

TRICARE Processing Standards

Revision: C-49, June 28, 2019

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 all claims received into their custody, whether for network or non-network care. In addition, the contractor shall provide courteous, accurate, and timely responses to all inquiries from beneficiaries, providers, Defense Health Agency (DHA), and other legitimately interested parties. The contractor shall provide management reports which identify actual contractor performance in relation to contract standards. Details for reporting are identified in DD Form 1423, Contract Data Requirements List (CDRL), located in Section J of the applicable contract. DHA has established standards of performance which will be monitored by DHA and other Government agencies to measure contractor performance. Minimum performance standards are listed below.

1.1 Preauthorizations/Authorizations

The contractor shall issue determinations on at least:

- Ninety percent (90%) of all requests for preauthorization/authorization within two working days following receipt of the request and all required information.
- One hundred percent (100%) of such requests within five working days following receipt of the request and all required information.

1.2 Referral Processing and Network Adequacy

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

- Ninety percent (90%) of all requests within two workdays.
- One hundred percent (100%) of all requests within three workdays.

1.2.2 A minimum of 96% of referrals for Prime enrollees who reside in TRICARE Prime Service Areas (PSAs) and Prime enrollees who reside outside PSAs and have waived the travel-time access standards shall be to the Military Treatment Facility (MTF)/Enhanced Multi-Service Market (eMSM) or a civilian network provider. All referrals, except the following, will be included to determine compliance with the standard:

- Referrals that are unknown to the contractor before the visit (specifically Emergency

TRICARE Operations Manual 6010.59-M, April 1, 2015

Chapter 1, Section 3

TRICARE Processing Standards

Room (ER) visits, retroactively authorized referrals);

- Self referrals and referrals of beneficiaries who use Other Health Insurance (OHI) as first payor; and
- MTF/eMSM directed referrals to non-network providers when network providers are available.

All other referrals are included without exception.

1.2.3 In addition to the referral timeliness standards identified in [paragraph 1.2.1](#), the contractor shall achieve and continuously maintain a referral processing accuracy percentage of at least 95% during Option Period 1. Beginning with Option Period 2, this referral processing accuracy standard shall increase by 1% each Option Period until the standard reaches 99% during Option Period 5. For purposes of evaluation, a referral shall be considered to be processed accurately when all three of the following actions are performed correctly:

- Consideration of Right of First Refusal (ROFR) rules on referrals from the private sector in CONUS;
- Verification of beneficiary eligibility in Defense Enrollment Eligibility Reporting System (DEERS); and
- Issuance of an authorization to an appropriate provider/facility based on the referral.

1.2.4 Referrals which do not result in an authorization (e.g., a referral which is returned to the MTF/eMSM for missing information) shall not be considered in calculating referral processing accuracy.

1.2.5 Details for reporting the timeliness standards for preauthorization/authorization, referrals and referral accuracy are identified in DD Form 1423, CDRL, located in Section J of the applicable contract.

1.3 Network Adequacy

Starting in Option Period 1, the following percent of claims for Prime enrollees region-wide (excluding TPR enrollees) will be for care rendered by a network provider. This includes all claims for Prime enrollees except emergency room claims, **urgent care claims**, Point of Service (POS) claims, or claims with OHI.

- Ninety percent (90%) Option Period 1.
- Ninety-one percent (91%) Option Period 2.
- Ninety-two percent (92%) Option Period 3.
- Ninety-three percent (93%) Option Period 4.
- Ninety-four percent (94%) Option Period 5.

1.4 Claims Processing Timeliness

Unless otherwise specified, the standards below apply to all claims.

1.4.1 Retained Claims

1.4.1.1 Ninety-eight (98%) of retained claims and adjustment claims shall be processed to completion within 30 calendar days from the date of receipt.

1.4.1.2 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.

1.4.2 Retained and Excluded Claims

One hundred percent (100%) of all claims (both retained and excluded, including adjustments), shall be processed to completion within 90 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 (TPL);
- Claims requiring intervention by another Prime contractor; and
- Claims requiring Government intervention (i.e., claims held for CHAMPUS Maximum Allowable Charge (CMAC) updates, claims held pending the issuance of a policy change, etc.).

1.5 Claims Processing Cycle

The contractor shall generate an initial submission claims processing cycle and transmit related TRICARE Encounter Data (TED) and required documents to DHA 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. The contractor shall provide claims processing statistics and deferred claims reports according to contract requirements.

1.6 Claims Processing Accuracy

1.6.1 Claim Payment Errors

The absolute value of the payment errors shall not exceed 2% of the total billed charges for the first two option periods. In all remaining option periods, the absolute value of the payment errors shall not exceed 1.75% of the total billed charges.

1.6.2 Claim Occurrence Errors

The TED occurrence error rate shall not exceed 3% for all types of TEDs.

1.7 TEDs - Timeliness

- One hundred percent (100%) of initial submission vouchers/batches shall be transmitted to DHA within five calendar days of the date of the batch/voucher create date.
- Eighty-five percent (85%) 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 DHA within 20 calendar days of the date the invalid data was transmitted to the contractor by DHA.
- One hundred percent (100%) of unprocessable vouchers/batches shall be corrected and returned for receipt at DHA within 30 calendar days of the date the invalid data was transmitted to the contractor by DHA.
- Ninety-nine and one-half percent (99.5%) of all vouchers/batches having TEDs (initial submissions, resubmissions, and adjustment/cancellation submissions) failing the edit system shall be corrected and resubmitted to DHA within 30 calendar days after the errors and rejected TEDs were transmitted to the contractor by DHA. The resubmission data shall contain all TEDs rejected on the voucher/batch in question.
- One hundred percent (100%) of all remaining vouchers/batches having TEDs failing the edit system shall be corrected and resubmitted to DHA within 45 calendar days after the errors and rejected TEDs were transmitted to the contractor by DHA. The resubmission data shall contain all TEDs rejected in the voucher/batch.

1.8 TEDs - Accuracy

1.8.1 Following the start of health care delivery (SHCD), the contractor shall have the following percentages of TEDs (initial submissions, resubmissions and adjustment/cancellation submissions) passing the DHA edit system at the following time lines:

- One through three months - 80%.
- Four through six months - 85%.
- Seven through nine months - 90%.
- Ten through 11 months - 95%.
- Twelve through 23 months - 96%.
- Month 24 through contract close - 97%.

1.8.2 Vouchers/Batches

Three months following the start of health care delivery (SHCD), the contractor shall have no more than 2% 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 digital/optical disk imaging of claims/adjustment claims, with attached documentation by Internal Control Number (ICN) and 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 digital image or optical disk. Provisions shall be made for appropriate retention and disposition of files in accordance with the Federal Records Act and DHA instructions (see [Chapter 9](#)).

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.

3.0 BENEFICIARY AND PROVIDER SERVICES (BPS)

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:

- Eighty-five percent (85%) within 15 calendar days of receipt;
- Ninety-seven percent (97%) within 30 calendar days of receipt; and
- One hundred percent (100%) within 45 calendar days of receipt.

3.2 Priority Written Inquiries (Congressional, ASD(HA), And DHA)

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:

- Eighty-five percent (85%) within 10 calendar days of receipt.
- One hundred percent (100%) within 30 calendar days of receipt.

3.3 Walk-In Inquiries (TRICARE Overseas Contract Only)

- Ninety-five percent (95%) of walk-in inquiries shall be acknowledged and be assisted by a service representative within 15 minutes of entering the reception area.
- Ninety-nine percent (99%) of walk-in inquiries shall be acknowledged and assisted by a service representative within 20 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 not exceed 5%.
- The call abandonment rate shall be less than 5%.
- The average speed of answer shall not exceed 45 seconds.
- If transferred to an individual, 90% 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.
- Eighty-five percent (85%) of all telephone caller inquiries shall achieve resolution in one call. (Includes calls transferred to an individual.)
- Ninety-nine and one-half percent (99.5%) of all inquiries not fully and completely resolved on the initial call shall be fully and completely resolved to the customer's satisfaction within 10 business days.

4.0 APPEALS

4.1 Expedited Preadmission/Preprocedure Reconsiderations

One hundred percent (100%) of requests for expedited preadmission/preprocedure reconsiderations shall be processed to completion within three working days of the date of receipt by the contractor 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

From the date of receipt by the contractor until processed to completion, the contractor shall meet the following processing standards for non-expedited medical necessity reconsiderations:

- Ninety-five percent (95%) within 30 calendar days; and
- One hundred percent (100%) within 60 calendar days.

4.3 Nonexpedited Factual Reconsiderations

From the date of receipt by the contractor until processed to completion, the contractor shall meet the following standards for non-expedited factual reconsiderations:

- Ninety-five percent (95%) within 30 calendar days of receipt; and
- One hundred percent (100%) within 60 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.

4.4 Determinations Reversed by the Appeals Process

One hundred percent (100%) of contractor determinations reversed by the appeals process shall be processed to completion within 21 calendar days of receipt.

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 (DCS) to resolve DHA 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 10% 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 DCS (see the TRICARE Systems Manual (TSM), Chapter 4, Addendum C, Summary/Management Report entitled "Performance Standard," for a description and example of the Performance Standard Report). The 10% standard becomes effective on the first day of the seventh month following the SHCD or following system installation whichever is later.

TRICARE Operations Manual 6010.59-M, April 1, 2015

Chapter 1, Section 3

TRICARE Processing Standards

6.3 The contractor shall not be responsible for meeting the performance standard during any month in which access to 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 DCS. Offsets shall be applied against any future payments to a debtor until the debt is satisfied.

7.0 DEBT COLLECTION RESEARCH ASSISTANCE

The contractor shall meet required response times for problem resolution (Standard: 85% within 10 days, 100% within 30 days). Resolution is defined as: Completely review all contractor actions on the claims, the correction of all contractor errors including the expeditious reprocessing of all claims with identified errors, preparing and providing a written explanation of any beneficiary liability and the provision of a case-specific response to the Government. If applicable, the response to the Debt Collection Assistance Officer (DCAO) should note that a check is being issued to the beneficiary or provider on a priority basis and the approximate date payment is expected.

- END -