Chapter 1 Section 3

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 all claims received into their custody, whether for network or non-network care. In addition, the contractor must provide courteous, accurate, and timely response to all inquiries from beneficiaries, providers, TRICARE Management Activity (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. 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 Referrals/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 ninety-six percent (96%) of referrals for Prime enrollees, Standard beneficiaries 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) or a civilian network provider. All referrals, except the following, will be included to determine compliance with the standard: (1) referrals that are unknown to the contractor before the visit (specifically Emergency Room (ER) visits, retroactively authorized referrals), (2) self referrals and referrals of beneficiaries who use Other Health Insurance (OHI) as first payor, (3) MTF directed referrals to non-network providers when network providers are available, and (4) the eight mental health self-referrals. All other referrals are included without exception.

1.2.3 Behavioral Health Care Appointments

A minimum of ninety percent (90%) of behavioral health care appointment requests

received during a quarter shall result in the establishment of an appointment that meets the access standards set forth in Chapter 11, Section 11, paragraph 2.2.

1.3 Network Adequacy

In Option Period One, 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, Point of Service (POS) claims, or claims with OHI.

- North Region: 86%
- South Region: 86%
- West Region: 72%

This percent for the number of claims from network providers will increase 1% each option period.

1.4 Electronic Claims Submittal

The following percentage of all claims shall be submitted electronically after the specified percentage of claims has been excluded. For the North Region, 30% of paper claims will be excluded each option year from the total number of paper claims processed. For the South Region, 25% of paper claims will be excluded each option year from the total number of paper claims processed. For the West Region, 28% of paper claims will be excluded each option year from the total number of paper claims processed.

OPTION YEAR	NORTH	SOUTH	WEST
1	72%	77%	75%
2	75%	80%	78%
3	77%	82%	80%
4	78%	83%	81%
5	79%	84%	82%

1.5 Claims Processing Timeliness

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

1.5.1 Retained Claims

- Ninety-eight (98%) of retained claims and adjustment claims shall be processed to completion within 30 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.

1.5.2 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;
- 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.).

1.6 Claims Processing Cycle

The contractor shall generate an initial submission claims processing cycle and transmit related TRICARE Encounter Data (TED) 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 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.

1.7.2 Claim Occurrence Errors

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

1.8 TEDs - Timeliness

- One hundred percent (100%) of initial submission vouchers/batches shall be transmitted to TMA 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 TMA within 20 calendar days of the date the invalid data was transmitted to the contractor by TMA.

- One hundred percent (100%) of unprocessable vouchers/batches shall be corrected and returned for receipt at TMA within 30 calendar days of the date the invalid data was transmitted to the contractor by TMA.

- 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 TMA within 30 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.

- One hundred percent (100%) of (all remaining) unprocessable vouchers/batches having failed the TEDs edit system shall be corrected and resubmitted to TMA within 45 calendar days after the data was transmitted to the contractor by TMA. The resubmission data shall contain all TEDs rejected in the voucher/batch.

1.9 TEDs - Accuracy

1.9.1 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 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%

1.9.2 Vouchers/Batches

Three months following the start work date of the contract, 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) 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 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.

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 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:

- 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

- 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 never exceed 5%. Never is defined as at any time during any day.
- Ninety-five percent (95%) of all telephones shall be answered within two rings by a Automated Response Unit (ARU). The caller shall have only two choices: transfer to an ARU (e.g., automated claims inquiry, recorded messages where to submit claims or correspondence, etc.) or to an individual.
- If transferred to an ARU, 100% of all telephone calls shall be acknowledged within 20 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 inquiries shall be fully and completely answered during the initial telephone call. (Applies to all calls transferred to an individual.)
- Ninety-nine and one-half percent (99.5%) of all inquiries not fully and completely answered initially shall be fully and completely answered within 10 business days.

3.4.1 Telephone Inquiries to Behavioral health Provider Locator and Assistance Service

For all telephone calls made to the contractor's dedicated behavioral health provider locator and assistance service during normal business hours for all time zones within the region, ninety-five percent (95%) shall be answered by a contractor staff member within 30 seconds.

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 medical necessity reconsiderations:

- Eighty-five percent (85%) within 30 calendar days;
- Ninety-five percent (95%) within 60 calendar days; and
- One hundred percent (100%) within 90 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 60 calendar days of receipt; and

- One hundred percent (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.

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 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 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 Chapter 9, Summary/Management Report entitled "Performance Standards," 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 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 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 WORKLOAD REPORTS

7.1 General

The contractor shall submit to the TMA a TRICARE Contractor Monthly Workload Report, TMA Form 742 of combined network and non-network data for the contract. The Monthly Workload Report is due on the 45th calendar day following the start date of the contract. For purposes of this report, a claim is defined as any request for payment for services rendered related to care and treatment of a disease or injury which is received from a claimant by a TMA contractor on any TMA-approved claim form or approved electronic media. Reports of services rendered, which do not result in the submission of claims, as defined above, are not to be included in the reports required.

7.2 Cycle Time/Aging Report

The contractor shall submit to TMA a TRICARE Contractor Monthly Cycle Time/Aging Report, TMA Form 743, of combined network and non-network data for the contract.

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