CHAPTER 1
SECTION 3

TRICARE PROCESSING STANDARDS

1.0. GENERAL

Contractors are charged with providing or arranging for delivery of quality, timely health care services and with responsibility for providing the timely and accurate processing of claims received into their custody, whether for network or non-network care. In addition, the contractor must provide courteous, accurate, and timely response to inquiries from beneficiaries, providers, TRICARE Management Activity (TMA), and other legitimately interested parties. TMA has established standards of performance which will be monitored by TMA and other government agencies to measure contractor performance. Paragraph 2.0., below, contains a summary of key performance standards. Some of the standards are prerequisites for contractors to earn positive incentives. (See individual contractor contracts for the prerequisites.)

2.0. TIMELINESS AND QUALITY STANDARDS OF PERFORMANCE

Unless otherwise specified, the standards below apply to both network and non-network claims separately. Contractors may propose tighter standards.

2.1. Claims Processing

2.1.1. All claims shall be stamped with an internal control number (ICN) and entered into the ADP system within five workdays of receipt. The actual date of receipt shall be counted as day one. The ICN uniquely identifies each claim, includes the actual date received in the contractor's custody, and permits aging and counting of the claim for workload reporting purposes at specific system locations at any time during its processing. Contractors receiving paperless claims shall provide procedures to ensure the actual date of receipt is entered into the ICN and all required claims aging and inventory controls are applied.

2.1.2. All claims and attached documents shall be individually retrievable by each of the following: beneficiary name, sponsor's Social Security Number, and ICN, within 15 calendar days following receipt in the contractor's custody through final disposition. The actual date of receipt shall be counted as the first day.

2.2. Claims Processing Timeliness

2.2.1. Retained Claims

2.2.1.1. Ninety-five percent (95%) of retained claims and adjustment claims shall be processed to completion within 30 calendar days from the date of receipt. One hundred percent (100%) of retained claims and adjustment claims shall be processed to completion within 60 calendar days from the date of receipt.

2.2.1.2. A "Retained Claim" is defined as any claim retained (held in the contractor's possession) for any reason. Contractors shall retain all claims that contain sufficient information to allow processing to completion and all claims for which missing information may be developed from in-house sources, including DEERS and contractor operated or maintained electronic, paper, or film files.

NOTE: Nothing in this definition prohibits a contractor from retaining a claim for external development.

2.2.2. Excluded Claims From The 30 And 60 Day Cycle Time Standards

2.2.2.1. One hundred percent (100%) of excluded claims shall be processed to completion within 120 calendar days unless the Government specifically directs the contractor to continue pending a claim or group of claims.

2.2.2.2. "Excluded Claims" are defined as:

- Claims retained at the discretion of the contractor for the external development of information necessary to process the claim to completion;
- Claims requiring development for possible third-party liability;
- Claims requiring intervention by another prime contractor; and
- Claims requiring Government intervention (i.e., claims held for CMAC updates, claims held pending the issuance of a policy change, etc.).

2.2.3. Simple Interest Payments

2.2.3.1. Simple interest shall be paid on the payment amount based upon the Prompt Payment Act Interest Rate in effect on the "processed to completion" date (see Appendix A), on all retained claims beginning with the 31st day following the date of receipt until processed to completion. The fiscal responsibility for the interest payment shall be determined based on the following hierarchy. The first cause for the delay in processing the claim shall remain with the claim for the purpose of determining who is responsible for interest payments.

- Claims pended at Government direction that the Government has specifically directed the contractor to hold for an extended period of time. These will primarily be claims pending a Program Integrity investigation. (The Government is fiscally responsible for any interest).
- Claims requiring Government intervention (the Government is fiscally responsible for any interest).
- Claims requiring development for potential third-party liability (the Government is fiscally responsible for any interest).
- Claims requiring an action/interface with another prime contractor (the contractor is fiscally responsible for any interest).

- Claims retained by the contractor that do not fall into one of the above categories (the contractor is fiscally responsible for any interest).

2.2.3.2. At the contractor's discretion, interest may be included with each benefit check, in which case the interest shall be paid to the nearest penny, or interest may be paid on a calendar quarter basis. If interest is paid on a calendar quarter, all interest to a given individual or entity shall be accumulated during the quarter, summed and distributed with a clearly understandable itemization within 15 calendar days following the end of each calendar quarter. No quarterly interest payments shall be issued in amounts of less than one dollar.

- All interest shall be paid to the recipient of the benefit check; however, if a payment is split as a result of a beneficiary overpaying a provider, the interest payment shall be made, in total, to the provider.

- No interest shall be paid on any claim pended in accordance with the provision of Chapter 11, Section 3, paragraph 3.3. and 3.4.

2.2.3.3. Interest payments shall not be reported on HCSRs or included as health care costs for the purposes of the bid-price adjustment.

2.2.3.4. The contractor shall maintain a record of all interest payments for inspection and delivery to the Government at the direction of the Contracting Officer.

2.2.3.5. The maximum interest penalty period shall be one year.

2.3. Claims/Adjustment Claims Processing Accuracy

2.3.1. Payment Errors

The absolute value of the payment errors shall not exceed two percent of the total billed charges.

2.3.2. HCSR Occurrence Errors

The HCSR occurrence error rate shall not exceed three percent for all types of HCSRs.

2.4. Claims Processing Cycle

The contractor shall generate an initial submission claims processing cycle and transmit related HCSR data and required documents to TMA not less than twice each seven calendar days. The contractor shall have an updated beneficiary processed claims history and deductible file available and accessible within one workday following each processing cycle. The contractor shall assure only one processed claims history and deductible file is maintained for each beneficiary.

3.0. FISCAL CONTROLS

3.1. Health Care Service Records - Timeliness

3.1.1. All initial submission vouchers / batches shall be transmitted to TMA within five calendar days of the date on which the contractor called TMA to report the payment run, when the HCSR is generated from a claim or from the date of the creation of the record for HCSRs from other treatment encounter sources.

3.1.2. Ninety percent (90%) of all unprocessable vouchers / batches, including but not limited to, out-of-balance conditions and invalid header record information shall be corrected by the contractor and returned for receipt at TMA within ten calendar days of the date the invalid data was transmitted to the contractor by TMA.

3.1.3. All 100% unprocessable vouchers / batches, cited in b. above, shall be corrected and returned for receipt at TMA within 20 calendar days of the date the invalid data was transmitted to the contractor by TMA.

3.1.4. Ninety percent (90%) of all vouchers / batches having HCSRs (initial submissions, resubmissions, and adjustment / cancellation submissions) failing the edit system shall be corrected and resubmitted to TMA within 30 calendar days after the errors and rejected HCSRs were transmitted to the contractor by TMA. The resubmission data shall contain all HCSRs rejected on the voucher / batch in question.

3.1.5. One hundred percent (100%) (all remaining) unprocessable vouchers / batches, cited in d. above, shall be corrected and resubmitted to TMA within 40 calendar days after the data was transmitted to the contractor by TMA. The resubmission data shall contain all HCSRs rejected in the voucher / batch.

3.2. Health Care Service Records - Accuracy

3.2.1. The contractor shall have the following percentages of HCSRs (initial submissions, resubmissions and adjustment / cancellation submission) passing the TMA edits following the start of health care delivery:

One through three months - 60%
Four through six months - 75%
Seven through nine months - 85%
More than nine months - 90%

3.2.2. After the first three months following the start work date of the contract, the contractor shall not have more than five percent of the vouchers / batches being unprocessable due to, but not limited to, such problems as: out-of-balance, invalid header conditions, invalid record type, invalid contractor number, invalid voucher / batch identifier, invalid voucher / batch date, invalid sequence number, invalid resubmission number, invalid period begin date, invalid period end date, invalid total number of records and invalid total amount paid.

3.2.3. Ninety percent (90%) of all vouchers / batches must be accepted by the HCSR edit system within three submissions, excluding voucher / batch header rejects.

3.2.4. One hundred percent (100%) of all vouchers / batches must be accepted by the HCSR edit system within five resubmissions, excluding voucher / batch header rejects. Each failure by a voucher / batch to pass the edits will be counted in the error calculations.

3.3. Refunds, Returned Checks and Stale Dated Checks

Refund checks for payments made with not-at-risk dollars shall be deposited in the TRICARE bank account within one workday after identification as a TRICARE refund. Returned checks shall be researched and remailed within five workdays of receipt, if a better address can be located, in accordance with the procedures in Chapter 8, Section 8, paragraph 6.0. Checks returned shall be properly safeguarded until stale dated or until claimed by the beneficiary or provider. Uncashed checks for payments made with not-at-risk dollars shall be cancelled after the 121st calendar day following issuance.

3.4. Reconcile the TRICARE Bank Account

The contractor, regardless of the number of TRICARE contracts awarded, shall contract with a Federal Reserve member bank to maintain a single account for each fiscal year. This account must be reconciled within 30 calendar days following receipt of the bank statement. This account is for not-at-risk funds only.

3.5. Benefit Checks

The contractor shall mail benefit checks no later than two workdays following TMA's approval of the transmitted report of the payment run, or when the HCSRs are generated from the claims, unless otherwise directed by TMA.

3.6. Special Checks

The contractor shall post all manually issued checks to the beneficiary processed claims history and deductible file within five workdays of issuance and these checks shall be reconciled with the contractor's claims processing and financial control systems within 30 calendar days of issuance.

3.7. Check Information

For all paid claims, the check number, issue date, payee name and ICN shall be:

- Available within one workday of the date the check was written, and
- Retrievable within one workday of an inquiry.

4.0. MANAGEMENT

4.1. Reports

All contractor Monthly Workload and Cycle Time / Aging Reports shall arrive at TMA on or before the 15th calendar day of the month following the month being reported.

4.2. Filing

The contractor shall file all hard copy, microform copies and optical disk imaging of claims / adjustment claims, with attached documentation by internal control number (ICN) by state or contract number within five calendar days after they are processed to completion. The claim and all supporting documents shall be maintained in hard copy, microcopy or optical disk. Provisions shall be made for appropriate retention and disposition of files in accordance with the Federal Records Act and TRICARE Management Activity (TMA) instructions. (See Chapter 2.)

4.3. Availability Of Information

Information required for appropriate response to inquiries, including but not limited to claim files, appeals files, previous correspondence, and check files shall be retrievable within five workdays following a request for the information.

4.4. Contract Changes

The contractor shall provide a complete reply to TMA requests for comments and / or cost estimates on all proposed changes, to include changes to the Operations Manual, the Policy Manual, and / or the ADP Manual, within 30 calendar days following receipt of the request, unless a different period of time is provided by TMA in the transmitting correspondence from the Contracting Officer.

5.0. BENEFICIARY AND PROVIDER SERVICES

For all processing standards, the actual date of receipt shall be counted as the first day. The date the reply is mailed shall be counted as the processed to completion date. The standards with which the contractor shall comply include:

5.1. Routine Written Inquiries

All routine written inquiries shall be stamped with the actual date of receipt within three workdays of receipt in the contractor's custody. The contractor shall provide final responses to:

- 85% of all routine written inquiries within 15 calendar days of receipt;
- 97% of routine written inquiries within 30 calendar days of receipt; and
- All routine written inquiries within 45 calendar days of receipt.

5.2. Priority Written Inquiries (Congressional, ASD(HA), And TMA)

All priority written inquiries shall be stamped with the actual date of receipt within three workdays of receipt in the contractor's custody. The contractor shall provide final responses to:

- Eighty-five percent (85%) of all priority written inquiries within ten calendar days of receipt; and
- All priority written inquiries within 30 calendar days of receipt.

5.3. Telephone Inquiries

5.3.1. Eighty percent (80%) of all telephone calls shall be acknowledged within 20 seconds by an individual or electronic device.

5.3.2. Ninety percent (90%) of all calls shall be answered by a telephone representative or automated response unit (ARU) within 120 seconds after acknowledgment by automated equipment.

5.3.3. Eighty percent (80%) of all telephone inquiries shall be fully and completely answered during the initial telephone call.

5.3.4. All telephone calls which do not receive a full and complete response during the initial call shall receive a substantive follow-up call within two workdays.

5.3.5. Ninety-five percent (95%) of all telephone inquiries not fully and completely answered at this time shall be fully and completely answered within ten calendar days and 100% shall be fully and completely answered within 20 calendar days.

6.0. APPEALS

6.1. Expedited Preadmission/Preprocedure Reconsiderations

The contractor shall process 100% of requests for expedited preadmission / preprocedure reconsiderations to completion within three working days of receipt of the reconsideration request (unless the reconsideration is rescheduled at the written request of the appealing party). Expedited preadmission / preprocedure requests are those requests filed by the beneficiary within three calendar days after the beneficiary receipt of the initial denial determination (unless there is evidence to the contrary, the beneficiary's receipt of the initial determination is considered to be five calendar days after the date on the notice of the initial denial determination).

6.2. Concurrent Review Cases

The contractor does not issue reconsideration determinations in concurrent review cases. Refer to Chapter 13, Section 4, paragraph 2.6.2., for contractor requirements relating to concurrent review reconsideration requests.

6.3. Nonexpedited Medical Necessity Reconsiderations

A reconsideration processing time begins with the receipt of the appeal in the contractor's custody (unless the reconsideration is rescheduled at the request of the appealing party) and ends with the date the reconsideration determination is mailed to the appropriate parties. The contractor shall meet the following processing standards:

6.3.1. Eight-five percent (85%) of nonexpedited medical necessity reconsiderations within 30 calendar days;

6.3.2. Ninety-five percent (95%) of nonexpedited medical necessity reconsiderations within 60 calendar days; and

6.3.3. One hundred percent (100%) of nonexpedited medical necessity reconsiderations within 90 calendar days.

6.4. Nonexpedited Factual Reconsiderations

The contractor shall process to completion, from the stamped date of receipt in the contractor's custody:

6.4.1. Ninety-five percent (95%) of factual reconsiderations within 60 calendar days of receipt; and

6.4.2. One hundred percent (100%) of factual reconsiderations within 90 calendar days from the date of receipt of the reconsideration request. The date of completion is considered to be the date the reconsideration determination is mailed to the appropriate parties.

7.0. GRIEVANCES

7.1. All written grievances shall be stamped with the actual date of receipt within three workdays of receipt in the contractor's custody.

7.2. The contractor must provide interim written response by the 30th calendar day after receipt for all grievances not processed to completion by that date. The interim response shall include an explanation for the delay and an estimated date of completion.

7.3. Ninety-five percent (95%) of all grievances shall be processed to completion within 60 calendar days from the date of receipt.

8.0. AUTHORIZATION REQUESTS

8.1. The contractor is responsible for reviewing all requests for authorization. Such requests shall be accepted when submitted by TRICARE beneficiaries, sponsors or providers requesting authorization on the beneficiary's behalf. Within TRICARE Standard, issuance of authorizations shall not be used to restrict freedom of choice of the beneficiary who chooses to receive care from authorized non-network providers, except as may be set forth in instructions from the Contracting Officer. If a beneficiary is enrolled in the Prime Program, appropriate authorizations to manage access to care may exceed those applicable under TRICARE Standard, provided the specific control has been approved by the Contracting Officer.

8.2. All authorization determinations shall be issued in writing. A negative determination shall include the right to file an appeal for both Prime enrollees and non-enrollees. In 85% of all requests for medical care authorization, the contractor shall review and make a determination on whether or not to cover care within two workdays following the receipt of a request for authorization.

8.3. The contractor shall provide a determination on 100% of all medical authorization requests within ten workdays following receipt of the request for authorization.

8.4. In 90% of all requests for mental health authorizations, the contractor shall review and make a determination on whether or not to cover care within one workday following the receipt of a request for authorization.

8.5. In 100% of all requests for mental health authorization, the contractor shall review and make a determination on whether or not to cover care within five workdays following the receipt of a request for authorization.

9.0. POTENTIAL DUPLICATE CLAIM RESOLUTION

9.1. The contractor shall utilize the automated TRICARE Duplicate Claims System (Duplicate Claims System) to resolve TMA identified potential duplicate claims payments (see Appendix A).

9.2. The contractor shall move OPEN status potential duplicate claim sets to PENDING, VALIDATE, or CLOSED status on a first-in / first-out basis. To this end, contractor performance will be measured against the percentage of claim sets in OPEN status at the end of a month with load dates over 30 days old. No more than ten percent of the potential duplicate claim sets remaining in OPEN status at the end of a month shall have load dates over 30 days old. Contractor compliance with this standard shall be determined from the Performance Standard Report generated by the Duplicate Claims System (see ADP Manual, Chapter 11, Addendum E, Summary / Management Report entitled "Performance Standards" (page 12.E-53), for a description and example of the performance Standard Report). The ten percent standard becomes effective on the first day of the seventh month following the start of Health Care Delivery or following system installation whichever is later.

9.3. The contractor shall not be responsible for meeting the performance standard during any month in which availability of the DCS is prevented for two working days due to failure of any system component for which the Government is responsible.

9.4. All overpayment recovery, refund, offset collection and adjustment requirements, including timeliness standards, are applicable to the operation of the Duplicate Claims System.