TRICARE PROCESSING STANDARDS

1.0. TIMELINESS AND QUALITY STANDARDS OF PERFORMANCE

Contractors are charged with providing or arranging for delivery of quality, timely health care services and have the 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, 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. A summary of key performance standards is listed below.

1.1. Preauthorizations/Authorizations

The contractor shall issue determinations on at least:

- 90% of all requests for preauthorization/authorization within one working day following receipt of the request and all required information.
- 100% of such requests within five working days following receipt of the request and all required information.

1.2. Referrals

Following the date of receipt of a request for a referral, the contractor shall issue a referral authorization or denial on at least:

- 85% of all requests within one workday
- 100% of all requests within three workdays
- 96% of all referrals of beneficiaries residing in TRICARE Prime service areas (does not include TRICARE Prime Remote areas) shall be to the MTF or a civilian network provider. (This percentage includes services rendered in network institutions by hospital-based providers even though no formal referral was made to that individual.)

1.3. Claims Processing Timeliness

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

1.3.1. Retained Claims

- 95% of retained claims and adjustment claims shall be processed to completion within 30 calendar days from the date of receipt.

- 100% of retained claims and adjustment claims shall be processed to completion within 60 calendar days from the date of receipt.

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.

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

- 100% of excluded claims, including adjustments, 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.

"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.).

1.4. Simple Interest Payments

For claims with addresses within the United States, 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. No interest shall be paid on claims with addresses outside the United States. 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).

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

- 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 for recoupment or future offset.

1.6. Claims Processing Cycle

The contractor shall generate an initial submission claims processing cycle and transmit related TRICARE Encounter Data (TEDs) and required documents to TMA not less than three times every 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 ensure only one processed claims history and deductible file is maintained for each beneficiary.

1.7. Claims Processing Accuracy

1.7.1. Claim Payment Errors

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

1.7.2. Claim Occurrence Errors

The TED occurrence error rate shall not exceed three percent for all types of TEDs.

1.8. TRICARE Encounter Data (TEDs) - Timeliness

- 100% initial submission vouchers/batches shall be transmitted to TMA within five calendar days of the date of the batch/voucher create date.

- 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.

- 100% unprocessable vouchers/batches 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.

- 95% of all vouchers/batches having TEDs (initial submissions, resubmissions, and adjustment/cancellation submissions) failing validity edits shall be corrected (clear all TMA validity edits) and resubmitted to TMA within 20 calendar days after the errors and rejected TEDs were transmitted to the contractor by TMA. The resubmission data shall contain all TEDs rejected on the voucher/batch in question.

- 100% (all remaining) unprocessable vouchers/batches having TEDs failing validity edits shall be corrected (clear all TMA validity edits) and resubmitted to TMA within 30 calendar days after the data was transmitted to the contractor by TMA. The resubmission data shall contain all TEDs rejected in the voucher/batch.

- 90% of all vouchers/batches having TEDs (initial submission, resubmissions, and adjustment/cancellation submissions) failing provisional edits shall be corrected (clear all TMA edits) and resubmitted to TMA within 40 calendar days after the errors and rejected TEDs were transmitted to the contractor by TMA.

- 100% (all remaining) vouchers/batches having TEDs failing provisional edits shall be corrected (clear all TMA edits) and resubmitted to TMA within 60 calendar days after the data was transmitted to the contractor by TMA.

1.9. TRICARE Encounter Data (TEDs) - Accuracy

1.9.1. Validity Edits

Following the start of health care delivery, the contractor shall have the following percentages of TEDs (initial submissions, resubmissions and adjustment/cancellation submission) passing the TMA validity edits at the following time lines:

- One through three months - 85%
- Four through six months - 90%
- Seven through nine months - 95%
- More than nine months - 99%

1.9.2. Provisional Edits

Following the start of health care delivery, the contractor shall have the following percentages of TEDs (initial submissions, resubmissions and adjustment/cancellation submissions) passing the TMA provisional edits at the following time lines:

- One through three months - 80%
- Four through six months - 85%
- Seven through nine months - 90%
- More than nine months - 95%

1.9.3. Vouchers/Batches

Three months following the start work date of the contract, the contractor shall have no more than two 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.

2.0. MANAGEMENT

2.1. 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 TMA instructions (see Chapter 2).

2.2. Availability Of Information

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

2.3. Contract Changes

The contractor shall provide a complete reply to TMA requests for comments, rough orders of magnitude, or cost estimates on all proposed changes, to include changes to the manuals 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.

2.4. HHS Privacy Regulation Training and Education

2.4.1. Workforce Training

2.4.1.1. The contractor shall train as necessary and appropriate all workforce members (all employees, volunteers, trainees, and other persons who conduct, and perform work for the contractor) to carry out their functions with respect to the HHS Privacy Regulation.

2.4.1.2. The contractor shall provide workforce training as follows:

- To each new member of the workforce within 30 work days of starting work.
- Subsequent refresher training shall be conducted annually to demonstrate the importance of the Regulation and to ensure the workforce understands the rules, policies, and procedures.
- Retraining must occur within 30 days for all members of the workforce whose functions are affected by a material change in TRICARE or the contractor's policies and procedures.

2.4.1.3. The contractor shall document all training provided to its workforce to include, as a minimum, who received the training and the date of training.

2.4.2. Education

2.4.2.1. The contractor shall include instructions on how to obtain the HIPAA Notice of Privacy Practices with educational materials provided to beneficiaries. General information on the HIPAA privacy requirements shall also be included in existing routine mailings to the beneficiary.

2.4.2.2. The contractor shall respond to beneficiary and provider questions regarding the HHS Privacy Regulations. The contractor shall respond to beneficiary and provider questions using the following standards: 85% of all requests shall be answered in 10 calendar days of receipt and 100% in 30 calendar days. Questions of a non-routine nature or that require additional assistance to resolve, shall be coordinated with the Military Treatment Facility Privacy Officer for co-located TRICARE Service Centers and to the Regional Director for all others.

3.0. 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:

3.1. 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 routine written inquiries as follows:

- 85% within 15 calendar days of receipt;
- 97% within 30 calendar days of receipt; and
- 100% within 45 calendar days of receipt.

3.2. 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 priority written inquiries as follows:

- 85% within 10 calendar days of receipt;
- 100% within 30 calendar days of receipt.

3.3. Walk-In Inquiries

- 95% walk-in inquiries shall be acknowledged and be assisted by a service representative within five minutes of entering the reception area.
- 100% of walk-in inquiries shall be acknowledged and assisted by a service representative within 10 minutes of entering the reception area.

3.4. Telephone Inquiries

The following required levels of service shall be available at all times - daily, weekly, monthly, etc. Averages are not acceptable.

- Blockage rates shall never exceed 5%. Never is defined as at any time during any day.
- 95% of all telephones shall be answered within 2 rings by a Automated Response Unit (ARU). The caller shall have only two choices: transfer to an automated response unit (e.g. automated claims inquiry, recorded messages where to submit claims or correspondence, etc.) or to an individual.

- If transferred to an automated response unit (ARU), 100% of all telephone calls shall be acknowledged within 20 seconds.

- If transferred to an individual, 80% of all telephone calls shall be answered by an individual (not an answering machine) within 20 seconds.

- If transferred to an individual, 95% of all calls shall be answered by an individual (not an answering machine) within 30 seconds.

- Total "on hold" time for 95% of all calls shall not exceed 30 seconds during the entire telephone call.

- 80% of all inquiries shall be fully and completely answered during the initial telephone call.

- 95% of all inquiries not fully and completely answered initially shall be fully and completely answered within 10 calendar days

- 100% of all inquiries not fully and completely answered initially shall be fully and completely answered within 20 calendar days.

- All calls not completely answered during the initial call shall receive a substantive follow-up call within two workdays.

4.0. APPEALS

4.1. Expedited Preadmission/Preprocedure Reconsiderations

One hundred percent (100%) of requests for expedited preadmission/preprocedure reconsiderations processed 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.

4.2. Nonexpedited Medical Necessity Reconsiderations

The contractor shall meet the following processing standards for non expedited medically necessity reconsiderations:

- 85% within 30 calendar days;
- 95% within 60 calendar days; and
- 100% within 90 calendar days.

4.3. Nonexpedited Factual Reconsiderations

From the stamped date of receipt in the contractor's custody until processed to completion, the contractor shall meet the following standards for non expedited factual reconsiderations:

- 95% within 60 calendar days of receipt; and

- 100% 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.

5.0. GRIEVANCES

All written grievances shall be stamped with the actual date of receipt within three workdays of receipt in the contractor's custody. The contractor shall 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. Ninety-five percent (95%) of all grievances shall be processed to completion within 60 calendar days from the date of receipt.

6.0. POTENTIAL DUPLICATE CLAIM RESOLUTION

6.1. The contractor shall utilize the automated TRICARE Duplicate Claims System to resolve TMA identified potential duplicate claims payments.

6.2. 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 Chapters 9 and 10, Summary/Management Report entitled "Performance Standards," 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.

6.3. 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.

6.4. All overpayment recovery, refund, offset collection and adjustment requirements, including timeliness standards, are applicable to the operation of the Duplicate Claims System. Offsets shall be applied against any future payments to a debtor regardless of the type of funds (i.e., financially underwritten or non-financially underwritten) that were used in the original overpayment, or that are being used in the payments, until the debt is satisfied or until other offset requirements are met.

EXAMPLE: If a provider received a duplicate payment from the "non-financially underwritten" account and an offset is being applied, the offset shall be applied to any future payment to that provider regardless of whether the future payment contains financially underwritten or non-financially underwritten funds. When an offset is being taken from an financially underwritten payment to satisfy a debtor's non-financially underwritten debt, it shall be applied to and accounted

for in the non-financially underwritten payment to satisfy a debtor's financially underwritten debt, the offset shall be applied to and accounted for in the financially underwritten account.