Chapter 1 Section 3

TRICARE Processing Standards

Revision: C-104, December 23, 2021

1.0 TIMELINESS AND QUALITY STANDARDS OF PERFORMANCE

The contractor shall provide or arrange for delivery of quality, timely health care services and shall provide 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 established standards of performance which DHA other Government agencies will monitor 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 business days following receipt of the request and all required information.
- One hundred percent (100%) of such requests within five business 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 business days.
- One hundred percent (100%) of all requests within three business days.

1.2.2 A minimum of 96% of referrals for TRICARE Prime enrollees who reside in TRICARE Prime Service Areas (PSAs) and TRICARE Prime enrollees who reside outside PSAs and have waived the travel-time access standards shall be to the Market/Military Treatment Facility (MTF) 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 Room (ER) visits, retroactively authorized referrals);

- Self referrals and referrals of beneficiaries who use Other Health Insurance (OHI) as first payer; and
- Market/MTF 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 the Continental United States (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 Market/MTF 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 TRICARE Prime Remote (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. This excludes non-network claims due to response to national public health emergency or pandemic and corresponding federal legislation, non-network claims as a result of network inpatient admissions, non-network claims for care in which TRICARE Policy allows delivery from network or non-network providers without referral or application of the POS option, and non-network claims when a TRICARE Prime active duty service member is directed to a non-network provider even though there is an appointment available to a network provider within access to care standards.

- 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 The contractor shall process to completion 98% of retained claims and adjustment claims within 30 days from the date of receipt.

1.4.1.2 The contractor 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 prohibits a contractor from retaining a claim for external development.

1.4.2 Retained and Excluded Claims

The contractor shall process 100% of all claims (both retained and excluded, including adjustments), to completion within 90 days unless the Government specifically directs the contractor to continue pending a claim or group of claims.

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 days. The contractor shall have an updated beneficiary processed claims history and deductible file available and accessible within one business day 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 contractor shall not allow the absolute value of the payment errors to exceed 2% of the total billed charges for the first two option periods. In all remaining option periods, the contractor shall not allow the absolute value of the payment errors to exceed 1.75% of the total billed charges.

1.6.2 Claim Occurrence Errors

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

1.7 TEDs - Timeliness

- The contractor shall transmit 100% of initial submission vouchers/batches to DHA within five days of the date of the batch/voucher create date.

- The contractor shall correct and return to DHA 85% of all unprocessable vouchers/batches, including but not limited to, out-of-balance conditions and invalid header record information within 20 days of the date the invalid data was transmitted to the contractor by DHA.

- The contractor shall correct and return to DHA 100% of unprocessable vouchers/batches within 30 days of the date the invalid data was transmitted to the contractor by DHA.

- The contractor shall correct and resubmit to DHA 99.5% of all vouchers/batches having TEDs (initial submissions, resubmissions, and adjustment/cancellation submissions) failing the edit system within 30 days after the errors and rejected TEDs were transmitted to the contractor by DHA. The contractor shall include all TEDs rejected on the voucher/batch in question in the resubmission.

- The contractor shall correct and resubmit to DHA 100% of all remaining vouchers/batches having TEDs failing the edit system within 45 days after the errors and rejected TEDs were transmitted to the contractor by DHA. The contractor shall include resubmission data shall contain all TEDs rejected in the voucher/batch in the resubmission.

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 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

2.1.1 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 days after they are processed to completion. The contractor shall maintain the claim and all supporting documents in hard copy, microcopy, or digital image or optical disk.

2.1.2 The contractor shall make provisions 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

The contractor shall ensure information required for appropriate responses to inquiries, including but not limited to claim files, appeals files, previous correspondence and check files are retrievable and forwarded within five business days 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

The contractor shall stamp all routine written inquiries with the actual date of receipt within three business days 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 days of receipt;
- Ninety-seven percent (97%) within 30 days of receipt; and
- One hundred percent (100%) within 45 days of receipt.

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

The contractor shall stamp all priority written inquiries with the actual date of receipt within three business days 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 days of receipt.
- One hundred percent (100%) within 30 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 contractor shall ensure the following levels of service are 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

The contractor shall process to completion 100% of requests for expedited preadmission/preprocedure reconsiderations within three business 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 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 days; and
- One hundred percent (100%) within 60 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 days of receipt; and
- One hundred percent (100%) within 60 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

The contractor shall process to completion 100% of contractor determinations reversed by the appeals process within 21 days of receipt.

5.0 GRIEVANCES

The contractor shall stamp all written grievances with the actual date of receipt within three business days of receipt in the contractor's custody. The contractor shall provide interim written response by the 30th day after receipt for all grievances not processed to completion by that date. The contractor shall ensure the interim response includes an explanation for the delay and an estimated date of completion. The contractor shall process to completion 95% of all grievances within 60 days from the date of receipt.

6.0 POTENTIAL DUPLICATE CLAIM RESOLUTION

6.1 The contractor shall use 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, the Government will measure contractor performance 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. The Government will use the Performance Standard Report generated by the DCS to determine contractor compliance with this standard (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.

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 business 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. The contractor shall apply offsets 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) shall note that a check is being issued to the beneficiary or provider on a priority basis and the approximate date payment is expected.

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