



Department of Defense INSTRUCTION

NUMBER 6000.14
September 5, 2007

USD(P&R)

SUBJECT: Patient Bill of Rights and Responsibilities in the Military Health System (MHS)

- References:
- (a) DoD Directive 6000.14, subject as above, July 30, 1998 (hereby canceled)
 - (b) Acting Deputy Secretary of Defense Memorandum, "DoD Directives Review - Phase II," July 13, 2005
 - (c) DoD Directive 5124.02, "Under Secretary of Defense for Personnel and Readiness (USD(P&R))", October 17, 2006
 - (d) Chapter 55 of title 10, United States Code
 - (e) through (k), see Enclosure 1

1. REISSUANCE AND PURPOSE

This Instruction reissues Reference (a) as a DoD Instruction in accordance with the guidance in Reference (b) and the authority in Reference (c).

2. APPLICABILITY AND SCOPE

This Instruction applies to the Office of the Secretary of Defense, the Military Departments, the Office of the Chairman of the Joint Chiefs of Staff, the Combatant Commands, the Office of the Inspector General of the Department of Defense, the Defense Agencies, the DoD Field Activities, and all other organizational entities in the Department of Defense (hereafter referred to collectively as the "DoD Components").

3. DEFINITIONS

Terms used in this Instruction are defined in Enclosure 2.

4. POLICY

It is DoD policy that MHS patients have explicit rights about information disclosure; choice of providers; health plans; access to emergency services; participation in treatment decisions; respect and nondiscrimination; confidentiality of protected health information, complaints, and appeals; as well as specific responsibilities to participate in their own health decisions. This Instruction does not expand the scope of benefits or create any entitlement inconsistent with chapter 55 of title 10, United States Code (Reference (d)); 32 Code of Federal Regulations (CFR) part 199 (Reference (e)); or other applicable law or regulation. Additionally, deviation from the guidelines in this Instruction does not result in a legal cause of action. Finally, failure of a patient to adhere to the “responsibilities” listed at paragraph E3.2.2.8. does not, alone, result in a loss of benefits or other adverse action.

5. RESPONSIBILITIES

5.1. The Assistant Secretary of Defense for Health Affairs (ASD(HA)), under the Under Secretary of Defense for Personnel and Readiness, shall exercise oversight to ensure compliance with this Instruction.

5.2. The Director, TRICARE Management Activity (TMA), under the authority, direction, and control of the ASD(HA) shall serve as the program manager for TRICARE health and medical resources, supervising and administering TRICARE programs and other resources within the Department of Defense.

5.3 The Secretaries of the Military Departments shall ensure compliance with this instruction by the Surgeons General of the Military Departments and Military Treatment Facility (MTF) Commanders.

5.4. MTF Commanders shall:

5.4.1. Promote and assure healthcare quality and protect patients in the MHS by adherence to the Patient Bill of Rights and Responsibilities in Enclosure 3.

5.4.2. Provide accurate, understandable, and timely information about the TRICARE program to beneficiaries.

5.4.3. Maintain a staff provider directory.

5.4.4. Ensure beneficiaries are given information how to access publicly available facility performance data.

5.4.5. Ensure dedicated representatives are available to fully explain the TRICARE health plan.

5.4.6. Provide information to beneficiaries on the healthcare facility.

5.4.7. Ensure beneficiaries have the right to a choice of healthcare providers, can access care within standard time frames, and receive quality care.

5.4.8. Ensure respectful care from all staff members and in an environment free from discrimination.

5.4.9. Ensure individually identifiable healthcare information is protected.

5.4.10. Ensure the rights of appealing parties are protected during all levels of the appeals process.

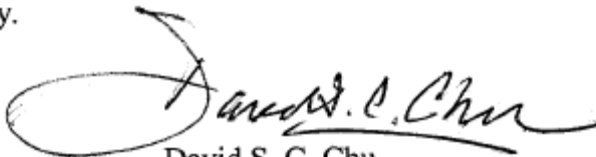
5.4.11. Ensure beneficiary grievances have the opportunity to seek resolution.

6. PROCEDURES

Procedures and compliance guidelines are contained in Enclosure 3.

7. EFFECTIVE DATE

This Instruction is effective immediately.



David S. C. Chu
Under Secretary of Defense for
Personnel and Readiness

Enclosures – 3

E1. References, continued

E2. Definitions

E3. Patient Bill of Rights and Responsibilities

E1. ENCLOSURE 1

REFERENCES, continued

- (e) Title 32, Code of Federal Regulations, part 199, “Civilian Health and Medical Program of the Uniformed Services (CHAMPUS)”
- (f) Executive Order 13410, “Promoting Quality and Efficient Health Care in Federal Government Administered or Sponsored Health Care Programs,” August 22, 2006
- (g) Joint Commission Accreditation Manual for Hospitals, current edition
- (h) Chapter 47 of title 10, United States Code
- (i) DoD 6025.18-R, “DoD Health Information Privacy Regulation,” January 2003
- (j) DoD Directive 5400.11, “DoD Privacy Program,” May 8, 2007
- (k) “Medical Management Guide,” January 2006¹

¹ The Medical Management Guide is available at <http://www.dodmedicalmanagement.info>

E2. ENCLOSURE 2

DEFINITIONS

E2.1. External Appeal. When the internal appeal process does not provide resolution for the beneficiary, the appeal is elevated to the external chain of responsibility at the National Quality Monitoring Contractor (NQMC) and TRICARE Management Activity (TMA) levels, to provide an independent review.

E2.2. Internal Appeal. An administrative review of program determinations regarding medical necessity that is internal to the Military Treatment Facility (MTF) (for direct care) or internal to the Managed Care Support Contractor (MCSC) (for purchased care). Progression through the successive levels of appeal occurs when the reviewing authority upholds the initial denial and the beneficiary, dissatisfied with the denial decision, files the next level of appeal.

E2.3. Military Health System. The combination of military and civilian medical systems used to provide healthcare to DoD medical beneficiaries.

E2.4. Military Treatment Facilities. Those inpatient and outpatient facilities owned, staffed, and managed by the Military Departments.

E2.5. National Quality Monitoring Contractor. A contract peer review organization that monitors the quality of the Military Health System delivered care and serves the Office of the Assistant Secretary of Defense for Health Affairs as the external peer reviewer for medical necessity determination appeals.

E2.6. Primary Care Manager. (PCM). Licensed and credentialed healthcare providers privileged to provide primary and preventive care services and to facilitate appropriate referrals for other services, including specialty services, for TRICARE Prime enrollees. PCMs may include physicians specialized in Family Practice, Internal Medicine, Pediatrics, and Obstetrics & Gynecology. Certified and privileged Adult, Family, Pediatric or Women's Health Nurse Practitioners, Nurse Midwives, and Physicians Assistants may also be privileged to serve as PCMs.

E2.7. Transparency. A broad-scale initiative enabling consumers to compare the quality and price of healthcare services, so they can make informed choices among providers and facilities.

E2.8. TRICARE. The DoD-managed health care program for active duty military, active duty service families, retirees and their families, and other beneficiaries.

E3. ENCLOSURE 3

PATIENT BILL OF RIGHTS AND RESPONSIBILITIES

E3.1. GENERAL

E3.1.1. The Patient Bill of Rights and Responsibilities is intended to accomplish three major goals.

E3.1.1.1. To strengthen patient confidence by assuring the health care system is fair and responsive to patients' needs, provides beneficiaries with credible and effective mechanisms to address their concerns, and encourages patients to take an active role in improving and assuring their health.

E3.1.1.2. To reaffirm the importance of a strong relationship between patients and their healthcare professionals.

E3.1.1.3. To reaffirm the critical role patients play in safeguarding their own health by establishing both rights and responsibilities for all participants in improving health status.

E3.2. GUIDELINES

E3.2.1. The Patient Bill of Rights and Responsibilities covers eight areas to include: Information Disclosure, Choice of Providers and Plans, Access to Emergency Services, Participation in Treatment Decisions, Respect and Nondiscrimination, Confidentiality of Health Information, Complaints and Appeals, and Beneficiary Responsibilities.

E3.2.2. Requirements for compliance with each of the eight rights subject to paragraph E3.2.1. are detailed below.

E3.2.2.1. Information Disclosure. MHS patients have the right to receive accurate, easily understood information and assistance in making informed healthcare decisions about their health plans, providers, and facilities. DoD facilities will promote quality and efficient healthcare through the use of health information technology; transparency regarding healthcare quality and price; and better incentives for beneficiaries, enrollees, and providers consistent with Executive Order 13410 (Reference (f)) and in accordance with specifications established by the ASD(HA).

E3.2.2.1.1. MHS beneficiaries shall be provided accurate, understandable, and timely information about the TRICARE program (section 199.17 of Reference (e)) including details of the covered health benefit, the various health plan options, and applicable cost-sharing arrangements.

E3.2.2.1.2. Each MTF shall maintain and have available a staff provider directory, including information regarding each provider's name, degree, licensure, specialty in which

privileges have been granted, and board certification. The directory shall be updated as required to ensure a current listing of staff providers and be available to assist beneficiaries in the selection of their Primary Care Manager.

E3.2.2.1.2.1. Directory information is not to be pulled from the Centralized Credentials and Quality Assurance System or other quality assurance systems.

E3.2.2.1.2.2. Staff provider directories contain Personal Identifiable Information (PII) regarding the healthcare provider. MTFs shall follow Privacy Act guidance in the notification, collection, maintenance, use, or disclosure of PII in accordance with DoD Directive 5400.11 (Reference (j)).

E3.2.2.1.3. To promote quality and efficient delivery of healthcare, each MTF shall provide beneficiaries with information on how to access publicly available facility performance data as appropriate.

E3.2.2.1.3.1. Upon enrollment to the MTF, beneficiaries shall be informed how to access facility compliance data on the Joint Commission Quality Check[®] web site (www.jointcommission.org) to include Quality Goals (ORYX measures), Patient Safety goals, and Joint Commission accreditation status according to the Joint Commission Accreditation Manual for Hospitals (Reference (g)). MTFs shall publish the Joint Commission Quality Check[®] site address in MTF communication or marketing materials for beneficiaries.

E3.2.2.1.3.2. MTFs that are accredited by organizations other than the Joint Commission shall provide beneficiaries with similar information in printed literature and facility internet home pages as appropriate.

E3.2.2.1.4. All TRICARE Regional offices (TROs) will have full-time dedicated Beneficiary Counseling and Assistance Coordinators (BCAC) and MTFs will have either full-time or collateral duty BCAC positions. The BCACs are representatives available to fully explain the TRICARE health plan and options available to assist beneficiaries in their healthcare decisions.

E3.2.2.1.5. The MTF Commander will ensure sustained, effective, two-way communication exists between the medical facility and its beneficiary population through meetings, publications, and various other media, as appropriate. Not only is it vital to keep beneficiaries informed about access to care issues, service interruptions, new programs, and other aspects of medical operations, the Commander shall also have a mechanism(s) in place to provide information upon request (e.g., provider credentials, patients satisfaction, accreditation survey results, procedures to register complaints.)

E3.2.2.2. Choice of Providers and Plans. MHS beneficiaries have the right to a choice of healthcare providers that is sufficient to ensure access to appropriate, high-quality healthcare.

E3.2.2.2.1. TRICARE Prime provider networks, coupled with the MTF capabilities, shall provide access to sufficient numbers and types of providers to ensure that all covered services are accessible within the TRICARE Prime access standards.

E3.2.2.2.1.1. TRICARE Prime access standards include emergency care 24 hours per day and 7 days per week, urgent care within 24 hours, routine primary care within 7 days, wellness and health promotion within 28 days, and specialty care within 28 days.

E3.2.2.2.1.2. MHS beneficiaries entitled under law to the Civilian Health and Medical Program of the Uniformed Services have a right to choose TRICARE Standard, which permits access to all authorized providers within guidelines of the TRICARE program.

E3.2.2.2.2. All active duty members and Prime enrollees will be assigned or allowed to select a PCM pursuant to a system established by the MTF Commander. The enrollee will be given the opportunity to register a preference for a PCM from a list of choices provided by the MTF. Preference requests shall be honored subject to availability, matching patient medical needs with appropriate level of healthcare provider, and other operational requirements established by the MTF Commander.

E3.2.2.2.3. The MHS shall promote the availability of providers who have special training in women's health issues to serve as PCMs for female Prime enrollees. To the extent available, female enrollees should be offered the option to choose a PCM who has advanced training in women's health issues.

E3.2.2.2.4. Prime enrollees shall obtain all Primary healthcare from the primary care manager or from another provider to which the enrollee is referred by the PCM. For any necessary specialty care and non-emergency inpatient care, the PCM will assist in making an appropriate referral.

E3.2.2.2.5. Beneficiaries undergoing a course of treatment for a chronic or disabling condition or who are in the second or third trimester of a pregnancy at the time there is an involuntary change in coverage of the specialty services being provided, shall, to the extent possible and legally permissible, be able to continue seeing their current specialty provider for up to 90 days (or through completion of postpartum care) to preserve continuity of care and allow for transition of care.

E3.2.2.2.5.1. For the purposes of this Instruction, an involuntary change includes an involuntary loss of eligibility for the MHS, an involuntary loss of other health insurance coincident with the initiation or continuation of MHS eligibility, or termination of the provider by the Managed Care Support Contractor (MCSC) for other than cause or a change in the applicable MCSC.

E3.2.2.2.5.2. In the case of an involuntary loss of eligibility for the MHS, the continued transitional access to healthcare shall be through the Transition Assistance Management Program or the Continued Health Benefits Program under Reference (e). They may also seek continued care under applicable procedures for the Secretarial Designee Program.

E3.2.2.2.5.3. In the case of an involuntary loss of other health insurance coverage coincident with the continuation or initiation of MHS eligibility, continued transitional coverage of the specialty care involved shall be through TRICARE, in accordance with section 199.17 of Reference (e).

E3.2.2.2.5.4. In the case of a termination of the provider involved (for other than quality concerns) or a change in the applicable MCSC affecting a TRICARE Prime enrollee, continued transitional coverage of the specialty care involved shall be in accordance with appropriate TRICARE policies and procedures (if the beneficiary remains enrolled in TRICARE Prime) with applicable TRICARE Prime cost-sharing amounts applied.

E3.2.2.3. Access to Emergency Services. MHS beneficiaries have the right to access emergency healthcare services when and where the need arises. Emergency services are covered in circumstances where acute symptoms are of sufficient severity that a “prudent layperson” could reasonably expect the absence of medical attention would result in serious health risks or death.

E3.2.2.3.1. There is no requirement for preauthorization for emergency services.

E3.2.2.3.2. Providers and/or facilities are subject to payment limits either because of network agreements or regulations on balance billing.

E3.2.2.3.3. Beneficiaries shall be provided information on the location, availability, and appropriate use of emergency services, cost sharing, provisions for civilian emergency services, and availability of care outside of an emergency department.

E3.2.2.4. Participation in Treatment Decisions. MHS beneficiaries have the right and responsibility to fully participate in all decisions related to their healthcare, subject to readiness requirements for active duty Service members.

E3.2.2.4.1. To the extent practical, MTF and TRICARE Prime network healthcare professionals shall provide patients with easily understood information and the opportunity to decide among treatment options consistent with the informed consent process. Specifically, providers should:

E3.2.2.4.1.1. Discuss all treatment options including the option of no treatment at all with a patient in a culturally sensitive manner;

E3.2.2.4.1.2. Ensure that patients with disabilities have effective communications with members of the health system in making such decisions;

E3.2.2.4.1.3. Discuss all current treatments a patient may be undergoing, including those alternative treatments that are self-administered;

E3.2.2.4.1.4. Discuss all risks, benefits, and consequences to treatment or non-treatment; and

E3.2.2.4.1.5. Give competent patients the opportunity to refuse treatment and to express preferences about future treatment.

E3.2.2.4.2. Providers shall discuss the use of advance directives—both living wills and durable powers of attorney—with patients and their designated representative and shall abide by all decisions made by their patients and/or their designated representatives. A provider who disagrees with a patient’s wishes as a matter of conscience shall arrange for transfer of care to another qualified provider willing to proceed according to the patient’s wishes within the limits of the law and medical ethics. Signed advance directives shall become a part of the patient’s medical record.

E3.2.2.4.3. MTF and MCSC providers and medical facilities shall disclose to patients financial arrangements, contractual restrictions, ownership of or interest in health care facilities, matters of conscience, or other factors that could influence medical advice or treatment decisions. MCSC contracts shall not contain any so-called “gag clauses” or other contractual mechanisms that restrict the healthcare provider’s ability to communicate with and advise patients about medically necessary treatment options.

E3.2.2.4.4. The MHS shall not penalize or seek retribution against healthcare professionals or other health workers for advocating on behalf of their patients.

E3.2.2.4.5. For active duty Service members, rights under paragraph E3.2.2.4. are subject to responsibilities of the member to comply with Service requirements for military readiness and the Uniform Code of Military Justice (Reference (h)).

E3.2.2.5. Respect and Nondiscrimination. MHS beneficiaries have the right to considerate, respectful care from all members of the MHS at all times and under all circumstances in an environment of mutual respect and free from discrimination. Subject to eligibility and other requirements of law and DoD regulation, including References (d) and (e), the MHS does not discriminate in the delivery of healthcare services or in information and enrollment practices based on race, ethnicity, national origin, religion, sex, age, mental or physical disability, genetic information, sexual orientation, or source of payment.

E3.2.2.6. Confidentiality of Health Information. MHS beneficiaries have the right to communicate with healthcare providers in confidence, to have the confidentiality of their individually identifiable healthcare information protected, and to review and copy their own medical records and request amendments to their records, subject to limited exceptions for which there is a clear legal basis. Uses and disclosures of protected health information shall be governed by DoD 6025.18-R (Reference (i)).

E3.2.2.7. Complaints and Appeals. MHS beneficiaries have the right to a fair and efficient process for resolving differences with their healthcare providers, MTF, or MCSC including a rigorous system of internal review and an independent system of external review.

E3.2.2.7.1. When healthcare services are denied by an MTF (which will neither provide nor authorize TRICARE payment for the services) or an MCSC (which will not authorize TRICARE payment for the services) based on a determination that the services are not medically necessary, the beneficiary has the right to internal and external appeals.

E3.2.2.7.2. Appeals at the MTF subject to paragraph E3.2.2.7.1. shall follow appeal procedures consistent with the most recent edition of the Medical Management Guide (Reference (k)). Internal appeals for purchased care subject to paragraph E3.2.2.7.1. shall follow reconsideration procedures consistent with paragraphs (f) through (h) of section 199.15 of Reference (e). This shall include written notification of the decision, the reasons for the decision, and appeal procedures; timely resolution, including expedited consideration for decisions involving concurrent review and preadmission/preprocedure cases; use of credentialed providers not involved in the initial decision; and written notification of the reconsideration decision, the reasons for it, and the external appeal procedures.

E3.2.2.7.3. External appeals for purchased care follow when all levels of internal appeals have been exhausted. External appeals subject to paragraph E3.2.2.7.1. shall follow the procedures established pursuant to paragraphs (f) through (i) of section 199.15 of Reference (e), including reconsideration by the independent NQMC and a hearing before the TRICARE Management Activity. NQMC procedures shall include written notification of the decision, the reasons for the decision, and appeal procedures; timely resolution, including expedited consideration for decisions involving concurrent review and preadmission/preprocedure cases; use of credentialed providers; and written notification of the reconsideration decision, the reasons for it, and the right to request a hearing.

E3.2.2.7.4. Beneficiaries with grievances about specific treatment or coverage decisions (e.g. decisions related to experimental, investigational, or unproven procedures) other than those covered by paragraph E3.2.2.7.1. shall have an opportunity to seek resolution through established MTF or MCSC grievance procedures.

E3.2.2.7.5. Paragraph E3.2.2.7. does not apply to beneficiary disagreements with eligibility requirements or other matters established by law or regulation including References (d) and (e) or MTF determinations of space available care (including the availability of services, pharmaceuticals, equipment, or other items from MTFs).

E3.2.2.8. Beneficiary Responsibilities. In the MHS, beneficiaries are expected and encouraged to assume reasonable responsibility for their health. This increases the likelihood of achieving the best outcomes and supports quality improvement and a cost-conscious environment. Such responsibilities include:

E3.2.2.8.1. Taking responsibility for maximizing healthy habits, such as exercising, not smoking, eating a healthful diet, and avoiding knowingly spreading disease.

E3.2.2.8.2. Becoming involved in specific healthcare decisions, working collaboratively with healthcare providers in developing and carrying out agreed-upon treatment plans, disclosing relevant information, and clearly communicating wants and needs.

E3.2.2.8.3. Recognizing the reality of risks and limits of the science of medical care and the human fallibility of the healthcare professional and being aware of a healthcare provider's obligation to be reasonably efficient and equitable in providing care to other patients.

E3.2.2.8.4. Becoming knowledgeable about MHS and TRICARE coverage, options, and rules and abiding by applicable procedures.

E3.2.2.8.5. Showing respect for other patients and health workers and making a good-faith effort to meet financial obligations.

E3.2.2.8.6. Reporting wrongdoing and fraud to appropriate authorities.