UNDER SECRETARY OF DEFENSE
4000 DEFENSE PENTAGON
WASHINGTON, DC 20301-4000

PERSONNEL AND
READINESS

JUN 4 2014

The Honorable Carl Levin
Chairman
Committee on Armed Services
United States Senate
Washington, DC 20510

Dear Mr. Chairman:

Senate Report 113-44, page 133, to accompany S. 1197, the National Defense Authorization Act for Fiscal Year 2014, requests the Secretary of Defense to submit a report to the Committees on Armed Services of the Senate and the House of Representatives on the TRICARE appeals process.

The Department has improved the timeliness and beneficiary orientation of TRICARE appeals and simplified the appeals process. We have implemented procedures to enhance the performance of the managed care support contractors that initiate the appeal process. The Office of General Counsel developed a sophisticated tracking system to better manage work flow and increase efficiency in case management. In developing this report, there was no evidence that the Director of the TRICARE Management Activity (now the Defense Health Agency) summarily overturned hearing officers' decisions. We will continue to closely monitor this process to ensure it is carried out in the manner required by regulation. A similar letter is being sent to Chairman McKeon.

Thank you for your interest in ensuring that our appeals process is meeting the needs of our military heroes and their families.

Sincerely,

Jessica L. Wright
Acting

Enclosure:
As stated

cc:
The Honorable James M. Inhofe
Ranking Member

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The Honorable Howard P. "Buck" McKeon
Chairman
Committee on Armed Services
U.S. House of Representatives
Washington, DC 20515

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Sincerely,

Jessica L. Wright
Acting

Enclosure:
As stated

cc:
The Honorable Adam Smith
Ranking Member

Report to Congress

TRICARE Appeal Process

In

Fiscal Year 2014

Preparation of this study/report cost the Department of Defense a total of approximately $3,200 in Fiscal Years 2014-2014.

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REPORT TO CONRESS
ON
TRICARE APPEAL PROCESS

Pursuant to the Report of the Senate Armed Services Committee Accompanying the Proposed National Defense Authorization Act for Fiscal Year 2014

BACKGROUND

The Senate Armed Services Committee requested the Director, TRICARE Management Activity (TMA) [now the Defense Health Agency (DHA)], to submit a report on the TRICARE appeal process. The Committee was informed by advocacy groups that the appeal process is perceived to be unfair because the Director may overturn a recommended decision made by an independent hearing officer at the final level of appeal. The Committee requested a report that: (1) describes the current TRICARE appeal process; (2) provides summary data showing the numbers and types of cases submitted by beneficiaries for appeals and hearings over the previous five fiscal years; (3) provides data to show both the favorable and unfavorable beneficiary outcomes of all independent hearing cases over the previous five fiscal years; (4) describes the average length of time for beneficiaries to obtain a decision from DHA either from an appeal or a hearing; and (5) provides data on the number of cases in which the Director, DHA makes a determination different than the recommended decision of the hearing officer to grant a beneficiary appeal.

THE REPORT

The TRICARE Appeal Process—Overview

The appeal process was mandated by a Federal District Court order that the then-Civilian Health and Medical Program of the Uniformed Services (CHAMPUS) promulgate an appeal procedure. *Edison v. Department of Defense, Civil Action C76-364A, Northern District of Georgia (1976).* The court ruled that CHAMPUS (now TRICARE) benefits represent property rights, and an appeal process must be established to protect such rights and provide due process. The appeal process was promulgated and codified in Title 32, Code of Federal Regulations, Section 199.10 (the Regulation).

The current appeal process provides for three levels of appeal: (1) reconsideration by the TRICARE contractor that issued the initial denial; (2) second reconsideration by the TRICARE Quality Monitoring Contractor, or the Defense Health Agency Appeals and Hearings Division (DHA Appeals); and (3) a hearing before an independent hearing officer. TRICARE appeals are administrative, non-adversarial proceedings. An appeal may be filed by any party to the initial denial, e.g., the TRICARE beneficiary or the provider of care participating in the claim. Each level of appeal is a *de novo* review, and the appealing party is afforded the opportunity to submit evidence in support of the party's position that the denied services are benefits under TRICARE. The Regulation provides that the burden of proof is on the appealing party to establish by substantial evidence the appealing party's entitlement under law and regulation. Appeal determinations are final if all issues are resolved in favor of the appealing party, or if the appealing party elects to not file at the next level of appeal.

First Level of Appeal—Reconsideration

At the reconsideration level of appeal, the appealing party files an appeal with the TRICARE contractor that issued the initial denial notice. An expedited appeal is available for appeals involving requests for preauthorization or preadmission when the denial is based solely on medical necessity. Under TRICARE, medical necessity means the frequency, extent, and types of services which represent appropriate medical care and that are generally accepted by qualified professionals to be reasonable and adequate for the diagnosis and treatment of illness, injury, pregnancy, and mental disorders, or that are reasonable and adequate for well-baby care. In general, the beneficiary must file an appeal within three days of receipt of the initial denial to be granted an expedited appeal. In expedited cases, the contractor is required to issue its decision within three workdays of receipt of the appeal unless the proceedings are rescheduled at the request of the appealing party. Medical peer review by a physician or other health care provider, e.g., speech pathologist, who is a peer of the treating provider, is required in cases involving medical necessity issues. In non-expedited cases, the contractor is required to issue its decision within 30 days of receipt of the appeal request unless rescheduled at the request of the appealing party.

Second Level of Appeal, Medical Necessity Cases—Second Reconsideration

The second level of appeal is filed with the Quality Monitoring Contractor or DHA Appeals depending on the basis for denial. If the denial is based strictly on medical necessity, the appeal is filed with the Quality Monitoring Contractor, which is then required to conduct a peer review. The Quality Monitoring Contractor contracts with physicians and other clinicians in all specialties to perform the reviews, and the reviewer must be in the specialty of the beneficiary's treating provider. An expedited appeal is available for preauthorization or preadmission following essentially the same timeframes as in the previous level of appeal, (i.e., the reconsideration process described above).

Second Level of Appeal, Non-medical Necessity Cases—Formal Review

Second level appeals based on TRICARE policy, regulation, or statute are filed with DHA Appeals and processed at the formal review level of appeal. Under current rules, an expedited appeal is not available for a formal review (although DHA Appeals expedites appeals for gravely ill beneficiaries). DHA Appeals normally issues the formal review determination no later than 90 days from the date the appeal is received at DHA. Some cases may take longer to review depending on the nature of the case and the extent that outside sources must be consulted to arrive at a benefit determination. The appealing party may request additional time to gather documentation necessary to meet the party's burden of proof. Attorneys and legal analysts conduct the reviews with input from Quality Monitoring Contractor peer reviewers, DHA policy analysts, and other officials within DHA. Reviewers examine existing coverage rules to determine whether the care may be covered pursuant to statute, regulation, and policy. When the formal review determination results in a change to TRICARE policy, revised policy is published which will grant the additional medical benefit to all eligible TRICARE beneficiaries.

Third and Final Level of Appeal—Hearing

The final level of the TRICARE administrative appeal process is a hearing where the appealing party may appear personally before an independent hearing officer. (All previous levels of appeal are made a part of the hearing record.) The appealing party may represent him or herself or may appoint an attorney or other representative. Within 60 days following receipt of the hearing request, the Director, DHA Appeals, will arrange appointment of a hearing officer. DHA currently has an agreement with the Defense Office of Hearings and Appeals (DOHA) to provide hearing officers to conduct the hearings. The hearing officer normally has 60 days from the written notice of assignment to review the file and schedule and hold the hearing, and issue a recommended decision to the Director, DHA. Such timelines may vary significantly depending on the nature of the case and the appealing party's schedule and need for time to develop and submit evidence. Moreover, the Director, DHA Appeals, may delay assignment of the case to a hearing officer if additional information is needed and cannot be obtained in the times specified above. In such cases, DHA will arrange assignment of a hearing officer within 30 days of the date of receipt of the additional documentation necessary for the hearing. The hearing officer determines a time and place for the hearing mutually convenient to both the appealing party and DHA. In practice, the hearing officers make every effort to accommodate the appealing party and hold the hearing at a location in close proximity to the appealing party's residence. Additionally, the appealing party may waive his or her right to appear, and if so, the hearing officer will conduct the hearing on the record.

At hearing, the DHA appeals attorney assigned the case presents DHA's position regarding coverage of the care in dispute. As with all TRICARE appeals, the appealing party has the burden of proof to establish by substantial evidence the appealing party's entitlement under law and regulation. The hearing is a forum for both the Government and the appealing party to present arguments and evidence in support of their positions. The proceeding is non-adversarial, the primary purpose of which is to determine whether the care in dispute is a benefit under the TRICARE program. The hearing officer must follow the statutes and regulations governing TRICARE benefits, and when addressing substantive issues, must meet the requirements expressed in policy manuals, instructions, procedures, and other guidelines issued by the Assistant Secretary of Defense (Health Affairs) (ASD/HA) and the Director, DHA.

A hearing officer may not establish or amend TRICARE policy. The Government and appealing party may call witnesses for examination and cross-examination. The hearing officer controls the taking of evidence in a manner best suited to ascertain the facts and safeguard the rights of the parties. The hearing officer may question witnesses as well, and admit any relevant evidence. Evidence that is irrelevant or unduly repetitious shall be excluded. As a matter of procedure, DHA evidence and witnesses are presented first, followed by that of the appealing party. Oral arguments, both opening and closing, and legal arguments may be presented to the hearing officer. Written closing arguments may be presented as well at the request of either the appealing party or DHA or both. Once all evidence is presented and all witnesses heard, the hearing officer may close the hearing. The record may be kept open for a reasonable period of time to allow the introduction of additional evidence relevant to the case. All parties to the hearing shall have the opportunity to examine any additional evidence and make comment. The hearing officer may re-open the hearing if fairness requires that additional evidence be heard.

Otherwise, the hearing officer will close the hearing record and render a recommended decision based on the weight of the testimony and evidence, and the provisions of statute, regulation, policy and other guidelines governing the issue in dispute. The recommended decision shall be presented to the Director, DHA.

The Final Agency Decision

The recommended decision shall be reviewed by the Director, DHA, or a designee, who adopts or rejects the recommended decision or refers the recommended decision for review by the ASD(HA). The Director normally takes action on the recommended decision within 90 days of receipt. In practice, the recommended decision is reviewed by a DHA attorney not involved in the case to confirm compliance with law. A draft final agency decision is routed through the Deputy General Counsel and General Counsel and presented to the Director, DHA, for signature. If the Director concurs with the recommended decision, no further agency action is required; the recommended decision is adopted and becomes the final agency decision in the appeal.

In the case of rejection, the Director, DHA, shall state the reason for disagreement with the recommended decision and the underlying facts supporting such disagreement. In these circumstances, the Director may have a final decision prepared based on the record, or may remand the matter to the Hearing Officer for appropriate action. In the latter instance, the Hearing Officer will take appropriate action and submit a new recommended decision within 60 days of receipt of the remand order. Ultimately, the decision by the Director shall be the final agency decision, and the final decision shall be sent by certified mail to the appealing party or parties. Generally, a final agency decision will not be relied on, used, or cited as precedent by the Department of Defense or its contractors. Should the Director find that the final agency decision should be precedential, the decision must be signed by the ASD(HA).

The Director may refer a hearing case to the ASD(HA) when the hearing involves the resolution of TRICARE policy and issuance of a final decision which may be relied on, used, or cited as precedent in the administration of TRICARE. In such a circumstance, the Director shall forward the hearing officer's recommended decision, together with the recommendation of the Director regarding disposition of the hearing case.

The ASD(HA), after reviewing a case, may issue a final decision based on the record in the hearing case or remand the case to the Director, DHA for appropriate action. A decision issued by the ASD(HA) shall be the final agency decision in the appeal and a copy of the final decision shall be sent by certified mail to the appealing party. Such final decision of the ASD(HA) may be relied on, used, or cited as precedent in the administration of TRICARE.

Types of Appeals

The types of cases considered in the above appeal process are categorized as "Medical Necessity" and "Factual." Medical Necessity cases involve those denied coverage because the care is not medically necessary for a beneficiary's particular condition. Factual cases involve those denied coverage because the care does not meet specific coverage criteria as provided in statute, regulation, or policy. Appeals extend to the broad range of medical benefits covered

under TRICARE, as well as emerging medical procedures and technologies in the developing stages but not yet recognized as the standard of care. Cases in dispute involving care currently covered under TRICARE may involve a finding that care is not medically necessary or the care was provided at an inappropriate level of care. For example, a beneficiary may be receiving inpatient treatment in a skill nursing facility, and a finding is made that the beneficiary is not receiving skill care; or the beneficiary may be receiving care in the inpatient facility that can be provided at a more appropriate level of care such as in an outpatient setting. Also, a beneficiary may be provided a medical procedure not in compliance with specific coverage criteria. For example, an asymptomatic beneficiary may be administered a Magnetic Resonance Imaging (MRI) of the breast during a routine physical examination which may not meet the limited coverage criteria for a breast MRI, e.g., evaluation of suspected cancer recurrence. This type of case involving a denial based on TRICARE policy would be a Factual determination.

Among the most compelling cases are those involving emerging medical treatments and technologies. An example of this type of case is cervical total disc replacement with an artificial disc. Denials of this procedure have been addressed at appeal on numerous occasions over the past few years with the finding that the care was unproven. However, in 2014, sufficient reliable evidence became available to determine the procedure now meets TRICARE criteria as proven treatment, and therefore a covered benefit. The revised policy has been published, and cervical total disc replacement with artificial disc is now a benefit for all TRICARE beneficiaries meeting coverage criteria.

Data for Past Five Fiscal Years

Quantity and Types of Appeals – Previous 5 Fiscal Years:

"...provides summary data showing the numbers and types of cases submitted by beneficiaries for appeals and hearings ..."

TRICARE Contractors
Medical Necessity and Factual Appeals

Fiscal Year:	Reconsideration Appeals:
2009	14,667
2010	14,766
2011	14,097
2012	12,560
2013	9,246

Quality Monitoring Contractors
Medical Necessity Appeals

Fiscal Year:	2nd Reconsideration Appeals:
2009	376
2010	395
2011	509
2012	624
2013	501

DHA Appeals, Hearings, and Claims Collection (OGC-AC)
Medical Necessity and Factual Appeals

Fiscal Year:	Formal Reviews:	Hearings:	Non-Appealable Issues:
2009	657	61	988
2010	830	53	1,278
2011	881	94	1,349
2012	824	59	1,221
2013	721	36	831

Outcome of DHA Hearings – Previous 5 Fiscal Years:

"...provides data to show both the favorable and unfavorable beneficiary outcomes of all independent hearing cases over the previous 5 fiscal years..."

Defense Health Agency, Office of General Counsel, Appeals and Claims Collection (OGC-AC)

Fiscal Year:	Favorable:	Unfavorable:	Partially Favorable:	Other Dispositions:
2009	22	11	6	20
2010	7	6	3	20
2011	25	10	5	35
2012	23	18	11	35
2013	16	14	11	31

Average Age of DHA Cases (days) – Previous 5 Fiscal Years:

"...describes the average length of time [in days] for beneficiaries to obtain a decision from the TMA either from an appeal or a hearing..."

DHA OGC-AC

Fiscal Year:	Formal Reviews:	Hearings:	Other Correspondence:
2009	96.14	424.4	17.70
2010	105.30	289	17.37
2011	125.30	374.6	24.62
2012	83.42	342.2	15.03
2013	67.81	298.10	9.71
Total Average:	95.59	345.66	13.88

Hearing Officer Recommended Decisions – Previous 5 Fiscal Years:

"...provides data on the number of cases in which the Director of the TMA made a determination different than the recommended decision of the hearing officer to grant a beneficiary appeal..."

DHA OGC-AC - Hearings

Fiscal Year:	Hearings Held:	Adopted:	Not Adopted:
2009	8	6	2
2010	15	12	3
2011	33	30	3
2012	41	35	6
2013	27	23	4
Totals	**124**	**106**	**18**

As indicated by the above, the hearing officers' recommended decisions were adopted by the Director's designee in 85 percent of the hearings held on the past five years. Only 18 of the 124 recommended decisions were not adopted in full by the Director's designee. In ten of those eighteen cases where the hearing officers recommended some payment, the Director's designee found that coverage criteria were not met, and no payments were made. However, in eight of the cases, the Director's designee found that coverage criteria were met for at least some of the care, and TRICARE made payments in those cases as follows: (1) In five of the cases, the Director's designee authorized partial payment, with three cases paying less than the hearing officers recommended, one paying the essentially the same, and one paying more than the hearing officer recommended; and (2) In three of the cases, the Director's designee found that coverage criteria were met and authorized payment in full, even though the hearing officers had recommended non-payment.

The above is evidence that the process is working as contemplated by the Regulation which provides, "The recommended decision shall be reviewed by the Director ... or a designee, who shall adopt or reject the recommended decision...." This final phase of the administrative appeal process is structured to allow an independent review of the evidence presented through the record and testimony. It provides a means for the hearing officer to hear and weigh the evidence, and present the recommended decision to the Director to use as a tool in making a final agency decision. As explained previously, the recommended decisions are reviewed first by DHA counsel as further assurance that benefits are allowed in accordance with governing provisions of statute and regulation. While the independent hearing officer's taking of evidence, analysis, and recommendations are critical to due process, it is but one instrument in assisting the Director or designee in arriving at the correct determination.