CHAPTER 12
SECTION 6

CORRESPONDENCE CONTROL, PROCESSING AND APPRAISAL

1.0. GENERAL

The contractor shall make timely, accurate answers to all TRICARE inquiries [written, telephone, electronic, walk-in, ASD(HA), TRICARE Management Activity (TMA), Regional Director, HBA, and congressional]. Written inquiries received shall be sorted and categorized as defined in paragraph 3.0. below. For standards refer to Chapter 1, Section 3. *On all outgoing correspondence from the contractor to the beneficiary, if the SSN is used it shall be limited to the last four digits due to security and privacy concerns.*

1.1. Correspondence Receipt And Control

The contractor shall establish and maintain an automated control system for routine and priority correspondence, appeals, and grievances which meets the requirements of Chapter 1, Section 3; Chapter 12; and Chapter 13. The contractor shall capture and retain needed data for input to workload and cycle time aging reports.

1.2. Availability Of information

Information required for appropriate responses to inquiries, including but not limited to TRICARE claim files, appeal files, previous correspondence, and canceled checks must be retrievable within five workdays following a request for the information.

2.0. CONTROL

Correspondence shall be controlled and stamped with the actual date of receipt in the contractor's custody. The control system shall be automated unless the contractor receives approval for another system which will produce comparable results. Information required for appropriate responses to inquiries shall be retrievable not less than five days following a request for the information. When appropriate, contractor must be able to associate incoming correspondence with prior inquiries. All correspondence or other documents received or generated in the services department shall be filed within five workdays following processing to completion. If correspondence is answered by telephone, a record of the conversation shall be filed with the inquiry.

3.0. CATEGORIES OF CORRESPONDENCE

All incoming correspondence shall be separated into the following categories for reporting purposes:

- Appeals
- Grievances

- Priority correspondence
- Routine inquiries, including allowable charge complaints
- Allowable Charge Complaints

4.0. ROUTINE CORRESPONDENCE

4.1. Responses may be provided by telephone, form letter, preprinted information, or individual letter. A copy of the response shall be filed with the inquiry. The text of written responses shall be typed. On form letters or preprinted information, the address may be neatly handwritten, if the contractor chooses. In situations of potential fraud or abuse, a referral to the contractor's Program Integrity Unit shall be completed and a copy of the referral filed with the correspondence. For standards see Chapter 1, Section 3.

4.2. If correspondence is received which does not contain enough information to identify the specific concern, the contractor should develop incomplete inquiries by using the quickest and most cost effective method for acquiring the information. Telephone contact is recommended. When a reasonable effort has been made to acquire the missing information, notify the correspondent that a response is not possible until receipt of the requested information. The contractor may then close the item for reporting purposes.

4.3. Correspondence status inquiries, such as "tracer" claims from providers or beneficiaries and provider and beneficiary letters inquiring about the status of a claim, may be closed without a written response if the claim was processed within five calendar days prior to receipt of the inquiry. The day that the determination was made that the inquiry may be closed without a written response is the day the inquiry is to be closed for correspondence cycle time purposes. Otherwise, "tracer" claims, usually submitted by providers, are to be researched to determine whether the initial claim was received. If the initial claim was received and processed to completion, the contractor is to advise the provider of the date processed and the amount of payment, if any, or reason for denial. If the initial claim was not received, the contractor shall indicate this on the claim and submit the claim for normal processing, advising the provider of this action.

5.0. PRIORITY CORRESPONDENCE

Priority written correspondence is correspondence received from members of the U.S. Congress, the Office of the Assistant Secretary of Defense (Health Affairs), TMA, Regional Director's Offices and such other classes as may be designated as "priority" by contractor management. Inquiries from the Surgeons General, Flag Officers, and state officials, such as insurance commissioners, are considered priority correspondence. The contractor shall forward all Congressional inquiries involving DEERS to the DEERS Research and Analysis Section, DMDC/DEERS, 400 Gigling Road, Seaside, CA 93955-6771, including any claim information required for them to respond to the inquiry. A notification shall be sent to the Congressional office informing them that the letter has been forwarded to the DMDC Support Office (DSO). For standards refer to Chapter 1, Section 3.

6.0. CORRESPONDENCE COMPLETION AND QUALITY CONTROL

6.1. A piece of correspondence shall be considered answered when the contractor's response to the individual provides a detailed outline of all actions taken to resolve the problem(s) and includes, as appropriate:

6.1.1. An explanation of the requirements leading to the benefit determination;

6.1.2. A clear, complete response to all stated or implied questions;

6.1.3. When necessary to understanding, the contractor shall send copies of Explanation(s) of Benefits (EOB), make reference to claim number(s) of the original claim(s) and the claim number(s) of adjustment claim(s) and provide sufficient details to establish an easily followed audit trail, or send other documents for full explanation and clarity.

6.1.4. Completion of a referral form to the contractor's Program Integrity Unit if potential fraud or abuse is identified. A copy of the referral shall be filed with the correspondence.

6.1.5. If the response states or implies that additional action will be taken by the contractor, but that final or additional action requires an action or reply by the inquirer, the contractor shall clearly explain what is required.

6.2. When TMA staff requests the contractor to provide claims processing information required for TMA to answer inquiry correspondence, the contractor need not provide detailed explanations of TRICARE policy, but shall provide a regulatory citation in support of the benefit determination, the date the claim was first received, the date the Explanation of Benefits (EOB) was mailed, and a detailed explanation of any delay. When requested, the contractor shall furnish TMA with copies of all claims, supporting documents, previous correspondence relating to the particular case, a recapitulation, and a narrative description of the claims processing history for that claim; e.g., date received, date completed, date paid, etc. In the case of a TRICARE Prime beneficiary, it may be necessary to provide information about special coverage, pamphlets, enrollment information, or copies of all or parts of a health care record.

6.3. The contractor shall ensure the correspondence it prepares is accurate, responsive, clear, timely, and that its tone conveys concern and a desire to be of service. To monitor correspondence, contractors shall establish a quality control procedure to ensure its correspondence reflects the elements previously listed. The findings of the quality control review shall be incorporated into training programs to upgrade the performance of all persons involved in correspondence preparation. Contractors are free to tailor the program to meet their needs. However, **service** to the beneficiaries and providers, as reflected in the quality and timeliness of correspondence, is a key management responsibility.

7.0. REQUIRED REPORTS

The contractor shall have the capability to provide data for the following management reports:

- An open correspondence reporting system which identifies priority correspondence over ten days old and routine inquiries over 15 days old for management follow-up action. This report shall include the sponsor's name and SSN, the patient's name, the name of the correspondent, the date of the correspondence, the date the correspondence was received by the contractor, the current status of the correspondence, the date of the latest interim response, and the anticipated or final response statement. This report is for contractor use only and the contractor may use any reporting system it chooses, provided there are adequate controls to meet timeliness standards.

- Correspondence statistics for prompt and accurate completion of the TRICARE Monthly Workload and Cycle Time/Aging Reports contained in Chapter 15.