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TRICARE
MANAGEMENT ACTIVITY

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CHANGE 54
6010.51-M
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PUBLICATIONS SYSTEM CHANGE TRANSMITTAL
FOR
TRICARE OPERATIONS MANUAL (TOM)

The TRICARE Management Activity has authorized the following addition(s)/
revision(s) to 6010.51-M, reissued August 2002.

CHANGE TITLE: AURORA SUMMIT FIXES

PAGE CHANGE(S): See page 2.

SUMMARY OF CHANGE(S): Changes were identified by the contractors during
the Aurora Summit Meeting. The changes provide clarification in a number of areas
and offer operational improvements.

EFFECTIVE AND IMPLEMENTATION DATE: Upon direction of the Contracting
Officer.

Evie Lammle
Director, Program Requirements Division

ATTACHMENT(S): 19 PAGES
DISTRIBUTION: 6010.51-M

WHEN PRESCRIBED ACTION HAS BEEN TAKEN, FILE THIS TRANSMITTAL WITH BASIC DOCUMENT

CHANGE 54
6010.51-M
September 24, 2007

REMOVE PAGE(S)

INSERT PAGE(S)

CHAPTER 1

Section 3, pages 7 and 8
Section 8, pages 7 through 18

Section 3, pages 7 and 8
Section 8, pages 7 through 19

CHAPTER 3

Section 6, page 1

Section 6, page 1

CHAPTER 12

Section 7, page 3

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CHAPTER 15

Section 3, pages 5 and 6

Section 3, pages 5 and 6

SUMMARY OF CHANGES

CHAPTER 1

1. Section 3, page 8. Eliminated 2-day callback requirement.
2. Section 8, page 8 Added new language for Network Inpatient Care During Contract Transition and Home Health Care During Contract Transition.
3. Section 8, pages 9 - 13. Revised language to Benchmark testing.

CHAPTER 3

4. Section 6, page 1. Added language that the contractors may require payment by EFT for electronic claims submitters.

CHAPTER 12

5. Section 7, page 3. Eliminated 2-day callback requirement.

CHAPTER 15

6. Section 3, page 6. Eliminated 2-day callback requirement.

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.

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 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 medically necessity reconsiderations:

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

NOTE: As of October 1, 2003, a former spouse will be considered a sponsor in their own right and will no longer be identified by their previous relationship to a military service member. Former spouses will be identified by their own individual Social Security Number and not the SSN of the military service member. DMDC will provide contractors with a crosswalk file for former spouses previously identified by the military service member's SSN.

2.10.2.2. During the 180 calendar days after the start of health care delivery when both the incoming and outgoing contractors are processing claims, both contractors shall maintain close interface on history update exchanges and provider file information. During the first 60 calendar days of dual operations, the contractors shall exchange beneficiary history updates with each contractor's claims processing cycle run. Thereafter, the exchange shall not be less than twice per week until the end of dual processing. The outgoing contractor shall have total responsibility for the maintenance of the Health Care Provider Record (HCPR) to support HCSR submission during the 180 day phase out period. The incoming contractor shall assume total responsibility for the maintenance of the TRICARE Encounter Provider Record (TEPRV) beginning with the start of health care delivery. The incoming contractor shall not rely on the outgoing contractor HCPR for creation of the TEPRV, but will create new TEPRVs for submission. The incoming contractor will coordinate and cooperate with the outgoing contractor to ensure that the outgoing contractor can continue to process claims accurately; conversely, the outgoing contractor has responsibility to notify the incoming contractor of any changes in provider status that they become aware of through their operations.

2.10.3. Phase-In Requirements Related To Transitional Cases

In notifying beneficiaries of the transition to another contractor, both the incoming and outgoing contractors shall include instructions on how the beneficiary may obtain assistance with transitional care. If the outgoing contractor succeeds itself, costs related to each contract will be kept separate for purposes of contract accountability.

2.10.3.1. Non-Network Inpatient Transitional Cases

These are beneficiaries who are inpatients (occupying an inpatient bed) at 0001 hours on the first day of any health care contract period in which the incoming contractor begins health care delivery. In the case of DRG reimbursement, the outgoing contractor shall pay through the first month of health care delivery or the date of discharge, whichever ever occurs first. If the facility is reimbursed on a per diem basis, the outgoing contractor is responsible for payment of all the institutional charges accrued prior to 0001 hours on the first day of health care delivery, under the incoming contractor. The incoming contractor thereafter is responsible for payment.

2.10.3.2. Non-Network Outpatient/Professional Transitional Cases

These are cases, such as obstetric care, that are billed and payable under "Global" billing provisions of CPT-4, HCPCS or local coding in use at the time of contract transition, and where an episode of care shall have commenced during the period of health care delivery of the outgoing contractor and continues, uninterrupted, after the start of health care delivery by the incoming contractor. Outpatient/Professional services related to transitional

cases are the responsibility of the outgoing contractor for services delivered prior to 0001 hours on the first day of health care delivery and of the incoming contractor thereafter.

2.10.3.3. Network Inpatient Care During Contract Transition

The status of a network provider changes (provider's network agreement with the outgoing contractor is terminated resulting in the provider's loss of network status) with the start of health care delivery of the new contract. As a result, claims for inpatient care shall be reimbursed in accordance with paragraph 2.10.3.1. for non-network transitional cases. Beneficiary copay is based on the date of admission; therefore, Prime beneficiaries who are inpatients as described in paragraph 2.10.3.1., shall continue to be subject to Prime network copayments and shall not be subject to Point-of-Service (POS) copayments.

2.10.3.4. Home Health Care (HHC) During Contract Transition

HHC, for a 60-day episode of care, initiated during the outgoing contractor's health care delivery period and extending, uninterrupted, into the health care delivery period of the incoming contractor are considered to be transitional cases. Reimbursement for both the Request for Anticipated Payment (RAP) and the final claim shall be the responsibility of the outgoing contractor for the entire 60-day episodes covering the transition period from the outgoing to the incoming contractor.

2.10.4. Prior Authorizations And Referrals

The incoming contractor shall honor outstanding prior authorizations and referrals issued by the outgoing contractor, covering care through 60 days after the start of health care delivery under the incoming contract, in accordance with the outgoing contractors existing practices and protocols, within the scope of the TRICARE program and applicable regulations or statutes. In the case of RTC care, both the incoming and outgoing contractors are responsible for authorizing that part of the stay falling within their areas of responsibility; however, the incoming contractor may utilize the authorization issued by the outgoing contractor as the basis for continued stay.

2.10.5. Health Insurance Portability And Accountability Act (HIPAA)

The covered entity may honor an authorization or other express legal document obtained from an individual permitting the use and disclosure of protected health information prior to the compliance date (HHS Privacy Regulation, §164.532).

2.10.6. Installation And Operation Of The Duplicate Claims System

The incoming contractor shall have purchased, installed, configured, and connected the personal computers and printers required to operate the Duplicate Claims System no later than 60 days prior to the start of the health care delivery. See [Chapter 9](#) and [10](#), for hardware, software, printer, configuration and communications requirements and contractor installation responsibilities. Approximately 30-45 days prior to health care delivery, TMA will provide and install the Duplicate Claims System application software on the incoming contractor designated personal computers and provide on-site training for users of the Duplicate Claims System in accordance with [Chapter 9](#) and [10](#). Following the start of health care delivery, the Duplicate Claims System will begin displaying identified

potential duplicate claim sets for which the incoming contractor has responsibility for resolving. The incoming contractor shall begin using the Duplicate Claims System to resolve potential duplicate claim sets in accordance with [Chapter 9](#) and [10](#) and the transition plan requirements.

2.11. Contractor Weekly Status Reporting

The incoming contractor shall submit a weekly status report of phase-in and operational activities and inventories to the TMA CO and COR beginning the 20th calendar day following "Notice of Award" by TMA through the 180th calendar day after the start of health care delivery (or as directed by the Contracting Officer based on the status of the transition and other operational factors) under a new contract according to specifications in the official transition schedule. The status report will address only those items identified as being key to the success of the transition as identified in the Transition Specifications Meeting or in the contractor's start-up plan.

2.12. Public Notification Program-Provider And Congressional Mailing

The contractor shall prepare a mailing to all non-network TRICARE providers and Congressional offices within the region by the 45th calendar day prior to the start of health care delivery according to the specifications of the official transition schedule. The proposed mailing shall be submitted to the CO and the COR, and the TMA Marketing and Education Committee for approval not later than 90 calendar days prior to the start of each health care delivery period. The mailing shall discuss any unique processing requirements of the contractor and any other needed information dictated by the official transition schedule.

2.13. Web-Based Services And Applications

No later than 15 days prior to the start of health care delivery, the incoming contractor shall demonstrate to TMA successful implementation of all Web-based capabilities as described in the proposal.

2.14. TRICARE Handbook Mailing

No later than thirty days prior to the start of health care delivery, the MCS contractor shall mail one TRICARE Handbook to every residence in the region based off DEERS.

3.0. INSTRUCTIONS FOR BENCHMARK TESTING

3.1. General

3.1.1. Prior to the start of health care delivery, the incoming contractor shall demonstrate the ability of its staff and its automated enrollment, authorization and referral, and claims processing systems to accurately process TRICARE claims in accordance with current requirements. This will be accomplished through a comprehensive Benchmark Test. The Benchmark Test is administered by the contractor under the oversight of TMA *and must be completed NLT 60 days prior to the start of services delivery*. In the event that an incumbent contractor succeeds itself, the extent of Benchmark testing may be reduced at the discretion of the TMA Contracting Officer.

3.1.2. A *Benchmark Test* shall consist of up to 1,000 network and non-network claims, testing a multitude of claim conditions *including, but not limited to, TRICARE covered/non-covered services, participating/non-participating providers, certified/non-certified providers and eligible/non-eligible beneficiaries. This Benchmark Test will require a TMA presence at the contractor's site.*

3.1.3. A *Benchmark Test* is comprised of one or more cycles or batches of claims. When more than one cycle is used, each cycle may be submitted on consecutive days. Each cycle after the initial one will include new test claims, as well as claims not completed during preceding cycles. All aspects of claims processing may be tested, e.g., receiving and sending electronic transactions, provider file development and maintenance including interface with the National Provider System when implemented, screening, coding, data entry, editing, pricing, data management, data linking, record building, access control, etc.

3.1.4. The contractor shall demonstrate its ability to conduct enrollment, authorization and referral, and claims processing functions to include: claims control and development, accessing and updating internal and external enrollment data, accessing and updating DEERS for eligibility status, calculating cost-shares and deductibles, querying and updating internal and external family and patient deductible and cost share files on the CCDD, submitting and modifying provider and pricing records, issuing referrals and authorizations, applying allowable charge parameters, performing duplicate checking, applying prepayment utilization review criteria, adjusting previously processed claims, demonstrating recoupment and offset procedures and producing the required output for paper and electronic transactions (EOBs, summary vouchers, payment records, checks, and management reports). Clerical functions will be evaluated including correctly coding diagnoses, medical and surgical procedures and accurately resolving edit exceptions. *Enrollment* and case management functions may also be included in the benchmark. The *Benchmark Test* may include testing of any and all systems (internal and external) used by the contractor to process claims. In addition to testing claims processing records, the *Benchmark* will test generation and acceptance of TRICARE Encounter Data (TED) records for every test claim. Contractor compliance with applicable Health Insurance Portability and Accountability Act of 1996 requirements and security requirements will be included in *Benchmark* tests as appropriate.

3.1.5. The *Benchmark Test* will be comprised of both paper and electronic claims. The contractor shall be required to create test claims, including referrals and authorizations from test scenarios provided to the incoming contractor by TMA. The contractor shall supplement these test scenarios with any internal conditions they feel appropriate for testing to ensure a minimum of 1,000 claims are tested. Under certain circumstances, however, this number may be reduced at the discretion of the Contracting Officer.

3.1.6. A *Benchmark Test* of a current contractor's system may be administered at any time by TMA upon instructions by the Contracting Officer. All contractor costs incurred to comply with the performance of the *Benchmark Test* are the responsibility of the contractor.

3.2. Conducting The Benchmark

3.2.1. At the time of the scheduled *Benchmark Test* a TMA Benchmark Team comprised of up to 12 people will arrive at the contractor’s work site to *conduct* the testing and *evaluate* the *Benchmark Test* results.

3.2.2. The amount of time a contractor shall have to process the *Benchmark Test* claims and provide all of the output (excluding TEDs) to the *Benchmark Team* for evaluation will vary depending on the scope of the *Benchmark* and volume of claims being tested. As a guide, the following table is provided for contractor planning purposes:

NUMBER OF BENCHMARK CLAIMS/SCENARIOS	NUMBER OF DAYS TO COMPLETE PROCESSING
UP TO 100	1-2
UP TO 500	2-4
UP TO 1000	4-7

3.2.3. The contractor will be informed at the pre-benchmark meeting (see [paragraph 3.3.1.](#)) of the exact number of days to be allotted for processing the *Benchmark* claims and test scenarios and providing all of the output (excluding TEDs) to the *Benchmark Team* for evaluation.

3.2.4. The *Benchmark Team* will provide answers to all contractors written and telephonic development questions related to the test scenarios provided by TMA and will evaluate the contractor’s output against the *Benchmark Test* conditions.

3.2.5. The *Benchmark Team* will require a conference room that can be locked with table(s) large enough to accommodate up to 12 people. The conference room must also be equipped with two telephones with access to internal and outside telephone lines.

3.2.6. The incoming contractor shall provide up-to-date copies of the TRICARE Operations Manual, TRICARE Systems Manual, TRICARE Policy Manual and TRICARE Reimbursement Manual, a complete set of current ICD- 9-CM diagnostic coding manuals, the currently approved CPT-4 procedural coding manual, in either hard copy or on-line, whichever is used by the contractor, explanations of the contractor’s EOB message codes, edits, and denial reason codes, and any overlays required to evaluate EOBs, checks or summary vouchers.

3.2.7. The incoming contractor shall provide an appropriate printer and a minimum of three computer terminals in the conference room with on-line access to all internal and external systems used to process the *Benchmark Test* claims to include, but not limited to: provider files (TEPRVs), including the contracted rate files for each provider; pricing files (TEPRCs) (area prevailing and CHAMPUS Maximum Allowable Charge pricing) DEERS; catastrophic cap and deductible files; and any other files used in processing claims, authorizations, referrals, enrollments, etc. The contractor’s requirements for issuing system passwords for members of the *Benchmark Team* will be discussed at the pre-benchmark meeting.

3.2.8. The contractor shall provide an organizational chart and personnel directory including telephone numbers. A listing of the contractor's staff involved in performing the *Benchmark Test* by function (e.g. data entry, development, medical review, etc.) is also required. Claims flow/decision diagrams including authorization and referral requirements will be provided prior to the *Benchmark Test*.

3.3. Procedures

3.3.1. Approximately 60 calendar days following award to the contractor, representatives from TMA will meet with the incoming contractor's staff to provide an overview of the *Benchmark Test* process, receive an overview of the claims processing system, collect data for use in the *Benchmark*, and discuss the dates of the test and information regarding the administration of the *Benchmark Test*. At this time, TMA will provide the test scenarios to the contractor that are to be used in the development of their test claims.

NOTE: At TMA's discretion, the test must be completed NLT *60* days prior to the start of health care delivery to allow time to make any needed corrections. The pre-benchmark meeting will be conducted at the incoming contractor's claims processing site. Provider and beneficiary data, to include enrollment forms, physician referrals, and authorizations, will be coordinated at the pre-benchmark meeting to ensure that the contractor adequately prepares all files prior to the *Benchmark*. Electronic transaction requirements shall be discussed to include timing and logistics.

3.3.2. On the first day of the *Benchmark Test*, a brief entrance conference will be held with contractor personnel to discuss the schedule of events, expectations and administrative instructions.

3.3.3. During the *Benchmark Test* the contractor shall process the claims and provide TMA with all output, including EOBs, summary vouchers, suspense reports, checks, claims histories, etc. Paper checks and EOBs may be printed on plain paper, with EOB and check overlays. Electronic output is required for electronic transactions.

3.3.4. The contractor shall provide output for evaluation by *the TMA Benchmark Team* as the claims are processed to completion. The specific schedule for claims processing and the procedures for providing the output to the *Benchmark Team* will be discussed with the contractor at the pre-benchmark meeting.

3.3.5. TMA personnel will compare the *Benchmark Test* claim output against the benchmark test conditions for each claim processed during the test *and provide the findings to contractor personnel*. All appropriate contractor and *Benchmark Team* personnel shall be present to answer any questions raised *during the Benchmark Test claims review*.

3.3.6. At the conclusion of the *Benchmark Test*, an exit conference may be held with the contractor staff to brief the contractor on all findings identified during the *Benchmark*. A draft report of the initial test results will be left with the contractor for review. The initial *Benchmark Test Report* will be forwarded to the contractor by TMA within 45 calendar days of the last day of the test. For any claims processing errors assessed with which the contractor disagrees, a written description of the disagreement along with any specific references must

be included with the claims. *The contractor's response to the Initial Benchmark Test Report shall be submitted to the TMA CO within 30 calendar days following the contractor's response. TMA shall provide the Final Benchmark Test Report to the contractor within 30 calendar days.*

3.3.7. The contractor shall prepare and submit the initial TRICARE Encounter Data (TEDs) submission to TMA for evaluation *during the Benchmark Test. A TED record shall be prepared for each Benchmark claim processed to completion, whether allowed or denied, within two calendar days from the processed date. TED records will not be created for claims removed from the contractor's processing system, i.e., out of jurisdiction transfers.* The contractor shall be notified of any TEDs failing the TMA edits. The contractor shall make the necessary corrections and resubmit the TEDs until 100% of the original *Benchmark Test* TEDs have passed the edits and are accepted by TMA. *TEDs submission files related to the Benchmark Tests must be identified by transmission file and batch/voucher numbers prior to submission to TMA.*

3.3.8. The contractor has 45 calendar days from the date of the initial *Benchmark Test* report to submit the final corrected TEDs to TMA. New TEDs need not be generated to reflect changes created from claims processing corrections, however, all TEDs originally submitted for the *Benchmark Test* claims which did not pass the TMA edits must continue to be corrected and resubmitted until all edit errors have been resolved and 100% of the TEDs have been accepted by TMA. *TEDs submission files related to the Benchmark Tests must be identified by transmission file and batch/voucher numbers prior to submission to TMA.*

3.4. Operational Aspects

3.4.1. The *Benchmark Test* may be conducted on the contractor's production system or an identical copy of the production system (test system). Whichever system is used for the *Benchmark*, it must meet all TRICARE requirements and contain all the system interconnections and features proposed for the production system in the contractor's proposal. When the *Benchmark Test* is conducted on the contractor's production system, the contractor shall prevent checks and EOBs from being mailed to the beneficiaries and providers, and prevent production TEDs from being generated and sent to TMA.

3.4.2. Certain external test systems and files (e.g., DEERS) are an integral component of the *Benchmark Test* and the contractor is expected to perform all necessary verifications, queries, etc., according to TRICARE procedures and policy. The contractor shall coordinate through the TMA, Contract Operations *Branch*, and the TMA *IT* contractor to ensure that direct interface with any required external test systems (i.e., DEERS) is established and operational prior to the *Benchmark Test*.

3.4.3. TEDs shall be generated from the *Benchmark Test* claims and provided to TMA for processing as scheduled at the pre-benchmark meeting. The contractor shall coordinate with the TMA, Operations/Advanced Technology Integration (O/ATIC), for TED submission procedures.

4.0. CONTRACT PHASE-OUT

4.1. Transitions Specifications Meeting

The outgoing contractor shall attend a meeting with representatives of the incoming contractor and TMA at the TMA office in Aurora, CO, within 15 calendar days following contract award. This meeting is for the purpose of developing a schedule of phase-out/phase-in activities. TMA will notify the contractor as to the exact date of the meeting. The outgoing contractor shall provide a proposed phase-out plan at the Transition Specifications Meeting.

4.2. Data

The outgoing contractor shall provide to TMA (or, at the option of TMA, to a successor contractor) such information as TMA shall require to facilitate transitions from the contractor's operations to operations under any successor contract. Such information may include, but is not limited to, the following:

- The data contained in the contractor's enrollment information system.
- The data contained in the contractor's claims processing systems.
- Information about the management of the contract that is not considered, under applicable Federal law, to be proprietary to the contractor.

4.3. Phase-Out of the Contractor's Claims Processing Operations

Upon notice of award to another contractor, and during the procurement process leading to a contract award, the contractor shall undertake the following phase-out activities regarding services as an outgoing contractor.

4.3.1. Provide Information

The contractor shall, upon receipt of written request from TMA, provide to potential offerors such items and data as required by TMA. This shall include non-proprietary information, such as record formats and specifications, field descriptions and data elements, claims and correspondence volumes, etc.

4.3.2. Transfer of Electronic File Specifications

The outgoing contractor shall transfer to the incoming contractor by express mail or similar overnight delivery service, not later than three calendar days following award announcement, electronic copies of the record layouts with specifications, formats, and definitions of fields, and data elements, access keys and sort orders, for the following:

- The TRICARE Provider Files (TEPRVs).
- The TRICARE Pricing Files (TEPRCs).

- The Enrolled Beneficiary and Primary Care Manager Assignment Files.
- Mental Health Provider Files - The outgoing contractor must assure that the incoming contractor has been given accurate provider payment information on all mental health providers paid under the TRICARE inpatient mental health per diem payment system. This should include provider name; tax identification number; address including zip code; high or low volume status; if high volume, provide the date the provider became high volume; and the current per diem rate along with the two prior year's per diem amounts. The providers under the per diem payment system must be designated by Medicare, or meets exemption criteria, as exempt from the inpatient mental health unit, the unit would be identified as the provider under the TRICARE inpatient mental health per diem payment system.

4.3.3. Transfer Of ADP Files (Electronic)

The outgoing contractor shall prepare in electronic format and transfer to the incoming contractor or TMA, by the 15th calendar day following the Transition Specifications meeting unless, otherwise negotiated by the incoming and outgoing contractors, all specified ADP files, such as the Provider and Pricing files, in accordance with specifications in the official transition schedule and will continue to participate in preparation and testing of these files until they are fully readable by the incoming contractor or TMA.

4.3.4. Outgoing Contractor Weekly Shipment Of History Updates

The outgoing contractor shall transfer to the incoming contractor, in electronic format, all beneficiary history and deductible transactions (occurring from the date of preparation for shipment of the initial transfer of such history files and every week thereafter) beginning the 120th calendar day prior to the start of health care delivery (until such a time that all processing is completed by the outgoing contractor) in accordance with the specifications in the official transition schedule. See dual operations in [paragraph 2.10.2](#).

4.3.5. Transfer Of Non-ADP Files

The outgoing contractor shall transfer to the incoming contractor all non-ADP files (e.g., authorization files, clinic billing authorizations, and tapes/CDs, etc. which identify Prime service areas, Congressional and TMA completed correspondence files, appeals files, TRICARE medical utilization, and administration files) in accordance with the specifications in the official transition schedule and [Chapter 2](#). The hard copies of the Beneficiary History Files are to be transferred to the incoming contractor or Federal Records Center as required by [Chapter 2](#). The contractor shall provide samples and descriptions of these files to the incoming contractor at the Transition Specification Meeting.

4.3.6. EOB Record Data Retention And Transmittal

If the contractor elects to retain the EOB data on a computer record, it must, in the event of a transition to another contractor, provide either a full set of electronic records covering the current and two prior years, or, at the Contracting Officer's discretion, provide

the data and necessary programs to reproduce the EOB in acceptable form and transfer such data and programs to the successor contractor or to TMA. TMA shall be the final authority in determining the form and/or acceptability of the data.

4.3.7. Outgoing Contractor Weekly Status Reporting

Until all inventories have been processed, the outgoing contractor shall submit a weekly status report of inventories and phase-out activities to TMA beginning the 20th calendar day following the Specifications Meeting until otherwise notified by the Contracting Officer to discontinue. This shall be done in accordance with specifications of the official transition schedule.

4.4. Final Processing Of Outgoing Contractor

The outgoing contractor shall:

- Process to completion all network claims, to include adjustments, for services rendered during its period of health care delivery.
- Process all non-network claims and adjustments for care rendered prior to the start of health care delivery of the new contract that are received through the 90th day following cessation of the outgoing contractor's health care delivery. Processing of these claims shall be completed within 180 calendar days following the start of the incoming contractor's health care delivery. All claims shall meet the same standards as outlined in the current contract.
- Be liable, after the termination of services under this contract, for any payments to subcontractors of the contractor arising from events that took place during the period of this contract.
- Refer to [paragraph 2.10.3.](#), for transitional case requirements.
- Process all correspondence, allowable charge complaints, and incoming telephonic inquiries which pertain to claims or services processed or delivered under this contract within the time frames established for response by the standards of the contract.
- Complete all appeal/grievance cases that pertain to claims or services processed or delivered under this contract within the time frames established for response by the standards of the contract.

4.4.1. Correction Of Edit Rejects

The outgoing contractor shall retain sufficient resources to ensure correction (and reprocessing through TMA) of all TED record edit errors not later than 210 calendar days following the start of the incoming contractor's health care delivery.

4.4.2. Phase-Out Of The Automated TRICARE Duplicate Claims System

The outgoing contractor shall phase-out the use of the automated TRICARE Duplicate Claims System in accordance with [Chapters 9](#) and [10](#) and transition plan requirements.

4.4.3. Phase-Out Of The Contractor's Provider Network, TRICARE Service Centers, And MTF Agreements

4.4.3.1. Upon notice of award to another contractor, the outgoing contractor shall provide full cooperation and support to the incoming contractor, to allow an orderly transition, without interruption, of all functions relating to the MTF interface and the establishment of a provider network by the incoming contractor. This shall include, but is not limited to, data relating to on-site service centers, resource sharing agreements, equipment, telephones and all other functions having an impact on the MTFs.

4.4.3.2. Within 15 calendar days of the Transitions Specifications Meeting the outgoing contractor shall draft and submit a revised plan for transition of the MTF interfaces. Resolution of differences identified through the coordination process must be accomplished in collaboration with the Transition Monitor appointed by TMA and according to the guidelines in the transition schedule.

4.4.3.3. The outgoing contractor shall vacate the TRICARE Service Centers (TSCs) on the 40th calendar day prior to the start of health care delivery and will establish a centralized Health Care Finder function to continue through the last date of health care delivery under the current contract, unless otherwise negotiated with the incoming contractor during the Transition Specifications Meeting. NOTE: This section only applies when both the incoming and outgoing contractors have TSCs.

4.4.3.4. The outgoing contractor shall continue to issue prior authorizations for care for which it is financially responsible. However, authorization-related information shall be shared between the incoming and the outgoing contractors to preclude requiring a provider or beneficiary to duplicate the paperwork and other effort related to establishing prior authorizations. The outgoing contractor may issue prior authorizations as late as midnight on the day prior to the end of its health care delivery for inpatient stays that will continue as transitional cases. The two contractors shall interface on the clinical issues of a case where both contractors will, or can reasonably expect to have periods of liability for the same episode of care.

4.4.3.5. The outgoing contractor shall maintain toll-free lines and Web-based customer service capabilities, accessible to the public during the first 90 calendar days of dual operations in order to properly respond to inquiries related to claims processed for services incurred during the period of their respective liability. Beneficiary inquiry lines will continue to be staffed as defined in the contract. In general, the outgoing contractor shall maintain adequate toll-free line coverage to ensure that the blockage rate does not exceed the blockage rate on the contractor's most critical private or other government business access line.

4.5. Phase-Out Of Enrollment Activities

4.5.1. Prior to the start of health care delivery under the successor contract, for all enrollment renewals or payments in which the new enrollment period or period covered by the premium payment will begin under the new contract, the outgoing contractor shall amend renewal notices and billing statements (or include a stuffer/insert) to advise the enrollee to direct any enrollment-related correspondence and enrollment fee payments to the successor contractor.

4.5.2. Prior to the start of health care delivery under the successor contract, the Government will provide the outgoing contractor with the software for the DEERS On-line Enrollment System (DOES) version to be used during transition. The software version should be loaded and used for the phase-out of enrollment activities.

4.5.2.1. Enrollment Actions During 45-Day Transition Period

4.5.2.2. For new enrollments in the Region with an effective date prior to the start of health care delivery (e.g., AD enrollment, mid-month enrollment; transfer-in, etc.), the outgoing contractor must effect an enrollment action with an end date of the current contract period (i.e., one day prior to the start of health care delivery under the incoming contract). Any enrollment fees due for an effective date that is prior to the start of health care delivery will be retained by the outgoing contractor. Once the enrollment is effected, the outgoing contractor will notify the incoming contractor of the new enrollment.

4.5.2.3. When a current enrollment in the Region requires deletion with an effective date prior to the start of health care delivery (e.g., transfers out; disenrollments for failure to pay fees; cancellations, etc.), the outgoing contractor must request the incoming contractor to cancel the future enrollment segment that was included on the Gold File. Once notified by the incoming contractor that the segment has been cancelled, the outgoing contractor completes the appropriate disenrollment action.

4.5.2.4. For all other enrollment actions with an effective date prior to start of health care delivery (e.g., PCM changes; DMIS ID changes; enrollment begin date changes; etc.), the outgoing contractor must request the incoming contractor cancel the future enrollment segment. Once notified that the cancellation has been completed, the outgoing contractor will make the necessary change. Upon completion of the change, the outgoing contractor must notify the incoming contractor so that the future enrollment segment can be restored.

4.5.2.5. The outgoing contractor should complete all pending enrollment actions prior to the DEERS freeze to transition enrollment. Any enrollment action not completed by the outgoing contractor prior to the freeze (and after the Gold File is created) will have to be accomplished following the above procedures.

4.5.2.6. Once health care delivery begins, all enrollment actions will be accomplished by the incoming contractor. If the outgoing contractor requires a retroactive change, they must submit their request to the incoming contractor who will perform the change and notify the outgoing contractor when it is complete.

4.5.3. Any enrollment-related correspondence and/or enrollment fee payments subsequently received by the outgoing contractor shall be forwarded to the incoming contractor within three business days of receipt.

4.5.4. The outgoing contractor shall terminate marketing and enrollment activity 40 calendar days prior to the start of the incoming contractor's health care delivery. Any enrollment requests or applications received after the 40th calendar day shall be transferred to the incoming contractor by overnight delivery at the outgoing contractor's expense.

4.5.5. Throughout the transition period, the outgoing and incoming contractors shall coordinate enrollment files no less than weekly to ensure that new enrollments and enrollment renewals are accurately and timely reflected in the incoming contractor's enrollment files and in DEERS.

4.6. Cost Accounting

If the outgoing contractor succeeds itself, costs related to each contract shall be kept separate for purposes of contract accountability, according to the above guidelines.

4.7. Records Disposition

The outgoing contractor shall comply with the provisions of [Chapter 2](#), in final disposition of all files and documentation. The contractor shall include a records disposition plan as part of the phase-out plan submitted to TMA at the Transition Specification Meeting.

PAYMENTS TO BENEFICIARIES/PROVIDERS

1.0. CHECKS

When issuing checks for payments to beneficiaries and providers, the contractor shall use the following formats/statements:

- The check shall be dated the same date the contractor received authorization from TMA, CRM Budget Office to release checks.
- The words "TRICARE Payment" shall be printed in at least 18-point font at the top of the check.
- The TRICARE logo and the contractor's name and address shall be on the check.
- The following endorsement statement shall be printed using 4 or 5 point type in the 1.5 inches allotted on the reverse side of the check. This will comply with Federal Reserve Bank Regulation CC regarding check endorsements. The endorsement shall read as follows:

"This payment is made with Federal funds. Fraud in procuring, forging of signature or endorsement, or materially altering this check is punishable under the U.S. Criminal Code. IF PAYABLE TO A PARTICIPATING PROVIDER OF SERVICES - By endorsing this check, the undersigned payee agrees that he/she is subject to the terms of the participating agreement (assignment) as set forth in the TRICARE regulation."

- A statement that the check must be negotiated within 120 calendar days.

2.0. ELECTRONIC FUNDS TRANSFER (EFT)

2.1. Payments may be made by EFT to beneficiaries and providers. EFTs shall be done under the same guidelines as checks other than situations unique to EFT type transactions (i.e., EFTs do not staledate since an EFT is accepted or returned almost immediately).

2.2. *The contractor may require providers who submit claims electronically to also accept an electronic remittance advice and to receive payment by EFT.*

3.10.2. Measure the number of calls received each month and the time elapsing between acknowledgment and handling by a telephone representative or Automated Response Unit (ARU). (Includes all calls that are directly answered by an individual or ARU (no waiting time). The on-hold time period begins when the telephone call is acknowledged and does not include the ring time.

3.11. Additional Equipment Requirements

The contractor shall furnish the following:

3.11.1. Access to a CRT for each telephone representative to retrieve or provide the information required in [paragraphs 3.0.](#) through [3.7.](#) above. The CRT shall be located to allow the telephone representatives to research data without leaving their work stations.

3.11.2. Outgoing lines sufficient to allow call backs.

3.11.3. Hard copy management reports regarding All Trunks Busy (ATB) data and the waiting time measurements. The hard copy management reports shall also include the total number of calls received, the number answered at the time of the call, the number fully answered within ten calendar days, the number fully answered within 20 calendar days, and the percentage of each.

3.11.4. A supervisor's console to monitor telephone representatives' telephone calls for accuracy, responsiveness, clarity, and tone.

3.11.5. Automatic call distributors and ARUs with after hours message recorders, an automated, interactive, 24 hour call-handling system designed to ensure maximum access to the toll-free lines. This system shall provide automated responses to requests for general program information and to beneficiary requests for claims status.

4.0. REPORTS

See [Chapter 15, Section 3](#) for the Contractor Monthly Toll-Free Telephone Report.

5.0. TELEPHONE APPRAISAL SYSTEM

The contractor shall establish a monitoring system or other methods to ensure quality of performance.

9.0. BENEFICIARY SERVICES AND ACCESS REPORTS

The contractor shall provide monthly summary reports on beneficiary services and access to services. These reports shall include accurate information about the program activities, service volumes, and organizational efficiency of each service function. Copies of all reports shall be provided to the Regional Director at the same time they are provided to the Contracting Officer in the format required by the Regional Director.

10.0. EDUCATION PRESENTATION REPORT

10.1. The Education Presentation Report shall be reported each month by region and copies submitted electronically by the 10th working day of each month to each of the following:

- Regional Director or designee
- MTF Commander of Designee
- TMA Contracting Office and Contracting Officer Representative
- TMA Communications and Customer Service Directorate

10.2. The report shall capture the following information:

- Calendar of briefings held during the prior month
- Number of attendees at each briefing
- Type of attendees by beneficiary category
- Location of briefing
- Duration of briefing
- Volume and type of materials distributed at each briefing
- Summarize major issues/questions brought out at the briefing
- Suggested follow-up actions to briefings
- Major facility issues/concerns
- Projected briefing schedule for the following month
- Participating briefers (name and organization)
- Contractor suggested changes (i.e., content of briefings, materials, etc.)

11.0. TOLL-FREE TELEPHONE REPORT

The contractor shall provide the following report to TMA and the appropriate Regional Director in the required format to arrive by the 15th calendar day of each month for the previous month. This report shall include:

- All lines busy (ALB) in percentage.
- Total calls attempting to reach the contractor.
- Total calls received.
- Percent of calls answered within two rings by the ARU.
- Percent of calls answered by an individual within 20 seconds
- Percent of calls answered by an individual within 30 seconds.
- Number of calls exceeding 30 seconds hold time during the entire telephone call.
- Number of calls totally answered during the initial telephone contact.
- Number of calls not fully completed within ten calendar days.
- Number of calls not fully completed within 20 calendar days.

12.0. 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 customer satisfaction during the previous reporting period. The report shall be provided to the Regional Office and the Contracting Officer. The Customer Satisfaction Report shall include:

- The contractor's measurement of satisfaction, by category, to include active duty personnel, dependents of active duty, retirees and other eligible beneficiaries under age 65;
- Network providers;
- Non-network providers;
- MTF providers; and
- MTF Commanders.