Learning Outcomes

After studying this chapter, you should be able to:

11.1 Discuss the eligibility requirements for TRICARE.
11.2 Compare TRICARE participating and nonparticipating providers.
11.3 Explain how the TRICARE Standard, TRICARE Prime, and TRICARE Extra programs differ.
11.4 Discuss the TRICARE for Life program.
11.5 Discuss the eligibility requirements for CHAMPVA.
11.6 Prepare accurate TRICARE and CHAMPVA claims.

KEY TERMS

catastrophic cap
catchment area
Civilian Health and Medical Program of the Department of Veterans Affairs (CHAMPVA)
Civilian Health and Medical Program of the Uniformed Services (CHAMPUS)
cost-share
Defense Enrollment Eligibility Reporting System (DEERS)
Military Treatment Facility (MTF)
nonavailability statement (NAS)
Primary Care Manager (PCM)
sponsor
TRICARE
TRICARE Extra
TRICARE for Life
TRICARE Prime
TRICARE Prime Remote
TRICARE Reserve Select (TRS)
TRICARE Standard
Participating providers in many parts of the country serve the government’s medical insurance programs for active-duty members, their families, and disabled veterans. Medical insurance specialists become familiar with the benefits, coverage, and billing rules for these programs in order to correctly verify eligibility, collect payments, and prepare claims.

**11.1 The TRICARE Program**

TRICARE is the Department of Defense’s health insurance plan for military personnel and their families. TRICARE, which includes managed care options, replaced the program known as the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS). TRICARE is a regionally managed healthcare program serving 9.6 million beneficiaries.

The TRICARE program brings the resources of military hospitals together with a network of civilian facilities and providers to offer increased access to healthcare services. All military treatment facilities, including hospitals and clinics, are part of the TRICARE system. TRICARE also contracts with civilian facilities and physicians to provide more extensive services to beneficiaries.

Members of the following uniformed services and their families are eligible for TRICARE: the Army, Navy, Air Force, Marine Corps, Coast Guard, Public Health Service (PHS), and National Oceanic and Atmospheric Administration (NOAA). Reserve and National Guard personnel become eligible when on active duty for more than thirty consecutive days or when they retire from reserve status at age sixty. The uniformed services member is referred to as a sponsor because the member’s status makes other family members eligible for TRICARE coverage.

When a TRICARE patient arrives for treatment, the medical information specialist photocopies or scans both sides of the individual’s military ID card and checks the expiration date to confirm that coverage is still valid (see Figure 11.1). The various branches of military service, not TRICARE, make decisions about eligibility. Information about patient eligibility is stored in the Defense Enrollment Eligibility Reporting System (DEERS). Sponsors may contact DEERS to verify eligibility; providers may not contact DEERS directly because the information is protected by the Privacy Act.

**BILLING TIP**

**Sponsor Information**

Enter the sponsor’s branch of service, status, and grade in the practice management program (PMP) when creating TRICARE patient cases.

**THINKING IT THROUGH 11.1**

1. TRICARE and CHAMPVA are government medical insurance plans primarily for families of members of the U.S. uniformed services. Special regulations apply to situations in which beneficiaries seek medical services outside of military treatment facilities. What are the best ways to find out about the rules and regulations pertaining to these patients?

**11.2 Provider Participation and Nonparticipation**

TRICARE pays only for services rendered by authorized providers. TRICARE regional contractors certify that authorized providers have met specific educational, licensing, and other requirements. Once authorized, a provider is assigned a PIN and must decide whether to participate.

**Participating Providers**

Providers who participate agree to accept the TRICARE allowable charge as payment in full for services. Providers may decide whether to participate on a case-by-case basis.
basis. Participating providers are required to file claims on behalf of patients. The regional TRICARE contractor sends payment directly to the provider, and the provider collects the patient’s share of the charges. Only participating providers may appeal claim decisions.

Nonparticipating Providers

A provider who chooses not to participate may not charge more than 115 percent of the allowable charge. If a provider bills more than 115 percent, the patient may refuse to pay the excess amount. For example, if the allowed charge for a procedure is $50.00, a nonparticipating provider may not charge more than $57.50 (115 percent of $50.00). If a nonparticipating provider were to charge $75.00 for the same procedure, the patient could refuse to pay the amount that exceeded 115 percent of the allowed amount. The provider would have to write off the difference of $17.50. The patient would pay the cost-share (either 20 or 25 percent)—a TRICARE term for the coinsurance, the amount that is the responsibility of the patient.

Once the nonPAR provider submits the claim, TRICARE pays its portion of the allowable charges but instead of sending it directly to the provider, TRICARE mails the payment to the patient. The patient is responsible for paying the provider. Payment should be collected at the time of the visit.
Reimbursement

Providers who participate in TRICARE are paid based on the amount specified in the Medicare Fee Schedule for most procedures. Medical supplies, durable medical equipment, and ambulance services are not subject to Medicare limits. The maximum amount TRICARE will pay for a procedure is known as the TRICARE Maximum Allowable Charge (TMAC). Providers are responsible for collecting the patients’ deductibles and their cost-share portions of the charges.

Network and Non-Network Providers

Providers who are authorized to treat TRICARE patients may also contract to become part of the TRICARE network. These providers serve patients in one of TRICARE’s managed care plans. They agree to provide care to beneficiaries at contracted rates and to act as participating providers on all claims in TRICARE’s managed care programs.

Providers who choose not to join the network may still provide care to managed care patients, but TRICARE will not pay for the services. The patient is 100 percent responsible for the charges.

THINKING IT THROUGH 11.2

1. The Military Health System (MHS) and the TRICARE health plan are required to comply with HIPAA privacy policies and procedures for the use and disclosure of PHI. The TRICARE website has this information about release of information:

   Some states have restrictions on disclosure of health information to family members to protect the privacy of certain minors and dependent adult family members. These restrictions on disclosure of information may include accessing personal health and medical information through electronic or Internet-based services. If you have questions regarding this matter, we recommend that you contact your local Military Treatment Facility (MTF) for more information about disclosure of health information and applicable privacy laws within the state or jurisdiction where you and your family receive care.

What steps should medical insurance specialists take to ensure compliance with this information?

11.3 TRICARE Plans

TRICARE offers beneficiaries access to a variety of healthcare plans.

TRICARE Standard

TRICARE Standard is a fee-for-service program that replaced the CHAMPUS program, which was also fee-for-service. The program covers medical services provided by a civilian physician or by a Military Treatment Facility (MTF). Military families may receive services at an MTF, but available services vary by facility, and first priority is given to service members on active duty. When service is not available, the individual seeks treatment from a civilian provider, and TRICARE Standard benefits go into effect.

Under TRICARE Standard, TRICARE and the beneficiary share medical expenses. Most enrollees pay annual deductibles. In addition, families of active-duty members pay 20 percent of outpatient charges. Retirees and their families, former spouses, and families of deceased personnel pay a 25 percent cost-share for outpatient
services. A beneficiary treated by a provider who does not accept assignment is also responsible for the provider’s additional charges up to 115 percent of the allowable charge. See Figure 11.2 for cost-share details.

Patient cost-share payments are subject to an annual catastrophic cap, a limit on the total medical expenses that beneficiaries are required to pay in one year. For active-duty families, the annual cap is $1,000, and for all other beneficiaries, the limit is $3,000. Once these caps have been met, TRICARE pays 100 percent of additional charges for covered services for that coverage year.

**Covered Services**

The following services are examples of those covered under TRICARE Standard:

- Ambulatory surgery
- Diagnostic testing
- Durable medical equipment
- Family planning
- Hospice care
- Inpatient care
- Laboratory and pathology services
- Maternity care
- Outpatient care
- Prescription drugs and medicines
- Surgery
- Well-child care (birth to seventeen years)
- X-ray services

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### FIGURE 11.2 Cost-Shares for TRICARE Plans

<table>
<thead>
<tr>
<th><strong>ACTIVE-DUTY FAMILY MEMBERS</strong></th>
<th>TRICARE Prime</th>
<th>TRICARE Extra</th>
<th>TRICARE Standard</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Annual Deductible</strong></td>
<td>None</td>
<td>$150/individual or $300/family for E-5 &amp; above; $50/$100 for E-4 &amp; below</td>
<td>$150/individual or $300/family for E-5 &amp; above; $50/$100 for E-4 &amp; below</td>
</tr>
<tr>
<td><strong>Annual Enrollment Fee</strong></td>
<td>None</td>
<td>15% of negotiated fee</td>
<td>None</td>
</tr>
<tr>
<td><strong>Civilian Outpatient Visit</strong></td>
<td>No cost</td>
<td>Greater of $25 or $17.05 per day</td>
<td>Greater of $25 or $17.05 per day</td>
</tr>
<tr>
<td><strong>Civilian Inpatient Admission</strong></td>
<td>No cost</td>
<td>25% of negotiated charges plus 25% of billed charges plus separately billed professional charges</td>
<td>25% of allowed professional fees</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>RETIREES, THEIR FAMILY MEMBERS, AND OTHERS</strong></th>
<th>TRICARE Prime</th>
<th>TRICARE Extra</th>
<th>TRICARE Standard</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Annual Deductible</strong></td>
<td>None</td>
<td>$150/individual or $300/family</td>
<td>$150/individual or $300/family</td>
</tr>
<tr>
<td><strong>Annual Enrollment Fee</strong></td>
<td>$520/family</td>
<td>20% of negotiated fee</td>
<td>None</td>
</tr>
<tr>
<td><strong>Civilian Provider Copays:</strong></td>
<td></td>
<td>25% of allowed charges for covered services</td>
<td>None</td>
</tr>
<tr>
<td>—Outpatient Visit</td>
<td>$12</td>
<td>Greater of $11 per day or $25 per admission; no separate copayment for separately billed professional charges</td>
<td>Greater of $708 per day or 25% of billed charges plus 25% of allowed professional fees</td>
</tr>
<tr>
<td>—Emergency Care</td>
<td>$30</td>
<td>Lesser of $250 per day or 25% of negotiated charges plus 20% of negotiated professional fees</td>
<td>Lesser of $250 per day or 25% of negotiated charges plus 25% of negotiated professional fees</td>
</tr>
<tr>
<td>—Mental Health Visit</td>
<td>$25; $17 for group visit</td>
<td>20% of negotiated fee</td>
<td>25% of allowed professional fees</td>
</tr>
</tbody>
</table>

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**catastrophic cap**  maximum annual amount a TRICARE beneficiary must pay for deductible and cost-share
TRICARE Standard also provides many preventive benefits for enrollees, including immunizations, Pap smears, mammograms, and screening examinations for colon and prostate cancer.

Noncovered Services
TRICARE Standard generally does not cover the following services:

- Cosmetic drugs and cosmetic surgery
- Custodial care
- Unproven (experimental) procedures or treatments
- Routine physical examinations or foot care

Hospital Care and Nonavailability Statements
TRICARE encourages individuals to first seek care at a military treatment facility (MTF) if living in a catchment area, defined as a geographic area served by a hospital, clinic, or dental clinic and usually based on Zip codes to set an approximate 40-mile radius of military inpatient treatment facilities. Formerly, a person living in a catchment area had to get a nonavailability statement before being treated for inpatient nonemergency care at a civilian hospital. A nonavailability statement (NAS) is an electronic document stating that the required service is not available at the nearby military treatment facility. The form is electronically transmitted to the DEERS database. Currently, under the 2002 National Defense Authorization Act, the requirement to obtain a NAS is eliminated except for nonemergency inpatient mental healthcare services. However, some MTFs have been given an exemption and may still require a NAS. Best practice is to advise TRICARE standard beneficiaries to check with the Beneficiary Counseling and Assistance Coordinator at the nearest MTF.

Preauthorization Requirements
TRICARE Standard does not require outpatient nonavailability statements for services other than outpatient prenatal and postpartum maternity care. A number of procedures do require preauthorization, including:

- Arthroscopy
- Cardiac catheterization
- Upper gastrointestinal endoscopy
- MRI
- Tonsillectomy or adenoidectomy
- Cataract removal
- Hernia repair

TRICARE Prime
TRICARE Prime is a managed care plan similar to an HMO. Note that all active-duty service members are automatically enrolled in TRICARE Prime and do not have the option of choosing from among the additional TRICARE options.

After enrolling in the plan, individuals are assigned a Primary Care Manager (PCM) who coordinates and manages their medical care. The PCM may be a single military or civilian provider or a group of providers. In addition to most of the benefits offered by TRICARE Standard, TRICARE Prime offers preventive care, including routine physical examinations. TRICARE Prime enrollees receive the majority of their healthcare services from military treatment facilities and receive priority at these facilities.

To join the TRICARE Prime program, individuals who are not active-duty family members must pay annual enrollment fees of $260 for an individual or $520 for a family. Under TRICARE Prime, there is no deductible, and no payment is required for outpatient treatment at a military facility. For active-duty family members, no
payment is required for visits to civilian network providers, but different copayments apply for other beneficiaries, depending on the type of visit. For example, for retirees and their family members, outpatient visits with civilian providers require $12 copayments.

Note that TRICARE Prime also has a point-of-service (POS) option that patients may select. The POS option has a deductible and coinsurance requirements.

**TRICARE Prime Remote**

TRICARE Prime Remote provides no-cost healthcare through civilian providers for service members and their families who are on remote assignment. Participants must live and work more than 50 miles (approximately one hour’s drive time) from the nearest Military Treatment Facility. Their residence address must be registered with DEERS for eligibility, which is based on their Zip code.

**TRICARE Extra**

TRICARE Extra is an alternative managed care plan for individuals who want to receive services primarily from civilian facilities and physicians rather than from military facilities. Because it is a managed care plan, individuals must receive healthcare services from a network of healthcare professionals. They may also seek treatment at military facilities, but active-duty personnel and other TRICARE Prime enrollees receive priority at those facilities, so care may not always be available.

TRICARE Extra is more expensive than TRICARE Prime but less costly than TRICARE Standard. There is no enrollment fee, but there is an annual deductible of $150 for an individual and $300 for a family. TRICARE Extra beneficiaries pay 15 percent (5 percent less than TRICARE Standard enrollees) for civilian outpatient charges. Beneficiaries are not subject to additional charges of up to 115 percent of the allowable charge because participating physicians agree to accept TRICARE’s fee schedule.

**TRICARE Reserve Select**

Because of the large number of military reservists who have been called up for active duty, the Department of Defense implemented TRICARE Reserve Select (TRS). This program is a premium-based health plan available for purchase by certain members of the National Guard and Reserve activated on or after September 11, 2001. TRS provides comprehensive healthcare coverage similar to TRICARE Standard and Extra for TRS members and their covered family members.

**THINKING IT THROUGH 11.3**

1. TRICARE claim forms are available from the program’s website:
   www.tricare.mil/claims
   Locate the website and review the information required for the TRICARE paper claim form DD 2642.

**11.4 TRICARE and Other Insurance Plans**

If the individual has other health insurance coverage that is primary to TRICARE, that insurance carrier must be billed first. TRICARE is a secondary payer in almost all circumstances; among the few exceptions is Medicaid.

Many TRICARE beneficiaries purchase supplemental insurance policies to help pay deductible and cost-share or copayment fees. Most military associations offer
supplementary plans, and so do private insurers. Supplemental plans are not regulated by TRICARE, so coverage varies. TRICARE is the primary payer; the purpose of a supplemental policy is simply to pick up the costs not paid by TRICARE.

**TRICARE for Life**

The Department of Defense offers a program for Medicare-eligible military retirees and Medicare-eligible family members called **TRICARE for Life**. Originally introduced in a trial program as TRICARE Senior Prime, TRICARE for Life offers the opportunity to receive healthcare at a military treatment facility to individuals age sixty-five and over who are eligible for both Medicare and TRICARE.

In the past, individuals became ineligible for TRICARE once they reached sixty-five, and they were required to enroll in Medicare to obtain any healthcare coverage. Beneficiaries could still seek treatment at military treatment facilities, but only if space was available. Under TRICARE for Life, enrollees in TRICARE who are sixty-five and over can continue to obtain medical services at military hospitals and clinics as they did before they turned sixty-five. (Note, however, that TRICARE beneficiaries entitled to Medicare Part A based on age, disability, or end-stage renal disease are required by law to enroll in Medicare Part B to retain their TRICARE benefits.) TRICARE for Life acts as a secondary payer to Medicare; Medicare pays first, and TRICARE pays the remaining out-of-pocket expenses. These claims are filed automatically. Enrollees do not need to submit a paper claim. Medicare pays its portion for Medicare-covered services and automatically forwards the claim to WPS/TFL for processing. However, if the patient has other health insurance (OHI), the claim does not automatically cross over to TRICARE. Instead, the patient must submit a claim to WPS/TFL. The patient’s Medicare Summary Notice along with a TRICARE paper claim (DD Form 2642) and the OHI’s Explanation of Benefits (EOB) statement should be mailed by the patient to:

WPS/TFL  
P.O. Box 7890  
Madison, WI 53707-7890

Benefits are similar to those of a Medicare HMO, with an emphasis on preventive and wellness services. Prescription drug benefits are also included in TRICARE for Life. All enrollees in TRICARE for Life must be enrolled in Medicare Parts A and B and must have Part B premiums deducted from their Social Security check. (Individuals already enrolled in a Medicare HMO may not participate in TRICARE for Life.) Other than Medicare costs, TRICARE for Life beneficiaries pay no enrollment fees and no cost-share fees for inpatient or outpatient care at a military facility. Treatment at a civilian network facility requires a copay.

**THINKING IT THROUGH 11.4**

1. For a Medicare-eligible retiree over age sixty-five, what are two advantages of enrolling in the TRICARE for Life program rather than in a comparable Medicare HMO?

**11.5 CHAMPVA**

The **Civilian Health and Medical Program of the Department of Veterans Affairs (CHAMPVA)** is the government’s health insurance program for the families of veterans with 100 percent service-related disabilities. Under the program, the Department of Veterans Affairs (VA) and the beneficiary share healthcare expenses.
The Veterans Health Care Eligibility Reform Act of 1996 requires a veteran with a 100 percent disability to be enrolled in the program in order to receive benefits. Prior to this legislation, enrollment was not required.

**Eligibility**

The VA is responsible for determining eligibility for the CHAMPVA program. Eligible beneficiaries include:

- Dependents of a veteran who is totally and permanently disabled due to a service-connected injury
- Dependents of a veteran who was totally and permanently disabled due to a service-connected condition at the time of death
- Survivors of a veteran who died as a result of a service-related disability
- Survivors of a veteran who died in the line of duty

**CHAMPVA Authorization Card**

Each eligible beneficiary possesses a CHAMPVA Authorization Card, known as an A-Card. The provider’s office checks this card to determine eligibility and photocopies or scans the front and back for inclusion in the patient record.

**Covered Services**

CHAMPVA provides coverage for most medically necessary services. The following is a partial list of covered services:

- **Inpatient services**
  - Room and board
  - Hospital services
  - Surgical procedures
  - Physician services
  - Anesthesia
  - Blood and blood products
  - Diagnostic tests and procedures
  - Cardiac rehabilitation programs
  - Chemotherapy
  - Occupational therapy
  - Physical therapy
  - Prescription medications
  - Speech therapy
  - Mental healthcare

- **Outpatient services**
  - Maternity care
  - Family planning
  - Cancer screenings
  - Cholesterol screenings
  - HIV testing
  - Immunizations
  - Well-child care up to age six
  - Prescription medications
  - Durable medical equipment
  - Mental healthcare
  - Ambulance services
  - Diagnostic tests
  - Hospice services
Excluded Services
CHAMPVA generally does not cover the following services:

▶ Medically unnecessary services and supplies
▶ Experimental or investigational procedures
▶ Custodial care
▶ Dental care (with some exceptions)

Preauthorization
Some procedures must be approved in advance; if they are not, CHAMPVA will not pay for them. It is the responsibility of the patient, not of the provider, to obtain preauthorization.

Some procedures that require preauthorization are:

▶ Mental health and substance abuse services
▶ Organ and bone marrow transplants
▶ Dental care
▶ Hospice services
▶ Durable medical equipment in excess of $300

CHAMPVA enrollees do not need to obtain nonavailability statements because they are not eligible to receive service in military treatment facilities. A VA hospital is not considered a military treatment facility.

Participating Providers
For most services, CHAMPVA does not contract with providers. Beneficiaries may receive care from providers of their choice as long as those providers are properly licensed to perform the services being delivered and are not on the Medicare exclusion list. For mental health treatment, CHAMPVA maintains a list of approved providers.

Providers who treat CHAMPVA patients are prohibited from charging more than the CHAMPVA allowable amounts. Providers agree to accept CHAMPVA payment and the patient’s cost-share payment as payment in full for services. See Figure 11.3 (on page 391) for a copy of an online CHAMPVA provider newsletter, a resource for updating CHAMPVA information in the medical practice.

Costs
Most persons enrolled in CHAMPVA pay an annual deductible and a portion of their healthcare charges. Some services are exempt from the deductible and cost-share requirement. A patient's out-of-pocket costs are subject to a catastrophic cap of $3,000 per calendar year. Once the beneficiary has paid $3,000 in medical bills for the year, CHAMPVA pays claims for covered services at 100 percent for the rest of that year.

In most cases, CHAMPVA pays equivalent to Medicare/TRICARE rates. The maximum amount CHAMPVA will pay for a procedure is known as the CHAMPVA Maximum Allowable Charge (CMAC). CHAMPVA has an outpatient deductible ($50 per person up to $100 per family per calendar year) and a cost-share of 25 percent. The cost-share percentages are 75 percent for CHAMPVA and 25 percent for the beneficiary. Beneficiaries are also responsible for the costs of healthcare services not covered by CHAMPVA.

CHAMPVA and Other Health Insurance Plans
When the individual has other health insurance benefits in addition to CHAMPVA, CHAMPVA is almost always the secondary payer. Two exceptions are Medicaid and supplemental policies purchased to cover deductibles, cost-shares, and other services.
Insurance claims are first filed with the primary payer. When the remittance advice from the primary plan arrives, a copy is attached to the claim that is then filed with CHAMPVA. Persons under age sixty-five who are eligible for Medicare benefits and who are enrolled in Parts A and B may also enroll in CHAMPVA.

CHAMPVA for Life

CHAMPVA for Life extends CHAMPVA benefits to spouses or dependents who are age sixty-five and over. Similar to TRICARE for Life, CHAMPVA for Life benefits are payable after payment by Medicare or other third-party payers. Eligible beneficiaries must be sixty-five or older and must be enrolled in Medicare Parts A and B. For services not covered by Medicare, CHAMPVA acts as the primary payer.
11.6 Filing Claims

TRICARE participating providers file claims on behalf of patients with the contractor for their region. Providers submit claims to the regional contractor based on the patient’s home address, not the location of the facility. Contact information for regional contractors is available on the TRICARE website.

Individuals file their own claims when they receive services from nonparticipating providers, using DD Form 2642, Patient’s Request for Medical Payment. A copy of the itemized bill from the provider must be attached to the form.

The three administration regions (see Figure 11.4) for TRICARE are TRICARE North, TRICARE South, and TRICARE West. A fourth region covers international claims.

HIPAA and TRICARE

The Military Health System (MHS) and the TRICARE health plan are required to comply with the HIPAA Privacy Policy and procedures for the use and disclosure of PHI. The MHS’s Notice of Privacy Practices, which describes how a patient’s medical information may be used and disclosed and how a patient can access the information, is posted at the TRICARE website at www.tricare.mil/HIPAA/. The HIPAA Electronic Health Care Transactions and Code Sets requirements, as well as the Security Rule, must also be followed.

Guidelines for Completing the CMS-1500

If a CMS-1500 paper claim is needed, follow the general guidelines shown in Table 7.3 (on pages 255–256) and Figure 11.5 (on page 393).

Fraud and Abuse

The Program Integrity Office oversees the fraud and abuse program for TRICARE, working with the Office of the Inspector General Defense Criminal Investigative Service (DCIS) to identify and prosecute cases of TRICARE fraud and abuse.

TRICARE providers are also subject to a quality and utilization review similar to the process used by Medicare. A qualified independent contractor (QIC) reviews claims, documentation, and records to ensure that services were medically necessary and appropriate, that procedures were coded appropriately, and that care was up to professional medical standards.
Some examples of activities considered fraudulent include:

- Billing for services, supplies, or equipment not furnished or used by the beneficiary
- Billing for costs of noncovered services, supplies, or equipment disguised as covered items
- Billing more than once for the same service
- Billing TRICARE and the enrollee for the same services

**FIGURE 11.5 CMS-1500 (02/12) Claim Completion for TRICARE**
Fraudulent and abusive activities can result in sanctions, exclusion from the TRICARE program, or civil or criminal penalties.

Filing CHAMPVA Claims

HIPAA regulations cover the CHAMPVA program. Providers file most CHAMPVA claims and submit them to the centralized CHAMPVA claims processing center in Denver, Colorado. The information required on a claim is the same as the information required for TRICARE.

In instances in which beneficiaries are filing their own claims, CHAMPVA Claim Form (VA Form 10-7959A) must be used. The claim must always be accompanied by an itemized bill from the provider. Claims must be filed within one year of the date of service or discharge.
<table>
<thead>
<tr>
<th>Learning Objective</th>
<th>Key Concepts/Examples</th>
</tr>
</thead>
</table>
| **11.3** Explain how the TRICARE Standard, TRICARE Prime, and TRICARE Extra programs differ. Pages 384–387 | TRICARE Standard:  
- It is a fee-for-service plan in which medical expenses are shared between TRICARE and the beneficiary.  
- Most enrollees pay annual deductibles and cost-share percentages.  
TRICARE Prime:  
- It is a managed care plan.  
- After enrolling in the plan, each individual is assigned a Primary Care Manager (PCM) who coordinates and manages that patient’s medical care.  
- In addition to most of the benefits offered by TRICARE Standard, TRICARE Prime offers additional preventive care, including routine physical examinations.  
TRICARE Extra:  
- It is a managed care plan, but instead of services being provided primarily from military facilities, civilian facilities and physicians provide the majority of care.  
- Individuals must receive healthcare services from a network of healthcare professionals. |
| **11.4** Discuss the TRICARE for Life program. Pages 387–388 | Under the TRICARE for Life program, individuals age sixty-five and over who are eligible for both Medicare and TRICARE may continue to receive healthcare at military treatment facilities. |
| **11.5** Discuss the eligibility requirements for CHAMPVA. Pages 388–391 | Individuals eligible for the CHAMPVA program include:  
- Veterans who are totally and permanently disabled due to service-connected injuries  
- Veterans who were totally and permanently disabled due to service-connected conditions at the time of death  
- Spouses or unmarried children of a veteran who is 100 percent disabled or who died as a result of a service-related disability or in the line of duty  
Under the CHAMPVA for Life program:  
- CHAMPVA benefits are extended to individuals age sixty-five and over who are eligible for both Medicare and CHAMPVA |
| **11.6** Prepare accurate TRICARE and CHAMPVA claims. Pages 392–394 | Participating providers file TRICARE claims with the contractor for the region on behalf of patients.  
- Individuals file their own TRICARE claims when services are received from non-participating providers.  
- Most CHAMPVA claims are filed by providers and submitted to the centralized CHAMPVA claims processing center. |
Review Questions

Match the key terms with their definitions.

1. **LO 11.3** Military Treatment Facility (MTF)
2. **LO 11.2** cost-share
3. **LO 11.1** TRICARE
4. **LO 11.3** TRICARE Extra
5. **LO 11.3** TRICARE Standard
6. **LO 11.1** Defense Enrollment Eligibility Reporting System (DEERS)
7. **LO 11.3** TRICARE Prime
8. **LO 11.3** catastrophic cap
9. **LO 11.1** CHAMPUS
10. **LO 11.3** Primary Care Manager (PCM)
11. **LO 11.3** nonavailability statement
12. **LO 11.4** TRICARE for Life
13. **LO 11.5** Civilian Health and Medical Program of the Department of Veterans Affairs (CHAMPVA)
14. **LO 11.1** sponsor

A. The amount of the provider charges for which the patient is responsible
B. A program for individuals age sixty-five and over who are eligible for both Medicare and TRICARE that allows patients to receive healthcare at military treatment facilities
C. A place where medical care is provided to members of the military service and their families
D. The Department of Defense’s new health insurance plan for military personnel and their families
E. A government database that contains information about patient eligibility for TRICARE
F. The government’s health insurance program for veterans with 100 percent service-related disabilities and their families
G. The uniformed services member whose status makes it possible for other family members to be eligible for TRICARE coverage
H. An electronic document stating that the service the patient requires is not available at the local military treatment facility
I. A fee-for-service program that covers medical services provided by a civilian physician when the individual cannot receive treatment from a Military Treatment Facility (MTF)
J. A managed care plan in which most services are provided at civilian facilities
K. A provider who coordinates and manages a patient’s medical care under a managed care plan
L. A managed care plan in which most services are provided at military treatment facilities
M. The Department of Defense’s health insurance plan for military personnel and their families that was replaced in 1998
N. An annual limit on the total medical expenses that an individual or family may pay in one year
Select the letter that best completes the statement or answers the question.

1. **LO 11.3** The TRICARE plan that is an HMO and requires a PCM is
   A. TRICARE Prime
   B. TRICARE for Life
   C. TRICARE Extra
   D. TRICARE Standard

2. **LO 11.3** _____ receive priority at military treatment facilities.
   A. Active-duty service members
   B. TRICARE Prime enrollees
   C. TRICARE Extra enrollees
   D. TRICARE Standard enrollees

3. **LO 11.4** A TRICARE for Life beneficiary must be at least _____ years old.
   A. seventy
   B. twenty-one
   C. sixty-five
   D. thirty

4. **LO 11.3** If a TRICARE Standard enrollee sees a provider for an outpatient visit, TRICARE pays _____ percent of the covered charges.
   A. 80
   B. 100
   C. 20
   D. 50

5. **LO 11.6** The TRICARE healthcare program is a covered entity and subject to privacy rules under
   A. NAS
   B. HIPAA
   C. TCS
   D. CHAMPVA

6. **LO 11.5** A person enrolled in CHAMPVA is responsible for _____ percent of covered charges.
   A. 20
   B. 25
   C. 50
   D. 60

7. **LO 11.2** Nonparticipating TRICARE providers cannot bill for more than _____ percent of allowable charges.
   A. 80
   B. 50
   C. 100
   D. 115

8. **LO 11.3** Active-duty service members are automatically enrolled in
   A. TRICARE Prime
   B. TRICARE Extra
   C. CHAMPUS
   D. TRICARE Standard

9. **LO 11.4** For individuals enrolled in TRICARE for Life, the primary payer is
   A. TRICARE
   B. CHAMPVA
   C. a supplementary plan
   D. Medicare

10. **LO 11.1** Decisions about an individual's eligibility for TRICARE are made by the
    A. military treatment facility
    B. provider
    C. Defense Enrollment Eligibility Reporting System
    D. branch of military service

Answer the following questions.

1. **LO 11.1** What is the purpose of the TRICARE program?

2. **LO 11.3** What is the priority of treatment in a military treatment facility?
Applying Your Knowledge

The objective of these exercises is to correctly complete TRICARE claims, applying what you have learned in the chapter. Following the information about the provider for the cases are two sections. The first section contains information about the patient, the insurance coverage, and the current medical condition. The second section is an encounter form for Valley Associates, PC.

If you are instructed to use the Medisoft simulation in Connect, follow the steps at the book’s Online Learning Center (OLC), www.mhhe.com/valerius6e, to complete the cases at connect.mcgraw-hill.com on your own once you have watched the demonstration and tried the steps with prompts in practice mode. Along with provider information, data from the first section, the patient information form, have already been entered into the program for you. You must enter information from the second section, the encounter form, to complete the claim.

If you are gaining experience by completing a paper CMS-1500 claim form, use the blank claim form supplied to you (from the back of the book or printed from the book’s Online Learning Center) and follow the instructions on pages 255–256 to fill in the form by hand. Alternatively, the Online Learning Center provides an electronic CMS-1500 form that can be used to fill in and print claims. See The Interactive Simulated CMS-1500 Form in Appendix B at the back of this text for further instructions.

The following provider information should be used for the case studies in this chapter.

Provider Information

<table>
<thead>
<tr>
<th>Name</th>
<th>Nancy Ronkowski, MD</th>
</tr>
</thead>
<tbody>
<tr>
<td>Address</td>
<td>1400 West Center Street</td>
</tr>
<tr>
<td>Telephone</td>
<td>555-321-0987</td>
</tr>
<tr>
<td>Employer ID Number</td>
<td>06-7890123</td>
</tr>
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<td>NPI</td>
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<td>Assignment</td>
<td>Accepts</td>
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Case 11.1

LO 11.2–LO 11.4 From the Patient Information Form:

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<th>Robyn Janssen</th>
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<tr>
<td>Address</td>
<td>310 Wilson Ave.</td>
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<tr>
<td></td>
<td>Brooklyn, OH 44144-3456</td>
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<td>334-62-5079</td>
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# Office Visits

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<td>Biopsy, Needle Asp., Breast</td>
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<tr>
<td></td>
<td>LIV Comp./Mod.</td>
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<td>Colposcopy</td>
</tr>
<tr>
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<td>Cyro of Cervix</td>
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# Established Patient

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# Procedures

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<td>Artificial Insemination</td>
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<td></td>
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<tr>
<td>Diaphragm Fitting</td>
<td>57170</td>
<td></td>
</tr>
<tr>
<td>Marsup. of Bartholin Cyst</td>
<td>56440</td>
<td></td>
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<tr>
<td>Norplant Insertion</td>
<td></td>
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<td>Norplant Removal</td>
<td></td>
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**Patient Information:**

- **Insured:** Lee Janssen
- **Patient Relationship to Insured:** Spouse
- **Date of Birth:** 01/05/1984
- **Sex:** M
- **Address:** Box 404, Fort Dix, NJ 08442-3456
- **Telephone:** 555-442-3600
- **SSN:** 602-37-0442
- **Insurance Plan:** TRICARE
- **Insurance ID Number:** 602370442
- **Signature:** On File
- **Copayment:** $10

---

**TRICARE AND CHAMPVA**

Chapter 11
Case 11.2

LO 11.2–LO 11.4 From the Patient Information Form:

<table>
<thead>
<tr>
<th>Name</th>
<th>Sylvia Evans</th>
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<td>13 Ascot Way, Sandusky, OH 44870-1234</td>
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### Office Visits

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### Established Patient

- LI Minimum: 99211, Endocervical Curettage: 57505
- LI Problem Focused: 99211, Enhanced: 99212, Hysteroscopy: 58558
- LIII Expanded: 99213, IUD Insertion: 58300
- LV Detailed: 99214, IUD Removal: 58301
- LV Comp./High: 99215, Mammography (Bilateral): 77057

### Consultation: Office/Op

- Consultation: Office/Op
- Norplant Insertion: 11975
- Pap Smear: 88150

### Procedures

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<tr>
<td>Biopsy, Needle Asp., Breast</td>
<td>19100</td>
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</tr>
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### Cultures

- Cultures

### Ultrasound

- Ultrasound
- USG: Preg Uterus, Comp.: 76805
- USG: Preg Uterus REPT: 76815

### Ultrasound

- Ultrasound
- USG: Preg Uterus, Comp.: 76805
- USG: Preg Uterus REPT: 76815

### Ultrasound

- Ultrasound
- USG: Preg Uterus, Comp.: 76805
- USG: Preg Uterus REPT: 76815

### Ultrasound

- Ultrasound
- USG: Preg Uterus, Comp.: 76805
- USG: Preg Uterus REPT: 76815
### Case 11.3

**LO 11.2–LO 11.4 From the Patient Information Form**

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<tr>
<td>Birth Date</td>
<td>11/03/1942</td>
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<tr>
<td>Marital Status</td>
<td>S</td>
</tr>
<tr>
<td>Employment</td>
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<tr>
<td>Address</td>
<td>693 River Rd. Toledo, OH 43601-1234</td>
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<tr>
<td>SSN</td>
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### Patient Information Form

**Name:** Eunice Walker  
**Sex:** F  
**Birth Date:** 11/03/1942  
**Marital Status:** S  
**Employment:** Retired  
**Address:** 693 River Rd. Toledo, OH 43601-1234  
**SSN:** 704-62-9930  
**Health Plan:** TRICARE  
**ID Number:** 704629930  
**Signature:** On File 01/01/16  
**Copayment:** $10

### Office Visits

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### Procedures

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### Consultation: Office/OP

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**VALLEY ASSOCIATES, PC**

Nancy Ronkowski, MD - Obstetrics & Gynecology  
555-321-0987  
NPI 9475830260