

Chapter 1

Section 4

Management

Revision:

1.0 GENERAL

The contractor shall establish and maintain sufficient staffing and management support services and commit all other resources and facilities necessary to achieve and maintain compliance with all quantitative and qualitative standards for claims processing timeliness, claims inventory levels, claims control, and claims accuracy. The requirements below outline minimum requirements of Defense Health Agency (DHA). Contractors are encouraged to develop and employ the most effective management techniques available to ensure economical and effective operation.

2.0 SYSTEM ADDITIONS OR ENHANCEMENTS

2.1 Implementation of Changes in Program Requirements

The contractor shall have the capacity, using either directly employed personnel or contracted personnel, to maintain and operate all required systems and to achieve timely implementation of changing program requirements.

2.2 Maintaining Current Status of Diagnostic and Procedural Coding Systems (PCS)

Contractors are required to use the current versions of the updated American Medical Association Physicians Current Procedural Terminology, 4th Edition (CPT-4), and the International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM) diagnostic coding system; and any special codes that may be directed by DHA. Beginning with dates of service on or after the mandated date, as directed by Health and Human Services (HHS) for International Classification of Diseases, 10th Revision (ICD-10) implementation, for outpatient facility and all non-facility services, and for inpatient facility charges with discharge dates on or after the mandated date, contractors will be required to replace the use of ICD-9-CM diagnosis codes with the current version of the ICD-10-CM and the International Classification of Diseases, 10th Revision, Procedure Coding System (ICD-10-PCS) for inpatient hospital procedures. The contractor is responsible for using the most current codes correctly. That responsibility includes making any needed revisions required by periodic CPT-4 and ICD-9-CM or ICD-10-CM and ICD-10-PCS updates issued by the publishers. When updates occur, contractors will be notified of the date the TRICARE Encounter Data (TED) editing system will be accepting changes in the codes.

2.3 Zip Code File

The contractor shall maintain and update an electronic file of all zip codes using a Government-furnished electronic zip code directory. The contractor shall incorporate this electronic file in its claims

processing system to determine the validity of a beneficiary or provider zip code. This directory will be provided by the Government no less than four and no more than 12 times per calendar year. Updates to the electronic zip code directory for the purposes of contract modifications, directed policy actions, and expansion or termination of zip codes by the U.S. Postal Service (USPS), shall be accomplished at no additional cost to the Government.

2.4 Updating And Maintaining TRICARE Reimbursement Systems

The contractor, at no additional cost to the Government and as directed by DHA shall implement all policy changes and clarifications to existing TRICARE reimbursement systems affecting both the level of payment and the basic method of reimbursement as they apply to current provider categories implemented at the time of contract award. The TRICARE Reimbursement Manual (TRM) is the source for instructions and guidance on all existing reimbursement systems for current provider categories.

3.0 MANAGEMENT CONTROLS

The contractor shall develop and employ management procedures necessary to ensure control, accuracy, and timeliness of transactions associated with operation of their call center, TRICARE Service Center (TSC) functions (TRICARE overseas contract only), enrollment, authorizations, provider referrals, claims processing, beneficiary services, provider services, reconsiderations, grievances, Automatic Data Processing (ADP), and financial functions. These procedures include such elements as:

3.1 An automated claims aging report, by status and location, for the purpose of identifying backlogs or other problem areas delaying claims processing. At a minimum, this report must be sorted to enable a count of the total number of claims pending for a specified length of time, e.g., the time periods specified in the Monthly Cycle Time/Aging Report.

3.2 An automated returned claims report counting the number of claims returned by the time periods specified in the Monthly Cycle Time/Aging Report.

3.3 Procedures to ensure confidentiality of all beneficiary and provider information, to ensure that the rights of the individual are protected in accordance with the provisions of the Privacy Act and the HIPAA and Health and Human Services (HHS) Privacy Regulation and prevent unauthorized use of DHA files.

3.4 A system to control adjustments to processed claims which will document the actual date the need for adjustment is identified, the reason for the adjustment and the names of both the requesting and authorizing persons. The controls shall also ensure the accurate and timely update of the beneficiary history files, the timely and accurate submission of the TED data and issuance of the proper notice to the beneficiaries and providers affected by the adjustments.

3.5 A set of processing guidelines, desk instructions/user's manuals and reference materials for internal use. These materials shall be maintained, on a current basis, for the life of the contract. Desk instructions shall be available to each employee in the immediate work area. Reference material such as procedure codes, diagnostic codes, and special processing guidelines, shall be available to each work station with a need for frequent referral. Other reference materials shall be provided in each unit with a reasonable need and in such quantity as to ensure the ease of availability needed to facilitate work flow. Electronic versions may be used.

4.0 QUALITY CONTROL

4.1 The contractor shall develop and implement an end-of-processing quality control program which assures accurate input and correct payments for authorized services received from certified providers by eligible beneficiaries.

4.2 The contractor shall have a quality control program consisting of supervisory review of appeals, grievances, correspondence, and telephone responses. This must begin by the end of the third month after the start of health care delivery (SHCD) and be carried out monthly thereafter. The review shall include a statistically valid sample or 30 records, whichever is greater, of each of the following: appeals, grievances, correspondence processed and telephonic responses completed. The criteria for review shall be accuracy and completeness of the written or telephonic response, clarity of the response, and timeliness with reference to the quantitative standards for the processing of appeals, grievances, and correspondence. Any lack of courtesy or respect in the response shall also be noted. All findings shall be documented, provided to DHA Contracting Officer's Representative (COR) staff, or authorized auditors, and used in a documented training program.

4.3 The quality review program will sample each quarter, a sufficient number of processed claims and adjustments to ensure the required quality of adjudication and processing and provide adequate management control. Claims in the sample shall include all claim types and be selected randomly, or by other acceptable statistical methods, in sufficient number to yield at least a 90% confidence level with a precision of 2%. The sample will be drawn at or near the end of each quarter from claims completed during the review period. The contractor may draw the sample up to 15 calendar days prior to the close of the quarter, but must include claims completed in the period between the date the sample is drawn and the close of the quarter in the next quarterly sample. The contractor shall reflect the inclusive processing dates of the claims in the sample in the report submitted to DHA. The sampling will begin by the end of the first quarter of processing. Documentation of the results shall be completed within 45 calendar days of the close of each contract quarter.

4.4 The contractor shall retain copies of the reviewed claims, appeals, grievances, correspondence, and related working documents, in separate files, for a period of no less than four months following submission of audit results to the Procuring Contracting Officer (PCO). DHA staff will review the results and will on a regular basis audit a selected sampling of the audited/quality review documents. The review may occur at the contractor's site or at a location specified by DHA. The contractor shall provide all documentation supporting this review within 10 calendar days of a DHA request.

5.0 STAFF TRAINING PROGRAM

The contractor shall develop and implement a formal initial and ongoing staff training program including training on program updates as they occur, to ensure a high quality of service to beneficiaries and providers. Such training shall include mandatory, documented training in Confidentiality of Patient Records (42 United States Code (USC) [290dd-3]) requirements (see [Section 5](#)). The contractor shall not only provide education on these requirements but must document the personnel files of the staff members who receive the training. Centralized documentation shall also be maintained of the training session agendas, identity of attendees, actual dates and duration of training sessions, etc. The contractor is also responsible for ensuring that subcontractor staff is fully trained.

6.0 INTERNAL AUDITS AND MANAGEMENT CONTROL PROGRAMS

Using its corporate internal review capability, the contractor is responsible for verifying that accounting data are correct, reliable and comply with all Government accounting standards and requirements. The contractor's corporate internal review staff must conduct regular, routine reviews to ensure proper monitoring in the areas of finance, financial accounting, internal controls, special checks issued and returned, and selected history maintenance transactions for possible fraud or abuse.

7.0 BENEFICIARY SURVEYS

In accordance with Department of Defense Instruction (DoDI) 1100.13, and Health Affairs Policy Memorandum 97-012, surveys of military members, retirees and their families must be approved and licensed through issuance of a Report Control Symbol (RCS). Contractors shall not conduct written or telephonic beneficiary surveys without the approval of the DHA Decision Support Division (DSD). DHA has an ongoing survey research and analysis program which includes periodic population-based and encounter-based surveys of DoD beneficiaries. The surveys address beneficiary information seeking strategies and preferences, health status, use of care, satisfaction with military and civilian care, and attitudes toward TRICARE. The data are collected at the Prime Service Area (PSA) level and can be aggregated to the regional level. Regional reports containing PSA data are available through the Director, TRICARE Regional Offices (TROs)/Program Office. Contractors shall work with the Director, TROs/Program Offices to define both their ongoing and special purpose requirements for survey data. Contractors with special needs not met by an existing instrument may submit surveys, sampling plans, and cost estimates through the Director, TROs/Program Office to the DHA, DSD, for approval and licensing.

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