

CHAPTER 11

HEALTH CARE PROCUREMENT

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A. Contracting For Health Care Services.

1. General. Commandant (CG-11) has fiscal responsibility for health care for all CG beneficiaries. The necessary care can be obtained through contracts with private concerns and individuals and interagency and other agreements with military facilities. COs are responsible for obtaining the necessary services for each fiscal year, subject to HSWL SC review and approval. HSWL SC first authorizes all non-emergency, non-Federal health care. The HSWL SC is responsible for all health services contracting in its area and shall comply with Federal Acquisition Regulations Part 37. The HSWL SC oversees all non-Federal care acquired and minimizes expenses by ensuring competitive contracting procedures take place.
2. Type of Services. The following services may be procured by contract as determined by the HSWL SC.
 - a. Allergist.
 - b. Dental Prosthetic Laboratory.
 - c. Dentist, Dental Hygienist, or chairside Dental Assistant.
 - d. General medicine (Physician or Midlevel Providers).
 - e. Group Practice Hospital.
 - f. Gynecologist.
 - g. Medical Laboratory.
 - h. Neurologist.
 - i. Nurse (Registered or Licensed Practical).
 - j. Obstetrician.
 - k. Occupational Health Services (for OCCMED Physicals).
 - l. Optometrist.
 - m. Orthopedist.
 - n. Pharmacist.
 - o. Physical Therapist or Certified Athletic Trainer.
 - p. Psychiatrist or Psychologist.
 - q. Radiologist.

3. Eligibility For Contract Health Care Services. Eligibility for contract health care services is the same as described in Chapter 2.
 - a. The following persons are NOT eligible for health care services rendered by contract providers:
 - (1) Family members of CG personnel and retired and retired members of the CG (however, they may receive health care services when the contractor performs the service at a CG Clinic or sickbay and/or if the CG has contracted with a health care provider as a demonstration project).
 - (2) Active duty beneficiaries separated from the Service while undergoing treatment (eligibility for treatment terminates and becomes the member's responsibility).
 - (3) CG civilian employees except for required Occupational Medical Surveillance and Evaluation Program (OMSEP) physical examinations and required pre-appointment examinations, all funded using HSWL SC funds.
 - b. Dental laboratory fees for non-active duty beneficiaries:
 - (1) Retirees. Retirees are authorized to use private sector dental laboratories. Pay retirees' dental laboratory fees in the same manner as for active duty members.
 - (2) Dependents. The dependent receiving the treatment shall pay all private sector laboratory fees resulting from space-available treatment . A suggested way to handle such payments is to require dependents to submit a check or money order payable to the private sector laboratory before delivery of appliances. The attending Dental Officer then photocopies the check or money order, pays the laboratory, and retains the photocopy in the dental record.
4. Approval to Contract for Services.
 - a. Units shall submit letter requests for contract health care services through the appropriate chain of command to the HSWL SC. All requests must contain this information:
 - (1) Description of services required (e.g., general health care, pharmacy, lab, or specialty care such as OB/GYN, optometry, or psychiatry), including desired days and hours of availability.
 - (2) A justification of the need for the service.
 - (3) Estimated annual cost of the required services.

- (4) A list of USMTFs within 40 miles of the unit and whether they could perform the desired service.
 - (5) A list of CG units benefiting from the services.
 - (6) The number of active duty members assigned to each unit.
 - (7) Either the names and mailing addresses of all interested, recommended providers or a justification of other than full, open competition (see paragraph 11-A-7, Pre-contract Award Actions, below).
 - (8) Preferred solicitation area and the rationale for it (e.g. "provider must be located within 20 miles of the unit", etc.).
 - (9) Estimated number of annual CG visits to the provider.
 - (10) A list (by type) of any other approved or requested health care contracts.
- b. Each request must be able to stand on its own merits and fulfill cost-to-benefit criteria. HSWL SC will analyze each request and provide written approval or disapproval (with alternative proposals) to the requesting unit through the chain of command. If approved, the HSWL SC Contracting Officer will undertake procurement.
 - c. HSWL SC will not renew existing contracts simply as a matter of convenience. Each contract must continue to prove its value annually on a cost-to-benefit basis before its renewal. HSWL SC will review each contract's current fiscal year activity. If the contract passes review, it may be renewed; if it does not, HSWL SC will so advise the unit receiving the contract services.
5. Funding.
- a. The HSWL SC shall budget, review, and pay for all HSWL SC authorized non-Federal health care obtained in its area. These documents contain detailed instructions:
 - (1) HSWL SC Standing Operating Procedures (HSWL SC SOP), Annex D.
 - (2) Maintenance and Logistics Command, Pacific Instruction M6000.1 (series).
 - b. Charge all HSWL SC authorized non-Federal health care expenditures to the HSWL SC AFC-57 account. HSWL SC can find detailed object class and cost center information in the Accounting Manual, COMDTINST M7300.4 (series).
6. Pre-contract Award Actions.

- a. The Contracting Officer issues solicitations to obtain supplies and services from industry on a competitive (more than 1 source) or non-competitive (1 source) basis. The Competition in Contracting Act of 1984 (PL-98-369) requires the Government to contract for supplies and services by means of full, open competition to the maximum extent possible. This means all responsible firms or individuals who can provide the supplies or services must be allowed to compete for a government contract. Contracting Officers locate potential contractors by publishing the proposed procurement in the *Commerce Business Daily* as required by Federal Acquisition Regulation (FAR), Part 5.
 - (1) Non-competitive Procurements. Pre-awarding a firm a Government contract violates the Competition in Contracting Act of 1984. If it is claimed only one firm can provide the supplies or service, the purchasing office must justify in writing other than full, open competition, setting forth the facts and rationale (see FAR, Part 6) to support this claim. The justification must be certified that it is accurate and complete and send it with the purchase request when sending it to the contracting officer for procurement action.
 - (2) Competitive Procurements. The Contracting Officer also may require certain information before contracting on a competitive basis. The Contracting Officer may request the types of information below to determinate responsibility within the meaning of Federal Acquisition Regulation, Part 9.
 - (a) Organizational structure and plan to accomplish the service.
 - (b) Summary of experience in performing the same or similar work.
 - (c) Evidence of pertinent state and local licenses.
 - (d) Evidence of professional liability insurance, or that the offeror can obtain such insurance.
 - (e) Membership in professional organizations.
 - (f) Resume of key personnel with particular emphasis on academic achievements pertinent to the proposed services.
 - (g) Information about the firm or its key individuals that reflects their status or professional recognition in their field, e.g., awards, published articles, and the like.
- b. Pre-award survey. Subject to the Contracting Officer's approval, a visit may be made to the offeror's facility before the award (pre-award survey) to review some of the above data to reduce submitted data. The following

paragraphs are examples of the information that may be required from an offer or

- (1) Brief description of the facility, how long established, where located relative to the required mile radius, daily operating hours, weekly operating hours (include holidays, Saturdays, and Sundays).
 - (2) Brief description of similar work performed under Government contracts including the government agency's name, contract number, contract price, and name and telephone number of the agency's contracting officer.
 - (3) A resume, X pages maximum, including education, past and present experience over the last X years, certificates, association membership, etc., of the key persons who will perform the work under the contract and their letter of intent indicating they intend to work for the offeror if it is awarded the medical services contract.
- c. Qualifications. Minimum qualifications required to perform the contract may be stated; however, these qualification requirements must be justified. For example:
- (1) Personnel.
 - (a) Physician. At a minimum, a X year degree in medicine from an accredited college, license to practice medicine in the location where the services will be performed, member of the AMA; X years' experience in practicing general medicine.
 - (b) Nurse. RN or LPN. B.S. degree (or equivalent) in nursing from an accredited college; ANA-certified or equivalent; X years' experience in handling patients, administering patient records, etc.
 - (c) Laboratory Technician. HHS certified, ASCP or eligible, X years' experience in all phases of laboratory work; e.g., x-rays, blood samples, etc.
 - (2) Facility.
 - (a) Within a X mile radius of the CG facility requiring the services.
 - (b) Capable of accommodating or rendering services for at least X patients simultaneously.
7. Award Evaluation Factors.
- a. State the steps or procedures to be used to evaluate the proposals.

- b. List the evaluation criteria in the descending order of relative importance and state whether one factor will have predominant consideration over another. For example:
 - (1) Personnel.
 - (2) Experience.
 - (3) Facility.
 - (4) Price.
- c. Establish the criteria to be used in evaluating the proposal. They must be the same as the evaluation factors for award the solicitation cited. The weights assigned to the factors may be in any form, e.g., adjective (acceptable, outstanding), numerical (50). Give this information to the Contracting Officer, preferably before he or she issues the solicitation, but in any event before receiving the proposals for evaluation.

8. Post-Contract Award Actions.

- a. Referring for Contract Services. Before referring any person to a medical services contractor, the cognizant authority shall determine whether:
 - (1) The person is eligible.
 - (2) Services are available in-house.
 - (3) Services are available from a USMTF.
 - (4) Services are available from another Federal facility, e.g., Department of Veterans Affairs, under an interagency support agreement.
- b. Contracting Officer's Technical Representative. The contracting office that awarded the contract administers it. If the requiring office requests, a Contracting Officer's Technical Representative (COTR) may be assigned to the contract. The COTR is preferably a health services program manager or medical administration officer having jurisdiction in the contract services area. The Contracting Officer designates the Contracting Officer's Technical Representative in a written, signed letter of appointment describing the COTR's responsibilities and limitations. These responsibilities and limitations must strictly be adhered to avoid any conflicts with the contractor about changes to contract terms and conditions.
- c. Health Care Invoices.
 - (1) Contractor Invoices.
 - (a) All invoices for health care services contractors by contractors shall be processed for payment under the applicable contract's terms and conditions. This Manual's Chapter 2 describes

certifying and processing non-Federal health care invoices. The Contracting Officer is responsible for including the applicable invoice and payment clauses (e.g., Federal Acquisition Regulations 52.204-3, Taxpayer Identification, 52.232-25, Prompt Payment, etc.) in the contract. Ensure the contracting officer also includes these invoice requirements in the contract so the invoice is proper for payment:

- (1) An itemized, priced list of the services by contract or order line item number.
 - (2) Any additional information deemed necessary to process the invoice for payment.
- (b) In addition to the invoice requirements above any invoice without the following supporting documentation will not be paid.
- (1) Services Rendered Under Non-Emergent Conditions. A referral slip or written confirmation of patient's eligibility from cognizant health services department representative.
 - (2) Services Rendered Under Emergent Conditions. A written statement from the patient describing the emergent condition(s). The cognizant health services department representative must certify the patient's eligibility and emergent condition.
- (c) If the eligible patient pays the contractor for services rendered under a contract and requests reimbursement, the reimbursement claim must be submitted to the appropriate accounting office on Public Voucher for Purchases and Services Other Than Personal SF-1034,. A patient's invoice cannot be reimbursed from funds obligated under a contract even though the contractor rendered the services. These documents must accompany the claim:
- (1) The contractor's itemized invoice.
 - (2) A copy of the invoice and receipt showing payment to the contractor.
 - (3) The patient's written statement of the circumstances justifying the claim.
 - (4) The cognizant health services department representative's approval of the claim.
- (2) Invoices outside the CONUS.

- (a) The nearest CG facility having an authorized certifying officer shall process invoices for emergency health care from civilian facilities furnish to CG members. The invoices and justification explaining the reasons for the emergency health care must be attached to the Claim for Reimbursement for Expenditures on Official Business, SF-1164.
- (b) Every attempt to pay for emergency health care should be made before departing from a foreign port to reduce paperwork and pay at the exchange rate. For emergency care under \$2500.00 the Imprest Fund may be used. If payment prior to departure is not feasible, advise the facility rendering the service to send all invoices to the United States Embassy or appropriate consular office for the area.

Figure 11.A.1

STATEMENT OF WORK

1. Scope. Provide all labor, materials, and facilities necessary to perform the tasks herein.
2. Definitions.
 - a. Patient. An eligible CG military member.
 - b. Emergency. Treatment required to curtail the patient's undue suffering or loss of life or limb.
 - c. Non-Elective Condition. A condition that, if untreated, would render the patient unfit for duty.
 - d. Elective Procedure. Treatment the patient *desires*, e.g., vasectomy, tubal ligation, sterility test, contact lenses, orthodontics, etc.
 - e. Duty Status. A determination of the patient's ability to perform the assigned tasks at the assigned work station. These statuses apply:
 - (1) Fit for Full Duty (FFD). Patient is not physically restricted or limited.
 - (2) Fit for Limited Duty (FLD). Patient is physically restricted or limited, e.g., office work only; no lifting, stooping, prolonged standing, walking, running, jumping, sea duty, etc.
 - (3) Not Fit for Duty (NFD). Patient cannot perform any assigned tasks at assigned work station.
3. The contractor shall perform these tasks:
 - a. Task I - Eligibility Determination. Provide service to the CG military personnel listed below. Each patient must show the required authorizations before the Contractor renders service.
 - b. Task II - Physical Examinations. Examine the patient according to Attachment (1) requirements. [Attach copy of appropriate section of Medical Manual, COMDTINST M6000.1 (series).]
 - c. Task III - Immunization. Immunize the patient and document appropriately on Standard Form 601 (Immunization Record) or Public Health Form 731 (International Certificate of Vaccination) in the CG Health Record the patient presents the contractor. Record also any sensitivity reactions to the immunization. The contractor shall use only those immunizing agents approved by the Department of Health and Human Services. Immunize the

patient at the time intervals Attachment 2 specifies. [Attach a copy of Immunization and Chemoprophylaxis, COMDTINST M6230.4 (series).]

- d. Task IV - Emergency Hospitalization. Provide all necessary services to patient while he or she is hospitalized, to a maximum of seven days. If the patient requires hospitalization for eight or more days, the contractor shall notify the CG point of contact by telephone. If the CG elects to transfer the patient to a military hospital, the contractor shall complete all necessary documents the civilian hospital may require to effect the transfer.
- e. Task V - Prosthetic and Orthopedic Appliances. The contractor shall provide prosthetic or orthopedic appliances to the patient only under emergency conditions (required immediately due to his or her condition). The contractor shall document the emergency condition on the CG Health Record. Under non-emergency conditions, the contractor shall refer the patient to a military hospital to obtain these appliances.
- f. Task VI - Communicable Disease. The contractor shall report all communicable diseases and recommended control measures to the CG health care provider or CO immediately after detecting the disease. The contractor also shall report to local authorities as required by local regulations.
- g. Task VII - Notification. The contractor shall notify the CG health care provider or patient's CO if a patient is seriously ill, injured, or dies.
- h. Task VIII - Records and Reports. For all patients the contractor shall maintain a record with this information:
 - (1) Outpatient Record. Record the name, rank or rating, Social Security Number, address, date of treatment, history of present illness, physical findings, diagnostic procedures including x-rays and laboratory, therapy provided, fitness for duty determination, duration and limitations if unfit or fit for limited duty, and the contractor's printed name and signature.
 - (2) Inpatient Report. On discharge from the hospital, furnish the patient's medical report written using diagnostic nomenclature (standard disease and operation nomenclature) to summarize the course of the case, laboratory and x-ray findings, surgeries and treatments, complications, current condition, final diagnosis, and a fitness for duty determination with duration and limitations if unfit or fit for limited duty.
- i. Task IX - Certificate of Services. After rendering services to the patient, complete Attachment (3) and obtain the patient's signature before he or she departs from the contractor's facility or location where the services were rendered. [Attach copy of certification form.]

4. The contractor shall not execute any oral or written agreements with the patient to render a more expensive type of service than that described in the contract in which the patient pays the difference in price between the contract unit price and the price the contractor charges (for eyeglasses, see Chapter 8 Section E).
5. The contractor must obtain written authority from the patient's CG unit before filling any prescriptions.
6. The contractor must obtain written authority from the patient's CG unit before performing any elective procedure.

Personnel	Required Authorization
Active Duty	<ol style="list-style-type: none"> 1. Valid Common Access I.D. Card 2. A referral slip signed by an authorized CG official
Reservists (Active Duty)	<ol style="list-style-type: none"> 1. Valid Common Access I.D. Card 2. Copy of active duty orders 3. A referral slip signed by an authorized CG official
Reservists	<ol style="list-style-type: none"> 1. Valid Common Access I.D. Card 2. A Notice of Eligibility. See Reserve Policy Manual, COMDTINST M1001.28 (series) for further details.
PHS Commissioned Officers on CG Active Duty	<ol style="list-style-type: none"> 1. Valid Common Access I.D. Card
Prospective CG Recruit	A letter signed by an authorized official at the CG recruiting unit
The contractor shall not provide services under this contract to personnel who do not have the required authorizations listed above.	

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B. Health Care Services Invoice Review and Auditing.**1. General.**

- a. Review and audit. All health care invoices are subject to review and audit to ensure the CG pays only for necessary, appropriate health care for its beneficiaries.
 - (1) The auditing process ensures the contractor's invoice charges for services provided at either reasonable fees or those in agreement with the contract.
 - (2) The review process determines the appropriateness of care for the diagnosis.
- b. Discrepancies. Personnel performing the review and audit functions must remember if they find discrepancies, they must give the care provider the opportunity to comment on the findings.
- c. Conduct. The process of health care invoice auditing and review is complex and lends itself to errors; thus, most reviews and audit inquiries are not dismissed. Finding must be presented in a non-threatening manner, demonstrating the CG's willingness to cooperate with our health care providers in determining fair, equitable charges.

2. Invoices Subject to Review and Audit. These contract and non-contract health services invoices are subject to review and audit. The unit processing the invoice should review bills in these categories before paying them:

- a. All outpatient invoices contractors submit;
- b. All inpatient and outpatient supplemental care.

3. Review and Audit Procedures. The personnel processing health care invoices should perform these procedures:

- a. Review.
 - (1) Is the diagnosis compatible with the prescribed care?
 - (2) Are ancillary services (e.g., lab, x-ray, pharmacy, electrodiagnostic tests, etc.) prescribed appropriately in amount and frequency?
 - (3) Is the length of care appropriate for the diagnosis?
- b. Audit. Does the contractor's invoice meet the contract definition of a proper invoice? If not, notify the Contracting Officer immediately.
 - (1) Is the bill mathematically correct?

- (2) Does it bill only for authorized care and services?
 - (3) Were services and billed care actually furnished?
 - (4) Do the charges agree with the provider's regular fee schedule or the prices listed in the contract?
 - (5) Does the bill give credit for incomplete, canceled, or partial treatments?
 - (6) Do dates of care match the time period the patient received the care or services?
 - (7) Have previous audits of this provider demonstrated billing errors?
4. Report of Potential Third Party Liability, RCN 6000-2. Under the Federal Medical Care Recovery Act the CG will collect the cost of health care provided to any eligible beneficiary from the appropriate insurance carrier or eligible third party. Refer to Health Care Third Party Claims Recovery, COMDTINST 6010.16 (series) for current policy. Submit this report on Report of Potential Third Party Liability, CG-4899.

Section C. Claims Processing

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C. Claims Processing.

1. General. The HSWL SC is responsible for processing Federal and nonfederal health care claims in compliance with the Federal Law and CG Regulations.
2. Certification. Certification ensures that only authorized payment services to eligible beneficiaries receiving health care within their entitlements and the care and related charges are appropriate. The HSWL SC shall:
 - a. Administratively screen each claim and supporting documents according to paragraph 3 below. Claims submission procedures from field units are provided by the HSWL SC Standard Operating Procedures.
 - b. Technically screen claims and supporting document according to paragraph 4 below. In screening, perform these actions:
 - (1) Refer claims that do not satisfy the Technical Screen criteria to a medical audit staff for Appropriateness Review and/or audit.
 - (2) Enter information from these claims into the Non-Federal Invoice Processing System (NIPS) data base and approve them for payment in this manner:
 - (a) Claims that satisfy Administrative and Technical Screen criteria (including Active Duty Claims Program (ADCP) claims coded through a TRICARE Fiscal Intermediary).
 - (b) Claims referred for Appropriateness Review and/or audit recommended for payment.
 - c. Transmit payment data electronically to the CG Finance Center.
 - d. Certify batch transmissions.
 - e. Correct batch errors.
 - f. Update vendor files.
3. Administrative Screen.
 - a. Administrative screening. Administrative screening of a claim package determines the patient's authorization and eligibility to receive billed services and also ensures the package contains all appropriate, necessary documents. At a minimum, administrative screening includes:
 - (1) Patient information is present and complete.
 - (2) Public Voucher for Purchases and Services other than Personal, SF-1034 is completed for reimbursement requests.

- (3) The claim is a complete, itemized original.
 - (4) A copy of the Report of Potential Third Party Liability, CG-4899 is attached if a third party is potentially liable.
 - (5) Verification of pre-authorization number.
 - (6) Support documentation is complete for Reservists' bills.
 - (7) Claims for formal contracts have the Contracting Officer's signature and amount to be paid.
 - (8) Claims for clinic support contracts have a CG beneficiary breakdown.
- b. Ensure that all claims that fail to satisfy the administrative screening are corrected by the unit through the most expeditious means possible.
4. Technical Screen.
- a. Health care claims must be reviewed to ensure they comply with Federal regulations. Part of that process compares claim packages to standard criteria to withstand the scrutiny of Departmental Accounting and Financial Information System (DAFIS) for payment. Technical screening of claim packages includes:
- (1) Comparing charges against contract fee schedules, pre-authorizations, blanket purchase agreements, or the geographic area's usual and customary fees; claims falling within ADCP guidelines are exempt from fee review.
 - (2) Entering relevant claim information into NIPS.
 - (3) Determining whether services were appropriate for the diagnosis.
 - (4) Identifying claims requiring further review under these circumstances.
 - (a) Unrelated charges to the initial diagnosis or injury.
 - (b) Duplicate charges for services received on a given day.
 - (c) Care was unauthorized or unnecessary.
 - (d) Claims submitted by different providers for the same service (e.g., anesthesiology charges from more than one provider).
 - (e) NIPS "flagged" the claim.
 - (f) The reviewer "feels" a need for further review.
- b. Claims a Technical Screen identifies for further review and/or audit require:

- (1) Documentation of the problem.
- (2) A recommended course of action.

5. Appropriateness Review.

- a. An Appropriateness Review is performed under these circumstances:
 - (1) The HSWL SC selects or NIPS flags a claim for further review and/or audit for a Technical Screen; and/or
 - (2) Periodically for quality assurance.
- b. An Appropriateness Review requires:
 - (1) An itemized claim.
 - (2) A patient's signed Request for Medical Records, DD-877 or its' equivalent, to request medical records and other information about an individual's care. Various records, which may include.
 - (a) Hospital records.
 - (b) Physician's orders.
 - (c) Physician and nursing progress notes.
 - (d) Lab and x-ray reports.
 - (e) Operative or endoscopic reports.
 - (f) Admission records (history and physical examinations).
 - (g) Discharge summaries.
- c. Appropriateness Review. An Appropriateness Review process often involves these activities:
 - (1) Reviewing records to verify treatment of therapy was:
 - (a) Appropriate for the diagnosis.
 - (b) Consistent with currently accepted medical practice.
 - (c) Not duplicated unnecessarily.
 - (d) The length of inpatient hospitalization was appropriate for the diagnosis and course of care.

- (e) The charges were reasonable; claims falling within ADCP guidelines are exempt from fee review.
- (2) Obtaining additional documentation and/or correspondence from health care providers.
- (3) Initially notifying health care providers of this information:
 - (a) Their claims are being reviewed and audited.
 - (b) The audit is a normal part of the CG's health care review process and does not indicate or allege the health care provider committed an offense.
 - (c) If reviewing cases for longer than 30 days, periodically communicate with health care providers to inform them of claim status.
- d. An Appropriateness Review may recommend.
 - (1) Full payment for services. Enter data into and process through NIPS.
 - (2) Partial payment for services. Attach decision documents; recommend the amount of payment; and enter data into NIPS. Initiate a reimbursement request if the claim initially was overpaid.
 - (3) Consulting a specialist for peer review.
 - (4) Referral to a contractor for further review or an on-site hospital audit.
 - (5) Closing the case with no further action.
- e. An Appropriateness Review includes.
 - (1) Fully documenting the decision process.
 - (2) Initiating payment or the provider's reimbursement.
 - (3) Drafting appropriate correspondence.
- 6. Peer Review.
 - a. A Peer Review will be performed under one of these circumstances:
 - (1) A health care provider objects to under these other reviews' findings.
 - (2) An Appropriateness Review reveals the need for a more sophisticated evaluation of the diagnosis, prognosis, or specific medical procedures employed.

- b. Send the case and health care provider's additional documentation (if any) to a qualified medical, pharmaceutical, or dental specialist for review. These services should be contracted if in-house specialists are not available. Obtain a business associate agreement that the privacy, confidentiality and security of protected health information will be safeguarded in compliance with Federal and State laws.
 - c. Peer Review may include these detailed examinations:
 - (1) Diagnosis.
 - (2) Prognosis.
 - (3) Appropriateness of the care provided.
 - (4) Claims submitted to a Fiscal Intermediary for pricing are exempt from fee review.
 - (5) Selection of the most cost-effective therapy.
 - d. Among other things a Pharmacist's review of pharmaceutical bills and supporting documents may include one of the following:
 - (1) Determine the efficacy of prescribed medication.
 - (2) Identify cost-effective choices.
 - (3) Recommend stocking pharmaceuticals for future issuance.
7. Guidelines for Initial Appropriateness and Peer Reviews. These common health care services guidelines are not all-inclusive. Appropriateness and Peer Reviews should be used to assist reviewers in deciding whether in-hospital audits or contracted review services are required.
- a. Trauma. Answer these questions:
 - (1) Does the level of care correspond to the diagnosis?
 - (2) Were appropriate facilities used?
 - (3) Were laboratory and x-ray procedures appropriate? Include justification for:
 - (a) Repeating procedures on a given day.
 - (b) Repeating normal procedures.
 - (c) Failing to follow up abnormal tests.

- (4) Were iatrogenic complications were identified appropriately? Include:
 - (a) Sepsis.
 - (b) Wound dehiscence.
 - (c) Hemorrhage.
 - (d) Pulmonary complications.
 - (e) Cardiovascular complications (thrombophlebitis, etc.).
 - (f) Urinary tract infection.
 - (g) Anesthetic or other drug reactions (appropriate drug and dosage, known allergies).
 - (h) Other associated injuries.
- (5) The length of stay was appropriate for the diagnosis and indicated complications.
- (6) The discharge diagnosis was compatible with admission diagnosis and the patient's history.
- (7) The patient's physical status on discharge:
 - (a) Alive.
 - (b) Complications were controlled.
 - (c) Wound(s) condition was satisfactory.
 - (d) Required follow-up arrangements are listed.
 - (e) Medications were prescribed.
- (8) Follow-up care was appropriate, including:
 - (a) Therapy.
 - (b) Office visits.
 - (c) Additional hospitalization was for a good reason, e.g., iatrogenic complications, continued therapy, or additional surgeries.
- (9) Fees are usual and customary for the geographic area (claims falling within ADCP guidelines are exempt from fee review).

- (10) The use of multiply providers is explained.
 - (11) Providers' and reviewers' differences in medical opinion (particularly involving altered treatment and length of hospital stay) are significant enough to warrant negotiation.
- b. Laboratory Services. Answer these questions:
- (1) Are tests related to or necessary for the diagnosis?
 - (2) Were ICU standing orders in effect?
 - (3) Were tests repeated excessively?
 - (4) Were charges duplicated for the same procedure on the same day?
 - (5) Were tests repeated due to equipment or operator error?
 - (6) Were tests repeated despite normal previous test(s) (justification is required)?
 - (7) Were there multiple charges for the same or similar tests?
 - (8) Were multiple tests performed in a logical sequence (i.e., the most invasive or sophisticated performed last)?
 - (9) Were fees usual and customary (claims falling within ADCP guidelines are exempt from fee review)?
 - (10) For a laboratory under CG contract, were:
 - (a) Tests covered by the contract?
 - (b) Charges within fee schedule?
- c. Radiology Services. Considerations:
- (1) Was the examination required given the diagnosis?
 - (2) Were charges for portable radiology of an ambulatory patient?
 - (3) Were examinations repeated?
 - (4) Were bilateral x-rays appropriate (patients over 12 years of age)?
 - (5) Were charges or exams of the same anatomical part duplicated?
 - (6) Do examinations and in-patient dates coincide?

(7) Were examinations repeated despite normal findings in previous examinations?

d. Physical Therapy. Considerations:

(1) Was the injury or diagnosis properly documented? Did it include:

- (a) Objective findings?
- (b) Functional findings?
- (c) Multiple provider discrepancies?
- (d) Documentation of improvement?

(2) Did a physician prescribe treatment?

(3) Were injury management and treatments reasonable and necessary? Did they cover these:

- (a) Was the treatment plan documented?
- (b) Did objective findings permit the therapist and/or physician to monitor treatment results?
- (c) Were changes in the treatment program due to unsuccessful results?
- (d) Was treatment only for subjective complaints?
- (e) Was the treatment related to diagnosis?
- (f) Did the treatment follow standard procedures and protocols?
- (g) Did the treatment plan include goals and objectives?

(4) Was the length or number of treatments excessive?

(5) Was treatment consistent or continuous or did patient attend sporadically?

(6) Did therapy continue after "Fit-For-Duty" status?

(7) Did therapy charges continue during stays in cardiac or intensive care units.

(8) Were charges duplicated for same-day, apparently inappropriate treatments?

(9) Was therapy frequency within accepted standards?

- (10) Were same-day charges for three or more modalities during a single therapy session?
- (11) Were charges usual and customary (claims falling within ADCP guidelines are exempt from fee review).

e. Dentistry.

- (1) For provider contract care, were:
 - (a) Services within the contract scope?
 - (b) Charges within fee schedules?
- (2) For emergency care, were:
 - (a) Services within the scope of entitlements?
 - (b) Charges reasonable and customary?
- (3) For care pre-authorized in Chapter 2-A-6, did any of these occur?
 - (a) Did the HSWL SC assign a pre-authorization number?
 - (b) Were services within the authorized, standard treatment plan?
 - (c) Were treatments split to circumvent pre-authorization requirements?
- (4) For all dental services, do any of these apply?
 - (a) Were services duplicated?
 - (b) Were billings for the same service duplicated?
 - (c) Were diagnosis charges consistent with services received?
 - (d) Were crowns constructed of precious metals?
 - (e) Are laboratory charges consistent with the service provided (bridges, crowns, partial or full dentures)?

f. Pharmacy.

- (1) For contract providers, were services within the scope of the contract?
- (2) For inpatient care, do any of these apply?
 - (a) Were billings duplicated?
 - (b) Was credit received for returned or unused medications?

- (c) Did medication and in-patient dates coincide?
- (d) Did medications' costs exceed 250 percent of Annual Pharmacists' Reference ("Red Book") average wholesale price (Note: This equals a 150 percent markup.)? Claims falling within ADCP guidelines are exempt from fee review.