III. CORRESPONDENCE PROCESSING AND APPRAISAL

A. Routine Correspondence

1. The contractor shall provide final responses to a minimum of *eighty-five* percent *(85%)* of all routine written inquiries within *fifteen (15)* calendar days of receipt. If a final response cannot be provided within *fifteen (15)* days, the contractor shall provide a written interim response by the *fifteenth (15th)* calendar day after receipt. Final response shall be provided on *ninety-seven* percent *(97%)* of all routine inquiries within *thirty (30)* calendar days of receipt; final response will be provided to all routine inquiries within *forty-five (45)* calendar days of receipt.

2. Responses may be provided by telephone, form letter, preprinted information, or individual letter. A copy of the response shall be filed with the inquiry. If the response is by telephone, a record of the conversation 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.

3. 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. 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 *(5)* calendar days prior to receipt of the inquiry. The day that the determination was made that the inquiry can be closed without a written response is the day the inquiry is to be closed for correspondence cycle time purposes.

5. 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 should indicate this on the claim and submit the claim for normal processing, advising the provider of this action.

B. Priority Correspondence

1. The contractor shall provide final responses to *eighty-five* percent *(85%)* of all priority written inquiries within *ten (10)* calendar days of receipt. It is expected that *one hundred* percent *(100%)* of priority written inquiries will be answered with a final response within *thirty (30)* calendar days of receipt. Priority written correspondence is correspondence received from members of the U.S. Congress, the Office of the Assistant Secretary of Defense (Health Affairs), TMA, 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.

2. The contractor shall forward all Congressional inquiries involving DEERS to the DEERS Directorate, Defense Medical Systems Support Center, 6 Skyline Place, Suite 502, 5109 Leesburg Pike, Falls Church, VA 22041-3201, 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 DEERS Program Office.

3. ***Reserved***

C. Correspondence Completion and Quality Control

1. Completing Correspondence

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:

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

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

c. When necessary to understanding, the contractor will 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.

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

e. 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.

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.

3. The contractor is responsible for ensuring 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 should 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, effective **service** to the beneficiaries and providers, as reflected in the quality and timeliness of correspondence, is a key management responsibility.

IV. TELEPHONE INQUIRIES

A. Telephone System

The contractor shall provide an incoming telephone inquiry system. The telephone system shall be fully staffed between 8 a.m. and 6 p.m. of the time zone specified in the contract or, in the absence of a specification, the predominant time zone of the region. All telephones must be staffed and able to respond throughout the entire period. The contractor shall *never exceed twenty percent (20%).* Substitute clerks shall be trained to fill-in for absences, breaks, and lunch periods. In addition, a recorded message indicating normal business hours shall be used on the telephone lines after hours. Calls will be handled in the order they are received. The phone number(s) shall be published on the EOBs and otherwise be made known to beneficiaries, providers, HBAs, and Congressional offices. The telephone inquiry system shall be separate from the health care finder lines.

B. Responsiveness

Telephone inquiries shall be answered according to the requirements in OPM Part One, Chapter 1, Section III.E.3. Contractors may respond to telephone inquiries by letter if written response provides better service. For example, it may be difficult to reestablish telephone contact with the calling party, a written response may provide the caller with needed documentation, or a situation may call for a complex explanation which is clearer if written. The contractor staff should be trained to respond in the most appropriate, accurate manner. Telephone inquiries reporting a potential fraud or abuse situation shall be documented and referred to the contractor's Program Integrity Unit.

C. Reports

Accurate data will be compiled to complete the Monthly Workload Reports to *TMA.* (See OPM Part One, Chapter 3.) Other reports should provide contractor management with a historical record workload and performance data. The reports should be designed to aid in planning for future seasonal workloads, staffing, evaluating representative's performance, providing guidance, evaluating training needs, and measuring work activity. See *Part Three, Chapter 6, Section I* for the Contractor Monthly Toll-Free Telephone Report.

D. Telephone Appraisal System

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

V. GRIEVANCES AND GRIEVANCE PROCESSING

A. Grievances and Grievance Processing

The contractor shall develop and implement a single automated grievance system, separate and apart from the appeal process. The grievance system shall allow full opportunity for aggrieved parties to seek and obtain an explanation for and/or correction of any perceived failure of *a network* provider, the health care finder, or other contractor or subcontractor personnel to furnish the level or quality of care and/or service to which the beneficiary may believe he/she is entitled. Any TRICARE beneficiary, sponsor, parent, guardian, or other representative who is aggrieved by any failure or perceived failure of the contractor, subcontractor or contracted providers of service or care to meet the obligations for timely, quality care and service at appropriate levels may file a grievance. All grievances must be submitted in writing. The subjects of grievances may be, but are not limited to, such issues as the refusal of a PCM to provide services or to refer a beneficiary to a specialist, the length of the waiting period to obtain an appointment, undue delays at an office when an appointment has been made, improper level of care, poor quality of care, or other factors which reflect upon the quality of the care provided or the quality and/or timeliness of the service. If the written complaint reveals an appealable issue, the correspondence shall be forwarded to the contractor's appeals unit for a reconsideration review.

1. Contractor Responsibilities

It is the contractor's responsibility to conduct an investigation and, if possible, resolve the aggrieved party's problem or concern. In this responsibility the contractor shall:

a. Ensure that information for filing of grievances is readily available to all beneficiaries within the service area.

b. Maintain a system of receipt, identification, and control which will enable accurate and timely handling. All grievances shall be stamped with the actual date of receipt within three (3) workdays of receipt in the contractor's custody. The date of receipt shall be counted as the first day.

c. Investigate the grievance and document the results within sixty (60) days of receipt of the grievance. The contractor shall notify the Contracting Officer of all grievances not reviewed within sixty (60) days of receipt.

d. Provide interim written response by the thirtieth (30) calendar day after receipt for all grievances not processed to completion by that date.

e. Take positive steps to resolve any problem identified within sixty *(60)* days of the problem identification. If the problem cannot be resolved within that period of time, the Contracting Officer or Contracting Officer's Representative shall be informed of the nature of the problem and the expected date of resolution. If there is no resolution to the problem, the contractor should acknowledge receipt of the grievance and explain to the grievant why the problem cannot be resolved.

f. Written notification of the results of the review shall be submitted to the beneficiary within sixty (60) days of the original receipt of the grievance.

The letter will indicate who the grievant may contact to obtain more information and provide an opportunity to appeal *an adverse* review decision of the grievance.

g. Ensure the involvement in the grievance review process of appropriate medical personnel, including personnel responsible for the contractor's quality assurance program in any case where the grievance is related to the quality of medical care or impacts on utilization review activities.

h. Maintain records for all grievances, including copies of the correspondence, the results of the review/investigation and the action taken to resolve any problems which are identified through the grievance.

VI. WALK-INS

A. Contractor Responsibility

The contractor shall provide for appropriate space and trained staff to enable it to handle walk-in inquiries. The contractor shall have a reception area to accommodate persons visiting its offices about *TRICARE* matters. This area shall provide sufficient privacy to preclude violation of the Privacy Act. The contractor staff shall be trained to meet with, and properly respond to, all visitors giving prompt, accurate answers to their concerns. Because personal interviews are difficult to monitor for quality of the contact, only the most skilled persons should be assigned.

VII. ALLOWABLE CHARGE REVIEWS (INCLUDES DRGS)

A. General

Beneficiaries and providers have the right to question the amount allowed for services received or rendered for *non-network* care. (*Network* providers should have complaint procedures included in their contracts or the administrative procedures established with the TRICARE contractor.) The amount of the allowance is not an appealable issue under the appeals procedures and regulations of the program. When a complaint is received, the accuracy of the application of the reimbursement methodology, including the procedure code and the profile development or the application of the TRICARE Claimcheck edits (including the procedure code) must be verified. The rights of the beneficiaries and providers must be protected by careful review of each case. For allowable charge complaints related to reimbursement based on the TRICARE National Allowable Charge System, see Section VII.D., below.

B. Allowable Charge Review Criteria

1. Requirements

The allowable charge inquiry must be received or postmarked within ninety (90) days from the date of the EOB or it may be denied for lack of timeliness. If the inquiry is in writing and the issue is not clearly a question of allowable charge, any doubt must be resolved in favor of handling the case as an appeal. Allowable charge complaints shall be reported on the workload report as required by OPM Part One, Chapter 3. The contractor shall respond only to a person entitled to the information; i.e., beneficiary, parent/guardian, participating provider, or to *TMA*.

2. Allowable Charge Complaint Procedures

An allowable charge complaint need not be submitted in writing. Oral inquiries (complaints) shall be documented on a contact report, by contractor staff. The handling requirements for timeliness of contractor processing are the same as for routine or priority correspondence. (Inquiries which are classified as priority are those specified in Section III.B.) Upon receipt of an allowable charge complaint, the contractor shall recover the claim and related documents, including the "Beneficiary History and Deductible File", to completely review the case and establish accuracy of processing. The following checklist is suggested:

a. Was the correct procedure code used?

b. Were there other clerical errors, such as wrong type of service code, which may have caused the difference?

c. Did the case go to medical review?

d. Was all needed medical documentation present to make a completely accurate determination?

e. Should the case be further documented and referred to medical review?

f. Was the profiled fee calculated correctly?

NOTE:

Contractors need not routinely validate the fee calculation; however, if the difference between billed and allowed is twenty percent (20%) or more, the dollar value of the difference is significant and all other factors appear to be correct, there is reason to question the validity of the fee.

3. Responses to Allowable Charge Complaints

A written response to allowable charge complaints is preferred, but the inquiry can be handled by documented telephone call, as may other correspondence. The beneficiary or provider must be offered a written response. If the complaining party indicates dissatisfaction with the contractor's oral explanation of *an* adverse determination, the contractor will send a detailed letter advising of the results. Occasionally the allowable charge complaint or inquiry will be sent directly to the TRICARE *Management Activity (TMA)* instead of the contractor. When this occurs, the complaint/inquiry will be forwarded to the contractor for response.

a. Adverse Determination

If the processing and payment were correct, the inquirer shall be told of the outcome and advised of the methodology for determining allowable charges. The explanation should clearly indicate that the determination was based on the information presented and, if more complex procedures were involved or if the case was unusually complex, whether additional information could change the determination. If such information is available to the inquirer, it should be submitted to the contractor for further review. If, after the contractor's review, it is determined that the original amount is still correct, the inquirer shall be informed that this is the final determination.

b. Additional Payment Due

If it is found that an error has occurred, or if added information is secured which changes the determination, an adjustment shall be made. The notice of the determination shall explain the reason for the adjustment, e.g., correction of clerical error, added claim information provided, correction of information provided on the claim, etc. Adjustments shall be prepared in accordance with instructions in OPM Part Two, Chapter 5.

C. Excess Charges Billed in Participating Provider Claim Cases

If an allowable charge inquiry/complaint indicates a participating provider is improperly billing for more than the allowable charge, refer to OPM Part Two, Chapter 7.

D. CHAMPUS Maximum Allowable Charge System.

1. For allowable charge complaints involving reimbursement based on the CHAMPUS Maximum Allowable Charge System, the contractor shall adhere to the limitations stated in Section VII.B.1. In addition, the contractor will follow the instructions stated in Section VII.B.2., including sub-sections a. through e. The contractor will have no responsibility for determining whether or not the profiled fee for any given Medicare locality was calculated correctly. Once the contractor verifies that the correct procedure code was used, no data entry errors were made (including determination of where the service was rendered), and that referral to second level or medical director review was appropriate, the

contractor shall respond to the inquiry stating that the payment calculation was correctly computed.

2. If it is determined that an error was made by the contractor in calculating the correct payment, the contractor shall follow the procedures in Section VII.B.3., above.

3. In the event the *TMA, B&PS* is notified by the contractor computing the CHAMPUS Maximum Allowable Charge (CMAC) that an error was made in the basic calculations, the contractor will receive a letter from *TMA* with the corrected CMAC directing the contractor to replace the incorrect CMAC as soon as possible but no later than *ten (10)* working days after receipt of the *TMA* letter. Contractors are not required to adjust all the claims processed with the incorrect CMACS; however, contractors shall adjust any claims which were processed using the incorrect CMAC when a provider or beneficiary requests that adjustment.

E. DRG Reviews

The request from a hospital for reclassification of a claim to a higher DRG must be received or postmarked within *sixty (60)* days from the date of the EOB; otherwise, the request will be denied for lack of timeliness. The contractor review is the final determination; there is no further review.

VIII. PROVIDER RELATIONS

A. General

The contractor is responsible for conducting an effective provider relations program. The program should include such elements as program education and participation incentives for both network and non-network providers. The contractor should obtain feedback concerning problems encountered by providers and make efforts to correct those within its area of responsibility. Information concerning problems beyond the contractor's scope of responsibility should be sent to TMA for review and resolution efforts.

B. Provider Relations Requirements

The contractor shall perform certain minimum functions for providers within its service area. These functions shall include:

1. *Reserved*

2. *Reserved*

3. High Volume Provider Contacts

a. Identification of High Volume Providers

On an annual basis, the contractor shall identify the top *five* percent *(5%)*, by dollar volume, of non-network institutional providers and professional providers, in each state of the service area. The contractor shall use the claims processed in the past twelve *(12)* months. If five percent *(5%)* is fewer than five (5) institutional providers and fewer than twenty (20) professional providers then the top five (5) and top twenty (20) in each state should be listed for contact. However, if any of the institutional providers listed billed less than $100,000 of TRICARE beneficiary care, or if the listed professional provider had less than $25,000 of TRICARE billings, they may be omitted from a visit list.

b. Procedures

At least annually, the contractor should contact, for public relations, problem solving, and possible change to network PPO status purposes, those non-network providers identified as being "high volume" providers of care. Contractor Representatives should develop information to present to the providers which will be useful and which will promote participation and understanding. In most high volume provider cases, it will be mutually beneficial to the provider and the contractor to explore network, preferred provider status. Any providers identified as having serious or repeated problems related to TRICARE shall be contacted irrespective of volume. Providers with significant problems will be contacted as frequently as necessary to resolve the problems. The high volume (top *five percent* (5%)) institutional providers shall be contacted with at least annual personal visits by a contractor representative. In addition, the contractor's representative shall contact the high volume professional providers. Because of the potential number and the possibility of a very remote provider being involved, *the* contractor may wish to use the telephone for contacts with some professional providers. However, if a provider is consistently having problems, a representative's visit should be considered necessary. If a provider appears repeatedly among the top five percent *(5%)*, a personal visit by a contractor

representative should be made at least every two (2) years, not withstanding the use of telephone contact at other times.

c. Provider Informational Services

Contractors are required to provide information services to keep all providers within their services area, whether network or non-network, informed of the TRICARE changes and requirements. A quarterly bulletin shall be mailed to all providers, congressional offices and HBAs in the service area. It should provide information on program coverages, claims filing requirements, eligibility requirements, and specifics of problems the contractor is encountering, such as proper itemization. It should periodically reiterate the requirements for signature authorizations, as required in the OPM Part Two, Chapter 1. Contractors shall provide a copy of the bulletin to the TMA concurrent with distribution.

C. Reporting Requirements

By the thirtieth (30th) day following the close of each contract quarter, the contractor shall submit a summary contact report (refer to Section IX.C.3.) to the Contracting Officer Representative (COR) at TMA. The report shall include the categories of contacts (high volume providers, Congressional representatives, HBAs, etc.) and the number of contacts per category, e.g., *one hundred (100)* high volume provider visits, *fifty (50)* HBA contacts. The contractor shall not routinely send the actual visit and contact reports or the internal contractor management monitoring reports to TMA, but shall maintain them at the contractor's office for review by TMA representatives. The contractor shall notify the COR at TMA of any accomplishments, problems, or recommendations and/or requests from a provider that needs special attention at TMA.