OTHER CONTRACT REQUIREMENTS

1.0. CUSTOMER SERVICE

1.1. Telephone Inquiries

The contractor must provide nationwide around-the-clock toll-free telephone access to a customer service staff in order to enable providers and TDEFIC beneficiaries to determine claims status as well as general TDEFIC information. *Access outside of normal business hours for a CONUS caller's time zone may be by automated means, such as provision for leaving messages and/or for obtaining information via an automated response mechanism. During normal CONUS business hours, callers must be offered the option of speaking live with a customer service representative.* Responses must be furnished within the time frames mandated under the TDEFIC contract.

1.2. Written Inquiries

The contractor must respond promptly and meaningfully to all written inquiries, including inquiries received via E-mail. Responses must be furnished within the time frames mandated under the TDEFIC contract.

2.0. REFERRALS

All MHS beneficiaries are allowed under the Managed Care Support (MCS) contract requirements to contact the TRICARE Service Center for referrals to network providers. This shall continue with TRICARE/Medicare dual eligible individuals under the TRICARE Dual Eligible Fiscal Intermediary Contract (TDEFIC). The MCS contractor is not required to make appointments with network providers. The *MCS* contractor shall provide the TDEFIC beneficiary with the name, telephone number, and address of network providers of the appropriate clinical speciality located within the beneficiary's geographic area.

3.0. CONTRACTOR'S RESPONSIBILITY IN PROGRAM INTEGRITY

In relation to TDEFIC, at any time the contractor receives an allegation of fraudulent behavior, or any type of improper activity relating to either a beneficiary or provider submitted claim, the contractor shall review the claim to ensure it was processed properly. Following completion of the review, if an error in payment is not detected, the contractor shall provide the allegation and a copy of the claim to CMS for investigation. A copy of all allegations forwarded to CMS shall be provided to the Office of Program Integrity, TRICARE Management Activity.

4.0. AUDITS OF TDEFIC CLAIMS

Claim audits shall be performed for claims processed under the TDEFIC contract. Sample means will be used as point estimates of payment and occurrence errors. There will be two kinds of payment samples, one for non-denied claims and one for denied claims. The design of non-denied payment and the occurrence samples utilizes a 90% confidence level, while the denied payment sample design uses an 80% confidence level. Precision estimates are 1% for the non-denied payment sample, 2% for the denied payment sample, and 1.5% for the occurrence sample. The non-denied payment sample will be drawn from all records with government payments of $1.00 to $25,000. In addition, all records with a government payment of $25,000 and over will be audited. The denied payment sample will be drawn from all records with billed amounts of $1.00 to $500,000. In addition, all records with billed amounts of $500,000 and over will be audited. The non-denied payment sample will be stratified at multiple levels within the $1.00 to $25,000 range and the denied payment sample will be stratified at multiple levels within the $1.00 to $500,000 range. Samples will be drawn on a quarterly basis from TEDs which pass TMA validity edits. Records to be sampled will be "net" records (i.e., the sum of transaction records available at the time the sample was drawn related to the initial transaction record). TEDs in vouchers which fail TRICARE validity edits or which are otherwise unprocessable as submitted by the contractor will be excluded from the sampling frame.

5.0. CLAIMS AGING REPORT BY STATUS/LOCATION

The contractor shall produce and furnish to the Contracting Officer's Representative Claims aging reports by Status Location on the first workday following the reporting week. These reports shall be sorted to enable a count of the total number of claims pending for a specified length of time; e.g., over 30 days, over 60 days and over 120 days. The contractor shall include excluded and retained claims on each report. Unless specifically requested by TMA or unless the contractor customarily makes a run of these reports concurrent with preparation of the month-end reports to TMA, they need not balance with the end-of-month reports. *The TDEFIC* contractor shall prepare an explanation of the individual reports and interpretation of the locations specific to each report to enable TMA staff to effectively review the data.

6.0. CUSTOMER SATISFACTION REPORT

Monthly, by the tenth calendar day following the end of the reported month, the contractor shall report to the Government the state of TDEFIC customer satisfaction during the previous reporting period. The report shall be provided to the Contracting Officer.

7.0. MEDICARE CROSSOVER FEES

Medicare crossover fees are paid to Medicare contractors by TMA contractors. These fees cover the transmission of data on paid claims from the Medicare contractor to TMA contractors in order to facilitate TMA processing as second payer on the TFL claims. The contractor shall submit non-TED vouchers (see Chapter 3, Section 4) covering these expenses to TMA on an as needed basis, generally once or twice a month.