

CHAPTER 15  
PEER REVIEW ORGANIZATION PROGRAM

A. GENERAL

This chapter establishes rules and procedures applicable to the CHAMPUS Peer Review Organization (PRO) program for utilization and quality review of services, especially services provided in hospitals for which the hospital care is covered by the CHAMPUS DRG-based payment system. In implementing the provisions of this chapter, OCHAMPUS will, in accordance with section 9100 of Public Law 101-165, be guided by the general policy of following Medicare PRO program requirements and procedures, with appropriate adaptations.

B. OBJECTIVES OF REVIEW SYSTEM

There are four required functions:

1. A review of the completeness, adequacy and quality of care provided;
2. A review of the reasonableness, necessity and appropriateness of hospital admissions under CHAMPUS DRG reimbursement;
3. A validation of diagnoses and procedural information that determines CHAMPUS reimbursement; and
4. A review of the necessity and appropriateness of care for which payment is sought on an **outlier** basis.

C. HOSPITAL COOPERATION

All hospitals which participate in CHAMPUS and submit CHAMPUS claims are required to provide all information necessary for CHAMPUS to properly process the claims. In order for CHAMPUS to be assured that services for which claims are submitted meet quality of care standards, hospitals are required to provide the Peer Review Organization (PRO) responsible for quality review with all the information, within timeframes to be established by OCHAMPUS, necessary to perform the review functions required by this chapter. Additionally, all participating hospitals shall provide CHAMPUS beneficiaries, upon admission, with information about the admission and quality review system including their appeal rights. A hospital which does not cooperate in this activity shall be subject to termination as a CHAMPUS-authorized provider.

1. Documentation that the beneficiary has received the required information about the CHAMPUS PRO program must be maintained in the same manner as is the notice required for the Medicare program by 42 CFR 466.78(b).

2. The physician attestation and physician acknowledgement required for Medicare under 42 CFR 412.40 and 412.46 are also required for CHAMPUS as a condition for payment and may be satisfied by the same statements as required for Medicare, with substitution or addition of "CHAMPUS" when the word "Medicare" is used.

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3. Participating hospitals must execute a memorandum of understanding with the PRO providing appropriate procedures for implementation of the PRO program.

4. Participating hospitals may not charge a CHAMPUS beneficiary for inpatient hospital services excluded on the basis of Chapter 4, section G.1. (not medically necessary), section G.3. (inappropriate level), or section G.7. (custodial care) unless all of the conditions established by 42 CFR 412.42(c) with respect to Medicare beneficiaries have been met with respect to the CHAMPUS beneficiary. In such cases in which the patient requests a PRO review while the patient is still an inpatient in the hospital, the hospital shall provide to the PRO the records required for the review by the close of business of the day the patient requests review, if such request was made before noon. If the hospital fails to provide the records by the close of business, that day and any subsequent working day during which the hospital continues to fail to provide the records shall not be counted for purposes of the two-day period of 42 CFR 412.42(c) (3) (ii).

5. With respect to cases subject to preadmission review, the provisions of 42 C.F.R. 466.78(b)(5)-(b)(7) shall apply to CHAMPUS cases as those provisions apply to Medicare cases.

#### D. AREAS OF REVIEW

1. Admissions. The following areas shall be subject to review to determine whether inpatient care was medically appropriate and necessary, was delivered in the most appropriate setting and met acceptable standards of quality. This review may include preadmission or prepayment review when appropriate.

a. Transfers of CHAMPUS beneficiaries from a hospital or hospital unit subject to the CHAMPUS DRG-based payment system to another hospital or hospital unit.

b. CHAMPUS admissions to a hospital or hospital unit subject to the CHAMPUS DRG-based payment system which occur within a certain period (specified by OCHAMPUS) of discharge from a hospital or hospital unit subject to the CHAMPUS DRG-based payment system.

c. A random sample of other CHAMPUS admissions for each hospital subject to the CHAMPUS DRG-based payment system.

d. CHAMPUS admissions in any DRGs which have been specifically identified by OCHAMPUS for review or which are under review for any other reason.

2. DRG validation. The review organization responsible for quality of care reviews shall be responsible for ensuring that the diagnostic and procedural information reported by hospitals on CHAMPUS claims which is used by the fiscal intermediary to assign claims to DRGs is correct and matches the information contained in the medical records. In order to accomplish this, the following review activities shall be done.

- a. Perform DRG validation reviews of each case under review.
  - b. Review of claim adjustments submitted by hospitals which result in the assignment of a higher weighted DRG.
  - c. Review for physician certification as to the major diagnoses and procedures and the physician's acknowledgment of annual receipt of the penalty statement as contained in the Medicare regulations at 42 CFR 412.40 and 412.46.
  - d. Review of a sample of claims for each hospital reimbursed under the CHAMPUS DRG-based payment system. Sample size shall be determined based upon the volume of claims submitted.
3. Outlier review. Claims which qualify for additional payment as a long-stay **outlier** or as a **cost-outlier** shall be subject to review to ensure that the additional days or costs were medically necessary and appropriate and met all other requirements for CHAMPUS coverage. In addition, claims which qualify as short-stay **outliers** shall be reviewed to ensure that the admission was medically necessary and appropriate and that the discharge was not premature.
4. Procedure review. Claims for procedures identified by **OCHAMPUS** as subject to a pattern of abuse shall be the subject of intensified quality assurance review.
5. Other review. Any other cases or types of cases identified by OCHAMPUS shall be subject to focused review.

E. ACTIONS AS A RESULT OF REVIEW

1. Findings related to individual claims. If it is determined, based upon information obtained during reviews, that a hospital has misrepresented admission, discharge, or billing information, or is found to have quality of care defects, or has taken an action that results **in** the unnecessary admissions of an individual entitled to benefits, unnecessary multiple admission of an individual, or other inappropriate medical or other practices with respect to beneficiaries or billing for services furnished to beneficiaries, the PRO, in conjunction with the fiscal intermediary, shall, as appropriate:
- a. Deny payment for or recoup (in whole or in part) any amount claimed or paid for the inpatient hospital and professional services related to such determination.
  - b. Require the hospital to take other corrective action necessary to prevent or correct the inappropriate practice.
  - c. Advise the provider and beneficiary of appeal rights, as required by Chapter 10 of this Regulation.
  - d. Notify OCHAMPUS of all such actions.

2. Findings related to a pattern of inappropriate practices. In **all** cases where a pattern of inappropriate admissions and billing practices that have the effect of circumventing the CHAMPUS DRG-based payment system is identified, **OCHAMPUS** shall be notified of the hospital and practice involved.

3. Revision of coding relating to DRG validation. The following provisions apply in connection with the DRG validation process set forth in subsection D.2. of this chapter.

a. If the diagnostic and procedural information attested to by the attending physician is found to be inconsistent with the hospital's coding or DRG assignment, the hospital's coding on the CHAMPUS claim will be appropriately changed and payments recalculated on the basis of the appropriate DRG assignment.

b. If the information attested to by the physician as stipulated under subsection E.2. of this chapter is found not to be correct, the PRO will change the coding and assign the appropriate DRG on the basis of the changed coding.

F. PROCEDURES REGARDING CERTAIN SERVICES, INCLUDING SERVICES NOT COVERED BY THE DRG-BASED PAYMENT SYSTEM

Sections B. through E. of this chapter are directed to the context of services covered by the CHAMPUS **DRG-based** payment system. The Director, OCHAMPUS, may activate PRO program review (using the same PROS or other similar organizations) of services not covered by the **DRG-based** payment system. For any such review activity designated by the Director, OCHAMPUS, the provisions of sections G. through M. of this chapter shall apply. In addition, the Director, **OCHAMPUS**, may establish procedures, appropriate to the types of services to be reviewed, substantively comparable to those applicable to services covered by the **DRG-based** payment system pertaining to obligations of providers to cooperate in PRO program review activities, authority to require precertification of services proposed to be required and authorities to require appropriate corrective actions. The Director, OCHAMPUS, may also establish such procedures for review of services which, although covered by the **DRG-based** payment system, are also affected by some other special circumstances concerning payment method, nature of care or other potential quality or utilization issue.

G. PROCEDURES REGARDING INITIAL DETERMINATIONS

The CHAMPUS PROS shall establish and follow procedures for initial determinations that are substantively the same or comparable to the procedures applicable to Medicare under 42 CFR 466.83 to 466.104. In addition, these procedures shall provide that a PRO's determination that an admission is medically necessary is not a guarantee of payment by CHAMPUS; normal CHAMPUS benefit and procedural coverage requirements must also be applied.

H. PROCEDURES REGARDING RECONSIDERATIONS

The CHAMPUS PROS shall establish and follow procedures for reconsiderations that are substantively the same or comparable to the

procedures applicable to reconsiderations under Medicare pursuant to 42 CFR 473.15 to 473.34, except that the time limit for requesting reconsideration (see 42 CFR 473.20(a)(1)) shall be 90 days. A PRO reconsidered determination is final and binding upon all parties to the reconsideration except to the extent of any further appeal pursuant to section I. of this chapter.

I. APPEALS AND HEARINGS

1. Beneficiaries may appeal a PRO reconsideration determination to **OCHAMPUS** and obtain a hearing on such appeal to the extent allowed and under the procedures set forth in Chapter 10, section D.

2. Except as provided in subsection 1.3., a PRO reconsidered determination may not be further appealed by a provider.

3. A provider may appeal a PRO reconsideration determination to **OCHAMPUS** and obtain a hearing on such appeal to the extent allowed under the procedures set forth in Chapter 10, section D. if it is a determination pursuant to Chapter 4, section H. that the provider knew or could reasonably have been expected to know that the services were excludable.

4. For purposes of the hearing process, a PRO reconsidered determination shall be considered as the procedural equivalent of a formal review determination under Chapter 10.

5. The provisions of Chapter 10, section E. concerning final action shall apply to hearings cases.

J. ACQUISITION, PROTECTION AND DISCLOSURE OF PEER REVIEW INFORMATION

The provisions of 42 CFR Part 476, except section **476.108**, shall be **applicable** to the CHAMPUS PRO program as they are to the Medicare PRO program.

K. LIMITED IMMUNITY FROM LIABILITY FOR PARTICIPANTS IN PRO PROGRAM

The provisions of section 1157 of the Social Security Act (42 U.S.C. 1320c-6) are applicable to the CHAMPUS PRO program in the same manner as they apply to the Medicare PRO program. Section **1102(g)** of title 10, United States Code also applies to the CHAMPUS PRO program.

L. ADDITIONAL PROVISION REGARDING CONFIDENTIALITY OF RECORDS

1. General rule. The provisions of 10 U.S.C. 1102 regarding the confidentiality of medical quality assurance records shall apply to the activities of the CHAMPUS PRO program as they do to the activities of the external civilian PRO program that reviews medical care provided in military hospitals.

2. Specific applications.

a. Records concerning PRO deliberations are generally **nondisclosable** quality assurance records under 10 U.S.C. 1102.

b. Initial denial determinations by PROS pursuant to section G. of this chapter (concerning medical necessity determinations, DRG validation actions, etc.) and subsequent decisions regarding those determinations are not **nondisclosable** quality assurance records under 10 U.S.C. 1102.

c. Information the subject of mandatory PRO disclosure under 42 CFR Part 476 is not a **nondisclosable** quality assurance record under 10 U.S.C. 1102.

**M. OBLIGATIONS, SANCTIONS AND PROCEDURES**

1. The provisions of 42 CFR 1004.1 - 1004.80 shall apply to the CHAMPUS PRO program as they do the Medicare PRO program, except that the functions specified in those sections for the Office of Inspector General of the Department of Health and Human Services shall be the responsibility of **OCHAMPUS**.

2. The provisions of 42 U.S.C. section 1395ww(f) (2) concerning circumvention by any hospital of the applicable payment methods for inpatient services shall apply to CHAMPUS payment methods as they do to Medicare payment methods.

3. The Director, or a designee, of CHAMPUS shall determine whether to impose a sanction pursuant to subsections M1. and M.2. of this chapter. Providers may appeal adverse sanctions decisions under the procedures set forth in Chapter 10, section D.