 below. An initial denial determination is final and binding unless the initial denial determination is reconsidered and revised. Lead Agents in conjunction with MTFs will develop written plans for and implement a formal appeals and grievance system that incorporates the requirements for initial denials as identified below.

18.3.1 *Opportunity for Discussion of Proposed Denial Determination.* Lead Agents will provide an opportunity to discuss a proposed initial denial determination. Before issuing an initial denial the patient's attending physician (or other attending health care practitioner) will be notified of the proposed determination and afforded an opportunity to discuss the matter with the reviewing physician. The purpose of this discussion is to allow further explanation of the nature of the patient's need for health care services, including all factors which preclude treatment of the patient as an outpatient or in an alternative level of inpatient care.

18.3.2 *Documentation.* MTF Commanders, in conjunction with the Lead Agent, will develop and implement a program for providing beneficiaries and providers with the written results of all review activities that affect benefit determinations. All notifications to beneficiaries and providers will be completed and mailed within the time limits established for the completion of reviews.

18.3.2.1 Notifications of denials will include: patient's name; sponsor's name and social security number; the clinical rationale for denial of authorization for specific services (form letters are unacceptable as the clinical rationale will 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.

18.3.2.2 See Attachments A & B for sample letters that contain specific language suggested for use for notification of denials in prospective or concurrent reviews.

18.3.3 *Notice of Initial Denial Determination* Lead Agents will ensure that a written notice of an initial denial

determination is provided to:

The patient, or if the patient is expected to be unable to comprehend the notice, the patient's next of kin, guardian or other representative or sponsor; and;

The attending physician, or other attending health care practitioner; and;

The facility (if applicable).

In the case of prospective review, the documentation will be accomplished stating that the patient and the provider received notice of the initial denial determination.

18.3.4 *Timing of the Notices***.** A written notice of an initial determination will be provided within the following timelines for:

- Admission: first working day after the initial denial determination
- Continued stay: within three (3) working days after the initial denial determination (applies to outliers in facilities where a length of stay has been assigned)

    - Preprocedure review: before the procedure is performed, or within 5 working days of the initial request (whichever is sooner)
    - Prospective review: before admission, or within 5 working days of the initial request (whichever is sooner)
    - Retrospective review: within three (3) working days of the initial denial determination
    - Postprocedure review: within three (3) working days of the initial denial determination

18.4 ***Third Level Review*** **(RecReconsideration**) An opportunity for reconsideration will be provided to the beneficiary (or representative) and provider (military, government contractor or civilian) and will include an appeals mechanism for the initial denial determination regarding the medical necessity, reasonableness or appropriateness of admission, continued stay, and/or services rendered. MTF Commanders, in conjunction with Lead Agents, will develop a written plan for and ensure implementation of formal appeals and grievance systems that incorporate the requirements below.

18.4.1 *Right to Reconsideration***.** The MTF Commander, in conjunction with the Lead Agent, will establish procedures to ensure that the beneficiary (or representative) and provider are notified in the initial denial notice of their right to a reconsideration of the initial denial decision. The only issues subject to reconsideration if the beneficiary and/or provider is dissatisfied with an initial denial determination are the reasonableness, medical necessity and appropriateness of the services furnished or proposed to be furnished and/or the appropriateness of the setting in which the services were or are proposed to be furnished.

18.4.2 *Request for Reconsideration.* A beneficiary (or representative) and/or provider will be allowed to submit a written request for initial reconsideration. A beneficiary may submit a written request for an expedited reconsideration of preadmission/preprocedure or for continued inpatient stay where the beneficiary is still in the facility.

18.4.3 *Time of Reconsideration Requests*. Initial denial determination will be reconsidered if a written request is made by an appropriate appealing party within the time frames described below. The request will be considered to be filed as of the date the request is postmarked, or, if the request does not have a postmark, it will be considered filed on the date it is received. The date of receipt of the request for reconsideration will be considered to be five (5) days after the date of mailing, unless receipt date is documented.

18.4.3.1 Reconsideration of a *concurrent review denial* (e.g., the patient is in the facility) must be filed by noon of the day following the day or receipt of the initial denial determination.

18.4.3.2 Expedited reconsideration of a *preadmission/ preprocedure* denial must be filed within three (3) calendar days after the date of the receipt of the denial determination.

18.4.3.3 All other requests for reconsideration must be filed within ninety (90) days after the date of the initial denial determination.

18.4.4 *Late Requests*. Late or untimely requests for reconsideration will be considered only if extraordinary circumstances, over which the appealing party had no practical control, exist. Extraordinary circumstances are limited to:

18.4.4.1 Administrative error (misrepresentation, mistake or other accountable action) of a staff member performing functions and acting within the scope of that individual's authority.

18.4.4.2 Inability of the appealing party to communicate (whether due to mental incompetence or because of physical disability).

18.4.5 *Provision of Reconsideration Information*

When a reconsideration is requested, all parties will be provided an opportunity, prior to the reconsideration, to examine and obtain documents and information upon which the initial denial determination was made, subject to rules concerning disclosure of information in Section 1160 of the Social Security Act. In accordance with regulations governing disclosure of information, deliberations, or the identity of the review coordinators, physician reviewers, or consultants who assisted in the review of the case, will not be disclosed unless these individuals have consented to the release of their names.

18.4.6 *Reconsideration Proceedings***.** All parties will be informed of their opportunity to present documenting material or additional information for consideration. MTF Commanders and Lead Agents will follow the reconsideration procedures listed below:

18.4.6.1 Advance notice of the date of the reconsideration will be given to allow sufficient time for the preparation and submission of additional information.

18.4.6.2 A reconsideration will be rescheduled if a party submits a written request presenting a reasonable justification.

18.4.6.3 A reconsideration will be based on the information that led to the initial determination, all information found in the medical record, and additional information submitted by the beneficiary or provider.

18.4.6.4 The beneficiary and/or provider will be informed that additional information must be provided in writing and that they will receive written notification of the reconsideration determination after the reviewing physician has decided the case.

18.4.7 *Timing of Reconsideration Determination.* Reconsideration determinations will be completed and sent to the parties involved within the following time frames:

18.4.7.1 Three (3) days after receipt of a request for an *expedited* reconsideration if the initial denial determination involves preadmission, procedures, or when the beneficiary is an inpatient.

18.4.7.2 Thirty (30) days after receipt of a request for reconsideration if the initial denial determination involves ambulatory or non-institutional care or services (except preprocedure reviews); the beneficiary is no longer an inpatient in a hospital; the request for *expedited* reconsideration was untimely; or the request was filed by a provider.

18.4.8 *Notice of Initial Reconsidered Determination* . The written notice of the initial reconsideration determination will contain the following:

18.4.8.1 An explanation of the reasons for the initial denial determination.

18.4.8.2 An explanation of the reasons for the initial reconsideration determination, including a detailed description of the medical facts and rationale for the determination.

18.4.8.3 A statement explaining the right of the beneficiary (or representative) and the provider to request the opportunity for an appeal of a reconsideration from the National Quality Monitoring Contractor (NQMC).

18.4.9. *Record of Reconsideration.* Reconsideration records will be maintained until four (4) years after the date on the notice of the reconsideration determination or completion of litigation and the passage of the time period for filing all appeals whichever is the later.

18.4.10. *Contents of the Record.* The record of the reconsideration must include:

- The initial determination and its basis
- Documentation of the date of receipt of the request for reconsideration
- The detailed basis for the reconsidered determination
- Evidence submitted by the parties
- A copy of the notice of the reconsidered determination that was provided to the parties
- Documentation of the delivery or mailing
- Receipt of the notice of the reconsidered determination by the parties (if appropriate).

18.4.11 *Confidentiality*. The reconsideration record is subject to prohibitions against disclosure of information as

specified in section 1160 of the Social Security Act.

18.5 ***Fourth Level Review (Appeal to***

2NQMC). The NQMC is responsible for reviewing requests from beneficiaries and/or providers for an appeal of a reconsideration when an initial denial determination is upheld on reconsideration.

18.5.1. *Timing of Appeals of Reconsideration Determinations*. NQMC will consider an appeal of a reconsideration denial determination if a written request is made by an appropriate appealing party within the following time frames:

18.5.1.1 A request for appeal of a reconsideration of a *concurrent review denial* (e.g., the patient is in the facility) must be filed by noon of the day following the day or receipt of the reconsideration denial determination.

18.5.1.2 A request for an *expedited* appeal of a reconsideration of a preadmission/ preprocedure denial must be filed within three (3) calendar days after the date of the receipt of the reconsideration denial determination.

18.5.1.3 All other requests for appeals of reconsideration denials must be filed within ninety (90) days after the date of the reconsidered denial determination. The request will be considered to be filed as of the date the request is postmarked, or, if the request does not have a postmark, it will be considered filed on the date it is received. The date of receipt of the request for appeal of reconsideration denial will be considered to be five (5) days after the date of mailing, unless receipt date is documented.

18.5.2 *Late Requests*. Late or untimely requests for appeal of reconsideration denials are considered only if extraordinary circumstances exist, over which the appealing party had no practical control. Extraordinary circumstances are limited to administrative errors (misrepresentation, mistake or other accountable action) of a staff member performing functions and acting within the scope of that individual's authority or inability to communicate of the appealing party (whether due to mental incompetence or physical disability).

18.5.3 *Determination and notification of Parties Appealing Reconsideration*. Following receipt of required documentation for review of reconsideration denial, the NQMC will make a determination and notify all parties to the determination within the following time frames:

18.5.3.1 Within three (3) days after the request for an appeal of the reconsideration of a denial determination for prospective review or concurrent review for continued inpatient stay or if otherwise identified as an "expedited reconsideration."

18.5.3.2 Within thirty (30) days after receipt of a request for an appeal of a reconsideration if the initial determination involves ambulatory or non-institutional care or services (except preprocedure reviews); the beneficiary is no longer an inpatient in a hospital; the request for *expedited* reconsideration was untimely; or the request was filed by a provider.

18.5.4 *Information provided by the NQMC*. The following information will be included in the notice of the decision of an appeal of the reconsideration determination provided by the NQMC:

18.5.4.1 A clear and concise summary of the reconsideration issue or issues, stating the decision and whether the reconsideration upholds or reverses the original determination in whole or in part.

18.5.4.2 An explanation of the reasons for the second reconsidered determination, including a narrative description of the medical facts and a detailed rationale for the determination.

18.5.5 *Changes to NQMC decision***.** The NQMC appeal decision of the reconsideration determination is final and binding upon all parties unless:

18.5.5.1 Reopened and revised by the NQMC, either on its own motion or at the request of a party, within one year from the date of the reconsidered determination.

18.5.5.2 Reopened and revised by the NQMC, after one (1) year but within four (4) years because: the NQMC receives new and material evidence; or there is a clerical error in the statement of the NQMC's reconsideration determination; or the NQMC erred in an interpretation or application of any service policy; or there is an error apparent on the face of the evidence upon which the NQMC's reconsideration was based.

18.5.5.3 Reopened and revised by the NQMC at any time, if the reconsidered determination was obtained through fraud or an abusive practice, e.g., describing services in such a way that a wrong conclusion is reached.

18.5.5.4 The decision is reversed by the MTF commander.

18. ***6 Fifth Level Review (Appeal of NQMC Decision).*** Beneficiaries dissatisfied with the NQMC decision may appeal that decision to the MTF Commander. The request must be in writing, must state the specific matter in dispute, include copies of the NQMC decision being appealed, and must include any additional documents or information not submitted previously. rpose of allowing appeal of the NQMC decision is to determine whether the initial determination or reconsideration determination was made in accordance with law, regulation, policies, and guidelines in effect at the time the care was requested or at the time of the initial determination or reconsideration. The MTF Commander’s determination will be based upon the information upon which the initial determination or reconsideration determination was based, and any additional information the appealing party may submit, or the MTF Commander may obtain.

18.6.1 *Allowed Time to File***.** Appeals must be filed within the following time guidelines.

18.6.1.1 Appeals of NQMC decisions for preprocedure or preadmission determinations must be filed within three (3) working days after the date of receipt of the NQMC decision.

18.6.1.2 Appeals of NQMC decisions for concurrent stay (when the beneficiary is an inpatient) must be filed by noon of the day following the date of receipt of the NQMC decision.

18.6.1.3 All other requests for appeal of an NQMC decision must be filed within ninety (90) days after the date of receipt of the NQMC decision.

18.6.2 *Official Filing Date.* A request for appeal of an NQMC decision will be deemed filed on the date it is mailed and postmarked. If the request does not have a postmark, it will be deemed filed on the date it is received.

18.6.3 *Timeliness of Appeal Determination*. MTF Commanders will notify beneficiaries, or their representatives, of the appeal decision within the following time frames:

18.6.3.1 Within three (3) days of the date of receipt of the appeal request for preprocedure, preadmission, or when the beneficiary is an inpatient.

18.6.3.2 Within thirty (30) days after receipt of the appeal request when the NQMC decision involves ambulatory or non-institutional care or services (except preprocedure reviews).

18.6.4 *Notice of MTF Commander Appeal Determination.* The commander, or a designee, will issue a written notice of the appeal decision to the appealing party at his or her last known address. The notice must contain the following elements:

18.6.4.1 A statement of the issue or issues under appeal.

18.6.4.2 The provisions of law, regulation, policies, and guidelines that apply to the issue or issues under appeal.

18.6.4.3 A discussion of the original and additional information that is relevant to the issue or issues under appeal.

18.6.4.4 Whether the formal review upholds the NQMC decision, or reverses the NQMC determination or determinations in whole or in part and the rationale for the action.

19. *Impediments*:

Any instructions, directives, policies or plans (including this policy) that are identified which impede effective or efficient implementation of Utilization/Quality Management should be surfaced, researched, submitted and coordinated through the chain of command (MTF to Intermediate Command to Service SG Office) and the Lead Agent for resolution. If required, a package should be forwarded to the appropriate Health Affairs (TMA) office for supplemental assistance.

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Procedure	***ICD-9-CM***	***CPT***
Arthroscopy (shoulder, elbow, wrist, knee ligament and ankle)	80.21, 80.23, 80.26, 80.27	29815-29898
Cardiac Catheterization	37.21, 37.22, 37.23, 88.55, 88.56, 88.57	93546-93553
Diagnostic Laparoscopy	54.21	56300
D&C for diagnostic or therapeutic reasons	69.095	8120
EGD	45.13, 45.16	43235-43258
Laparoscopic cholecystectomy	51.23	49310,49311
MRI	88.91-88.97	70336,70540 70553,71550 72141-72158 72196,73220 73221,73720 73721,74181 75552,76400
Nose repair (rhinoplasty or septoplasty)	21.5, 21.81-21.89	30400-30520
Tonsillectomy or adenoidectomy	28.2-28.3, 28.6	42820-42836
Breast mass or tumor excision	85.2	19120

Cataract removal	13.1-13.6	66830-66985
Cystoscopy	57.3	52000-52340
Hernia repair	53.0-53.4	49500-49590 except 49530, 49535
Ligation/transection of Fallopian tubes	66.2-66.3	56302, 58600-58615
Myringotomy or tympanostomy	20.0-20.2	69420-69436
Neuroplasty	04.4, 04.7	64702-64727
Strabismus repair	15.0-15.9	67311-67343

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