Introduction

This guide identifies and standardizes the administrative and billing processes associated with treating TRICARE patients. The information contained in this document was compiled under guidance of the VHA Chief Business Office and Chief Finance Office and reflects best practices of the staffs at the VA Medical Centers in Palo Alto, CA; Loma Linda, CA and the Brevard VA Outpatient Clinic, FL.

An electronic copy of this guide can be downloaded from the VistA University web page at:

http://vaww.vistau.med.va.gov/vistau/tricare

How is TRICARE Different?

These are the key areas where the administrative activities related to treatment of TRICARE patients differs from the activities performed when caring for our veteran population:

Registration

- Record the correct Eligibility. TRICARE patients may be TRICARE/CHAMPUS beneficiaries or Veterans with dual-eligibility.
- TRICARE plans (Standard, Extra, Prime, TRICARE For Life (TFL)) are entered under Insurance screen <5>.
- TRICARE sponsor information must be obtained.

Outpatient Visits

- Authorizations or referrals may be required prior to most care being provided.
- The authorization number must be entered into Claims Tracking.
- Appointment Type must be entered in **V***IST***A** as SHARING AGREEMENT.
- Only TRICARE-certified clinicians may provide care.

Inpatient Stay

- Only TRICARE-certified clinicians may provide care.
- Utilization Review Nurses contact TRICARE Health Care Finder (HCF) for authorization of ongoing patient care.

Utilization Review

- Use Claims Tracking to record all communications with the TRICARE HCF – including reviews for outpatient visits, pre-certifications, admission, continued stay and discharge reviews, additional authorizations and denials.
- Emergency or Urgent care should be provided as needed, with TRICARE authorization being obtained as soon as the patient's condition stabilizes (within 24 hours of treatment).

Billing TRICARE

- Correct TRICARE Contract billing rates must be loaded in **V***IST***A**'s Charge Master. Do not use Reasonable Charges. Your Information Technology/Information Resources Management (IT/IRM) staff must download CHAMPUS Maximum Allowable Charges (CMAC) rates for your facility and enter rate adjustment formulas as necessary.
- Bill inpatient care at Diagnosis Related Groups (DRG) rates if negotiated in your TRICARE contract.
- Bill for care provided – consult with Utilization Review Nurse and refer to Claims Tracking records to insure accuracy of clinical data on bill.
- Follow TRICARE billing rules for proper place of service code, referring provider ID in appropriate blocks of HCFA 1500 Forms, etc.

Billing TRICARE Patients

- Use TRICARE Explanation of Benefits (EOB) to bill patients' cost share charges (copayment and/or deductible).

Payment Processing

- Refer to TRICARE contract to ensure payment received is in accordance with TRICARE contract.
- Consult with Utilization Review Nurse and refer to Claims Tracking records to insure accuracy of data.

Management of TRICARE Program

- Ensure **V***IST***A** files contain the correct TRICARE entries.
- Evaluate the cost of care vs. cost of reimbursement for TRICARE patients.
- Negotiate TRICARE contracts that ensure revenue covers costs.
- Monitor TRICARE program at your facility.
- Provide TRICARE Managed Care Support Contractor with updates to certified TRICARE provider rosters.

It is important to follow the step-by-step instructions in this guide to ensure TRICARE patients are identified correctly, their treatment is authorized and proper, bills generated to both TRICARE and TRICARE patients are appropriate, and the correct payment is received.

TRICARE Entities

This guide refers to three TRICARE entities. Each one performs a different function when processing information for TRICARE.

- TRICARE Fiscal Intermediary –also called Managed Care Support Contractor (MCSC) – An entity (Health Net Federal Services, TRIWEST, Humana, etc.) awarded by Department of Defense, with the responsibility to manage the health care of TRICARE beneficiaries. The TRICARE Fiscal Intermediary/MCSC

integrates the military's direct patient care system with the civilian network of specialty and institutional providers to support the needs of all individuals eligible to receive services.

- TRICARE Health Care Finder (HCF) – a health care professional, usually a Registered Nurse, who helps patients find the care they need. The HCF works with the patient's Primary Care Manager (PCM) to locate a specialist, or obtain a pre-authorization for care. Health Care Finders are available 24-hours a day, seven days a week.
- TRICARE Claims Administrator –-a subcontractor, (i.e. Palmetto Government Benefits Administrators - PGBA), responsible for processing all TRICARE/CHAMPUS claims. There are different addresses for all states and regions. After TRICARE claims are processed, reimbursement is made directly by the TRICARE Claims Administrator.

TRICARE Directives

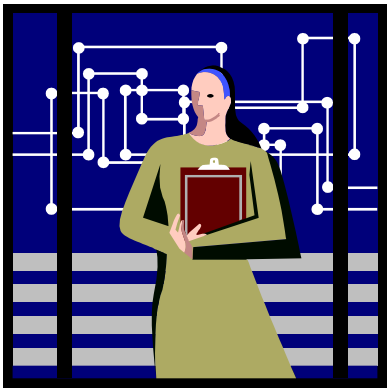
The Veterans Health Administration (VHA) has issued two directives providing guidance to Veterans Affairs (VA) medical centers and Veterans Integrated Service Networks (VISNs) as network providers on the treatment of TRICARE beneficiaries in the Department of Defense's (DOD's) TRICARE managed care program. All VHA Directives and Publications are located on the VHA Forms, Publications, and Records Management web page at http://vaww.va.gov/publ/direc/health/ .

Click on these links to access the TRICARE-related VHA Directives:

VHA Directive 99-027, dated June 22, 1999
Treatment of TRICARE Beneficiaries at VA Medical Facilities Through Agreements with Department of Defense Managed Care Support Contractors
http://www.va.gov/publ/direc/health/direct/199027.pdf

VA Directive 2002-036, dated June 21, 2002
Guidance for VA's Role in TRICARE for Life
http://www.va.gov/publ/direc/health/direct/12002036.pdf

TRICARE - Standardize File Entries



VA Medical Centers must ensure the information concerning TRICARE patients is entered in a standard method. Accurate processing and reporting of data is compromised if national standards are not followed. There is the potential that the VA may lose revenue because care for TRICARE patients is not identified and processed correctly. Verify that your **V***IST***A** files contain the following entries. Locally modified entries should be inactivated.

File: MAS ELIGIBILITY CODE (#8.1)
Eligibility Code: TRICARE/CHAMPUS 7 NON-VETERAN
All TRICARE patients should be assigned this eligibility code. Local codes for TRICARE Prime, Standard and Extra are not eligibilities, but rather, types of insurance coverage.

File: INSURANCE COMPANY (#36)
The insurance company name should be entered as specified by your TRICARE Claims Administrator. If your TRICARE Claims Administrator has **a different mailing address** for claims for TRICARE Extra or TRICARE Prime, then it will be necessary to create an Insurance Company entry for each billing address.

If your TRICARE Claims Administrator is **PGBA**, these are examples of how the entries in your Insurance Company file would look:

PGBA TRICARE STANDARD – PO BOX 11111
Group Plan: Standard
PGBA TRICARE EXTRA – PO BOX 22222
Group Plan: Extra
PGBA TRICARE PRIME – PO BOX 33333
Group Plan: Prime
PGBA TRICARE FOR LIFE – PO BOX 44444
Group Plan: TFL (TRICARE for Life)

If your TRICARE Claims Administrator uses only **ONE mailing address**, then you only need to create ONE Insurance Company entry and specify Extra, Prime and TRICARE for Life (TFL) in the Group Plans.

WPS TRICARE – PO BOX 4444
- Group Plan: Standard
- Group Plan: Extra
- Group Plan: Prime
- Group Plan: TFL (TRICARE for Life)

Appendix A shows screen captures of how to enter insurance information for a TRICARE patient.

File: RATE SCHEDULE (#363)

TRICARE billing is based on negotiated rates contained in your contract with your TRICARE Fiscal Intermediary / MCSC. Some facilities have contracts to use a percentage of CMAC Rates. Other facilities have negotiated specific costs associated with specific procedures and/or Diagnosis Related Groups (DRGs).

The correct billing rates (as negotiated in your local TRICARE Contract) must be entered into Integrated Billings' Charge Master. IT/IRM may enter Special Rate Adjustments if appropriate. See **Appendix B** for step-by-step instructions on downloading CMAC rates and creating TRICARE/CHAMPUS billing rates into **V***IST***A**'s Charge Master.

TRICARE DRG rates cannot be entered into the Charge Master. These charges must be entered manually onto the bill. See page **Appendix C** for instructions on how to prepare a DRG Billing Spreadsheet for use when billing DRG Rates for Inpatient stays.

Reasonable Charges must NOT be used when billing TRICARE. They will inflate your facilities receivables and Accounts Receivable staff will be forced to spend extra time trying to analyze payments.

TRICARE-Related Billing Rates Release Schedules and Sources:

➢ CMAC Rates	January	http://vaww.va.gov/vadod/
➢ TRICARE DRG rates	October	http://mytricare.com
➢ AWP – Average Wholesale Price		via Pharmacy patch

Counseling TRICARE Patients

In order to have a successful TRICARE program, it is important to take time to sit with the TRICARE patient and explain all of the processes and procedures associated with their care. Most importantly, patients need to understand their financial responsibility to VA and TRICARE.

When a TRICARE patient first registers for care (or when their benefits change), the intake staff should discuss the following topics:

- TRICARE Benefits
- TRICARE Eligibility
- Dual-Eligibility – financial responsibilities as a veteran vs. TRICARE (the applicant must choose which benefit to use prior to each encounter)
- Patient responsibility for cost shares; includes copayments and/or deductibles
- Assignment and role of the Primary Care Manager (PCM)
- TRICARE referral and authorization process
- Check-in process for each visit
- Prescriptions (some VA facilities cannot fill TRICARE prescriptions)

The patient must sign these documents:

- 1010EZ form
- Consent to Release Information forms (one for TRICARE and one for VA)
- Assignment of Benefits form (where TRICARE pays VA and not the patient)
- Patient Bill of Rights and Responsibilities

Registering TRICARE Patients

Patient brings ID (Military and Prime ID Card) to VA Health Facility.

TRICARE patients should be instructed to bring their TRICARE identification cards (military ID card and/or Prime ID Card) to the VA Health Facility whenever they require medical care.

TRICARE must be contacted to verify that **new** patients are eligible for care as TRICARE beneficiaries before any administrative or medical actions are initiated.

(New Patients or Patients with changed Eligibility only)

TRICARE contacted to verify patient is eligible for care as a TRICARE Patient.

If a TRICARE patient presents for emergent care, TRICARE is contacted AFTER the patient's condition stabilizes.

There are two ways to verify a patient's TRICARE eligibility:

- Call the phone number that TRICARE provides to your facility.
- Access the myTRICARE web site at http://myTRICARE.com .

TRICARE Phone #: _____

(TRICARE will provide correct phone number to use)

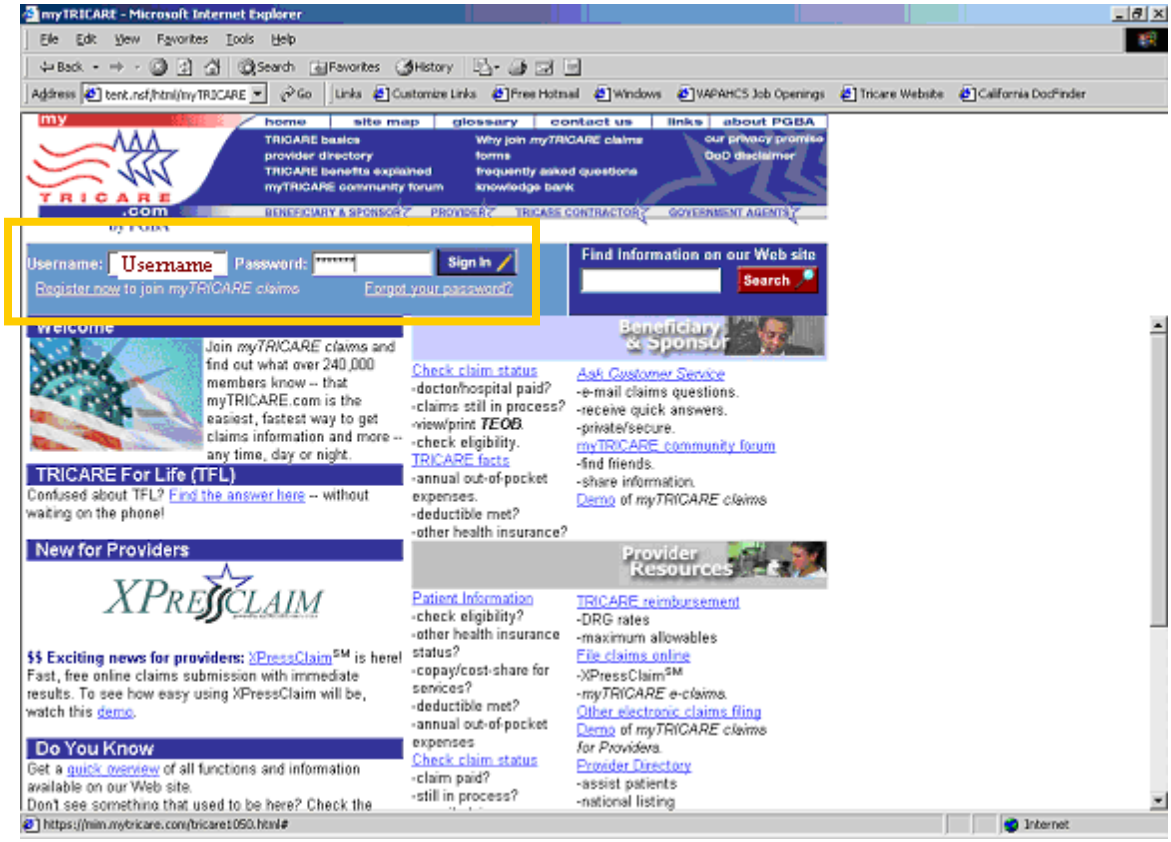
Information available on myTRICARE.com website

VA staff members who have registered with the web site http://myTRICARE.com can check a TRICARE patient's eligibility and claim status on-line. Contact TRICARE for assistance if you have difficulty registering with myTRICARE.com.

The next few pages show how to view current TRICARE eligibility information.

After you sign in as a registered user you can select the type of information to view.

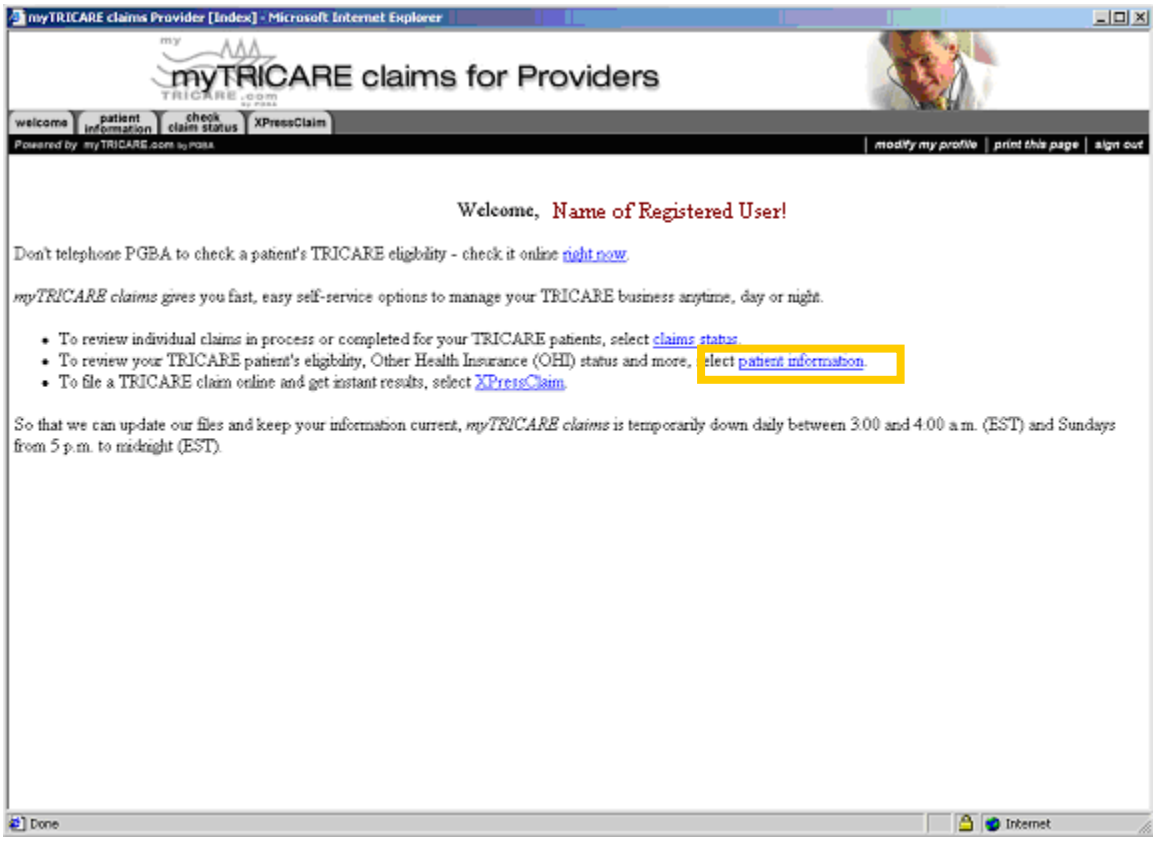
Home Page for website is http://myTRICARE.com .



The myTRICARE.com website contains information of interest to TRICARE beneficiaries and TRICARE providers.

Registered users must enter their TRICARE username and password and click the Sign In button to view the myTRICARE for Providers screen. (See area of screen highlighted with box.)

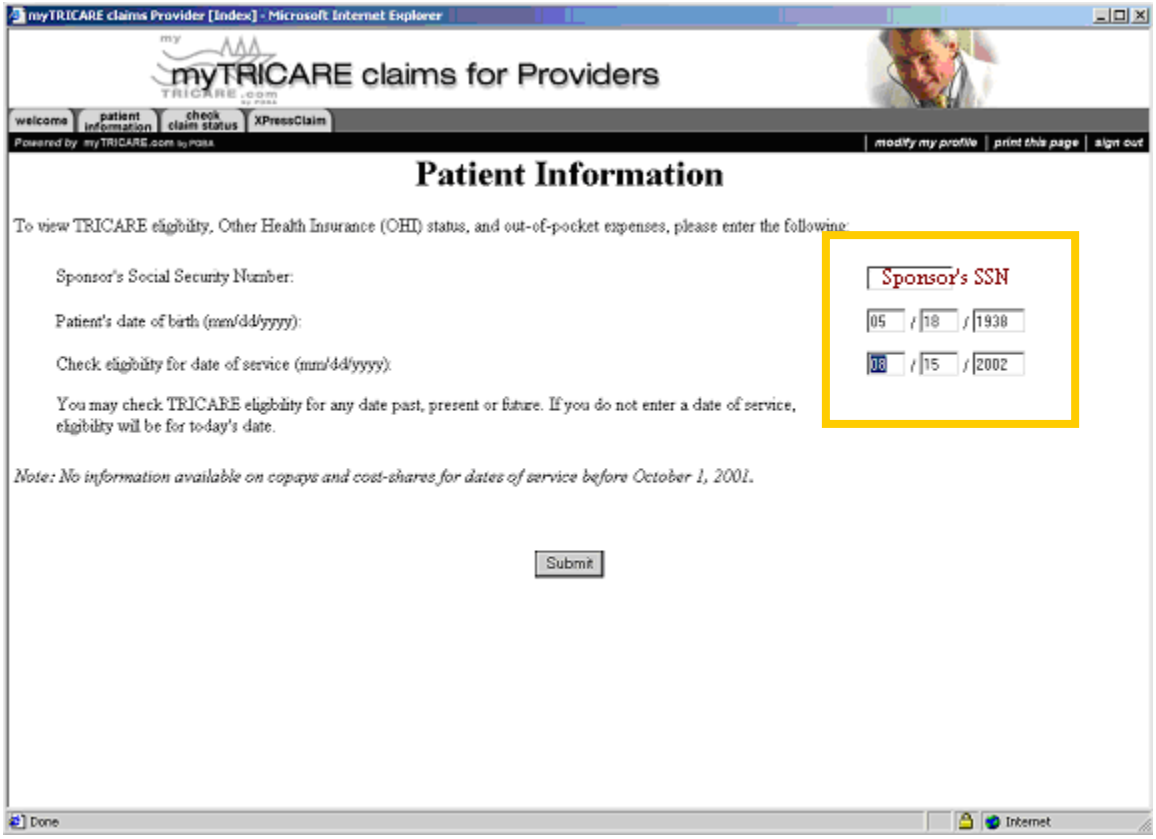
MyTRICARE claims for Providers Screen



The myTRICARE claims for Provider screen provides access to view claim or patient information. Select **Patient Information**, the second bullet point on the list to view current TRICARE eligibility. (See area of screen highlighted with box.)

MyTRICARE claims for Providers Screen

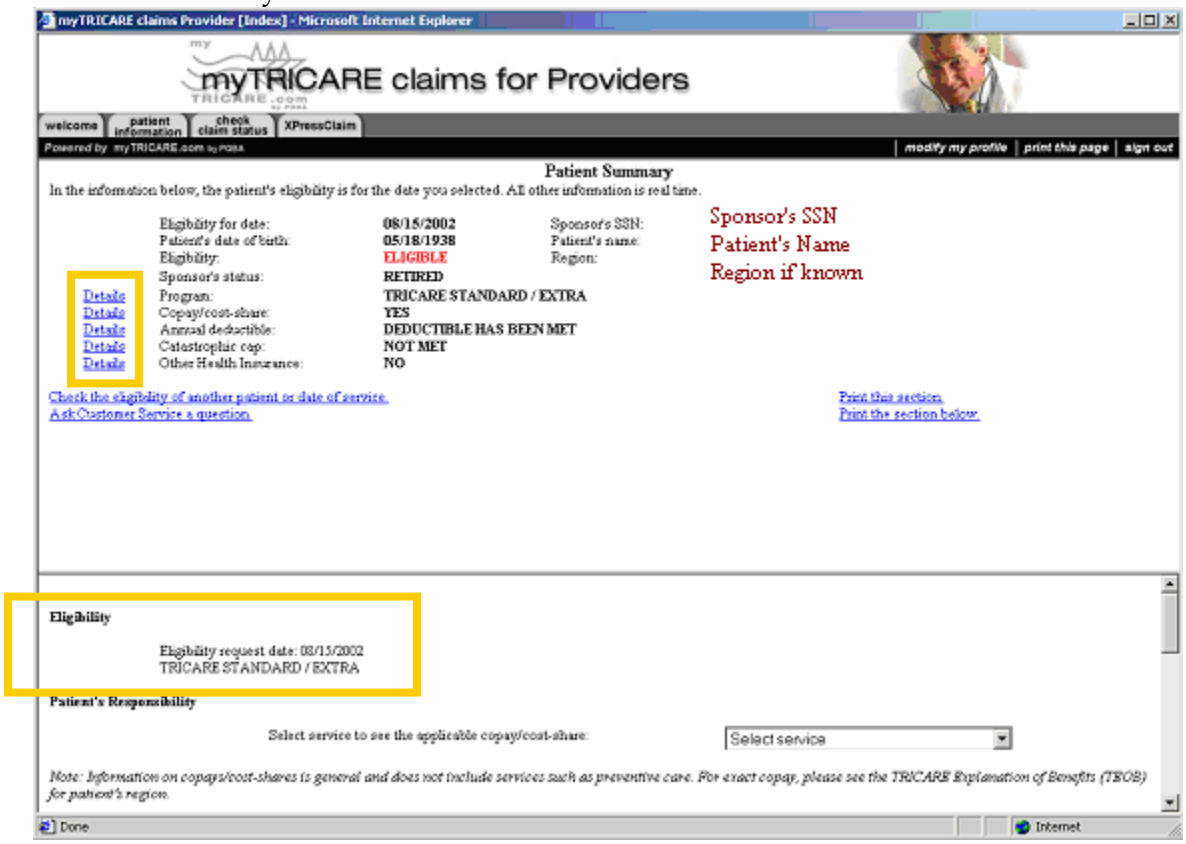
Patient Information



Enter the **Sponsor's Social Security Number**, Patient's date of birth and the eligibility date of service on the Patient Information screen. (See area of screen highlighted with box.)

MyTRICARE claims for Providers Screen

Patient Summary



The **Patient Summary** screen displays eligibility information for the date range entered on the previous screen. The **Details** link next to topics related to copay/cost share, annual deductible, other health insurance, etc. can be used to display more information. (See areas of screen highlighted with boxes.)

See **Appendix D** to see samples of information available on the myTRICARE.com web site.

TRICARE vs. Dual Eligibility

Some TRICARE beneficiaries may be eligible for both veterans' and TRICARE benefits. This "dual eligibility" can cause confusion to patients, TRICARE staff, and VA staff alike. Here are some simple rules that will help determine how to register a "dual eligibility" patient.

If a veteran is seeking care for a *service-connected* condition in a VA medical facility, he/she must receive that care under their veterans' benefits. VA may not bill TRICARE for treatment of a service-connected condition.

If a veteran is seeking care for a *non service-connected* condition in a VA medical facility, he/she may receive that care under either his/her veterans' or TRICARE benefits. Once he/she makes that choice, however, he/she must continue to use that benefit for the complete "episode of care." An episode of care generally includes all covered services provided for a particular medical incident

See **Appendix E** for more information concerning VA /TRICARE Dual Eligibility processes.

TRICARE beneficiaries with dual eligibility should also evaluate the costs and benefits related to being enrolled as a veteran vs. the costs and benefits of being enrolled as a TRICARE patient *before* beginning the registration process.

This chart shows key registration fields and how they differ when registering a patient under the TRICARE eligibility and dual eligibility – where the primary eligibility code is the appropriate VETERAN code (SC, NSC, etc.) and secondary eligibility code is TRICARE/CHAMPUS.

DUAL Eligibility (Veteran Primary/TRICARE Secondary)
Patient Type: **NSC VETERAN**
Veteran (Y/N)? **Yes**
Eligibility Code: **Appropriate VETERAN code** (SC LESS THAN 50%, NSC VETERAN, etc.)
Secondary Eligibility Code: **TRICARE/CHAMPUS**
Period of Service: **Veteran's Period Of Service** (WWII, VIETNAM ERA, PERSIAN GULF WAR, etc.)

Once TRICARE verifies the patient is eligible for care, the **V***IST***A** Registration process can begin. Special attention must be taken when registering a TRICARE patient. The

interview process requires the patient to provide additional information in their application for care.

Completing Registration Screens

Completing the Registration Screens in **V*IST*A** for a TRICARE beneficiary patient is similar to completing the screens for registering a veteran with the following exceptions.

```
PATIENT DEMOGRAPHIC DATA, SCREEN <1>

   PATIENT TYPE: TRICARE
   PATIENT VETERAN (Y/N)? NO

Other Hints:
   Use ALL CAPS in NAME and ADDRESS fields
   Must enter LAST NAME, FIRST NAME and FULL MIDDLE NAME (no initials)
   Do not use punctuation except comma between CITY, STATE
   Telephone # s are hyphenated
   Always include ZIP AND COUNTY CODE to prevent errors
```

```
EMERGENCY CONTACT DATA, SCREEN <3>

NEXT OF KIN INFORMATION:
   Must enter LAST NAME, FIRST NAME and FULL MIDDLE NAME (no initials)
```

```
INSURANCE DATA, SCREEN <5>

[1] Covered by Health Insurance: YES

   INSURANCE COMPANY NAME: TRICARE
   GROUP NAME: STANDARD, EXTRA, PRIME or TFL (TRICARE FOR LIFE)
   TYPE OF PLAN: CHAMPUS
   WHOSE INSURANCE: OTHER
   SUBSCRIBER ID: TRICARE ID #
   NAME OF INSURED: NAME OF TRICARE SPONSOR
   INSURED'S SSN: SPONSOR'S SSN

Ask if the patient, spouse or sponsor has Other Health Insurance. (i.e., BLUE
CROSS, AETNA, etc.) This information must be entered on Screen <5> also.
```

```
ELIGIBILITY STATUS DATA, SCREEN <7>
<Enter the appropriate information based on the Patient's Eligibility

TRICARE BENEFICIARY
   Patient Type:  TRICARE
   Veteran (Y/N)?   NO
   Primary Eligibility Code:  TRICARE/CHAMPUS
   Secondary Eligibility Code: (optional)
   Period of Service:  T - Other/Non Veteran

   - OR -

DUAL ELIGIBILITY - Veteran Primary/TRICARE Secondary
   Patient Type:  NSC VETERAN
   Veteran (Y/N)?   YES
   Primary Eligibility Code:  Appropriate VETERAN code
      (SC LESS THAN 50%, NSC VETERAN, etc.)
   Secondary Eligibility Code:  TRICARE/CHAMPUS
   Period of Service:  Veteran's Period Of Service
      (WWII, VIETNAM ERA, PERSIAN GULF WAR, etc.)

   - OR -

ACTIVE DUTY
   Patient Type: ACTIVE DUTY
   Veteran (Y/N)?   NO
   Primary Eligibility Code: SHARING AGREEMENT
   Secondary Eligibility Code (optional):  TRICARE/CHAMPUS
   Period of Service: (SERVICE NAME - ACTIVE DUTY)
```

```
SPONSOR DEMOGRAPHIC INFORMATION, SCREEN <15>

[1] Sponsor Information:
    Name : NAME OF SPONSOR              Military Status : RET'D/A DUTY
     DOB : DOB                        Branch of Service : SERVICE NAME
     SSN : 000000001                             Rank : RANK
  Prefix : 01-SPOUSE, 02-OLDEST CHILD, 03 ETC.     Type : TRICARE
   Effective Date:                     Expiration Date:
```

Appendix F shows all of the **V***IST***A** Registration screens used when registering a TRICARE patient. Special notations indicate where the data entered differs from that used when registering a Veteran.

Application For Care

TRICARE beneficiary patients must be assigned the correct Registration Eligibility Code in order to insure all subsequent processing of patient data is correct.

```
Registration login date/time: NOW//   (APR 16,2002@12:23)

TYPE OF BENEFIT APPLIED FOR: ?
     Enter the type of benefit this patient is now applying for.
     Choose from:
       1        HOSPITAL
       2        DOMICILIARY
       3        OUTPATIENT MEDICAL
       4        OUTPATIENT DENTAL
       5        NURSING HOME CARE
TYPE OF BENEFIT APPLIED FOR: 3  OUTPATIENT MEDICAL

TYPE OF CARE APPLIED FOR: ALL OTHER
FACILITY APPLYING TO: YOUR FACILITY
REGISTRATION ELIGIBILITY CODE: TRICARE/CHAMPUS     NON-VETERAN

Updating eligibility status for this registration...
```

At the Registration Eligibility Code prompt, type **TRICARE/CHAMPUS**.

Following completion of the **V***IST***A** Registration, print the 10-10EZ and have the TRICARE patient sign the form. Remember, TRICARE beneficiary patients are not responsible for MEANS TEST or CO PAY TEST. TRICARE patients should not sign either of those lines of the 10-10 form.

Secure a copy of the applicable TRICARE beneficiary card(s) (Military ID Card and/or Prime ID Card). Retain these copies for the record on clients first visit for care.

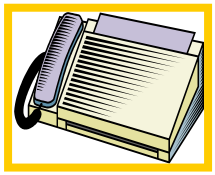
Create a Consolidated Health Record (CHR) making sure the TRICARE patient is identified as such.

If the TRICARE patient is to be seen on the day of registration, stamp a progress note, print an encounter form, and refer the patient and records to the Clinic for care. If the TRICARE patient does not want or need to be seen at the time of registration, schedule an appointment for a future date.

NOTE: If the patient presents with an urgent or emergent care need – treat the patient and obtain the correct authorization as soon as possible.

Prior To Clinic Appointment:

TRICARE Health Care Finder (HCF) contacted to obtain authorization for patient to receive specialty care.



In most cases, TRICARE patients are referred to the VA for a specific procedure or for treatment in a specialized clinic. These procedures and clinics are clearly defined by your facility's VA/TRICARE contract.

TRICARE authorized procedures must be performed by a clinician who is certified with TRICARE. Treatment provided by a substitute clinician (one who is not certified with TRICARE) will result in a denial of payment or reduced payment for any billing claim.

If a TRICARE patient does not have an Authorization number at the time they request a clinic appointment, one should be obtained from the TRICARE Health Care Finder prior to making the clinic appointment.

It is critical to obtain proper referral and/or authorization, as it is a condition of the VA/TRICARE contract. Encounters that do not have referral or authorization from the TRICARE HCF can result in denial of payment or reduced payment from PGBA, the TRICARE Claims Administrator.

TRICARE Phone #: _____

(TRICARE will provide correct phone number to use)

All communications with TRICARE, including eligibility and referral/authorization information, should be recorded in Claims Tracking.

Make Appointment for a TRICARE Beneficiary

Making an appointment for a TRICARE beneficiary is just like making an appointment for a Veteran EXCEPT – the Appointment Type is **Sharing Agreement**.

```
Select Action: Quit//  Make Appointment

Patient: TRICARE,DEMO BENEFICIARY (0202)                              Outpatient

Select CLINIC: TRICARE CLINIC       JONES,JAMES R

APPOINTMENT TYPE: REGULAR//SHARING AGREEMENT
THE [SHARING AGREEMENT] APPOINTMENT TYPE
HAS THE FOLLOWING SUB-CATEGORIES DEFINED.
     COMMUNITY CONTRACT
     TRICARE/CHAMPUS
ENTER THE SUB-CAT FOR THE [SHARING AGREEMENT] APPT TYPE: TRICARE/CHAMPUS
NO PENDING APPOINTMENTS

ENTER THE DATE DESIRED FOR THIS APPOINTMENT:
```

NOTE: There is no "TRICARE" Appointment Type in **V*IST*A**.
Therefore, **Sharing Agreement** must be used when making an appointment for two types of patients:

- Patients being treated under a sharing agreement contract with a local University or community hospital
- TRICARE patients being treated under the VA/TRICARE contract

Sharing Agreement sub-categories can be defined locally. The example above shows two sub-categories were created -- Community Contracts and TRICARE/CHAMPUS. The sub-category TRICARE/CHAMPUS was selected for this appointment. Sharing Agreement sub-categories apply to both Appointment Types and Admitting Regulations.

Make Appointment for a Dual Eligible patient using TRICARE Benefits

As with making an appointment for a TRICARE beneficiary, you must select the Appointment Type called **Sharing Agreement**.

```
Select Action: Quit//  Make Appointment

Patient: TRICARE,DEMO PATIENT (0101)
Select CLINIC: TRICARE CLINIC       DOCTOR,JAMES R

APPOINTMENT TYPE: REGULAR//SHARING AGREEMENT
THE [SHARING AGREEMENT] APPOINTMENT TYPE
HAS THE FOLLOWING SUB-CATEGORIES DEFINED.
     COMMUNITY CONTRACT
     TRICARE/CHAMPUS
ENTER THE SUB-CAT FOR THE [SHARING AGREEMENT] APPT TYPE: TRICARE/CHAMPUS

   <Appointment specific prompts>

THIS PATIENT HAS OTHER ENTITLED ELIGIBILITIES:
     TRICARE/CHAMPUS
ENTER THE ELIGIBILITY FOR THIS APPOINTMENT: NSC// TRICARE/CHAMPUS
```

This example shows this dual-eligible patient's other entitled eligibilities. At the ENTER THE ELIGIBILITY FOR THIS APPOINTMENT prompt, type **TRICARE/CHAMPUS**, the correct eligibility code for the appointment.

Treating a TRICARE Patient

Patient receives treatment. Care documented in medical record.

TRICARE patients receive medical treatment as authorized by the TRICARE Health Care Finder. That treatment is documented in the patient's medical record.

NOTE: If additional care is provided within the authorized visit, notify TRICARE Health Care Finder, immediately.

If the TRICARE patient requires a referral to a specialty clinic, the provider must complete a TRICARE Referral Form (available through your TRICARE FI/MCSC) to be forwarded to the TRICARE HCF along with the encounter form and chart at the time of check out.

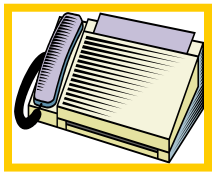
See **Appendix G and H** for samples of two types of prior authorization request forms:

- the Medical Care form, and
- the Durable Medical Equipment (DME), Home Health care, and IV therapy form.

TRICARE Patient Check Out Process

The clerical function of checking out a TRICARE patient is no different than checking out a Veteran. Following the visit, the TRICARE patient may be scheduled to return to the Primary Care Manager (PCM), a specialty clinic with authorization, or advised to call for an appointment in the future when further care is required.

TRICARE Health Care Finder (HCF) contacted to obtain authorization for patient to receive specialty care.

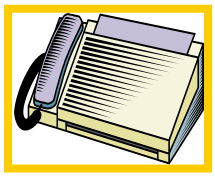


The TRICARE Referral Form must be faxed to the nearest appropriate TRICARE Health Care Finder. Appointments to specialty clinics cannot be made until the TRICARE Health Care Finder provides authorization.

Scheduled Admissions

In most cases, TRICARE patients are referred to the VA for a specific inpatient procedure or for treatment in a specialized treatment program. These procedures and programs are clearly defined by your facility's VA/TRICARE contract. In addition, TRICARE authorized treatment **must** be performed by a clinician who is certified with TRICARE. Treatment provided by a substitute clinician (one who is not certified with TRICARE) at any time during a TRICARE patient's inpatient stay may result in a denial of payment for those days of care.

TRICARE Health Care Finder (HCF) contacted to obtain authorization for patient to receive specialty care.



If a TRICARE patient does not have an authorization number at the time they schedule their admission, one should be obtained (if required) from the TRICARE HCF prior to scheduling the admission.

TRICARE Phone #: _____

(TRICARE will provide correct phone number to use)

All communications between TRICARE and Utilization Review Nurses must be recorded in Claims Tracking. This includes the following activities:

- TRICARE eligibility
- prior-authorization and authorization numbers
- admission review
- continued stay reviews
- discharge review payments
- appeals, denials and approvals

Special attention must be taken when using **V*IST*A**'s **Admit a Patient** option for a TRICARE patient.

Completing the admission screens in **V*IST*A** for a TRICARE patient is similar to completing the screens for admitting a veteran with the following exceptions.

```
Admit a Patient Option

ADMITTING REGULATION: SHARING AGREEMENT
THE [SHARING AGREEMENT] ADMITTING REGULATION
HAS THE FOLLOWING SUB-CATEGORIES DEFINED.
     COMMUNITY CONTRACT
     TRICARE/CHAMPUS
ENTER THE SUB-CAT FOR THE [SHARING AGREEMENT] ADMITTING REG: TRICARE
  /CHAMPUS
SOURCE OF ADMISSION: NON-VETERAN OTHER THAN MILITARY     HOSPITAL
```

The Admitting Regulation used must be **Sharing Agreement**.

Sharing Agreement sub-categories can be defined locally. The example above shows two sub-categories were created -- Community Contracts and TRICARE/CHAMPUS. The sub-category TRICARE/CHAMPUS was selected for this admission. Sharing Agreement sub-categories apply to both Admitting Regulations and Appointment Types.

At the Source of Admission prompt, answer NON-VETERAN OTHER THAN MILITARY.

When entering an admission for a **Dual Eligible patient using TRICARE benefits** for this episode of care, **V***IST***A** displays the patient's other entitled eligibilities. Be sure to select TRICARE/CHAMPUS as the eligibility for this admission.

```
THIS PATIENT HAS OTHER ENTITLED ELIGIBILITIES:
     NSC VETERAN
     TRICARE/CHAMPUS
ENTER THE ELIGIBILITY FOR THIS ADMISSION: NSC// TRICARE/CHAMPUS
```

Discharge a Patient

Select the NON-VETERAN type of discharge when discharging a TRICARE beneficiary or dual-eligible patient being treated using their TRICARE eligibility.

```
Discharge a Patient Option

DISCHARGE DATE:  NOW//
TYPE OF DISCHARGE: NON-VETERAN       DISCHARGE     ACTIVE

Patient Discharged
```

Utilization Review and Claims Tracking

Utilization Review Nurse coordinates care and communication.

Best practices show that VA Medical Centers that have proactive Utilization Review Nurses also have successful TRICARE programs. These Utilization Review Nurses are in constant communication with the TRICARE Health Care Finder (HCF) making sure they are kept up-to-date on the care being provided to TRICARE patients. These Utilization Review Nurses use **Claims Tracking** to record all interactions. The information entered is readily available to billers and accounts receivable technicians to assist them in preparing TRICARE claims.

The following screens show how to enter an insurance review for **an outpatient encounter**.

```
Select Claims Tracking Master Menu Option: IR  Claims Tracking Menu (Insurance
Reviews)


   PR      Pending Reviews
   AD      Appeal/Denial Edit
   CT      Claims Tracking Edit
   IC      Inquire to Claims Tracking
   IR      Insurance Review Edit
   RM      Reports Menu (Claims Tracking) ...
   SM      Supervisors Menu (Claims Tracking) ...
   SP      Single Patient Admission Sheet
   TP      Third Party Joint Inquiry

Select Claims Tracking Menu (Insurance Reviews) Option: CT  Claims Tracking Edit
Select PATIENT NAME:    TRICARE,DEMO PATIENT        8-8-72    000000101
   TRICARE             ...
```

Select the **Claims Tracking Edit** option from the **Claims Tracking Menu (Insurance Reviews)**. At the **Select PATIENT NAME**: prompt, enter the patient name.

```
Claims Tracking Editor     Jul 29, 2002@09:22:21      Page:   1 of   1
Claims Tracking Entries for: TRICARE,DEMO PATIENT 0101
    for Visits beginning on: 07/29/01 to 08/12/02
   Type    Urgent Date        Ins. UR   ROI       Bill Ward
1   OPT.       NO      07/29/02 12:00 a YES          OBTAINED      YES
2   INPT.      NO      04/17/02 4:15 pm NO     R                   YES
3   OPT.       NO      04/17/02 11:00 a YES                        NO




          Service Connected: NO                                              >>>
AT  Add Tracking Entry    IR  Insurance Reviews      PU  Procedure Update
DT  Delete Tracking Entry SC  SC Conditions          PV  Provider Update
QE  Quick Edit            AE  Appeals Edit           VP  View Pat. Ins.
AC  Assign Case           CP  Change Patient         EX  Exit
BI  Billing Info Edit     CD  Change Date Range
VE  View/Edit Episode     DU  Diagnosis Update
Select Action: Quit//  VE   View/Edit Episode
Select Visit(s):  (1-3): 1........
```

At the **Select Action: Quit//**, type **VE** to View/Edit an Episode of care. Select Visit **1**, from the list of visits.

```
Expanded Claims Tracking EntryJul 29, 2002@09:23:43          Page:    1 of    3
Expanded Claims Tracking Info for: TRICARE,DEMO PATIENT 0101   ROI: OBTAINED
                                For: OUTPATIENT VISIT on 07/29/02 12:00 am

  Visit Information                          Treatment Authorization Info
     Visit Type: OUTPATIENT VISIT            Authorization #:
     Visit Date: 07/29/02 12:00 am                 No. Days Approved:   0
         Clinic: ENT-STAFF-PM                Second Opinion Required:
   Appt. Status: CHECKED OUT                 Second Opinion Obtained:
     Appt. Type: SHARING AGREEMENT
  Clinical Information                             Review Information
       Provider: DOCTOR,DEMO                        Insurance Claim: YES
       Provider:                                     Follow-up Type:
      Diagnosis: 462. - ACUTE PHARYNGITI              Random Sample:
      Diagnosis:                                 Special Condition:
    Special Cond:                                   Local Addition:
                                                     Ins. Reviewer:
                                                  Hospital Reviewer:
+         Enter ?? for more actions
BI  Billing Info Edit     IR  Insurance Reviews      PV  Provider Update
RI  Review Info           DU  Diagnosis Update       EX  Exit
TA  Treatment Auth.       PU  Procedure Update
Select Action: Next Screen//  IR Insurance Reviews
```

At the **Select Action: Next Screen//** prompt, type **IR** to enter an Insurance Review.

```
Insurance Reviews/Contacts     Jul 29, 2002@09:24:55          Page:    0 of    0
Insurance Review Entries for: TRICARE,DEMO PATIENT 0101   ROI: OBTAINED
                          for: OUTPATIENT VISIT on 07/29/02 12:00 am
   Date     Ins. Co.       Type Contact     Action   Auth. No.  Days




          Service Connected: NO                                              >>>
AI  Add Ins. Review       SC  SC Conditions          PV  Provider Update
DR  Delete Ins. Review    AE  Appeals Edit           RW  Review Wksheet Print
CS  Change Status         AC  Add Comment            CP  Change Patient
QE  Quick Edit            DU  Diagnosis Update       EX  Exit
VE  View/Edit Ins. Review PU  Procedure Update
Select Action: Quit// AI  Add Ins. Review
```

There are no current Insurance Reviews for this outpatient visit. At the **Select Action: Quit//** prompt, type **AI** to add a new Insurance Review.

```
REVIEW DATE: JUL 29,2002@09:25//
TYPE OF CONTACT: OUTPATIENT TREATMENT//

   Insurance    COB Subscriber ID     Group        Holder  Effective  Expires
   ================================================================================
   TRICARE       p  12345TEST         PRIME        OTHER


HEALTH INSURANCE POLICY: TRICARE//
PERSON CONTACTED: J SMITH
METHOD OF CONTACT: PHONE//   PHONE
CONTACT PHONE #:
CALL REFERENCE NUMBER: 123456789
OUTPATIENT TREATMENT: ENT CONSULTATION
ACTION: APPROVED
AUTHORIZATION NUMBER: 123456789
COMMENTS:
  1>AUTHORIZATION IS EFFECTIVE 7/29-9/29/02.  GOOD FOR 2 OUTPATIENT VISITS FOR
  2>ACUTE PARYNGITIS, DX 462, CPT CODES 99211-99215.
  3>
EDIT Option:
REVIEW STATUS: PENDING// C  COMPLETE
NEXT REVIEW DATE:
```

Complete the prompts related to this review, taking care to complete the PERSON CONTACTED, AUTHORIZATION NUMBER and COMMENTS fields. Precise and comprehensive documentation is essential to ensure Billers prepare accurate TRICARE bills.

```
Insurance Reviews/Contacts     Jul 29, 2002@09:29:31          Page:    1 of    1
Insurance Review Entries for: TRICARE,DEMO PATIENT 0101   ROI: OBTAINED
                          for: OUTPATIENT VISIT on 07/29/02 12:00 am
    Date       Ins. Co.            Type Contact       Action    Auth. No.  Days
1   07/29/02   TRICARE             OPT                APPROVED  1234567


          Service Connected: NO                                          >>>
AI  Add Ins. Review       SC  SC Conditions          PV  Provider Update
DR  Delete Ins. Review    AE  Appeals Edit           RW  Review Wksheet Print
CS  Change Status         AC  Add Comment           CP  Change Patient
QE  Quick Edit            DU  Diagnosis Update      EX  Exit
VE  View/Edit Ins. Review PU  Procedure Update
Select Action: Quit//
```

Once the Insurance Review information is entered, the Insurance Review/Contacts screen is displayed again. At the **Select Action: Quit//** prompt, press the **Enter** key to quit or enter **CP** to Change Patient and enter another Insurance Review.

The following screens show how to enter an Insurance Review for **an inpatient stay**.

```
Select Claims Tracking Master Menu Option: IR  Claims Tracking Menu (Insurance
Reviews)


   PR     Pending Reviews
   AD     Appeal/Denial Edit
   CT     Claims Tracking Edit
   IC     Inquire to Claims Tracking
   IR     Insurance Review Edit
   RM     Reports Menu (Claims Tracking) ...
   SM     Supervisors Menu (Claims Tracking) ...
   SP     Single Patient Admission Sheet
   TP     Third Party Joint Inquiry

Select Claims Tracking Menu (Insurance Reviews) Option: CT  Claims Tracking Edit
Select PATIENT NAME:    TRICARE,DEMO PATIENT        8-8-72    000000101
   TRICARE            ...
```

Select the **Claims Tracking Edit** option from the **Claims Tracking Menu (Insurance Reviews)**. At the **Select PATIENT NAME**: prompt, enter the patient name.

```
Claims Tracking Editor      Oct 25, 2002@10:23:58      Page:   1 of   1
Claims Tracking Entries for: TRICARE,PATIENT T1212
    for Visits beginning on: 10/25/01 to 11/08/02
    Type       Urgent  Date              Ins.  UR    ROI            Bill  Ward
1   INPT.      NO      10/23/02 10:32 a YES                         YES


     Service Connected: NO                              >>>
AT  Add Tracking Entry    IR  Insurance Reviews     PU  Procedure Update
DT  Delete Tracking Entry SC  SC Conditions         PV  Provider Update
QE  Quick Edit            AE  Appeals Edit          VP  View Pat. Ins.
AC  Assign Case           CP  Change Patient        EX  Exit
BI  Billing Info Edit     CD  Change Date Range
VE  View/Edit Episode     DU  Diagnosis Update
Select Action: Quit//  VE  View/Edit Episode
Select Review(s):
```

At the **Select Action**: prompt, type **VE** to View/Edit an episode of care.
At the **Select Review(s)** prompt, type the number of the inpatient stay you wish to edit.

```
Expanded Claims Tracking EntryOct 25, 2002@10:25:03      Page:   1 of   3
Expanded Claims Tracking Info for: TRICARE,PATIENT T1212   ROI:
                                For: INPATIENT ADMISSION on 10/23/02 10:32 am

  Visit Information                          Treatment Authorization Info
     Visit Type: INPATIENT ADMISSION        Authorization #:
 Admission Date: OCT 23,2002@10:32                No. Days Approved:   0
           Ward: 7A GEN MED                 Second Opinion Required:
      Specialty: GASTROENTEROLOGY           Second Opinion Obtained:

  Clinical Information                             Review Information
       Provider: DOCTOR,MICHAEL J                   Insurance Claim: YES
 Admitting Diag: SOB                                 Follow-up Type:
   Primary Diag:                                      Random Sample:
  1st Procedure:                                  Special Condition:
  2nd Procedure:                                     Local Addition:
                                                      Ins. Reviewer:
                                                  Hospital Reviewer:
+         Enter ?? for more actions
BI  Billing Info Edit     IR  Insurance Reviews     PV  Provider Update
RI  Review Info           DU  Diagnosis Update      EX  Exit
TA  Treatment Auth.       PU  Procedure Update
Select Action: Next Screen//  IR  Insurance Reviews
```

At the **Select Action**: prompt, type **IR** to enter an Insurance Review.

```
Insurance Reviews/Contacts    Oct 25, 2002@10:25:43          Page:    1 of    1
Insurance Review Entries for: TRICARE,PATIENT T1212   ROI:
                         for: INPATIENT ADMISSION on 10/23/02 10:32 am
     Date       Ins. Co.            Type Contact       Action    Auth. No.  Days
1    10/25/02   PGBA TRICARE EXTRA  URG ADM




     Service Connected: NO                                  >>>
AI  Add Ins. Review       SC  SC Conditions          PV  Provider Update
DR  Delete Ins. Review    AE  Appeals Edit           RW  Review Wksheet Print
CS  Change Status         AC  Add Comment            CP  Change Patient
QE  Quick Edit            DU  Diagnosis Update       EX  Exit
VE  View/Edit Ins. Review PU  Procedure Update
Select Action: Quit// VE=1   View/Edit Ins. Review
```

In this example, the Admission Review was created automatically when the **Admit a Patient** option was used. At the **Select Action:** prompt, type **VE=1** to select the first review. If you need to add a continued stay review or discharge review type **AI** to add a new insurance review.

```
Expanded Insurance Reviews  Oct 25, 2002@10:26      Page:  1 of  2
Expanded Insurance Reviews for: TRICARE,PATIENT T1212   ROI:
                           for: INPATIENT ADMISSION on 10/23/02 10:32 am

  Contact Information                          Action Information
     Contact Date: 10/25/02                     Type Contact: URGENT/EMERGENT ADM
 Person Contacted:                                    Action:
   Contact Method:
 Call Ref. Number:
      Review Date: 10/25/02


                          Insurance Policy Information
    Ins. Co. Name: PGBA TRICARE EXTRA CLAIM Subscriber Name: TRICARE,JOHN
     Group Number: <FI # if req'd>           Subscriber ID: 000000000
  Whose Insurance: OTHER                      Effective Date:
   Pre-Cert Phone:                           Expiration Date:

+         Enter ?? for more actions
AA  Appeal Address        AI  Action Info           PU  Procedure Update
CI  Contact Info          AC  Add Comments          PV  Provider Update
CS  Change Status         VP  View Pat. Ins.        RW  Review Wksheet Print
IU  Ins. Co. Update       DU  Diagnosis Update      EX  Exit
Select Action: Next Screen// AI   Action Info
```

At the **Select Action** prompt, type **AI** to add Action Information regarding the authorization provided by TRICARE.
Complete the prompts related to each type review, taking care to complete the PERSON CONTACTED, AUTHORIZATION NUMBER and COMMENTS fields. Precise and comprehensive documentation is essential to ensure Billers prepare accurate TRICARE claims.

All inpatient billing from civilian hospitals, including VA, must include itemized revenue codes for all services rendered to the patient while inpatient. This includes, but is not limited to: physical/occupational/speech therapies, radiology, pharmacy, nursing, operating room, anesthesia, labs, durable medical equipments, supplies, chaplain services, etc.

The example below shows how to enter add these additional revenue codes in the comments section when completing the Discharge Review for an inpatient stay. Billing staff will use this information when generating the TRICARE claim.

```
TYPE OF CONTACT: CONTINUED STAY REVIEW// DISCHARGE REVIEW       40

   Insurance   COB Subscriber ID     Group       Holder  Effective  Expires

================================================================================
   PGBA TRICA   p  000000000         <FI # if r  OTHER

HEALTH INSURANCE POLICY: PGBA TRICARE EXTRA CLAIMS

PERSON CONTACTED: JANE JONES, RN
METHOD OF CONTACT: PHONE//   PHONE
CONTACT PHONE #:
CALL REFERENCE NUMBER:
COMMENTS:
  1>PATIENT DISCHARGED 10/25/02.  PENDING AUTH
  2>  *** NOTE FROM UR ***
  3> PLEASE INCLUDE THE FOLLOWING REVENUE CODES ON FACILITY CLAIM TO TRICARE:
  4>   730, 321, 305, 301, 250, AND 370.
  5>
EDIT Option:
REVIEW STATUS: ENTERED// COMPLETE
NEXT REVIEW DATE: ...
```

Itemization of revenue codes for each reoccurring services is not required (i.e. PT/OT/SPEECH therapies only require one line vs. multiple for each day service is provided).

Revenue code 636 is for drugs/detail coding and only requires multiple entries if associated with one particular diagnoses, Hemophilia.

Identifying Billable TRICARE Events

Outpatient Care

Most VA facilities use a manual method to identify when to bill for **Outpatient care** received by TRICARE Patients. Your facility must devise a method to notify billing staff when TRICARE encounters have been checked out.

Inpatient Care

The UR Admission Bulletin notifies the members of the DGPM UR mail group when a patient with insurance is admitted. Since the patient in the following example has both TRICARE Extra and Blue Cross listed as insurance companies, recipients of this bulletin can research how to bill for this episode of care.

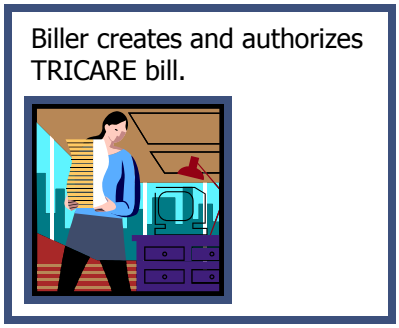
```
Subj: UR ADMISSION BULLETIN  [#6034475] 22 May 02 15:02  20 lines
From: SMITH,KAREN J - PROGRAM ASSISTANT  In 'IN' basket.   Page 1
---------------------------------------------------------------------------
Admission for   : TRICARE,DEMO PATIENT 0000010101
Date/Time       : MAY 22,2002@11:01
Type of Admit   : DIRECT

Ward Location  : 1003CS
Room-Bed       : 100C3-133-OC2
Admitting DX   : MICRODIRECT LARYNGOSCOPY

Insurance Co.   : PBGA TRICARE EXTRA
Group           : EXTRA
Policy Holder   : TRICARE,DEMO PATIENT
Subscriber ID   : 0000010101
Ins. Co Phone#  : 877 555 9179

Insurance Co.   : BLUE CROSS
Group           : FEP 105
Policy Holder   : TRICARE,DEMO PATIENT
Subscriber ID   : R0000010101
Ins. Co Phone#  :800 555 6788
```

Creating TRICARE Claims



Billing for Medical Care for TRICARE Patients is handled in two parts. The first part is to create the claim that is sent to the TRICARE Claims Administrator. The second part is to create the Cost Share bill that is the responsibility of the TRICARE Patient. (Copayment + deductible = cost share)

If the patient has "other health insurance" (OHI) that is primary, create the CHAMPUS Reimbursable Insurance bill first. Once payment is received from the other health insurance a decision can be made if a bill to the secondary carrier, TRICARE, is appropriate.

Special attention must be taken when using **V*IST*A's Enter/Edit Billing Information** option when creating a TRICARE bill. Completing the billing screens in **V*IST*A** for a TRICARE Patient is similar to completing the screens for billing insurance companies with the following exceptions:

```
Billing Screen 3

[1] Rate Type  : CHAMPUS                        Form Type: HCFA 1500
    Responsible: INSURER                        Payer Sequence: Primary
    Bill Payer : TRICARE CLAIMS ADMINISTRATOR (STANDARD, EXTRA, PRIME, TFL)
```

```
Billing Screen 4 or 5

CPT Procedure information:
PLACE OF SERVICE:   11 OFFICE or 22 OUTPATIENT HOSPITAL
TYPE OF SERVICE: 1      MEDICAL CARE
EMERGENCY PROCEDURE?: NO//   NO
HCFA BOX 24K (LOCAL USE ONLY): PROVIDER'S UNIQUE IDENTIFIER (See below)
```

Be sure to check with your TRICARE Claims Administrator to see if they require Place of Service (POS) and/or Type Of Service (TOS) codes that are different from third party payers.

All inpatient billing from civilian hospitals, including VA, must include itemized revenue codes for all services rendered to the patient while inpatient. This includes, but is not limited to: physical/occupational/speech therapies, radiology, pharmacy, nursing, operating room, anesthesia, labs, durable medical equipments, supplies, chaplain services, etc.

The Utilization Review and Claims Tracking section of the guide instructs Utilization Review Nurses to enter these additional revenue codes in the comments section of Claims Tracking as part of the Discharge Review for an inpatient stay.

Use the option called **Print CT Summary for Billing** to print Claims Tracking information.

```
Select Claims Tracking Menu for Billing Option: ?

   CT     Claims Tracking Edit
   PS      Print CT Summary for Billing
   RN     Assign Reason Not Billable
   TP     Third Party Joint Inquiry

Select Claims Tracking Menu for Billing Option: Print CT Summary for Billing

Bill Preparation Report for a Single Visit



Select PATIENT NAME:    TRICARE,PATIENT        1-1-40    000001212     NO     TR
ICARE     DOCTOR,MICHAEL J

Choose from:
   500908    TRICARE,PATIENT         10-03-97  OUTPA  [PRIMARY CARE]
   500913    TRICARE,PATIENT         11-04-97  OUTPA  [CARDIOLOGY]
   5551680   TRICARE,PATIENT         10-23-02  INPAT  URGENT

Select VISIT: 5551680//       TRICARE,PATIENT     10-23-02  URGENT   INPATIENT A
DMISSION

DEVICE: HOME//
```

At the **Select PATIENT NAME** prompt, type the name of the patient.
At the **Select VISIT** prompt, enter the number associated with the inpatient stay being billed.

This report provides the most complete summary of information about a single encounter (inpatient stay or outpatient encounter) available in Claims Tracking. The sample report on the next page has been shortened to highlight the comments in the discharge review that list the revenue codes that must be added to the inpatient claim.

```
Bill Preparation Report                          Page 1  Nov 02, 2002@15:24:09

TRICARE,PATIENT             000-00-1212           DOB: Jan 01, 1940
INPATIENT ADMISSION on Oct 23, 2002@10:32
-------------------------------------------------------------------------------
 Visit Information
    Visit Type: INPATIENT ADMISSION          Visit Billable: YES
Admission Date: OCT 23,2002@10:32            Second Opinion: NOT REQUIRED
          Ward: 7A GEN MED                   Auto Bill Date: Oct 31, 2002
     Specialty: GASTROENTEROLOGY            Special Consent: ROI NOT DETERMINED
Discharge Date: Oct 28, 2002@10:23:21       Special Billing:
    ---------------------------------------------------------------------

  Insurance Information
          Ins. Co 1: PGBA TRICARE EXTRA CLAI Pre-Cert Phone:
             Subsc.: TRICARE,JOHN                     Type: CHAMPUS
          Subsc. ID: 000000000                       Group: <FI # if req'd>
          Coord Ben: PRIMARY                Billing Phone:
     Filing Time Fr:                         Claims Phone:
Group Plan Comments:
                              ----------------------------------
    ---------------------------------------------------------------------

  Insurance Review Information
    Type Review: DISCHARGE REVIEW              Review Date: 10/28/02 11:28 am
                                          Insurance Co.: PGBA TRICARE EXTRA C
                                       Person Contacted: JOAN
                                         Contact Method: PHONE
                                       Call Ref. Number:
                                                 Status: PENDING
                                         Last Edited By: GIGLIA,ELLEN
Comment: PATIENT DISCHARGED 10/28/02.  PENDING AUTH
         *** NOTE FROM UR  ***
          PLEASE INCLUDE THE FOLLOWING REVENUE CODES ON FACILITY
          CLAIM TO TRICARE:
            351 AND 250.

                              ----------------------------------
    Type Review: CONTINUED STAY REVIEW         Review Date: 10/27/02 3:00 pm
         Action: APPROVED                   Insurance Co.: PGBA TRICARE EXTRA C
```

The following screens show how to enter revenue codes for ancillary services listed in the Claims Tracking summary report.

```
Select REVENUE CODE: 351        CT SCAN/HEAD     HEAD SCAN
   REVENUE CODE NUMBER: 2//
   REVENUE CODE BEDSECTION: GENERAL MEDICAL CARE        1
  CHARGES: .01
  UNITS OF SERVICE: 1
  TOTAL: .01//   (No Editing)
  BEDSECTION: GENERAL MEDICAL CARE//
  NON-COVERED CHARGE: .01
  PROCEDURE:
  TYPE:
  COMPONENT:
  UB92 FORM LOCATOR 49:
Select REVENUE CODE: 250        PHARMACY     GENERAL CLASSIFICATION
   REVENUE CODE NUMBER: 3//
   REVENUE CODE BEDSECTION: GENERAL MEDICAL CARE        1
  CHARGES: .01
  UNITS OF SERVICE: 1
  TOTAL: .01//   (No Editing)
  NON-COVERED CHARGE: .01
  PROCEDURE:
  TYPE:
  COMPONENT:
  UB92 FORM LOCATOR 49:
Select REVENUE CODE:
```

Ancillary revenue codes should be entered as a non-covered charge of one cent under the appropriate bedsection for the care provided.

```
TRICARE,PATIENT 000-00-1212  BILL#: K22AKF4 - Inpat/UB92             SCREEN <6>
================================================================================
                          BILLING - GENERAL INFORMATION
[1] Bill Type    : 111               Loc. of Care: HOSPITAL - INPT OR OPT (INCLU
    Covered Days: 5                 Bill Classif: INPATIENT (MEDICARE-A)
    Non-Cov Days: 0                    Timeframe: ADMIT THRU DISCHARGE
    Charge Type : INSTITUTIONAL         Division: VA MEDICAL CENTER
    Form Type    : UB-92           Co-Insur Days: UNSPECIFIED [NOT REQUIRED]
[2] Sensitive?   : NO                 Assignment: YES
[3] Bill From    : OCT 23, 2002          Bill To: OCT 28, 2002
[4] Bedsection   : GENERAL MEDICAL CARE
    LOS          : 5
[5] Rev. Code    : 101-ALL INCL R&B              5   $1,111.10  GENERAL MEDICAL
    Rev. Code    : 351-CT SCAN/HEAD              1       $0.01  REHABILITATION M
                                                         $0.01   (Non-Covered)
    Rev. Code    : 250-PHARMACY                  1       $0.01  REHABILITATION M
                                                         $0.01   (Non-Covered)
    OFFSET       :       $0.00   [NO OFFSET RECORDED]
    BILL TOTAL   :   $1,111.12
                                      Non-Cov:       $0.02
[6] Rate Sched   : (re-calculate charges)
[7] Prior Claims: UNSPECIFIED
<RET> to CONTINUE, 1-7 to EDIT, '^N' for screen N, or '^' to QUIT:
```

Billing Screen <6> shows ancillary revenue codes 351 – CT Scan/Head and 250 – Pharmacy were added as non-covered charges to the inpatient bill.

Some TRICARE Claims Administrators require you enter the Provider's unique identifier in Box 24K of the HCFA 1500 form. This may be the provider's license number, SSN or a number assigned by the TRICARE FI.

```
Billing Screen 8

  Tx Auth. Code(s)   : AUTHORIZATION NUMBER FROM TRICARE HCF
  Providers          :
  REFERRING Physician REQUIRED when billing for consult, x-ray, lab, MRI, etc.
```

The Referring Provider and their unique identifier must be entered on Screen 8 when billing for a consult, x-ray, lab, MRI, etc. The following table shows where to enter the Unique Provider ID number when billing for care provided to a TRICARE Patient referred to an Orthopedic Clinic.

Screen 8 Provider Type	Provider Specialty	Where to enter Unique Provider ID
Rendering	Orthopedist	Screen 4 - CPT Code: HCFA BOX 24K (LOCAL USE ONLY)
Referring	Primary Care Provider	Screen 8 – Provider: PRIMARY INS CO ID #

TRICARE claims should be **printed locally** at this time. In the future, when TRICARE accepts EDI transmissions from VA, your local TRICARE Claims Administrator will provide instructions concerning their Provider's unique ID number requirements.

Creating a TRICARE DRG Claim

A VA/TRICARE Contract may be negotiated to allow you to bill TRICARE DRG rates for inpatient care. TRICARE DRG rates cannot be entered into the Charge Master. These charges must be entered manually onto the bill.

Appendix C explains all of the steps necessary to obtain and calculate the TRICARE DRG Billing Rates for a locality and prepare a spreadsheet that can be used by billers and accounts receivable technicians to prepare and process a TRICARE DRG claim.

The following set of instructions show how to create a TRICARE DRG claim using the spreadsheet.

DRG Billing Step 1 – Prepare your institutional claim as you would for any inpatient stay. Be sure to use the correct Rate Type and Bill Payer.

```
Billing Screen 3

[1] Rate Type  : CHAMPUS                          Form Type: UB-92
    Responsible: INSURER                          Payer Sequence: Primary
    Bill Payer : TRICARE CLAIMS ADMINISTRATOR (STANDARD, EXTRA, PRIME, TFL)
```

DRG Billing Step 2 – On Billing Screen <4> select the diagnosis from the PTF Record to include on the bill. Obtain the DRG number associated with this episode of care from the PTF. You will need this number when you calculate the DRG Charges entered on Billing Screen <6>.

```
SELECT DIAGNOSIS FROM THE PTF RECORD TO INCLUDE ON THE BILL: X1-X5,X7-X10
YOU HAVE SELECTED X1,X2,X3,X4,X5,X7,X8,X9,X10, TO BE ADDED TO THE BILL
IS THIS CORRECT? YES// .........

     -----------------  Existing Diagnoses for Bill  -----------------

            288.0         AGRANULOCYTOSIS                    (3)
            276.5         HYPOVOLEMIA                        (6)
            787.91        DIARRHEA                           (9)
            558.2         TOXIC GASTROENTERITIS              (12)
            E933.1        ADV EFF ANTINEOPLASTIC             (15)
            482.41        PNEUMONIA DUE TO STAPH AUREUS      (18)
            427.31        ATRIAL FIBRILLATION                (21)
            414.01        COR ATHEROSCL NATV C VSL           (24)
            276.8         HYPOPOTASSEMIA                     (27)

Admitting Diagnosis: 288.0

Select ICD DIAGNOSIS:
DISCHARGE STATUS: DISCHARGED TO HOME OR SELF CARE
         //
                    OPERATION/PROCEDURE SCREEN


 * No PROCEDURE CODES in PTF record for this episode of care.
Select PROCEDURE DATE (10/13/99-10/28/99):
Removing old Revenue Codes and Rate Schedules...
Updating Revenue Codes and Charges
```

DRG Billing Step 3 – Proceed to Billing Screen <6>. The Revenue Code information, item [5] must be selected so the DRG cost can be entered.

```
TRICARE,DEMO P 000-00-0872P  BILL#: K22AKF4 - Inpat/UB92            SCREEN <6>
================================================================================
                          BILLING - GENERAL INFORMATION
[1] Bill Type    : 111              Loc. of Care: HOSPITAL - INPT OR OPT (INCLU
    Covered Days: 5                 Bill Classif: INPATIENT (MEDICARE-A)
    Non-Cov Days: 0                    Timeframe: ADMIT THRU DISCHARGE
    Charge Type : INSTITUTIONAL         Division: VA MEDICAL CENTER
    Form Type    : UB-92           Co-Insur Days: UNSPECIFIED [NOT REQUIRED]
[2] Sensitive?   : NO                 Assignment: YES

[3] Bill From    : OCT 13, 2001           Bill To: OCT 18, 2001
[4] Bedsection   : GENERAL MEDICAL CARE
    LOS          : 5
[5] Rev. Code    :
    OFFSET       :       $0.00   [NO OFFSET RECORDED]
    BILL TOTAL   :       $0.00
[6] Rate Sched   : (re-calculate charges)
[7] Prior Claims: UNSPECIFIED


<RET> to CONTINUE, 1-7 to EDIT, '^N' for screen N, or '^' to QUIT:
```

DRG Billing Step 4 – Use the DRG Spreadsheet <See **Appendix C**> and find the DRG number displayed on Screen 4.

(a)	(b)	©	(d)	(e)	(f)	(g)	(h)	
		CHAMPUS	DRG Base				Short Stay	Short Stay
DRG#	Description	DRG WTD	Reimb Amt	Arithmetic Mean LOS	Geometric Mean LOS	Short Stay Threshold	Outlier Per Diem	Outlier Basic Amt. (col.h*#ofdays*2.00)
398	RETICULOENDOTHELIAL & IMMUNITY DISORDER	1.4734	8481.810074	5.7	4.4	1	1488.036855	
399	RETICULOENDOTHELIAL & IMMUNITY DISORDER	0.5762	1881.933154	3.1	2.7	1	607.0752108	14
400	LYMPHOMA & LEUKEMIA W MAJOR O.R. PROCED	3.2492	10612.24784	7.9	4.5	1	1343.322511	
401	LYMPHOMA & NON-ACUTE LEUKEMIA W OTHER	3.3689	11003.20132	11.4	7.8	1	965.1930983	

Billing Step 5 – The dollar amount for the DRG is entered on Screen <6>. Select item [5], Revenue Code. The screen below shows the dollar amount for DRG 398 (column h) entered at the CHARGES prompt. The units of service equal the number of days of care.

```
Select REVENUE CODE: 120        ROOM-BOARD/SEMI     GENERAL CLASSIFICATION
   REVENUE CODE NUMBER: 1//
   REVENUE CODE BEDSECTION: GENERAL MEDICAL CARE        1
  CHARGES: 1488.04
  UNITS OF SERVICE: 5//
  TOTAL: 7440.2//   (No Editing)
  BEDSECTION: GENERAL MEDICAL CARE//
  NON-COVERED CHARGE:
  PROCEDURE:
  TYPE: DRG
  COMPONENT: INS
  UB92 FORM LOCATOR 49:
Select REVENUE CODE:
```

```
TRICARE,DEMO P 000-00-0872P  BILL#: K22AKF4 - Inpat/UB92              SCREEN <6>
================================================================================
                          BILLING - GENERAL INFORMATION
[1] Bill Type    : 111               Loc. of Care: HOSPITAL - INPT OR OPT (INCLU
    Covered Days: 5                 Bill Classif: INPATIENT (MEDICARE-A)
    Non-Cov Days: 0                    Timeframe: ADMIT THRU DISCHARGE
    Charge Type : INSTITUTIONAL         Division: VA MEDICAL CENTER
    Form Type    : UB-92           Co-Insur Days: UNSPECIFIED [NOT REQUIRED]
[2] Sensitive?   : NO                 Assignment: YES
[3] Bill From    : OCT 13, 1999          Bill To: OCT 18, 1999
[4] Bedsection   : GENERAL MEDICAL CARE
    LOS          : 5
[5] Rev. Code    : 120-ROOM-BOARD/SEMI           5  $7440.20  GENERAL MEDICAL
    OFFSET       :       $0.00   [NO OFFSET RECORDED]
    BILL TOTAL   :  $7440.20
[6] Rate Sched   : (re-calculate charges)
[7] Prior Claims: UNSPECIFIED



<RET> to CONTINUE, 1-7 to EDIT, '^N' for screen N, or '^' to QUIT:
```

DRG Billing Step 6 – Be sure to enter the correct Occurrence and Value Codes on Screen <4> if required.

DRG Billing Step 7 – Authorize the bill and mail to the TRICARE Claims Administrator.

Processing a payment for a TRICARE DRG Bill

Accounts Receivable Technicians must check to make sure the DRG number and billed amount on the VA claim and the TRICARE EOB match. If there is a discrepancy, contact the TRICARE Claims Administrator for clarification and resolution. The DRG Spreadsheet <See **Appendix C**> is used to verify the payment amount on the EOB is correct. Payment from TRICARE will be a percentage of the dollar amount listed for the DRG in column d of your DRG Spreadsheet.

(a)	(b)	©	(d)	(e)	(f)	(g)	(h)	
		CHAMPUS	**DRG Base**				**Short Stay**	Short Stay
DRG#	Description	DRG WTD	**Reimb Amt**	Arithmetic Mean LOS	Geometric Mean LOS	Short Stay Threshold	**Outlier Per Diem**	Outlier Basic Amt. (col.h*#ofdays*2.00)
398	RETICULOENDOTHELIAL & IMMUNITY DISORDER	1.4734	**8481.810074**	5.7	4.4	1	**1488.036855**	
399	RETICULOENDOTHELIAL & IMMUNITY DISORDER	0.5762	**1881.933154**	3.1	2.7	1	**607.0752108**	14
400	LYMPHOMA & LEUKEMIA W MAJOR O.R. PROCED	3.2492	**10612.24784**	7.9	4.5	1	**1343.322511**	
401	LYMPHOMA & NON-ACUTE LEUKEMIA W OTHER	3.3689	**11003.20132**	11.4	7.8	1	**965.1930983**	

Refer to your TRICARE contract to determine the percentage of payment. You may need to contact the Utilization Review Nurse familiar with this episode of care for assistance if the payment amount is in question.

Auditing TRICARE Claims

Accounts Receivable Technicians must take special care when auditing TRICARE bills to ensure the correct Revenue Source Code is being used. The Revenue Source Codes 8025, 8026, and 8027 should not be used. These codes related to older CHAMPUS claims. TRICARE Revenue Source Codes are listed below.

Revenue Source Code	Type of Care	Status
8025	CHAMPUS – Inpatient Care	Inactive
8026	CHAMPUS – Outpatient Care	Inactive
8027	CHAMPUS – All Other	Inactive
8028	TRICARE – Inpatient Care	Active
8029	TRICARE – Outpatient Care	Active
8030	TRICARE – All Other	Active

The following example shows the prompts seen when auditing an electronic bill for TRICARE – Outpatient Care. .

```
Select ACCOUNTS RECEIVABLE BILL NO.: K22A7LC  555-K22A7LC     CHAMPUS    05-09-
================================================================================
BILL #:   555-K22A7LC        CATEGORY:   CHAMPUS

DATE BILL PREPARED: MAY  9,2002
PATIENT: TRICARE,MICHAEL W                    SSN: 000-00-1227

DEBTOR:  PGBA - CHAMPUS EXTRA CLAIMS
         PO BOX 870001
         SURFSIDE BEACH, SC 295878701         PHONE NO.:

INSURED'S NAME              ID NO.           GROUP NAME       GROUP NO.
  TRICARE,MICHAEL W         000001227        EXTRA

RECEIVABLE CODE:   FEDERAL

APPROVED IN MAS BY : TECHNICIAN,VIRGINIA
```

Pay particular attention to the RECEIVABLE CODE and REVENUE SOURCE prompts to make sure they are correct. As long as the Biller selects the correct Rate Type, the Revenue Source Code will be correct

```
Date       Description            Quantity   Units   Cost      Total Cost
================================================================================
         BILL # : 555-K22A7LC              DEBTOR : PGBA - TRICARE EXTRA CLAIMS
                                  RECEIVABLE CODE :   FEDERAL

FISCAL YEAR               FUND (APPROPRIATION)                    ORIGINAL AMOUNT
    02                         0160A1                                  198.20
================================================================================
                                  ***  REFUND  ***

CONTROL POINT :

BUDGET OBJECT :                              COST CENTER  :
          SUB :                                       SUB :
================================================================================
                              ***  REIMBURSEMENT  ***

REVENUE SOURCE : 8029                                SUB :

IS THIS DATA CORRECT? No// Y  (Yes)
BILL RESULTING FROM: SPUS       SERVICE PROVIDED UNDER SHARING AGREEMENT
         ...OK? Yes//   (Yes)

Do you want to write any comments for this bill ? No//   (No)
Enter Electronic Signature Code:     <Signature verified>
Building FMS Billing Document. Please hold...


FMS document, # 12345678, built and queued for transmission.


*** AUDITED AND RELEASED ***
```

If the Category and Revenue Source Codes are not correct, please return the bill to the Billing staff so they can edit the bill using the correct Rate Type.

Payment Processing

Accounts Receivable Technicians must analyze the TRICARE Explanation of Benefits (EOB). The payment received from TRICARE **plus** the patient cost share amount should equal the payment amount agreed to in your TRICARE contract.

Sample of Medical Care EOB

Total Charges	Reason Codes	Allowed Covered Charges	Deductible	Procedure Code CPT-4 / Cost Share/ Copay	TRICARE Payment
323.65		275.10	.00	25.00	250.10
439.76		373.80	150.00	44.76	179.04
607.76		516.60	.00	103.32	413.28

In the example above, the dollar amounts from the Deductible, Cost Share/Copay and TRICARE Payment columns added together equals the dollar amount listed in the Allowed Covered Charges column. That dollar amount is 85% of the dollar amount listed in the Total Charges column for the bill. The TRICARE/VA contract for this facility states the payment will be 85% of the CMAC rate. Refer to your local TRICARE/VA contract for your negotiated rate.

Sample of Pharmacy EOB

Total Charges	Reason Codes	Allowed Covered Charges	Deductible	Procedure Code CPT-4 / Cost Share/ Copay	TRICARE Payment
5.94 5.94		5.94 5.94	.00 .00	 3.00	2.94 2.94
54.43 54.43		54.43 54.43	.00 .00	 27.00	27.43 27.43
9.00 9.00		9.00 9.00	.00 .00	 9.00	.00 .00
56.18 56.18		56.18 56.18	.00 .00	 9.00	47.18 47.18

The TRICARE/VA contract for this example states the payment will be 100% of the Average Wholesale Price (APW) rate. Your TRICARE/VA contract for pharmacy may be a different negotiated rate.

The Accounts Receivable Technician should initiate an appeal if necessary.
A Utilization Review Nurse may need to be involved in the appeal process.

Accounts Receivable Technician audits bill.

Receives/Analyzes EOB from TRICARE.
Processes payment.
Initiates appeal if necessary.

Forwards Patient Cost Share, Copayment, and Deductible info to Billing (if appropriate).

Use the Agent Cashier menu to process the TRICARE payment – the amount listed in the far right column of the EOB.

Once all TRICARE payments are processed, the TRICARE EOB must be forwarded to the individual responsible for creating Patient bills in order to create the charges for the TRICARE cost share (copayment and/or deductible). These patient charges will be added to the Patient Statement sent out monthly by the Austin Automation Center.

Creating TRICARE Patient Charges
(Copayment + Deductible = Cost Share)

Biller creates and authorizes Patient bill(s) for Cost Share, copayment, and deductible.

TRICARE Patients are responsible for applicable cost share (copayment and/or deductible) payments. **These charges are not subject for waiver through the VA process.**

The TRICARE Explanation of Benefits (EOB) document shows the dollar amount the patient owes the VA for the episode of care. A separate patient charge should be created for the deductible charge and the Cost Share/copay charge.

Sample of Medical Care EOB

Total Charges	Reason Codes	Allowed Covered Charges	Deductible	Procedure Code CPT-4 / Cost Share/ Copay	TRICARE Payment
323.65		275.10	.00	25.00	250.10
439.76		373.80	150.00	44.76	179.04
607.76		516.60	.00	103.32	413.28

In this sample EOB, four (4) patient charges should be created ($25.00, $150.00, $44.76 and $103.32).

Sample of Pharmacy EOB

Total Charges	Reason Codes	Allowed Covered Charges	Deductible	Procedure Code CPT-4 / Cost Share/ Copay	TRICARE Payment
5.94 5.94		5.94 5.94	.00 .00	 3.00	2.94 2.94
54.43 54.43		54.43 54.43	.00 .00	 27.00	27.43 27.43
9.00 9.00		9.00 9.00	.00 .00	 9.00	.00 .00
56.18 56.18		56.18 56.18	.00 .00	 9.00	47.18 47.18

Use the option **Cancel/Edit/Add Patient Charges** to create these patient charges in Integrated Billing.

```
Select Automated Means Test Billing Menu Option: Cancel/Edit/Add Patient
Charges
Select PATIENT NAME:  TRICARE,MICHAEL W       7-11-47       TRICARE
Search for CHARGES from: APR 04, 2001//   (APR 04, 2001)
                      to: APR 04, 2002//   (APR 04, 2002)
```

Enter the name of the TRICARE Patient. The system will search for Patient charges created in the past calendar year for this patient.

```
Charges                    Apr 04, 2002@12:05:21          Page:  1 of    1
Cancel/Edit/Add Charges                                04/04/01 THRU 04/04/02
Patient: TRICARE,MICHAEL WILSON      T1227
   Bill From  Bill To   Charge Type     Stop  Bill #   Status     Charge
1  10/09/01   10/09/01  CHAMPUS OPT COPAY NEW   K210750  BILLED     $12
2  10/10/01   10/10/01  CHAMPUS OPT COPAY NEW   K210751  BILLED     $12

          Enter ?? for more actions
AC  Add a Charge          CP  Change Patient        UE  Update Events
EC  Edit a Charge         CD  Change Date Range
CC  Cancel a Charge       PC  Pass a Charge
Select Action:  AC  Add a Charge
```

At the **Select Action:** prompt, type **AC** to **add a charge** for this patient.

```
                     A D D   A   C H A R G E
---------------------------------------------------------------------
   Name: TRICARE,MICHAEL WILSON           ** NO ACTIVE BILLING CLOCK *
     ID: 000-00-1227
---------------------------------------------------------------------

Select CHARGE TYPE: CHAMPUS

   Choose from:
   CHAMPUS INPT COPAY      DG CHAMPUS INPT COPAY NEW
   CHAMPUS OPT COPAY      DG CHAMPUS OPT COPAY NEW
   CHAMPUS RX COPAY      DG CHAMPUS RX COPAY NEW

Select CHARGE TYPE: CHAMPUS OPT COPAY   DG CHAMPUS OPT COPAY NEW
```

At the **Select Charge Type:** prompt, type **CHAMPUS** to see the three types of TRICARE/CHAMPUS copay charges:

- CHAMPUS INPT COPAY – Copay for Inpatient Stay
- CHAMPUS OPT COPAY – Copay for Outpatient Visit
- CHAMPUS RX COPAY – Copay for Prescription

For this example, type **CHAMPUS OPT COPAY** to create a new patient charge for an outpatient visit.

```
 CHAMPUS coverage for TRICARE,MICHAEL WILSON:

 Insured Person: TRICARE,MICHAEL W        Company: PGBA - TRICARE PRIME
 Effective Date: 10/01/99               Plan Name: PRIME
Expiration Date:                      Plan Number:
 Service Branch: AIR FORCE

Visit Date: 102401  (OCT 24, 2001)
Charge Amount: 25.00

Okay to add this charge? YES
Billing the CHAMPUS patient copayment charge...completed.


Press RETURN to process the next charge or to return to the list:
```

At the **Visit Date:** prompt, enter the date of the outpatient visit.
At the **Charge Amount:** prompt, enter the dollar amount from the TRICARE EOB form. For this example, the cost share amount is $25.00.
At the **Okay to add this charge?** prompt, type **YES** to accept this charge.
Repeat this process for all cost share charges for this patient.

```
Charges                    Apr 04, 2002@12:05:21          Page:  1 of    1
Cancel/Edit/Add Charges                                  04/04/01 THRU 04/04/02
Patient: TRICARE,MICHAEL WILSON      T1227
   Bill From  Bill To   Charge Type    Stop  Bill #   Status     Charge
1  10/09/01   10/09/01  CHAMPUS OPT COPAY NEW   K210750  BILLED     $12
2  10/10/01   10/10/01  CHAMPUS OPT COPAY NEW   K210751  BILLED     $12
3  10/24/01   10/24/01  CHAMPUS OPT COPAY NEW   K229SWX  BILLED     $25

          Enter ?? for more actions
AC  Add a Charge          CP  Change Patient        UE  Update Events
EC  Edit a Charge         CD  Change Date Range
CC  Cancel a Charge       PC  Pass a Charge
Select Action:
```

The Cancel/Edit/Add Charges screen displays the charges added for this patient.

Appendix A

Insurance Company Enter/Edit

The Insurance Company name should be entered as specified by your TRICARE Claims Administrator. If your TRICARE Claims Administrator has a different mailing address for claims for TRICARE Extra or TRICARE Prime, or if they have separate PO numbers for each state, then it will be necessary to create an Insurance Company entry for each billing address.

If your TRICARE Claims Administrator is PGBA, this is how the entries in your Insurance Company file would look.

PGBA TRICARE STANDARD – PO BOX 11111
    Group Plan: Standard
PGBA TRICARE EXTRA – PO BOX 22222
    Group Plan: Extra
PGBA TRICARE PRIME – PO BOX 33333
    Group Plan: Prime
PGBA TRICARE FOR LIFE – PO BOX 44444
    Group Plan: TFL (TRICARE for Life)

If your TRICARE Claims Administrator uses only ONE mailing address, then you only need to create ONE Ins Company entry and specify Extra, Prime and TFL in the Group Plans.

WPS TRICARE – PO BOX 4444
    Group Plan: Standard
    Group Plan: Extra
    Group Plan: Prime
    Group Plan: TFL (TRICARE for Life)

The following screen captures show how to enter this information in **V*IST*A**.

Patient Insurance Info View/Edit

```
Patient Insurance Management  Apr 24, 2002@14:44:44          Page:    1 of    1
Insurance Management for Patient: TRICARE,DEMO PATIENT T0872P

    Insurance Co.    Type of Policy   Group        Holder   Effect.    Expires
+                                                                             .
    No Insurance Policies on file for this patient.

          Enter ?? for more actions
AP  Add Policy            EA  Fast Edit All         CP  Change Patient
VP  Policy Edit/View      BU  Benefits Used         WP  Worksheet Print
DP  Delete Policy         VC  Verify Coverage       PC  Print Insurance Cov.
AB  Annual Benefits       RI  Personal Riders       EX  Exit
Select Item(s): Quit//  VP
```

Select the action **Add Policy** to add the appropriate TRICARE Group Plan. (i.e. EXTRA, PRIME, TRICARE for Life (TFL)

```
Patient Policy Information    Apr 24, 2002@14:51:45          Page:    1 of    5
Expanded Policy Information for: TRICARE,DEMO PATIENT  267-08-0872P
<TRICARE CA> TRICARE EXTRA  Insurance Company       ** Plan Currently Active **
+                                                                             .
  Plan Information                          Insurance Company
    Is Group Plan: YES                        Company: PGBA TRICARE EXTRA       Group
Name: EXTRA                          Street: PO BOX NUMBER
     Group Number: <FI # if req'd>       City/State: SURFSIDE BEACH, SC 29587
     Type of Plan: CHAMPUS                  Billing Ph:
   Plan Filing TF: <FI will provide>        Precert Ph:


  Utilization Review Info                 Effective Dates & Source
          Require UR: YES
Effective Date: <From TRICARE ID>
    Require Amb Cert: YES                    Expiration Date:
    Require Pre-Cert: YES                     Source of Info: INTERVIEW
    Exclude Pre-Cond:                    Policy Not Billable: NO
          Enter ?? for more actions
PI  Change Plan Info      IC  Insur. Contact Inf.   CP  Change Policy Plan
UI  UR Info               EM  Employer Info         VC  Verify Coverage
ED  Effective Dates       CV  Add/Edit Coverage     AB  Annual Benefits
SU  Subscriber Update     AC  Add Comment           BU  Benefits Used
IP  Inactivate Plan       EA  Fast Edit All         EX  Exit
Select Action: Next Screen//
```

At the **Type of Plan**: prompt, enter **CHAMPUS**. This will enable the CHAMPUS billing rates to be used when creating a TRICARE claim.

```
Patient Policy Information    Apr 24, 2002@14:51:45          Page:    2 of    5
Expanded Policy Information for: TRICARE,DEMO PATIENT  267-08-0872P
PGBA TRICARE EXTRA Insurance Company          ** Plan Currently Active **
+                                                                            .
 Benefits Assignable: YES

  Subscriber Information                 Subscriber's Employer Information
  Whose Insurance: OTHER                Emp Sponsored Plan: No
  Subscriber Name: TRICARE,DEMO PATIENT           Employer:
     Relationship: PATIENT               Employment Status:
 Insurance Number: 000000000               Retirement Date:
 Coord.  Benefits: PRIMARY             Claims to Employer: No, Send to Insurance
 Primary Provider:                                  Street:
  Prim Prov Phone:                               City/State:
                                                      Phone:


          Enter ?? for more actions
PI  Change Plan Info      IC  Insur. Contact Inf.   CP  Change Policy Plan
UI  UR Info               EM  Employer Info         VC  Verify Coverage
ED  Effective Dates       CV  Add/Edit Coverage     AB  Annual Benefits
SU  Subscriber Update     AC  Add Comment           BU  Benefits Used
IP  Inactivate Plan       EA  Fast Edit All         EX  Exit
Select Action: Next Screen//
```

At the **Whose Insurance:** prompt, enter **OTHER** when the patient is using their TRICARE eligibility.

```
WHOSE INSURANCE:  ?
   Choose from:
     v      VETERAN
     s      SPOUSE
     o      OTHER
WHOSE INSURANCE: OTHER
```

TRICARE Patients may have other insurance coverage in addition to TRICARE coverage. At the **Coord. Benefits:** prompt, enter **PRIMARY** or **SECONDARY** depending on the other type of coverage the patient holds.

```
Patient Policy Information    Apr 24, 2002@14:51:45          Page:    3 of    5
Expanded Policy Information for: TRICARE,DEMO PATIENT  267-08-0872P
PGBA TRICARE EXTRA C Insurance Company         ** Plan Currently Active **
+                                                                            .
    Insured Person's Information (use Subscriber Update action)
       Insured's DOB: 08/08/1972           Str 1:
    Insured's Branch:                      Str 2:
      Insured's Rank:                       City:
       Insured's SSN:                     St/Zip:
                                           Phone:

  Plan Coverage Limitations
   Coverage            Effective Date   Covered?       Limit Comments
   --------            --------------   --------       --------------
   INPATIENT                            BY DEFAULT
   OUTPATIENT                           BY DEFAULT
   PHARMACY                             BY DEFAULT
          Enter ?? for more actions
PI  Change Plan Info      IC  Insur. Contact Inf.   CP  Change Policy Plan
UI  UR Info               EM  Employer Info         VC  Verify Coverage
ED  Effective Dates       CV  Add/Edit Coverage     AB  Annual Benefits
SU  Subscriber Update     AC  Add Comment           BU  Benefits Used
IP  Inactivate Plan       EA  Fast Edit All         EX  Exit
Select Action: Next Screen//
```

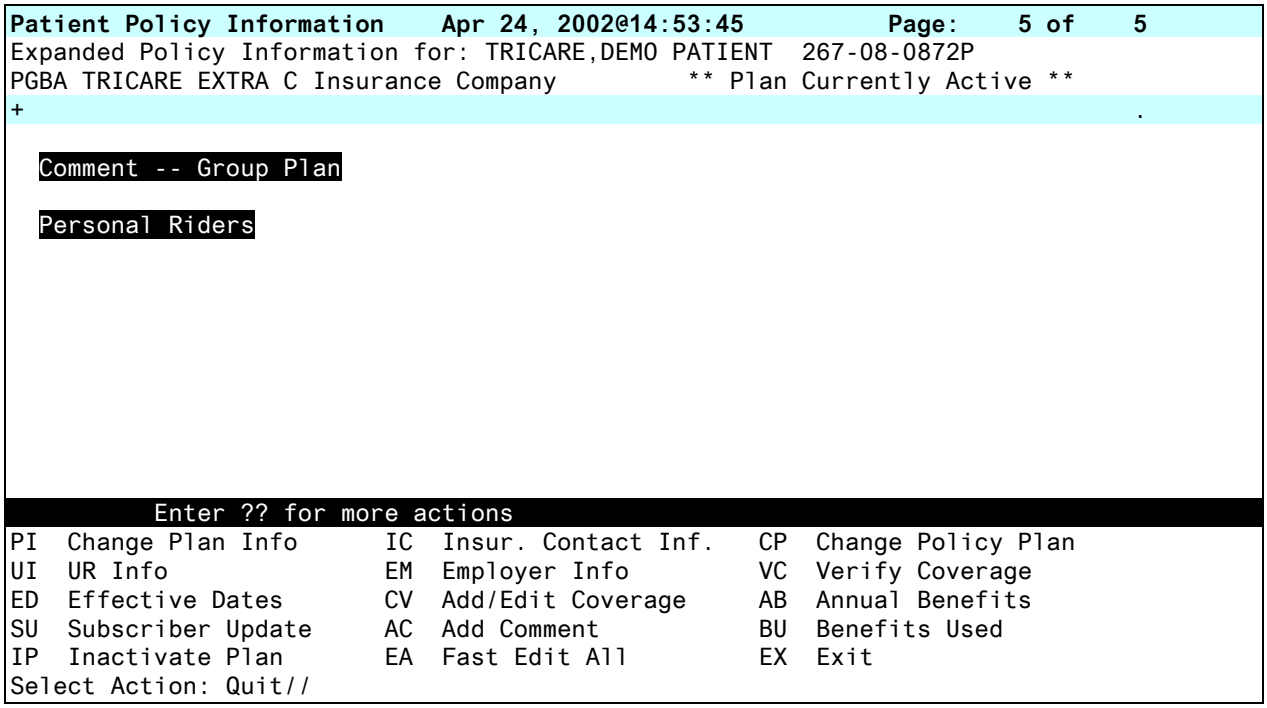
The TRICARE Sponsor is the Active Duty or Retired military person. Make sure the SSN entered at the **Insured's SSN:** prompt is the **SSN of the TRICARE Sponsor.**

```
Patient Policy Information    Apr 24, 2002@14:51:45          Page:    4 of    5
Expanded Policy Information for: TRICARE,DEMO PATIENT  267-08-0872P
PGBA TRICARE EXTRA C Insurance Company         ** Plan Currently Active **
+                                                                            .
   DENTAL                               BY DEFAULT
   MENTAL HEALTH                        BY DEFAULT

  User Information                       Insurance Contact (last)
       Entered By: VERIFIER,M             Person Contacted:
       Entered On: 04/24/02              Method of Contact:
 Last Verified By:                         Contact's Phone:
 Last Verified On:                            Contact Date:
  Last Updated By: VERIFIER,M
  Last Updated On: 04/24/02

  Comment -- Patient Policy
 None
          Enter ?? for more actions
PI  Change Plan Info      IC  Insur. Contact Inf.   CP  Change Policy Plan
UI  UR Info               EM  Employer Info         VC  Verify Coverage
ED  Effective Dates       CV  Add/Edit Coverage     AB  Annual Benefits
SU  Subscriber Update     AC  Add Comment           BU  Benefits Used
IP  Inactivate Plan       EA  Fast Edit All         EX  Exit
Select Action: Next Screen//
```

Complete these fields if appropriate.



Complete these fields if appropriate.

Appendix B

Entering Billing Rates

Current CMAC Rates are available for download from the following website:

http://vaww.va.gov/vadod/

The website is user friendly and should make it easy for your IRM Support staff (or whomever has FTP access) to find the appropriate locality file(s) for your facility and retrieve them for uploading into **V***IST***A**.

1. At the above web site, select "**CMAC (CHAMPUS/TRICARE) RATES**", under the **News & Announcements** header.
2. The web page lists all of the rates and files available for download sorted by calendar year. Find the **correct year** header and click on "**CMAC Rates (Intranet Only)"**.
3. Next enter the **ZIP** code for each unique TRICARE billing locality at your facility (may have to retrieve more than one rate file).
4. Left click on the **Locality Code** (3 digit number) and let the file open up in your browser. Give it a few minutes. Wait for the scroll bar on the right to stop moving and for the word **DONE** to appear in the bottom left hand corner. Then left click on **FILE** and then select **SAVE AS.** Pick a directory on your hard drive.
5. The file then needs to be placed in the **Default Directory** or in the **User Directory** of the person loading the rates, and must be accessible from **V***IST***A**. Be sure you use **ASCII** file transfer protocol when placing the file in the Default Directory.
6. Once the rate files have been placed the correct directory login to **V***IST***A**. Use the **Load Host File into Charge Master** option, selecting item 1.1 (Load CMAC into XTMP) from the menu. Specify the path to the directory containing the host file and enter **26** for the Professional Component Modifier and **TC** for the Technical Component Modifier.
7. Complete items 2-4 on the Load Host menu, paying particular attention to Step 2 (**Assign Charge Set**). It is important that EACH of the Subfiles (left hand column) has the appropriate CMAC Charge Set assigned to it (right hand column). (See the attached, updated version of Chapter 2 of the original Universal Billing Document from November of 1997).

Be advised that, if the CMAC rates are loaded BEFORE the current year CPT Code update to **V***IST***A**, then you will need to reload the CMAC rates AFTER the CPT patch is

released. This is because a CPT code contained in the Rate file will not be added to **V***IST***A**, if that CPT code is not active at the time of the rate upload.

Loading CMAC Rates into Charge Master

Step 1

CMAC billing rate files can be obtained via the Intranet. In order to download the appropriate CMAC rates into the Charge Master, IRM support staff must have the zip code(s) for each unique TRICARE billing locality. This may include Medical Centers, Community Based Outpatient Clinics (CBOCs), etc.

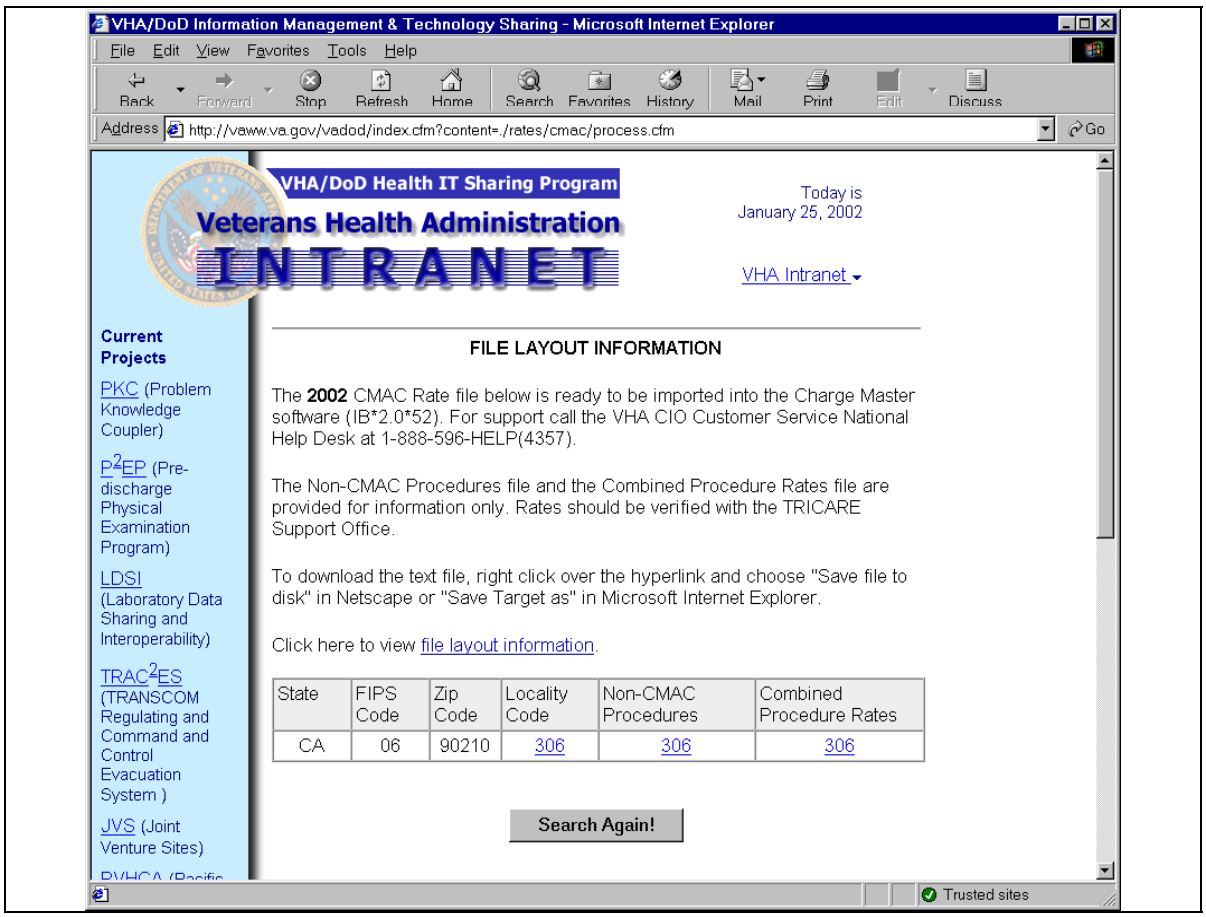
Rates are located at **http://vaww.va.gov/vadod/** .
Click on the link labeled "CMAC (CHAMPUS/TRICARE) Rates"

NOTE: The locality codes for may change from year to year. It is important for IRM to share those numbers with your billing staff so when charge sets are set up they use the

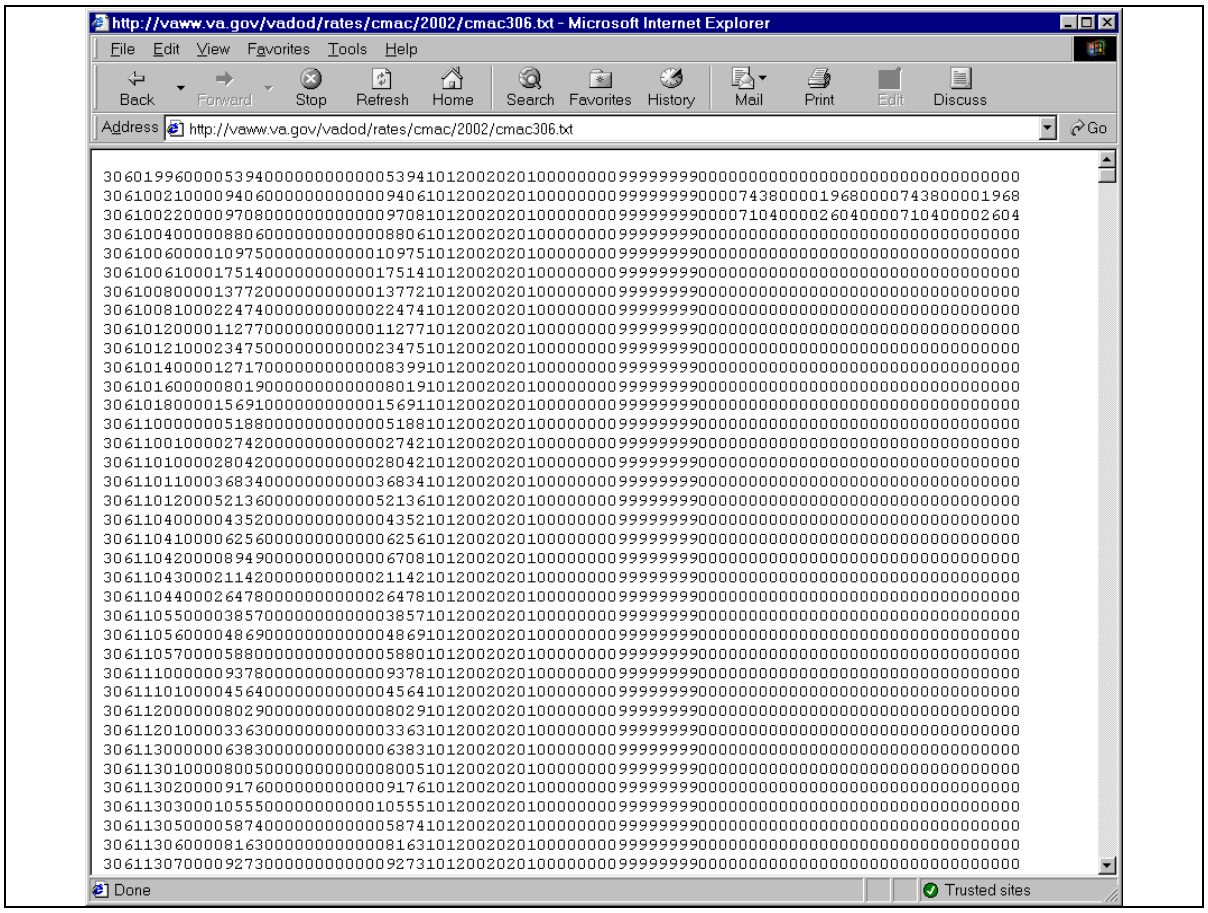
locality code in the name of the charge set. When IRM accesses the web site, they will can search by zip code for CMAC rates for different years.

Click on the link labeled **CMAC Rates (Intranet Only)** for the year you wish to search.

Enter the **ZIP** code for the first TRICARE billing locality and hit the Search button. (You may have to retrieve more than one rate file).



To retrieve the locality code host file(s):
Click on the link in the table labeled “Locality Code”. The rate file for that locality will open (It may take a minute or two since the file is large).



This is what the locality file looks like. Make sure you wait for the scroll bar on the right to stop moving and for the word **DONE** to appear in the bottom left hand corner. Then left click on **FILE** and then select **SAVE AS.** Pick a directory on your hard drive. The file then needs to be placed in the **Default Directory** or in the **User Directory** of the person loading the rates, and must be accessible from **V*IST*A**. Be sure and give it a file name of **cmacxxx.txt** where **xxx** is the locality code. Repeat this process for all the locality codes needed by your facility.

Be sure you use **ASCII** file transfer protocol when placing the file in the Default Directory.

```
Load host File into Charge Master

     Select one of the following:

          1.1       Load CMAC into XTMP
          1.2       Load AWP into XTMP
          2         Assign Charge Set
          3         Check Data Validity
          4         Load into Charge Master
          5         Delete XTMP files

Enter response: 1.1  Load CMAC into XTMP

Upload the CMAC from a host file:   'CMACxxx.TXT'   w/xxx = locality number

CMAC Host files available for upload in: ARCHV1$:[ANONYMOUS]

                               CMAC020.TXT
                               CMAC023.TXT
                               CMAC125.TXT

Enter a Host File Name: CMAC023.TXT

 Professional Component Modifier: // 26
Technical Component Modifier: // TC

Proceed with upload now? YES

Loading CMAC023.TXT into ^XTMP ..............
```

Loading the host file(s)

Use FTP utilities to move the host file to the **V*IST*A** computer system. After the host file is on the **V*IST*A** ystem, sign on and ensure that the current directory is set to the same directory where the host file(s) are located.

The next step is to move the data in the **cmacxxx.txt** files from the directory into the Integrated Billing's Charge Master. From **V*IST*A**, use the **Load Host File into Charge Master** option, selecting item 1.1 (Load CMAC into XTMP) from the menu. Specify the path to the directory containing the host file and enter **26** for the Professional Component Modifier and **TC** for the Technical Component Modifier.

If the following error message appears: **First line of file has no data, cannot continue!,** go back and edit the host file so there are no blank lines at the top. Some Intranet viewers will place a blank line or two at the top of the file. The first line on the file *MUST* be a data string. After editing the file, return to the option Load Host File into Charge Master [IBCR HOST FILE LOAD].

```
Enter response: 2  Assign Charge Set

Assign charges loaded into XTMP to Charge Sets.

------------------------------------------------------------------------------

A)  IB upload of Host file CMAC023.TXT, on 02/21/2002@12:43:31 by JAMES,EDWARD L

    IBCR UPLOAD CMAC023.TXT  023        Count = 16091     Item = CPT

             Subfile             Count       Charge Set
             -------             -----       -------------------------
        1    CLASS 1             6820
        2    CLASS 1 PC           828
        3    CLASS 1 TC           828
        4    CLASS 2               21
        5    CLASS 3&4           5978
        6    CLASS 4 PC           808
        7    CLASS 4 TC           808

Assign Charge Set to which file:  (1-7): 1
Select CHARGE SET NAME: CMAC 023 C1 PAD/SJC

       Charge Set: CMAC 023 C1 PAD/SJC       Billable Item: CPT
```

Once step 1.1 is complete, IRM must assign a charge set to each of the classes that are requested to load to Charge Master. This is step 2 in the **Load Host File into Charge Master** option. Work with your billing personnel to get their naming conventions for each Charge Set name as well as which Class to load into the appropriate charge set. Any of the listed (above) classes will not load if there is no assigned charge set to the class.

It is important that EACH of the Subfile Classes (left hand column) has the appropriate CMAC Charge Set assigned to it (right hand column).

```
Enter response: 3  Check Data Validity

Check files waiting to be loaded into the Charge Master for data validity.

A)  IB upload of Host file CMAC023.TXT, on 10/21/97@12:52:36 by JAMES,EDWARD L

    IBCR UPLOAD CMAC023.TXT  023        Count = 16091     Item = CPT

           Subfile                 Count       Charge Set
           -------                 -----       -------------------------
       1   CLASS 1                  6820        CMAC 023 C1 PAD/SJC
       2   CLASS 1 PC               828         CMAC 023 C1(PC) PAD/SJC
       3   CLASS 1 TC               828         CMAC 023 C1(TC) PAD/SJC
       4   CLASS 2                    21        CMAC 023 C2 PAD/SJC
       5   CLASS 3&4               5978         CMAC 023 C3&4 PAD/SJC
       6   CLASS 4 PC               808         CMAC 023 C4(PC) PAD/SJC
       7   CLASS 4 TC               808         CMAC 023 C4(TC) PAD/SJC


Report requires 120 columns
OUTPUT DEVICE: HOME//   DEVICE NAME


Data validity check on temporary files:

IBCR UPLOAD CMAC023.TXT  023       CLASS 1        .....
```

After the charge sets have been loaded, select step 3 to **Check Data Validity**. For CMAC Charge Sets, the report will compare the CPT codes in your system to the ones in the data file as well as the CPTs already loaded into Charge Master. Some errors will appear. The errors are not M code errors, but rather a problem with that individual data line. Quite often, errors will reflect some CPT codes in the CMAC data file are not in the **V***IST***A** CPT file.

```
Enter response: 4  Load into Charge Master

Check files waiting to be loaded into the Charge Master for data validity.

A)  IB upload of Host file CMAC023.TXT, on 10/21/97@12:52:36 by JAMES,EDWARD L
    IBCR UPLOAD CMAC023.TXT  023        Count = 16091     Item = CPT

             Subfile               Count             Charge Set
             -------               -----           -----------
        1    CLASS 1               6820          CMAC 023 C1 PAD/SJC
        2    CLASS 1 PC             828          CMAC 023 C1(PC) PAD/SJC
        3    CLASS 1 TC             828          CMAC 023 C1(TC) PAD/SJC
        4    CLASS 2                 21          CMAC 023 C2 PAD/SJC
        5    CLASS 3&4             5978          CMAC 023 C3&4 PAD/SJC
        6    CLASS 4 PC             808          CMAC 023 C4(PC) PAD/SJC
        7    CLASS 4 TC             808          CMAC 023 C4(TC) PAD/SJC

Load the above files into the Charge Master?  YES
A summary report of the results will be printed.

 Report requires 120 columns
OUTPUT DEVICE: HOME// DEVICE NAME

 Loading data into Charge Master:

IBCR UPLOAD CMAC023.TXT  023       CLASS 1        ..............................
............................
```

After the data check, IRM will use **step 4** to load the rates into the Charge Master. While the rates are loading, the system will display a similar report to the data validity report. This report reflects what was actually loaded into Charge Master.

```
  Enter response: 5  Delete XTMP files

  Delete files in XTMP:
  ------------------------------------------------------------------------------

  A)  IB upload of Host file CMAC023.TXT, on 10/21/97@12:52:36 by JAMES,EDWARD
  L
      IBCR UPLOAD CMAC023.TXT  023        Count = 16091     Item = CPT

               Subfile               Count             Charge Set
               -------               -----           -------------------------
          1    CLASS 1               6820          CMAC 023 C1 PAD/SJC
          2    CLASS 1 PC             828          CMAC 023 C1(PC) PAD/SJC
          3    CLASS 1 TC             828          CMAC 023 C1(TC) PAD/SJC
          4    CLASS 2                 21          CMAC 023 C2 PAD/SJC
          5    CLASS 3&4             5978          CMAC 023 C3&4 PAD/SJC
          6    CLASS 4 PC             808          CMAC 023 C4(PC) PAD/SJC
          7    CLASS 4 TC             808          CMAC 023 C4(TC) PAD/SJC

  Delete which files:  (1-7): 1-7
```

After the rates are loaded, IRM can use **step 5** to delete the XTMP files from the system.

Be advised that, if the CMAC rates are loaded BEFORE the current year CPT Code update to **V***IST***A**, then you will need to reload the CMAC rates AFTER the CPT patch is released. This is because a CPT code contained in the Rate file will not be added to **V***IST***A**, if that CPT code is not active at the time of the rate upload.

In most cases, TRICARE rates for Prescriptions and Prosthetic items are adjusted rates. An IRM staff member, with programmer access, must enter the rate adjustment.

```
Select Charge Master IRM Menu Option:  Rate Schedule Adjustment Enter/Edit
Select RATE SCHEDULE NAME:  PROST COST +10%

        The base unit charges are not currently Adjusted.

ADJUSTMENT:    S X=X*1.1     This is standard M code where you set the
                             variable X equal to X with the adjustment.
                             This example will add 10% to X.

Example:  If the base unit charge is $100,
          this adjustment will result in a charge of $110

Is this correct?   YES
```

The rate schedule adjustment is an M code field. Use the **Charge Master IRM Enter/Edit** [IBCR CHARGE MASTER IRM] option to enter or edit the rate schedule adjustment.

This demonstrates adding the CHAMPUS rate schedule that includes a CMAC charge set. It is important that the following steps are accomplished in order.

Once the CMAC charge set has been defined, identify that it is an auto add. Doing this allows the ability to download the CMAC rate and have it populate the billing rates file automatically.

```
Select Charge Master IRM Menu Option:  Rate Schedule Adjustment Enter/Edit
Select RATE SCHEDULE NAME:    CHAMPVA RX COST+$5

        The base unit charges are not currently Adjusted.

ADJUSTMENT:    S X=X+5     This is standard M code where you set the
                           variable X equal to X with the adjustment.
                           This example will add a $5 fee to X.

Example: If the base unit charge is $100,
         this adjustment will result in a charge of $105

Is this correct?   YES
```

Appendix C

Calculating TRICARE DRG Rates

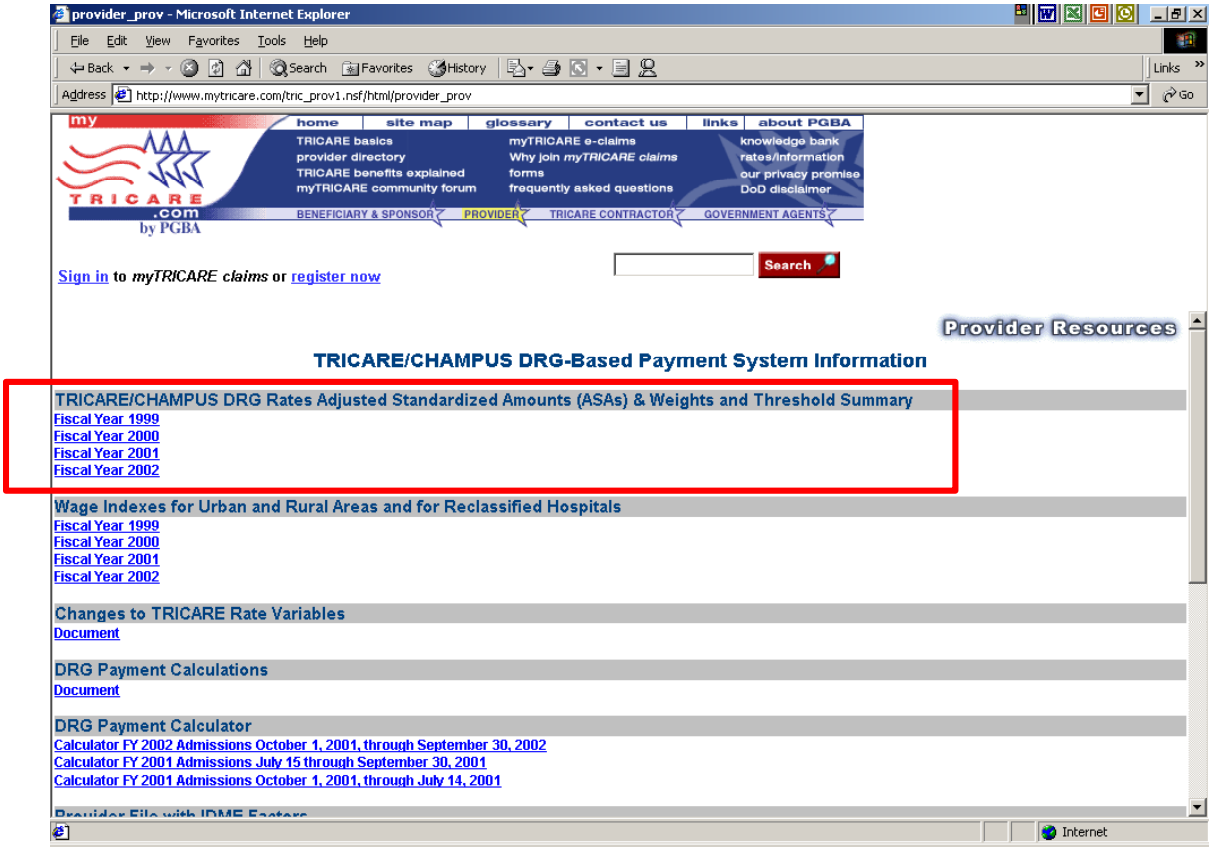
A VA/TRICARE Contract may be negotiated to allow you to bill TRICARE DRG rates for inpatient care. TRICARE DRG rates cannot be entered into the Charge Master. These charges must be entered manually onto the bill.

This section of the guide explains all of the steps necessary to obtain and calculate the TRICARE DRG Rates for a locality; use those rates on a TRICARE Inpatient Bill; and ensure the proper payment has been received for bills using these rates.

Create facility-based TRICARE DRG Spreadsheet

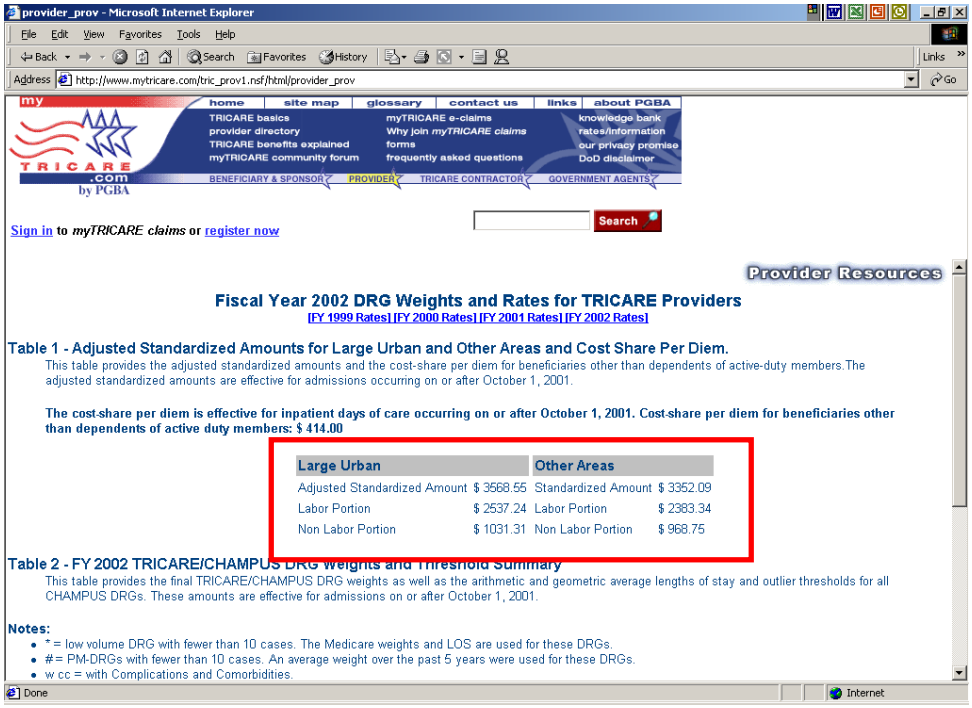
This action is performed in October of every year when the TRICARE DRG Rates are published in the Federal Register.

DRG Spreadsheet Step 1 – Connect to the My TRICARE website at http://mytricare.com. Navigate to the section on TRICARE/CHAMPUS DRG Information.



Select the correct Fiscal Year from the section titled TRICARE/CHAMPUS DRG Rates Adjusted Standardized Amounts (ASAs) & Weights and Threshold Summary.

DRG Spreadsheet Step 2 – Go to **Table 1 – Adjusted Standardized Amounts for Large Urban and Other Areas and Cost Share Per Diem**. Write down the dollar amounts associated with the Labor Portion and Non Labor Portion for the area (Large Urban or Other Area) where Inpatient Care is provided.



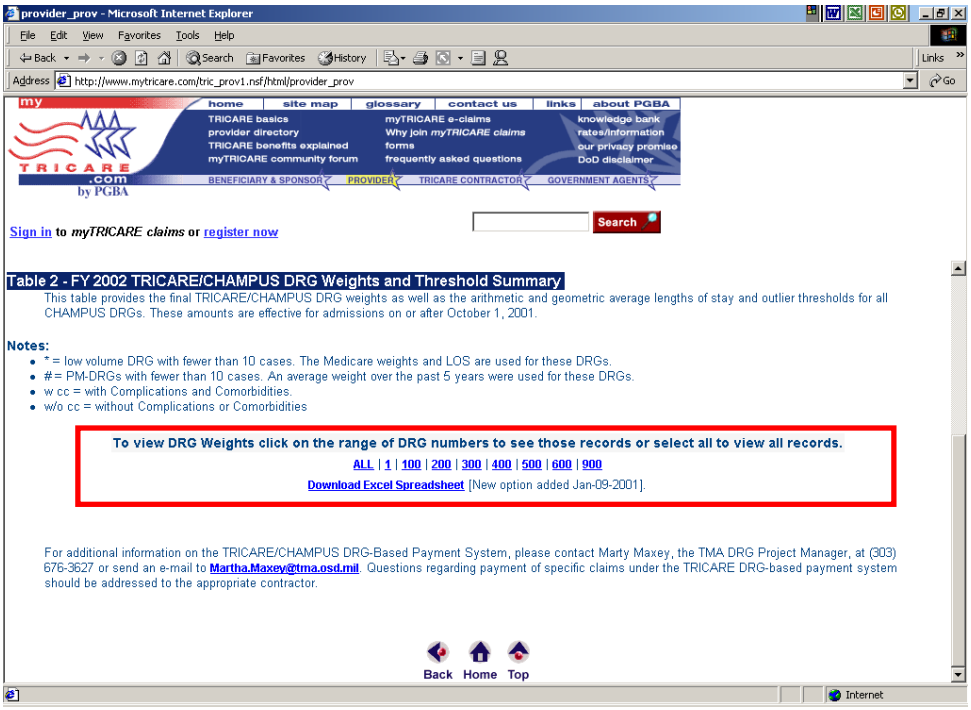
For example, if your facility were located in a large urban area, you would write down:

Labor Portion	$2537.24
Non Labor Portion	$1031.31

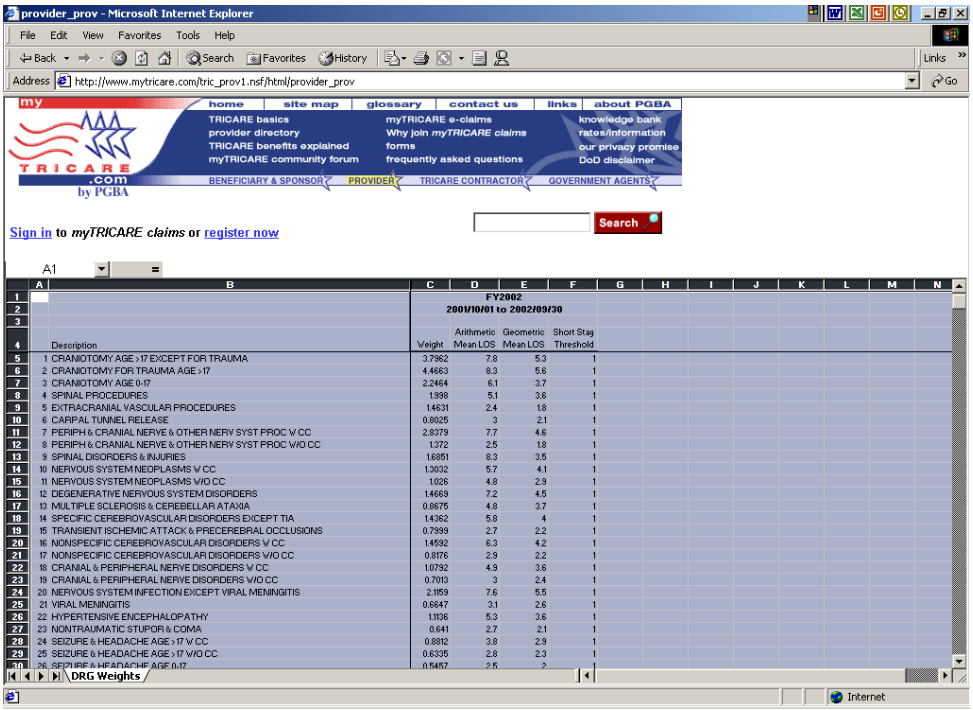
For example, if your facility were located in a rural area, you would write down:

Labor Portion	$2383.34
Non Labor Portion	$ 968.75

DRG Spreadsheet Step 3 – Scroll down this same page to **Table 2 - FY 2002 TRICARE/CHAMPUS DRG Weights and Threshold Summary.**

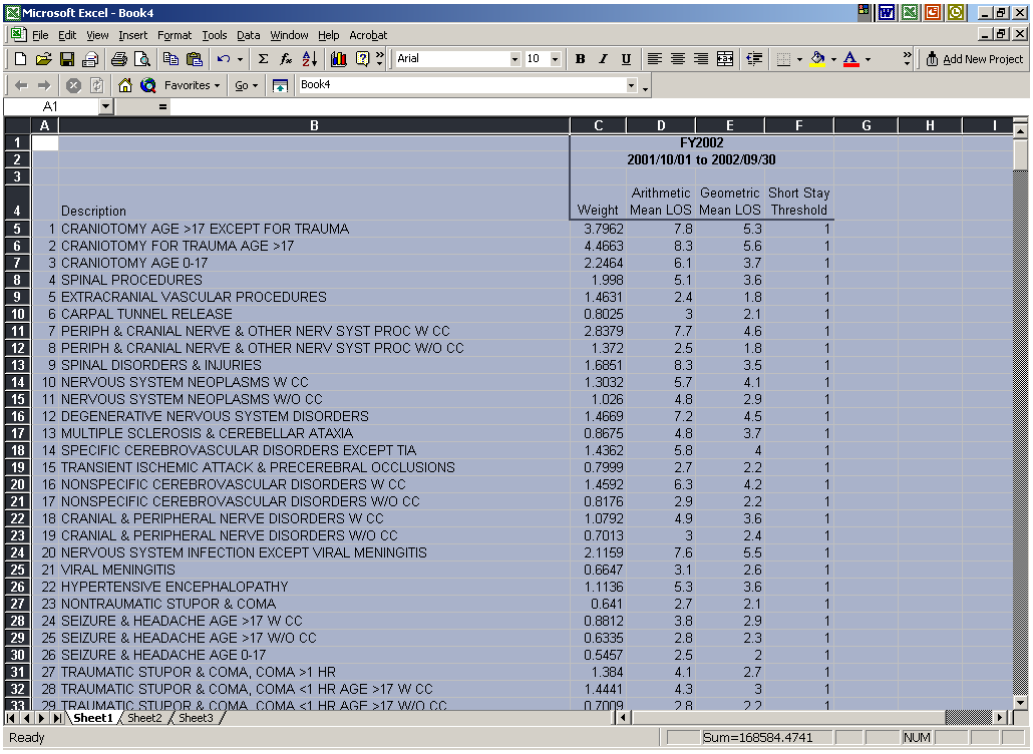


Click on the **Download Excel Spreadsheet** link.



Click in the top left cell to select all cells on the spreadsheet. (Spreadsheet turns blue). Then right click and select copy.

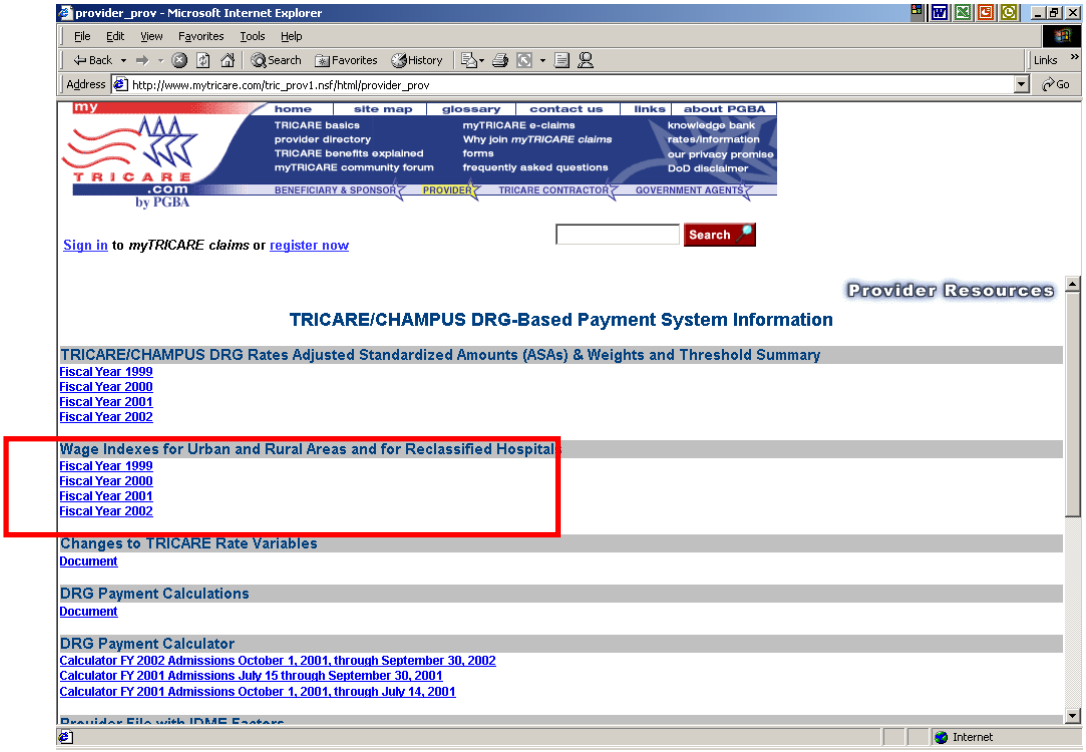
Open a new Excel spreadsheet and paste the contents into the highlighted cell.



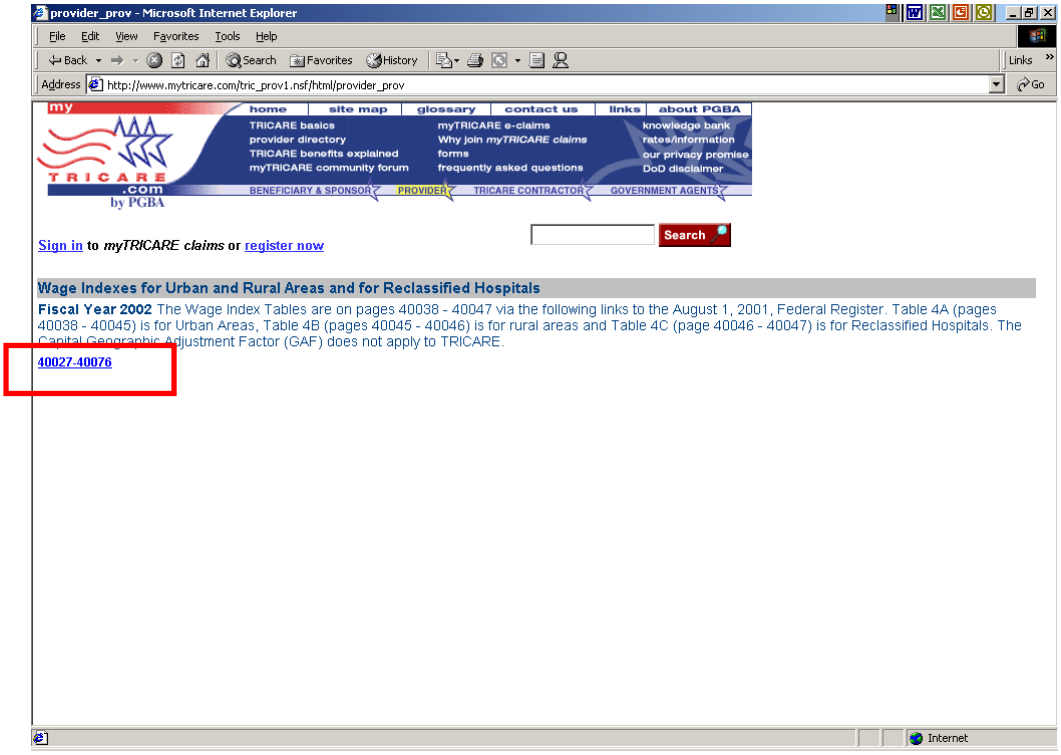
	A	B	C	D	E	F	G	H	I
1			FY2002						
2			2001/10/01 to 2002/09/30						
3									
4		Description	Weight	Arithmetic Mean LOS	Geometric Mean LOS	Short Stay Threshold			
5	1	CRANIOTOMY AGE >17 EXCEPT FOR TRAUMA	3.7962	7.8	5.3	1			
6	2	CRANIOTOMY FOR TRAUMA AGE >17	4.4663	8.3	5.6	1			
7	3	CRANIOTOMY AGE 0-17	2.2464	6.1	3.7	1			
8	4	SPINAL PROCEDURES	1.998	5.1	3.6	1			
9	5	EXTRACRANIAL VASCULAR PROCEDURES	1.4631	2.4	1.8	1			
10	6	CARPAL TUNNEL RELEASE	0.8025	3	2.1	1			
11	7	PERIPH & CRANIAL NERVE & OTHER NERV SYST PROC W CC	2.8379	7.7	4.6	1			
12	8	PERIPH & CRANIAL NERVE & OTHER NERV SYST PROC W/O CC	1.372	2.5	1.8	1			
13	9	SPINAL DISORDERS & INJURIES	1.6851	8.3	3.5	1			
14	10	NERVOUS SYSTEM NEOPLASMS W CC	1.3032	5.7	4.1	1			
15	11	NERVOUS SYSTEM NEOPLASMS W/O CC	1.026	4.8	2.9	1			
16	12	DEGENERATIVE NERVOUS SYSTEM DISORDERS	1.4669	7.2	4.5	1			
17	13	MULTIPLE SCLEROSIS & CEREBELLAR ATAXIA	0.8675	4.8	3.7	1			
18	14	SPECIFIC CEREBROVASCULAR DISORDERS EXCEPT TIA	1.4362	5.8	4	1			
19	15	TRANSIENT ISCHEMIC ATTACK & PRECEREBRAL OCCLUSIONS	0.7999	2.7	2.2	1			
20	16	NONSPECIFIC CEREBROVASCULAR DISORDERS W CC	1.4592	6.3	4.2	1			
21	17	NONSPECIFIC CEREBROVASCULAR DISORDERS W/O CC	0.8176	2.9	2.2	1			
22	18	CRANIAL & PERIPHERAL NERVE DISORDERS W CC	1.0792	4.9	3.6	1			
23	19	CRANIAL & PERIPHERAL NERVE DISORDERS W/O CC	0.7013	3	2.4	1			
24	20	NERVOUS SYSTEM INFECTION EXCEPT VIRAL MENINGITIS	2.1159	7.6	5.5	1			
25	21	VIRAL MENINGITIS	0.6647	3.1	2.6	1			
26	22	HYPERTENSIVE ENCEPHALOPATHY	1.1136	5.3	3.6	1			
27	23	NONTRAUMATIC STUPOR & COMA	0.641	2.7	2.1	1			
28	24	SEIZURE & HEADACHE AGE >17 W CC	0.8812	3.8	2.9	1			
29	25	SEIZURE & HEADACHE AGE >17 W/O CC	0.6335	2.8	2.3	1			
30	26	SEIZURE & HEADACHE AGE 0-17	0.5457	2.5	2	1			
31	27	TRAUMATIC STUPOR & COMA, COMA >1 HR	1.384	4.1	2.7	1			
32	28	TRAUMATIC STUPOR & COMA, COMA <1 HR AGE >17 W CC	1.4441	4.3	3	1			
33	29	TRAUMATIC STUPOR & COMA, COMA <1 HR AGE >17 W/O CC	0.7009	2.8	2.2	1			

Save this copy of the TRICARE DRG Spreadsheet.

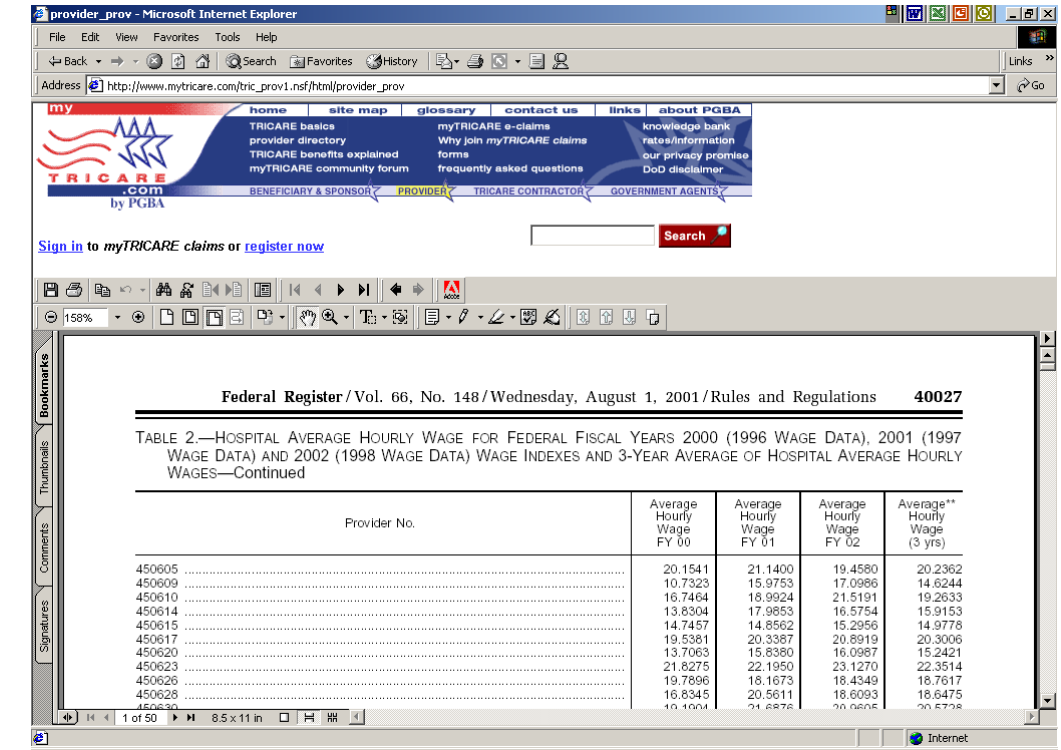
DRG Spreadsheet Step 4 – Back out to the main TRICARE DRG page.



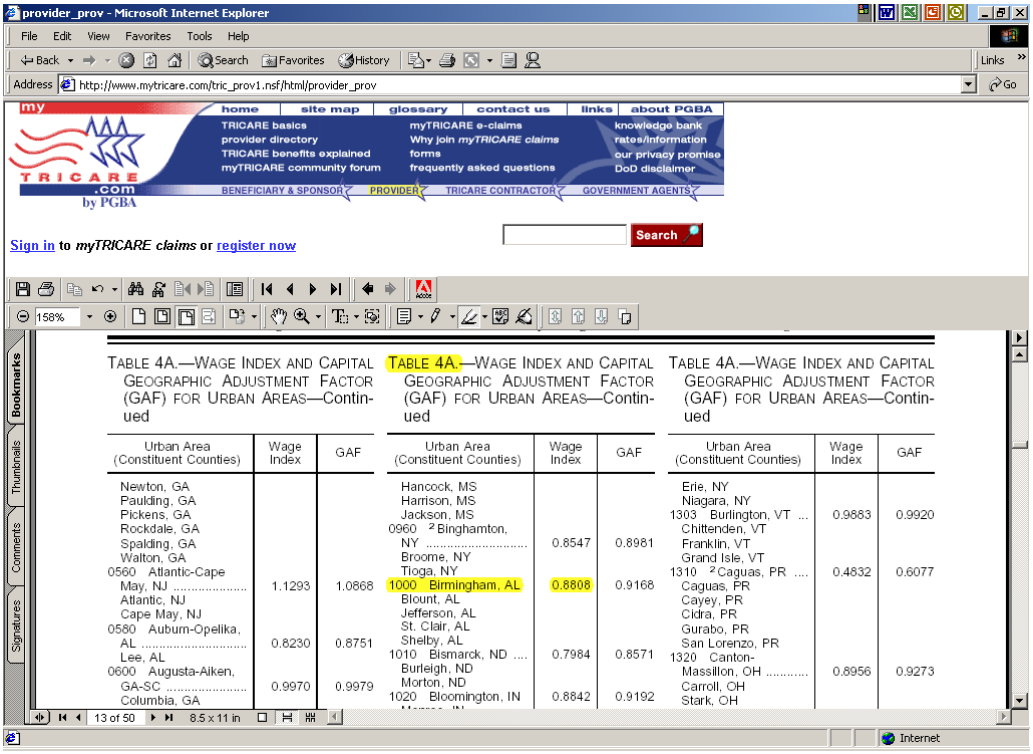
Select the correct Fiscal Year from the section titled **Wage Indexes for Urban and Rural Areas and for Reclassified Hospitals**. Click on the link to see the Wage Index Tables in the Federal Register.



The Wage Indexes are displayed in an Adobe Acrobat format.



Scroll down this document until you reach the table that contains your Geographic Wage Index information. Table 4A – Wage Index and Capital Geographic Adjustment Factor (GAF) for Urban Areas. Table 4B - Wage Index and Capital Geographic Adjustment Factor (GAF) for Rural Areas.



Find your county on the correct table and write down the Wage Index. This example shows the Wage Index for Birmingham, Alabama is 0.8808.

Now you have all the elements you need to create the formula that calculate the base DRG reimbursement amounts on your local TRICARE DRG spreadsheet.

- Adjusted Standard Labor Portion – Step 2
- Adjusted Standard Non Labor Portion – Step 2
- Geographic Wage index – Step 4
- DRG (Champus) Weight – Step 3

DRG Spreadsheet Step 5 – Add three columns to the TRICARE DRG Spreadsheet created in Step 3. The columns are shown in yellow below. The column headings should read:

- DRG Base Reimb Amt
- Short Stay Outlier Per Diem
- Short Stay Outlier Basic Amt

(a)	(b)	©	(d)	(e)	(f)	(g)	(h)	
		CHAMPUS	**DRG Base**				Short Stay	Short Stay
	Description	DRG WTD	**Reimb Amt**	Arithmetic Mean LOS	Geometric Mean LOS	Short Stay Threshold	Outlier Per Diem	Outlier Basic Amt. (col.h*#ofdays*2.00
1	CRANIOTOMY AGE >17 EXCEPT FOR	3.7962		7.8	5.3	1		
2	CRANIOTOMY FOR TRAUMA AGE	4.4663		8.3	5.6	1		
3	CRANIOTOMY AGE 0-	2.2464		6.1	3.7	1		
4	SPINAL	1.998		5.1	3.6	1		

DRG Spreadsheet Step 6 – Click on the first empty data cell under the column Base DRG Reimb Amt. And enter the formula to calculate the Base DRG Reimbursement Amount

The formula consists of the following components:
((Adjusted Standard Amounts Labor Portion * Geographic Wage Index) + Adjusted Standard Amounts Non Labor Portion) * DRG (Champus) Weight = Base DRG Reimbursement Amount

If we use the numbers from the examples above, the formula entered in the first cell should look like this:

=(($2537.24*0.8808)+1031.31)*[Cell number]

(a)	(b)	©	(d)	(e)	(f)	(g)	(h)	
		CHAMPUS	**DRG Base**				Short Stay	Short Stay
	Description	DRG WTD	**Reimb Amt**	Arithmetic Mean LOS	Geometric Mean LOS	Short Stay Threshold	Outlier Per Diem	Outlier Basic Amt. (col.h*#ofdays*2.00)
1	CRANIOTOMY AGE >17 EXCEPT FOR TRAUMA	3.7962		7.8	5.3	1		
2	CRANIOTOMY FOR TRAUMA AGE >17	4.4663		8.3	5.6	1		
3	CRANIOTOMY AGE 0-17	2.2464		6.1	3.7	1		
4	SPINAL PROCEDURES	1.998		5.1	3.6	1		

The same formula can be copied down the remaining cells in that column. Please consult with a person proficient in Excel if you need help with these steps.

DRG Spreadsheet Step 7 – Calculate the Short Stay Outlier Per Diem column by entering the formula that divides the cell in row D by the cell in row E. The formula should look like this example:

=D4/E4

Here is the same spreadsheet with the formulas entered.

(a)	(b)	©	(d)	(e)	(f)	(g)	(h)	
		CHAMPUS	**DRG Base**				**Short Stay**	Short Stay
	Description	DRG WTD	**Reimb Amt**	Arithmetic Mean LOS	Geometric Mean LOS	Short Stay Threshold	**Outlier Per Diem**	Outlier Basic Amt. (col.h*#ofdays*2.00)
1	CRANIOTOMY AGE >17 EXCEPT FOR TRAUMA	3.7962	**12398.81055**	7.8	5.3	1	**1589.591096**	
2	CRANIOTOMY FOR TRAUMA AGE >17	4.4663	**14587.43152**	8.3	5.6	1	**1757.52187**	
3	CRANIOTOMY AGE 0-17	2.2464	**7336.991732**	6.1	3.7	1	**1202.78553**	
4	SPINAL PROCEDURES	1.998	**6525.689762**	5.1	3.6	1	**1279.547012**	

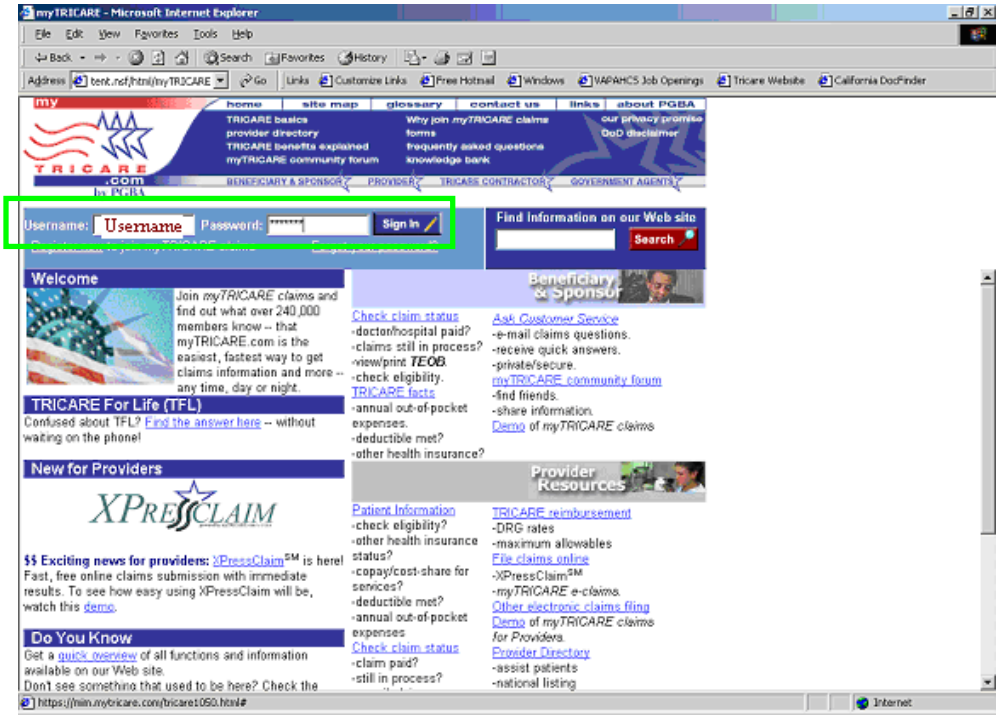
Please note: The Short Stay Outlier Basic Amount column is left blank. The Billers will use this column when creating the TRICARE DRG Bill.

DRG Spreadsheet Step 8 – Add any additional columns that you may need in order to help calculate the correct billing rates based on the TRICARE contract in place at your facility.

Appendix D

Information on the myTRICARE.com Web Site

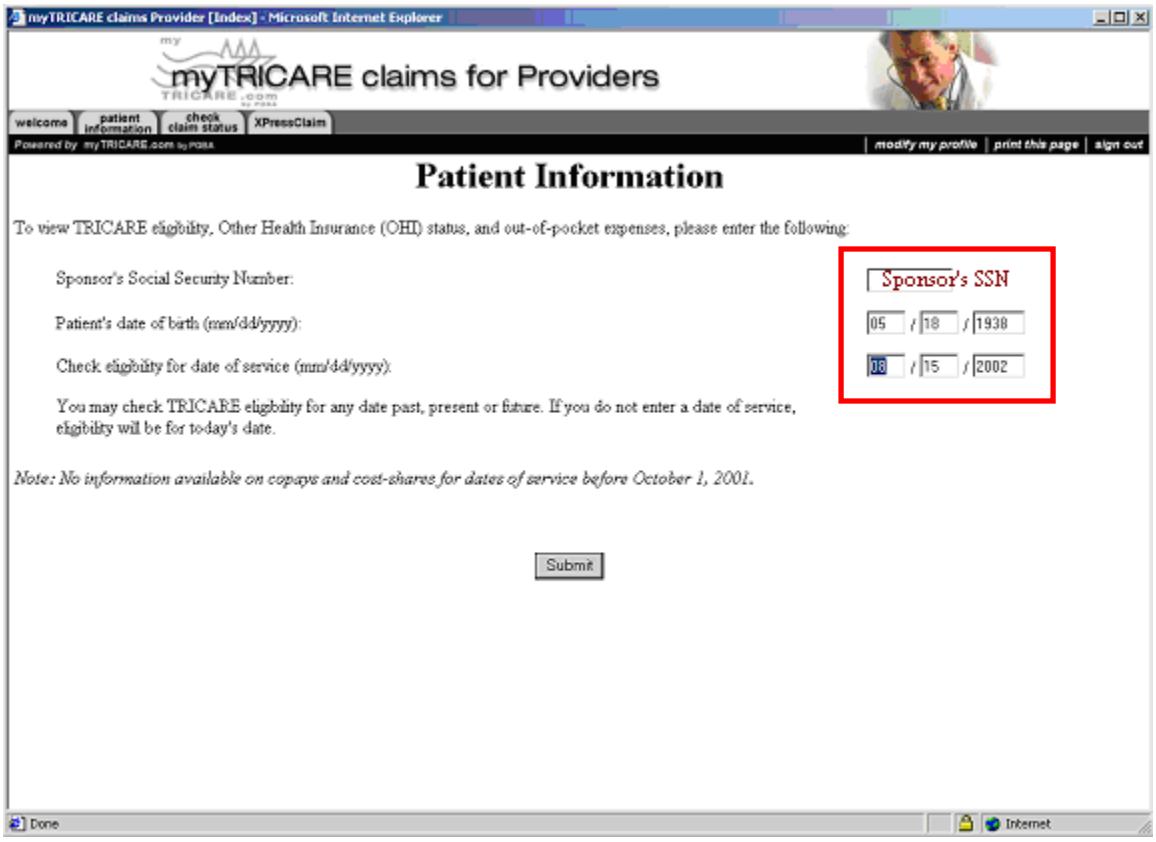
Individuals who have registered with myTRICARE.com can check a TRICARE patient's eligibility and claim status on that web site. The following screens show the type of information available.



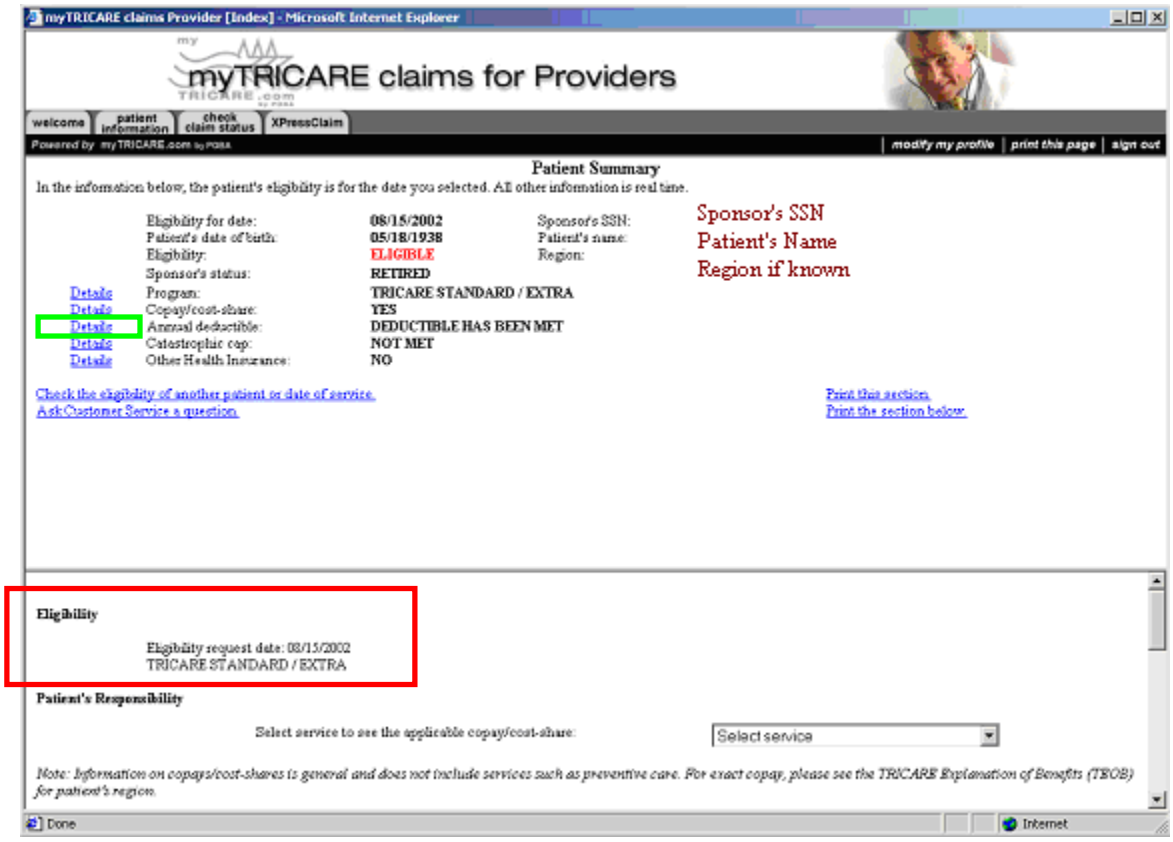
After you sign in as a registered user you will see the myTRICARE for Providers screen.

The following pages will show examples of Patient Information and Claims Status screens.

For the first example, select **Patient Information**, the second bullet point on the list.



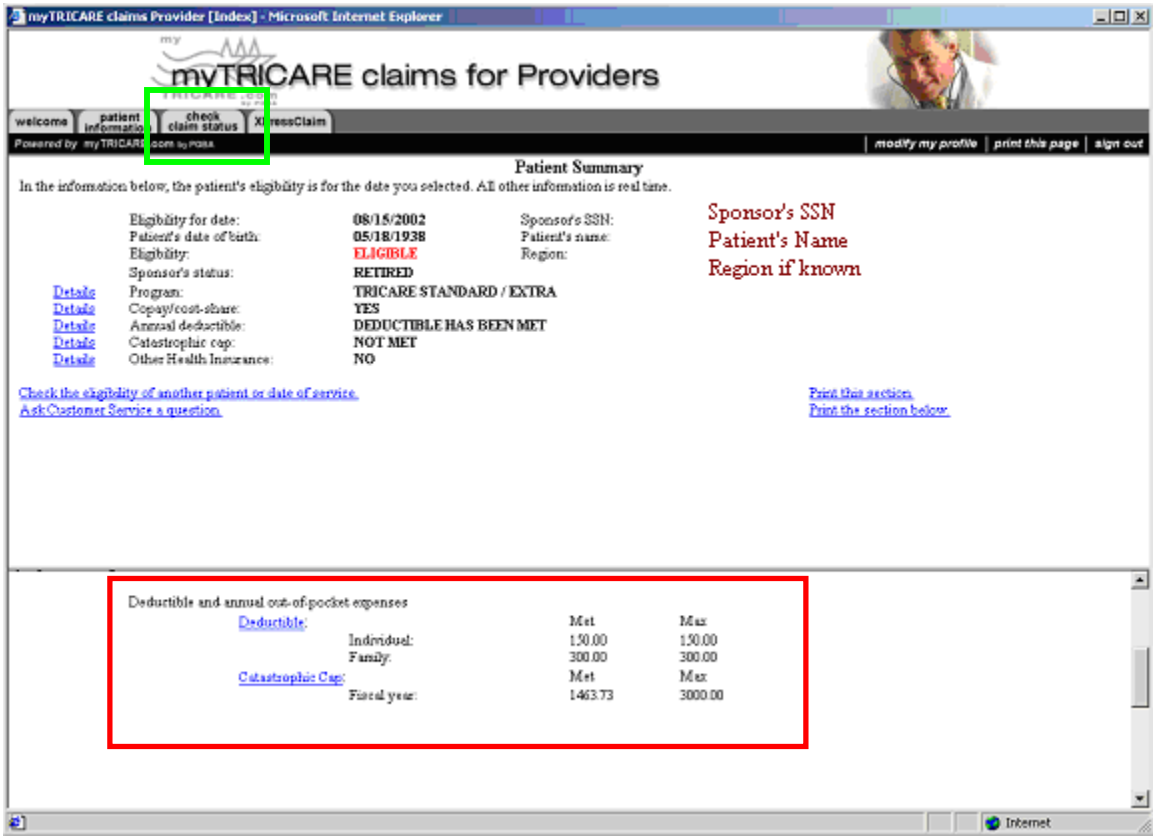
Enter the **Sponsor's Social Security Number** and the other required fields on the Patient Information screen.



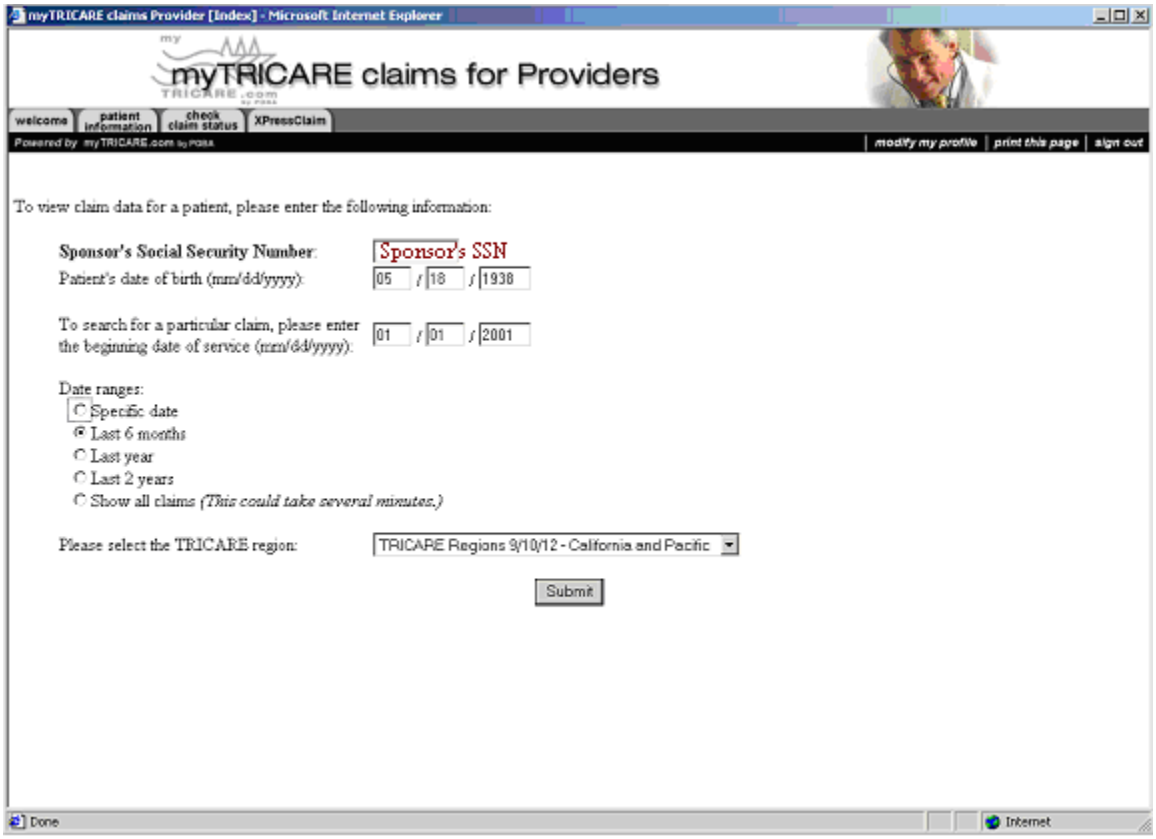
The **Patient Summary** screen displays eligibility information for the date range entered on the previous screen. The **Details** link next to each topic can be used to display more information.

Click on the **Details** link next to the topic called **Annual Deductible**.

The screen changes to show the deductible and out-of pocket expenses for this Sponsor at the bottom of the screen.

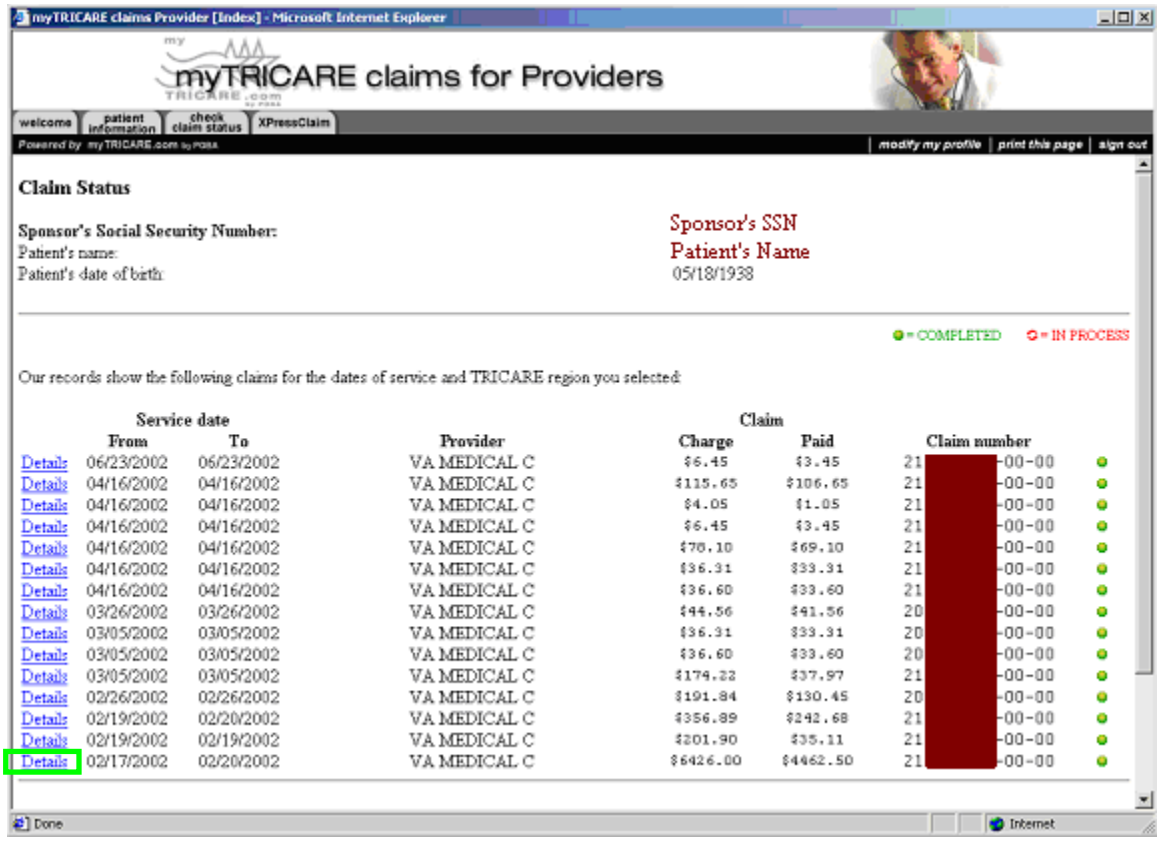


In order to view claim data for a patient, click on the **Check Claim Status** tab located under the myTRICARE logo at the top of the screen.



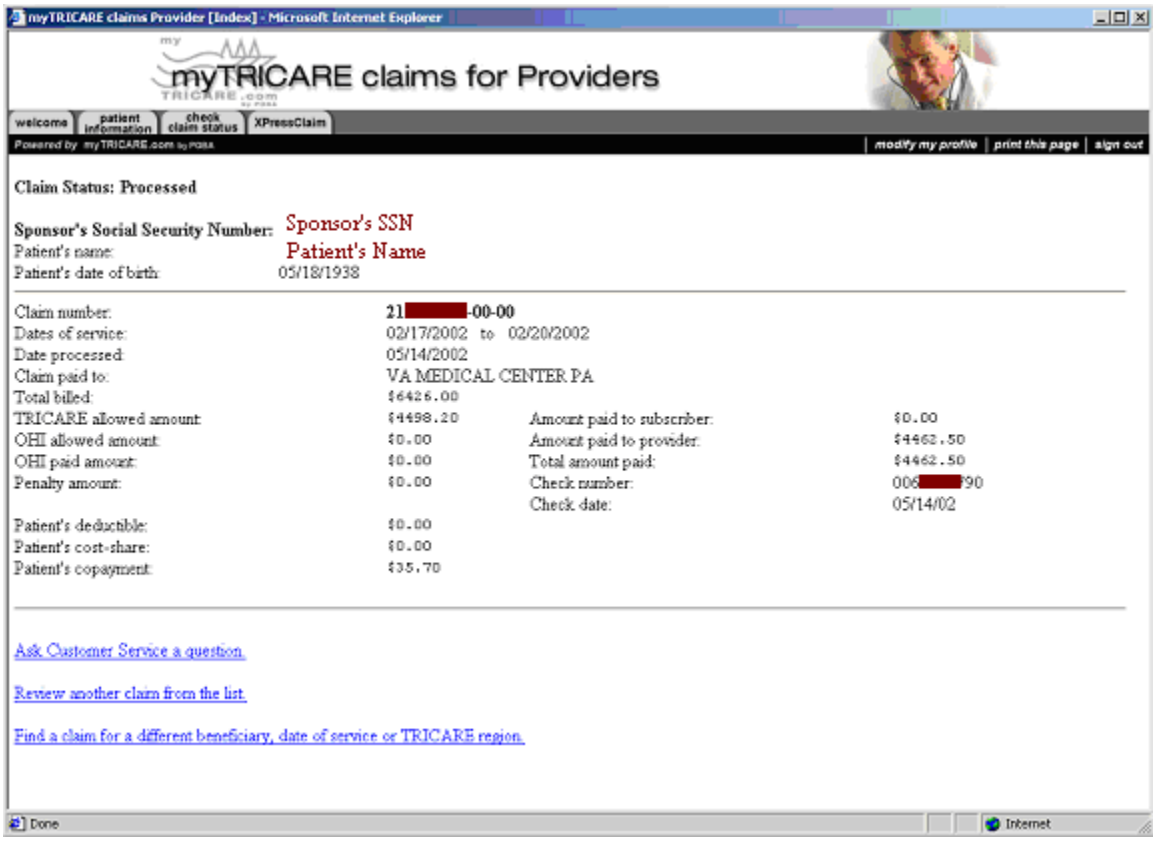
Enter the **Sponsor's Social Security Number** and the other required fields on the Claim Data screen.

The Claim Status Screen displays claim information for the date range entered.



Click on the **Details** link for more information about a specific claim.

This screen shows the Claim detail information.



Please contact http://myTRICARE.com for more information.

Appendix E

VA / TRICARE - Dual Eligibility

TRICARE beneficiaries may be eligible for both veterans' and TRICARE benefits. The following information is provided regarding medical care for TRICARE beneficiaries who are also eligible for veterans' benefits.

Dual Eligibility

Veterans are considered "dual-eligible" when they are eligible for both veterans' medical benefits and TRICARE benefits.

Selection of Veterans' (Priority 7) or TRICARE Benefits

Veterans seeking care for a *service-connected* condition in VA medical facilities must receive that care under their veterans' benefits. VA may not bill TRICARE for treatment of service-connected conditions.

Veterans seeking care for *non service-connected* conditions in VA medical facilities may receive care under either veterans' or TRICARE benefits. However, once that choice is made they must continue to use that program's benefit for the complete "episode of care." An episode of care generally includes all covered services provided for a particular medical incident

Veterans seeking care in facilities, *other* than VA facilities, may choose to use their TRICARE benefits regardless of whether the condition is service-connected. However, once the individual makes that choice they must continue to use that program's benefit for the continuation of that episode of care.

TRICARE contractors will manage the care and benefits for dual-eligible veterans seeking care from civilian providers who present their TRICARE card at the time of service. VA has no responsibility.

If a dual-eligible patient seeks emergency care from a civilian provider and says he/she is a veteran, the civilian facility is responsible for stabilizing the patient and contacting TRICARE and the VA to authorize payment and other services. Although the individual is dual-eligible, VA may be responsible for continuation of this episode of care. If VA denies the claim, based on regulatory authority, the civilian provider and/or the patient may submit the claim under TRICARE.

If VA authorizes payment for the dual eligible patient VA may arrange to transfer the veteran to a VA facility. In this case, the veteran cannot convert to TRICARE in order to

stay in the civilian facility. Failure to comply with VA and/or TRICARE policies will result in denial of benefits. TRICARE will not cost-share for services related to the continuation of care for which VA has already authorized payment for initial treatment.

Using TRICARE benefits in a VA Medical Center

TRICARE benefits may be used if the VA Medical Center is a participating provider in the TRICARE network and the veteran is seeking care for a non-service-connected condition. However, if the individual applies and is accepted for care as a veteran, VA assumes responsibility for providing the full continuum of inpatient and outpatient care. The dual eligible beneficiary has a choice only at the time he/she first presents for a particular episode of care.

TRICARE Referrals for Specialty Care and TRICARE Prime Point-of-Service Option

TRICARE Prime beneficiaries need a specialty referral from their TRICARE Primary Care Manager (i.e. authorization from a Health Care Finder) to be seen in a specialty clinic (even if a VA physician is also the patient's PCM). However, if the TRICARE Prime beneficiary wishes to receive non-emergency, TRICARE-covered services without a referral or authorization they may do so under the "Point of Service" option. The cost shares and deductibles are substantial.

If the beneficiary is TRICARE Extra (i.e. not enrolled in TRICARE Prime), he/she does not need a referral, but the individual should contact the TRICARE point of contact at the VA Medical Center for an appointment. TRICARE Extra beneficiaries must still obtain prior authorizations for applicable services. "Point of Service" charges do not apply. A list of services requiring prior authorization is available from TRICARE.

Coordination/authorization of follow-up care for dual-eligible patients

Coordination of follow-up care depends on which benefit the veteran has chosen for that episode of care. If veterans' benefits are chosen, VA will be responsible for coordinating follow-up care. If TRICARE benefits are selected, follow-up care will need to be authorized by TRICARE.

VA Medical Centers may refuse to see dual-eligible veterans as TRICARE beneficiaries

Even if the Medical Center participates in the local TRICARE provider network the VA Medical Center may refuse to see a dual-eligible beneficiaries if space is not available. TRICARE beneficiaries and Priority 7 patients are seen on a space available basis only.

Coordination of Benefits and dual-eligible veterans

Individuals must choose to use either their veterans' or their TRICARE benefits. However, once the selection has been made crossover is not permitted for that episode of care. The individual is responsible for complying with the rules of the program chosen. If the dual eligible veteran selects TRICARE and has other health insurance (OHI) TRICARE is the secondary payer (except in the case of Medicaid, Indian Health Services or state-sponsored Medical programs).

Contact the Health Administration Service in your facility or contact the appropriate TRICARE office for additional information.

TRICARE for Life (TFL) and dual eligible veterans

Beneficiaries choosing to utilize TFL benefits through VA providers will self-refer. If the beneficiary has OHI, TRICARE becomes the secondary payer. VA services provided through TFL will be subject to cost-sharing requirements such as annual deductibles and co-payments. Medicare is not authorized to pay VA for any services provided to Medicare-eligible patients, including those covered by TFL. TFL beneficiaries' out-of-pocket cost shares may not be waived for services provided by VA under the TFL program. VA medical facilities must provide information on current cost-sharing requirements for DOD beneficiaries considering utilizing TFL benefits at VA at the time TFL beneficiaries first present for care. This information is to include cost-sharing information for (1) TFL services provided by the private sector; (2) TFL services that would be provided by VA facilities; and (3) veterans' benefits available if seen as a veteran. For further information see "Guidance for VA's Role in TRICARE for Life," VA Directive 2002-036 (June 21, 2002).

Appendix F

Registering a TRICARE Patient

The next few pages show how to complete **V*IST*A** Registration screens for a TRICARE Patient. Special notations indicate where the data entered differs from that used when registering a Veteran.

```
Select Registration Menu Option: REGISTER A PATIENT
Select 1010 printer: <local device name>


Select PATIENT NAME: TRICARE,DEMO PATIENT
   ARE YOU ADDING 'TRICARE,DEMO PATIENT' AS A NEW PATIENT (THE 3352ND)? No// Y
  (Yes)
   PATIENT SEX: M MALE
   PATIENT DATE OF BIRTH: 080872  (AUG 08, 1972)
   PATIENT SOCIAL SECURITY NUMBER: P  267080872P
   PATIENT TYPE: TRICARE
   PATIENT VETERAN (Y/N)?: NO

   ...searching for potential duplicates

   No potential duplicates have been identified.

   ...adding new patient

   Please enter the following additional information:
```

All patient names should be entered in all capital letters. The complete name should include the patient's LAST NAME, FIRST NAME and FULL MIDDLE NAME.

At the **PATIENT TYPE:** prompt, type **TRICARE** when registering a TRICARE Patient.

At the **PATIENT VETERAN (Y/N)?** prompt, type **NO**. This response will cause the program to skip some of the Registration Screens normally shown when registering a Veteran. This means that some required fields (Marital Status, Religious Preference, Employment information) will display as inconsistencies and must be completed at that time.

Most of the fields on this first screen will be unspecified because this is a new TRICARE Patient.

```
TRICARE,DEMO PATIENT                    267-08-0872P            AUG 8,1972
================================================================================
               COORDINATING MASTER OF RECORD:
Address: STREET ADDRESS UNKNOWN         Temporary: NO TEMPORARY ADDRESS
         UNK. CITY/STATE
 County: UNSPECIFIED                      From/To: NOT APPLICABLE
  Phone: UNSPECIFIED                        Phone: NOT APPLICABLE
 Office: UNSPECIFIED

Primary Eligibility: UNSPECIFIED
Other Eligibilities:

Status      : PATIENT HAS NO INPATIENT OR LODGER ACTIVITY IN THE COMPUTER

Future Appointments: NONE

Remarks:
     Money Verified: NOT VERIFIED          Service Verified: NOT VERIFIED
Do you wish to request a HINQ inquiry  ? No//



Select Admitting Area:

Do you want to enter Patient Data? Yes//   (Yes)
```

```
              PATIENT DEMOGRAPHIC DATA, SCREEN <1>
TRICARE,DEMO PATIENT; 267-08-0872P                                   TRICARE
================================================================================

[1]    Name: TRICARE,DEMO PATIENT           SS: 267-08-0872P DOB: AUG 8,1972
[2]   Alias: NO ALIAS ON FILE FOR THIS APPLICANT
[3] Remarks: NO REMARKS ENTERED FOR THIS PATIENT
[4] Permanent Address:                  [5] Temporary Address:
         123 DEMO STREET                            NO TEMPORARY ADDRESS
         DEMO,NY 14001
 County: ERIE (029)                       County: NOT APPLICABLE
  Phone: 555-1212                          Phone: NOT APPLICABLE
 Office: UNANSWERED                      From/To: NOT APPLICABLE









<RET> to CONTINUE, 1-5 or ALL to EDIT, ^N for screen N or '^' to QUIT:
```

```
                EMERGENCY CONTACT DATA, SCREEN <3>
TRICARE,DEMO PATIENT; 267-08-0872P                                    TRICARE
================================================================================
[1]      NOK: TRICARE,SUSAN MARY          [2] NOK-2: UNANSWERED
    Relation: WIFE                         Relation: UNANSWERED
              123 DEMO STREET
              DEMO,NY 14001
       Phone: 000-555-1212                     Phone: UNANSWERED
  Work Phone: 000-555-1234                Work Phone: UNANSWERED
[3]  E-Cont.: UNANSWERED               [4] E2-Cont.: UNANSWERED
    Relation: UNANSWERED                   Relation: UNANSWERED
       Phone: UNANSWERED                       Phone: UNANSWERED
  Work Phone: UNANSWERED                  Work Phone: UNANSWERED
[5] Designee: UNANSWERED                  Relation: UNANSWERED
       Phone: UNANSWERED                  Work Phone: UNANSWERED




<RET> to CONTINUE, 1-5 or ALL to EDIT, ^N for screen N or '^' to QUIT:
```

```
                    INSURANCE DATA, SCREEN <5>
TRICARE,DEMO PATIENT; 267-08-0872P                                    TRICARE
================================================================================

[1] Covered by Health Insurance: NOT ANSWERED

   Insurance   COB Subscriber ID     Group       Holder  Effective  Expires

   ============================================================================

    No Insurance Information


[2] Eligible for MEDICAID: UNANSWERED

[3] Medicaid Number:




<RET> to CONTINUE, 1-3 or ALL to EDIT, ^N for screen N or '^' to QUIT: 1
```

TRICARE Prime, Standard, Extra and TFL (TRICARE For Life) are not eligibilities, but rather, types of Insurance Coverage. Special care must be taken to ensure the correct information is entered on Insurance Data Screen <5>.

How To Enter Insurance Info - Screen 5

```
COVERED BY HEALTH INSURANCE?: YES
COVERED BY HEALTH INSURANCE changed to 'NO'.


  This option adds or edits insurance information in the Insurance Buffer File.
  This is a temporary file that will hold all new insurance information until
  authorized insurance personnel can coordinate this new information with the
  patient's existing insurance.  You may add a new Buffer entry or edit a
  Buffer entry that you previously created for this patient if that entry
  has not yet been processed by insurance personnel.

  Please enter all available insurance information.

Select INSURANCE COMPANY: TRICARE
Add a new Insurance Buffer entry for this patient? YES// YES


INSURANCE COMPANY NAME: TRICARE//
PHONE NUMBER:
BILLING PHONE NUMBER:
PRECERTIFICATION PHONE NUMBER:
STREET ADDRESS [LINE 1]:
CITY:
STATE:
ZIP CODE:

GROUP NAME: STANDARD, EXTRA, PRIME or TFL (TRICARE for Life)
GROUP NUMBER:
TYPE OF PLAN: CHAMPUS
EFFECTIVE DATE:
EXPIRATION DATE:
WHOSE INSURANCE: OTHER
PT. RELATIONSHIP TO INSURED: PATIENT, SPOUSE or OTHER APPROPRIATE RELATIONSHIP
SUBSCRIBER ID: TRICARE ID #
NAME OF INSURED: <NAME OF TRICARE SPONSOR>
INSURED'S DOB:
INSURED'S SSN: <SPONSOR'S SSN>
```

```
                    INSURANCE DATA, SCREEN <5>
TRICARE,DEMO PATIENT; 267-08-0872P                                    TRICARE
================================================================================
[1] Covered by Health Insurance: NO

   Insurance   COB Subscriber ID     Group       Holder  Effective  Expires
   ================================================================================
    No Insurance Information

                ***  Patient has Insurance Buffer entries  ***

[2] Eligible for MEDICAID: UNANSWERED

[3] Medicaid Number:


<RET> to CONTINUE, 1-3 or ALL to EDIT, ^N for screen N or '^' to QUIT:
```

```
               ELIGIBILITY STATUS DATA, SCREEN <7>
TRICARE,DEMO PATIENT; 267-08-0872P                                    TRICARE
================================================================================
[1]       Patient Type: TRICARE                          Veteran: NO
         Svc Connected: N/A                           SC Percent: N/A
         Rated Incomp.: NO
          Claim Number: UNANSWERED
           Folder Loc.: UNANSWERED
[2]   Aid & Attendance: NO                             Housebound: NO
           VA Pension: NO                          VA Disability: NO
    Total Check Amount: NOT APPLICABLE
         GI Insurance: NO                                 Amount: UNANSWERED
[3]  Primary Elig Code: TRICARE/CHAMPUS
    Other Elig Code(s): NO ADDITIONAL ELIGIBILITIES IDENTIFIED
     Period of Service: OTHER NON-VETERANS

<4> Service Connected Conditions as stated by applicant
    ---------------------------------------------------
    NONE STATED


<RET> to CONTINUE, 1-3 or ALL to EDIT, ^N for screen N or '^' to QUIT:
```

TRICARE Patients should be entered as follows:

Patient Type: **TRICARE**
Veteran: **NO**
Primary Elig Code: **TRICARE/CHAMPUS**
Period of Service: **OTHER NON-VETERANS**

Locally defined eligibility codes for TRICARE Prime, Standard and Extra are not eligibilities, but rather, types of Insurance Coverage.

```
               ADMISSION INFORMATION, SCREEN <12>
TRICARE,DEMO PATIENT; 267-08-0872P                                    TRICARE
================================================================================

NO ADMISSION DATA ON FILE FOR THIS PATIENT!!



<RET> to CONTINUE, ^N for screen N or '^' to QUIT:
```

```
              APPLICATION INFORMATION, SCREEN <13>
TRICARE,DEMO PATIENT; 267-08-0872P                                    TRICARE
================================================================================

NO APPLICATION DATA ON FILE FOR THIS PATIENT!



<RET> to CONTINUE, ^N for screen N or '^' to QUIT:
```

```
              APPOINTMENT INFORMATION, SCREEN <14>
TRICARE,DEMO PATIENT; 267-08-0872P                                    TRICARE
================================================================================
<1> Enrollment Clinics: NOT ACTIVELY ENROLLED IN ANY CLINICS AT THIS TIME

<2>     Pending Appt's: NO PENDING APPOINTMENTS ON FILE



<RET> to CONTINUE, ^N for screen N or '^' to QUIT
```

```
          SPONSOR DEMOGRAPHIC INFORMATION, SCREEN <15>
TRICARE,DEMO PATIENT; 267-08-0872P                                    TRICARE
================================================================================
[1] Sponsor Information:

    Name : TRICARE,DEMO PATIENT          Military Status : RETIRED
     DOB : AUG 8,1972                  Branch of Service : ARMY
     SSN : 267-08-0872P                             Rank : LT
  Prefix : 01-SPOUSE, 02-OLDEST CHILD, 03 ETC   Type : TRICARE
   Effective Date : AUG 8,2000     Expiration Date:

                            *** Team Information ***

                  -- No team assignment information found --




<RET> to QUIT, 1 or ALL to EDIT, ^N for screen N or '^' to QUIT:
```

The TRICARE Patient may or may not be the same person as the TRICARE Sponsor. Gather and enter all Sponsor information, as this is required when billing TRICARE for care provided to the TRICARE Patient.

```
TRICARE,DEMO PATIENT (267-08-0872P)                              AUG 8,1972
================================================================================
5  - MARITAL STATUS UNSPECIFIED        6  - RELIGION UNSPECIFIED
53 - EMPLOYMENT STATUS UNANSWERED

DO YOU WANT TO UPDATE THESE INCONSISTENCIES NOW? Yes//   (Yes)
MARITAL STATUS:
RELIGIOUS PREFERENCE:
OCCUPATION:
EMPLOYMENT STATUS:
EMPLOYER NAME:

Checking data for consistency...

===> No inconsistencies found in 0 seconds...

===> Removing patient from Inconsistency file...
Patient is exempt from Copay.

Is the patient currently being followed in a clinic for the same condition? N
  (No)



Is the patient to be examined in the medical center today? Yes//
```

Inconsistencies will be displayed if the answer entered at the PATIENT **VETERAN (Y/N)?** prompt was **NO**. The program skipped some of the Registration Screens normally shown when registering a Veteran.

Complete the required fields related to **Marital Status**, **Religious Preference**, and **Employment** now.

FOUNDATION HEALTH FEDERAL SERVICES (CHAMPUS)
FAX PRIOR AUTHORIZATION REQUEST FORM

**RECOMMENDATION: do not schedule procedures of appointments prior to receiving Authorization
TRICARE Service Center: _____ Fax # _____

HCF/CRN _____ Ph# 800-XXX-XXXX

This Fax Applies to: (Check appropriate boxes)
- ❑ Emergent ❑ Urgent
- ❑ Referral/Consult ❑ Prior Authorization
- ❑ Second Opinion Program

Other Insurance? ❑ No ❑ Yes
If yes, specify: _____

Auth/Referral # _____
Effective dates: _____

NAS (If required _____
Effective dates: _____
FOR OFFICE USE OLY

Sponsor's SSN: _____ Sex ❑M❑F Sponsor's Name: _____

_____ _____ Plan: Prime ❑
Patient Last Name First Name Middle Initial Patient's Date of Birth TPR ❑ Extra ❑
SHCP ❑ Standard ❑
TSP ❑

_____ _____
Patient Address City State Zip Code Phone Number

Contact Person: _____ Ph # _____ Fax #: _____

Requesting MD (if not PCM): _____ TIN: _____

Refer to Facility (Name): _____ Ph #: _____

Refer to Provider (Name): _____ Specialty: _____ Ph #: _____

TIN number of Provider _____ Suffix: _____

TYPE: ❑ Inpatient ❑ Outpatient ** Anticipated date of Services _____

PCM: _____ Ph #: _____

Diagnosis (description): _____ ICD9 code _____

Request DME/HH/IV infusion on a separate DME/HH preauthorization request form

CPT Code: _____ Units _____ Description: _____

CPT Code: _____ Units _____ Description: _____

CPT Code: _____ Units _____ Description: _____

CPT Code: _____ Units _____ Description: _____

Request CANNOT be processed without the following: Clinical History/Previous Treatments/Plan of Treatment/Supporting Lab and x-ray reports, etc. _____

_____

_____

_____

Quality Assurance document under 10 U.S.C. 1102. Copies of this document, enclosures thereto, and information therefrom will not be further released under penalties of law. Unauthorized disclosure caries a possible $3000 fine. Form Update 9/29/00

FHFS TRICARE PRIOR AUTHORIZATION FORM

DME/Home Health/IV & Enteral Therapy

Do not schedule services or appointments prior to receiving Authorization

TRICARE Call Center/Office: _____ Fax # _____

HCF/CRN/CM _____ Ph# 800-XXX-XXXX

This Fax Applies to: (Check appropriate boxes)

❑ Initial Request ❑ Reauthorization Request

Other Insurance? ❑ No ❑ Yes
If yes, specify: _____

FOR FHFS OFFICE USE ONLY

Modifications Made YES ❑ NO ❑

Auth/Referral # _____
Effective dates: _____

Sponsor's SSN: _____ Sex ❑M❑F Sponsor's Name: _____

_____
Patient Last Name First Name Middle Initial

_____
Patient Address City State Zip Code

Plan: Prime ❑ Standard ❑ Extra ❑
TPR ❑ SHCP ❑ TSP ❑

_____
Patient's Date of Birth

_____
Patient's Phone Number

Requesting Provider: _____ TIN: _____

Contact Person: _____ Fax #: _____

TYPE: ❑ IV Therapy ❑ DME ❑ Home Health ** Anticipated date of Services _____

Referring MD: _____ TIN #: _____

Diagnosis (description): _____ ICD9 code _____

Procedure/Service If DME, Purchase (P) or Rental (R) (circle choice)

HCPC/NDC/CPT Code: _____ Units/da _____ Description: _____ P or R

Frequency/# visits/L.per minute: _____ Duration: _____

Modified Y/N Code _____ Units/da _____ Description: _____

HCPC/NDC/CPT Code: _____ Units/da _____ Description: _____ P or R

Frequency/# visits/L.per minute: _____ Duration: _____

Modified Y/N Code _____ Units/da _____ Description: _____

HCPC/NDC/CPT Code: _____ Units/da _____ Description: _____ P or R

Frequency/# visits/L.per minute: _____ Duration: _____

Modified Y/N Code _____ Units/da _____ Description: _____

NOTE ALL MEDICATIONS MUST USE **JXXXX** WITH THE NDC CODE FOR DRUG

ALL ENTERALS MUST USE **BXXXX** WITH THE NDC AND UNIT = NUMBER OF CANS

PLEASE ATTACH ALL SUPPORTIVE MEDICAL DOCUMENTATION

Quality Assurance document under 10 U.S.C. 1102. Copies of this document, enclosures thereto, and information therefrom will not be further released under penalties of law. Unauthorized disclosure caries a possible $3000 fine. 08/10/2000

TRICARE Glossary

Accounts Receivable	**V***IST***A** software application developed to manage all of the unpaid accounts the facility has on its books.
Austin Automation Center	The national data processing center for VA, located in Austin, TX.
AWP – Average Wholesale Price	Average Wholesale Pricelist used to calculate the cost of prescription drugs.
CHAMPUS Maximum Allowable Charges (CMAC)	CHAMPUS Maximum Allowable Charges are a set of billing rates based on prices applicable to a location for care. These rates are published on an Internet web page and are available for downloading to **V***IST***A** files.
Charge Master	Integrated Billing software that provides menu options to enter and edit Billing Rates, Charge Sets, Charge Items used in the creation of Third Party Claims. The Charge Master software provides a foundation upon which itemized bills can be created.
Claims Tracking	**V***IST***A** software application used to record information concerning outpatient visits, inpatient stays, insurance reviews, denials and appeals.
Diagnosis Related Groups (DRG)	A method of dividing hospital patients into clinically coherent groups based on the consumption of resources. Patients are assigned to the groups based on their principal diagnosis (the reason for admission, determined after study), secondary diagnosis, procedures performed and the patient's age, sex, and discharge status. These groups form the basis of one payment methodology for inpatient care. DRGs may be primary or secondary, and an outlier classification also exists. This is the form of reimbursement used by HCFA to pay hospitals for Medicare recipients. Also used by a few states for all payers and by some private health plans for contracting purposes.
DOD	Department of Defense

Explanation of Benefits (EOB)	The form sent to the insured person and/or VA after a claim for the insurance company has processed payment. This form explains the action taken on the claim. This explanation might include the amount paid, the benefits available, reasons for denying payment, the claims appeal process etc.
HCF	A health care professional, usually a Registered Nurse, who helps patients find the care they need. The HCF works with the patient's Primary Care Manager (PCM) to locate a specialist, or obtain a pre-authorization for care. Health Care Finders are available 24-hours a day, seven days a week.
http://myTRICARE.com	PGBA web site devoted to TRICARE-related issues.
Information Technology/Information Resources Management (IT/IRM)	VA staff members who are computer, hardware, software, and network experts.
Managed Care Support Contractor (MCSC)	Also called TRICARE Fiscal Intermediary (FI) – An entity (Health Net Federal Services, TRIWEST, Humana, etc.) awarded by Department of Defense, with the responsibility to manage the health care of TRICARE beneficiaries. The TRICARE Fiscal Intermediary/MCSC integrates the military's direct patient care system with the civilian network of specialty and institutional providers to support the needs of all individuals eligible to receive services.
Palmetto Government Benefits Administrators – (PGBA)	One of the TRICARE Claims Administrators (subcontractor) responsible for processing TRICARE/CHAMPUS claims.
Place of Service (POS)	Codes that identify the Place of Service associated with a visit.

Primary Care Manager (PCM)	In a managed care organization, a primary care manager is accountable for the total health services of enrollees, arranges referrals, and supervises other care, such as specialist services and hospitalization.
Reasonable Charges	Public Law 105-33, the Balanced Budget Act of 1997 granted the VA the authority to begin billing 'reasonable charges' instead of billing average cost-based per diems for care provided to veterans.
TRICARE Claims Administrator	A subcontractor, (i.e. Palmetto Government Benefits Administrators - PGBA), responsible for processing all TRICARE/CHAMPUS claims. There are different addresses for all states and regions. After TRICARE claims are processed, reimbursement is made directly by the TRICARE Claims Administrator.
TRICARE DRG	TRICARE DRG billing rates that must be calculated based on the locality's Adjusted Standardized Amounts for Large Urban and Other Areas and Cost Share Per Diem. As well as the Geographic Wage Indexes for Urban and Rural Areas and for Reclassified Hospitals. See Appendix C for details on how to create a spreadsheet for TRICARE DRG rates.
TRICARE Fiscal Intermediary	Also called Managed Care Support Contractor (MCSC) – An entity (Health Net Federal Services, TRIWEST, Humana, etc.) awarded by Department of Defense, with the responsibility to manage the health care of TRICARE beneficiaries. The TRICARE Fiscal Intermediary/MCSC integrates the military's direct patient care system with the civilian network of specialty and institutional providers to support the needs of all individuals eligible to receive services.
TRICARE For Life (TFL)	This program offers TRICARE benefits to Medicare-eligible military retirees and dependents that are enrolled in Medicare Part B. By law, TRICARE is second payer to Medicare on all services covered by both Medicare and TRICARE.

TRICARE Health Care Finder (HCF)	A health care professional, usually a Registered Nurse, who helps patients find the care they need. The HCF works with the patient's Primary Care Manager (PCM) to locate a specialist, or obtain a pre-authorization for care. Health Care Finders are available 24-hours a day, seven days a week.
Type Of Service (TOS)	Codes that identify a Type of Service associated with a visit.
VISN	Veterans Integrated Service Networks responsible for managing the activities of Veterans Health Administration (VHA) field facilities.
V*IST***A**	Veterans Health Information Systems and Technology Architecture - The automated environment at local VA health care facilities that support the day-to-day operations. **V***IST***A** includes VA's application software (DHCP, Windows based and locally developed applications) and interfaces. **V***IST***A** encompasses the rich automated environment present at local VA medical facilities that goes far beyond DHCP.