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TRICARE
MANAGEMENT ACTIVITY

OD

CHANGE 121
6010.51-M
MARCH 31, 2011

PUBLICATIONS SYSTEM CHANGE TRANSMITTAL FOR TRICARE OPERATIONS MANUAL (TOM), AUGUST 2002

The TRICARE Management Activity has authorized the following addition(s)/revision(s).

CHANGE TITLE: **INTEGRATED DISABILITY EVALUATION SYSTEM (IDES) CHANGE**

CONREQ: 15204

PAGE CHANGE(S): See page 2.

SUMMARY OF CHANGE(S): This change requires the Managed Care Support Contractors (MCSCs) to reimburse the Department of Veterans Affairs (DVA) for services provided under the current national Department of Defense (DoD)/DVA Memorandum of Agreement (MOA), for Disability Compensation and Pension Examinations (DCPE).

EFFECTIVE DATE: January 1, 2011.

IMPLEMENTATION DATE: Upon direction of the Contracting Officer.

This change is made in conjunction with Aug 2002 TSM, Change No. 89.

Reta M. Michak
Director, Operations Division

ATTACHMENT(S): **24 PAGES**
DISTRIBUTION: **6010.51-M**

WHEN PRESCRIBED ACTION HAS BEEN TAKEN, FILE THIS TRANSMITTAL WITH BASIC DOCUMENT.

REMOVE PAGE(S)	**INSERT PAGE(S)**
CHAPTER 8	
Section 5, pages 5 through 9	Section 5, pages 5 through 9
CHAPTER 18	
Table of Contents, page i	Table of Contents, pages i and ii
Section 2, pages 1 through 3	Section 2, pages 1 through 4
★ ★ ★ ★ ★ ★	Addendum D, pages 1 through 13

and authorizations, with approval of the contracting officer. Any such development and the subsequent implementation of any alternative shall be without cost to the government.

7.2. The contractor shall process referrals in accordance with the following:

7.2.1. Referrals From The MTF To The Contractor

Referrals from the MTF shall include all of the following information, at a minimum, unless otherwise specified. Contractors shall receive the MTF referral via fax (or by other electronic means agreed upon by the MTF and the MCSC). The MTF is not required to provide diagnosis or procedure codes. The MCSC shall translate the narrative descriptions into standard diagnosis and procedure codes.

REQUIRED DATA ELEMENT*	DESCRIPTION/PURPOSE/USE
Request Date/Time	DD MMM YY hhmm
Request Priority	STAT/24-hour/ASAP/Today/72-hour/Routine
Requester	
Referring Provider Name	Name of PCM/MTF individual provider making request
Referring Provider NPI	HIPAA National Provider Identifier (NPI) - Type 1 (Individual)
Referring MTF	Name of Military Treatment Facility (MTF)
Referring MT NPI	HIPAA National Provider Identifier - Type 2 (Organizational)
	PATIENT INFO
Sponsor SSN	
Patient ID	EDI_PN (from DEERS) if available
Patient Name	Full Name of Patient (if no EDI_PN available)
Patient DOB	Date of Birth (required if patient not on DEERS)
Patient Gender	
Patient Address	Full Address of Beneficiary (including zip)
Patient Telephone Number	If available - Telephone Number (including area code)
	CLINICAL INFO
Patient Primary Provisional Diagnosis	Description
Reason for Request	Sufficient Clinical Info to Perform MNR
	SERVICE
Service 1 - Provider	Specialty of Service Provider
Service 1 - Provider Sub-Specialty	Additional Sub-Specialist Info if Needed (Free Text Clarifying Info Entered with Reason for Request) e.g., Pediatric Nephrologist

REQUIRED DATA ELEMENT*	DESCRIPTION/PURPOSE/USE
SERVICE (CONTINUED)	
Service 1 - By Name Provider Request if Applicable - First and Last Name	Optional Info Regarding Preferred Specialist Provider (Free Text)
Service 1 - Service Type	Inpatient, Specialty Referral, DME Purchase/Rental, Other Health Service, et al DME Provider to do CMN.
Service 1 - Service Quantity (optional)	Number of Visits, Units, etc.
CHCS Generated Order Number (DMIS-YYMMDD-XXXXX)	Unique Identifier Number (UIN). The UIN is the DMIS (of the referring facility identified in the "Referring MTF" field on this request) -- Date in format indicated -- Consult Order Number from CHCS.

Special Instructions:

NOTE 1: *Above data elements are required unless otherwise noted as "Optional."

NOTE 2: Use of the NPI is required in accordance with the HHS NPI Final Rule by May 23, 2007 or upon Service direction and/or direction of the Contracting Officer (CO). Implementation requirements may be found at Chapter 21, Section 4.

NOTE 3: When issuing a preauthorization for an ADSM while in terminal leave status to obtain medical care from the Department of Veterans Affairs (DVA), as required by Chapter 18, Section 1, paragraph 4.6., the MTF shall make special entries for data elements as follows:

Patient Primary Provisional Diagnosis	Condition of a routine or urgent nature as specified by the patient at a future date.
Reason for Request	Provide preauthorization for outpatient treatment by the DVA for routine or urgent conditions while the active duty patient is in a terminal leave status.
Service 1 - Provider	Any DVA provider
Service 1 - By Name Provider Request if Applicable - First and Last Name	DVA provider only

NOTE 4: *When issuing an authorization for the DVA to provide a Compensation and Pension (C&P) examination for a service member as required by Chapter 18, Section 2, paragraph 3.2.2., the MTF shall make special entries for data elements as follows:*

Patient Primary Provisional Diagnosis	*V68.01 - Disability Examination*
Reason for Request	*DVA only: Integrated Disability Evaluation System (IDES) C&P Examinations for Fitness for Duty Determination*
Service 1 - Provider	*Any DVA Provider*

REQUIRED DATA ELEMENT*	DESCRIPTION/PURPOSE/USE
SERVICE (CONTINUED)	
Service 1 - By Name Provider Request if Applicable - First and Last Name	*DVA Provider Only*
Service 1 - Service Quantity	*Number of C&P Examination Authorized*
Special Instructions:	
This blanket preauthorization is only for routine and urgent outpatient primary medical care provided by the DVA while the patient is in a terminal leave status. Terminal leave for this patient concludes at midnight on DD MMM YY.	

7.2.1.1. The contractor shall use the CHCS generated order number (DMIS-YYMMDD-XXXXX) as a unique identifier. The first four digits of the UIN is the DMIS of the referring facility only. Using the unique identifier, the contractor will locate related referrals, authorizations, and claims, and track consult results. Contractor generated MTF reports shall be modified to accommodate the unique identifier and NPI as needed. The unique identifier shall also be used for all related customer service inquiries. UINs and NPIs will be attached to all MTF referrals and will be portable across all regions of care. The contractor shall capture the NPIs from the referral transmission report and forward the NPI to the referred-to provider on all referrals.

7.2.1.2. The MCSC where care is rendered will apply their best business practices when authorizing care for referrals to their network and will retain responsibility for managing requests for additional services or inpatient concurrent stay reviews associated with the original referral as well as changes to the speciality provider identified to deliver the care. The MCSC authorizing the care shall forward the referral/authorization information, including the range of codes authorized (i.e., episode of care) and the name, the NPI and demographic information of the speciality provider to the MCSC for the region to which the patient is enrolled. Claims submitted by the provider will be processed by the MCSC for the region to which the patient is enrolled using the referral/authorization information provided by the out-of-region MCSC.

7.2.1.3. The contractor shall screen the information provided and return, by fax or other electronic means acceptable to the MTF and the MCSC, incomplete requests within one business day. The return of a referral to the MTF is considered processed to completion. One business day is defined as the work day following the day of transmission at the close of business at the location of the receiving entity. A business day is Monday through Friday, excluding federal holidays.

7.2.1.4. The contractor shall verify that the services are a TRICARE benefit through appropriate medical review and screening to ensure that the service requested is reimbursable through TRICARE. The contractor's medical review shall be in accordance with the contractor's best business practices. This process does not alter the TRICARE Operations Manual (TOM), TRICARE Policy Manual (TPM), or TRICARE Systems Manual (TSM) provisions covering active duty personnel or TFL beneficiaries.

7.2.1.5. The MCSC shall advise the patient, referring MTF, and receiving provider of all approved referrals. The MTF single Point Of Contact (POC) shall be advised via fax or other electronic means acceptable to the MTF and the MCSC. (The MTF single POC may be an individual or a single office with more than one telephone number.) The notice to the beneficiary shall contain the unique identifier and information necessary to support obtaining ordered services or an appointment with the referred to provider within the access standards. The notice shall also provide the beneficiary with instructions on how to change their provider, if desired. If the MCSC is made aware the beneficiary changed the provider listed on the referral, the MCSC will make appropriate modifications to MTF issued referral (to revise the provider the beneficiary was referred to by the MTF). The revised referral shall contain the same level of data as the initial MTF referral. The revised referral will be issued to the current provider, with a copy to the MTF. For Same Day and 72-hour referrals no beneficiary notification shall be issued. The MCSC shall notify the provider to whom the beneficiary is being referred of the approved services, to include clinical information furnished by the referring provider.

7.2.1.6. If services are denied, the MCSC shall notify the patient and shall advise the patient of their right to appeal consistent with the TOM. The MCSC shall also notify the referring single MTF POC by fax of the initial denial.

7.2.1.7. For services beyond the initial authorization, the MCSC shall use its best practices in determining the extent of additional services to authorize. The MCSC shall not request a referral from the MTF but shall provide the MTF, through the MTF's single POC, a copy of the authorization and clinical information that served as the basis for the new authorization.

7.2.1.8. The MCSC shall provide the consult results to a single POC at the MTF in accordance with contract requirements. Returned results shall include the patient's name, name of the rendering provider, and the consult order number (CHCS generated order number) assigned by the MTF.

7.2.2. Referrals From The Contractor To The MTF

Referrals subject to the ROFR provision from the civilian sector shall be processed in accordance with the following procedures.

7.2.2.1. The contractor shall fax, or other electronic means acceptable to the MTF and the MCSC, the referral to the single MTF POC. The request shall contain the minimum data set described in paragraph 7.2.1. (with the exception of the UIN) plus the civilian provider's fax number, telephone number, and mailing address. This data set shall be provided to the MTF in plain text with or without diagnosis or procedure codes.

7.2.2.2. The MTF will respond via fax or other electronic means acceptable to the MTF and the MCSC, generally within one business day, as defined in paragraph 7.2.2.1., from receipt of the request to the single POC provided in the MOU by the contractor. When no response is received from the MTF in response to the ROFR request in one business day as defined above, the contractor shall process the referral request as if the MTF declined to see the patient. Monthly, no later than the 10th calendar day in the following month, the contractor shall provide each MTF with a report of the number of referrals forwarded based on the ROFR provision, the number accepted by the MTF, the number individually rejected

by the MTF, and the number rejected by the MTF as a result of the automatic rejection after one business day.

7.2.2.3. The contractor shall contact the MTF POC for the coordination of Same Day and Seventy-two Hour referrals in accordance with the MTF MOU. In general, the MTF will respond within 30 minutes of notification. When no response is received from the MTF within 30 minutes, the contractor shall process the referral request as if the MTF declined to see the patient.

7.2.2.4. The ROFR will be forwarded for only those beneficiaries residing within the PSA access standards and for whom the MTF has indicated the desire to receive referral request based on specialty or selective diagnosis code or procedure codes, and/or enrollment category. ROFR requests shall be provided prior to the MCSCs medical necessity and covered benefit review to afford the MTF the opportunity to see the patient prior to any decision.

7.2.2.5. In instances where the MTF elects to accept the patient, the MTF will advise the MCSC within one business day, as defined in paragraph 7.2.2.1. The MCSC will notify the beneficiary of the MTF's acceptance and provide instructions for contacting the MTF to obtain an appointment.

7.2.3. Provision Of Reports

7.2.3.1. The contractor shall ensure that network specialty providers provide clearly legible specialty care consultation or referral reports, operative reports, and discharge summaries to the beneficiary's initiating provider within 10 working days of the initial referral visit, procedure(s), follow-up clinic visits (when a report to the referring provider is considered clinically warranted), and after the final authorized visit. The contractor will ensure a report from the initial specialty encounter is returned to the initiating provider within 10 working days 98% of the time. The preferred method of delivery to MTF providers is electronic and will be addressed in the MOU. Each MTF will establish a single POC for the receipt of the required documents. (The MTF single POC may be an individual or a single office with more than one telephone number.) In urgent/emergent situations, a preliminary report of a specialty consultation shall be conveyed to the beneficiary's initiating provider within 24 hours (unless best medical practices dictate less time is required for a preliminary report) by telephone, fax or other means with a formal written report provided within the standard 98% of the time. All consultation or referral reports, operative reports, and discharge summaries shall be provided to the provider who initiated the referral within 30 calendar days. If the accreditation standards organization has a more stringent specialty referral-reporting requirement, the contractor shall adhere to that standard.

7.2.3.2. The requirements specified in paragraph 7.2.3.1., apply to all referrals for professional services provided by a health care provider (as defined in 32 CFR 199) to assist the initiating provider in the diagnosis and treatment of a patient, including, for example, imaging studies (reports by the interpreting radiologist), physical therapy, occupational therapy, and speech therapy. The performance requirement does not apply to referrals for non-professional services such as durable medical equipment or laboratory studies.

CHAPTER 18

CIVILIAN CARE REFERRED BY MHS FACILITIES

SECTION	SUBJECT
1	**GENERAL** 1.0. Introduction 2.0. Military Service Participation In The SHCP 3.0. Contractor Responsibilities 4.0. Supplemental Health Care Program Differences
2	**PROVIDERS OF CARE** 1.0. Civilian Providers 2.0. Uniformed Services Family Health Plan (USFHP) (Formerly Uniformed Services Treatment Facilities [USTFs]) 3.0. *Department of* Veterans Affairs *(DVA)* FIGURE 18-2-1 *Disability Pay Schedule*
3	**CONTRACTOR RESPONSIBILITIES** 1.0. Contractor Receipt And Control Of SHCP Claims 2.0. Coverage 3.0. Enrollment Status Effect On Claims Processing 4.0. Medical Records 5.0. Reimbursement 6.0. End Of Processing 7.0. Claims Payments And Contractor Reimbursement 8.0. TED Submittal 9.0. Required Reports 10.0. Contractor's Responsibility To Respond To Inquiries 11.0. Dedicated SHCP Unit
4	**PAYMENT FOR CONTRACTOR SERVICES RENDERED** 1.0. Voucher Submissions 2.0. Audits And Inspection Of The Contractor's Records
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SECTION	SUBJECT
ADDENDUM C	DEFINITIONS, TERMS, AND LIMITATIONS AS APPLIED TO THE RESPITE BENEFIT UNDER THIS SECTION 1.0. Qualifying Condition For Receipt Of Respite Benefits 2.0. Limitations On Respite Benefits
ADDENDUM D	*MEMORANDUM OF AGREEMENT (MOA) BETWEEN DEPARTMENT OF VETERANS AFFAIRS (DVA) AND DEPARTMENT OF DEFENSE (DOD) FOR PROCESSING PAYMENT FOR DISABILITY COMPENSATION AND PENSION EXAMINATIONS (DCPE) IN THE INTEGRATED DISABILITY EVALUATION SYSTEM (IDES)*

PROVIDERS OF CARE

1.0. CIVILIAN PROVIDERS

The *Supplemental Health Care Program (*SHCP*)* payment structure applies to inpatient and outpatient medical claims submitted by civilian institutions, individual professional providers, resource sharing providers, *Military Treatment Facilities (*MTFs*)*, suppliers, pharmacies and uniformed service members for civilian health care received within the 50 United States and the District of Columbia. The *Managed Care Support Contractor (*MCSC*)* will make referrals to network providers as required by contract. No dental services rendered to *Active Duty Service Members (*ADSMs*)*, including adjunctive dental care, are covered under the SHCP (except adjunctive dental care under the National *Department of Defense (*DoD*)/ Department of Veterans Affairs (D*VA*) Memorandum of Agreement (*MOA*)* as described in paragraph 3.1.). Chapter 18, Addendum B provides guidelines for dental claims for ADSMs. All other claims received for dental services rendered to patients other than ADSMs shall be adjudicated in accordance with existing TRICARE policy.

2.0. UNIFORMED SERVICES FAMILY HEALTH PLAN (USFHP) (FORMERLY UNIFORMED SERVICES TREATMENT FACILITIES [USTFs])

2.1. In addition to receiving claims from civilian providers, the contractor may also receive SHCP claims from certain USFHP designated providers, formerly referred to as USTFs. The provisions of the SHCP will not apply to services furnished by a USFHP designated provider if the services are included as covered services under the current negotiated agreement between the USFHP designated provider and Office of the Assistant Secretary of Defense, Health Affairs (OASD(HA)). However, any services not included in the USFHP designated provider agreement shall be paid by the contractor in accordance with the requirements in this chapter.

2.2. The USFHP, administered by the designated providers listed below currently have negotiated agreements which provide the Prime benefit (inpatient and outpatient care). Since these facilities have the capability for inpatient services, they can submit claims which will be paid in accordance with applicable TRICARE reimbursement rules under the SHCP:

- CHRISTUS Health, Houston, TX (which also includes):

  St. Mary's Hospital, Port Arthur, TX
  St. John Hospital, Nassau Bay, TX
  St. Joseph Hospital, Houston, TX

- Martin's Point Health Care, Portland, ME

- Johns Hopkins Health Care Corporation, Baltimore, MD

- Brighton Marine Health Center, Boston, MA
- St. Vincent's Catholic Medical Centers of New York, New York City, NY
- Pacific Medical Clinics, Seattle, WA

3.0. *DEPARTMENT OF* VETERANS AFFAIRS *(DVA)*

In addition to receiving claims from civilian providers, the contractor may also receive SHCP claims from the DVA. The provisions of the SHCP will not apply to services provided under any *MOA for sharing* between the DoD (including the Army, Air Force, Navy/Marine Corps, *and Coast Guard* facilities) and the DVA. Claims for these services will continue to be processed by the Services. However, any services not included in *any* MO*A described below* shall be paid by the contractor in accordance with the *TRICARE Reimbursement Manual (TRM)* to include claims referred for beneficiaries on the Temporary Disability Retirement List (TDRL).

3.1. Claims for Care Provided Under the National DoD/*D*VA MOA for Spinal Cord Injury (SCI), Traumatic Brain Injury (TBI)*,* and Blind Rehabilitation

3.1.1. The contractor shall reimburse for services provided under the current national DoD/*D*VA MOA for "Referral of Active Duty Military Personnel Who Sustain Spinal Cord Injury, Traumatic Brain Injury, or Blindness to Veterans Affairs Medical Facilities for Health Care and Rehabilitative Services." The contractor shall begin processing these claims effective January 1, 2007. Previously, these claims were processed/paid for by either MMSO (for Army and Navy care) or by the Air Force. MOA claims shall be processed in accordance with this chapter and the following.

3.1.2. Claims received from a Veterans Affairs health care facility for ADSM care with any of the following diagnosis codes (principal or secondary) shall be processed as an MOA claim: V57.4; 049.9; 139.0; 310.2; 323.x; 324.0; 326; 344.0x; 344.1; 348.1; 367.9; 368.9; 369.01; 369.02; 369.05; 369.11; 369.15; 369.4; 430; 431; 432.x; 800.xx; 801.xx; 803.xx; 804.xx; 806.xx; 851.xx; 852.xx; 853.xx; 854.xx; 905.0; 907.0; 907.2; and 952.xx.

3.1.3. The contractor shall verify whether the MOA *D*VA-provided care has been authorized by MMSO. MMSO will send authorizations to the contractor by fax. If an authorization is on file, the contractor shall process the claim to payment. The contractor shall not deny claims for lack of authorization. Rather, if a required authorization is not on file, the contractor will place the claim in a pending status and will forward appropriate documentation to MMSO for determination (following the procedures in Chapter 19, Addendum B for MMSO SPOC referral and review procedures).

3.1.4. MOA claims shall be reimbursed as follows:

3.1.4.1. Claims for inpatient care shall be paid using *D*VA interagency rates. The interagency rate is a daily per diem to cover an inpatient stay and includes room and board, nursing, physician, and ancillary care. These rates will be provided to the contractor by *the TRICARE Management Activity (*TMA*)* (including periodic updates as needed). There are three different interagency rates to be paid for rehabilitation care under the MOA. The

Rehabilitation Medicine rate will apply to traumatic brain injury care. Blind rehabilitation and spinal cord injury care each have their own separate interagency rate. Additionally, it is possible that two or more separate rates may apply to one inpatient stay. If the DVA-submitted claim identifies more than one rate (with the appropriate number of days identified for each separate rate), the contractor shall pay the claim using the separate rate. (For example, a stay for spinal cord injury may include days paid with the spinal cord injury rate and days paid at a surgery rate.)

3.1.4.2. Claims for outpatient services shall be paid at the appropriate TRICARE allowable rate (e.g., CMAC) with a 10% discount applied.

3.1.4.3. Claims for the following care shall be paid at the interagency rate if one exists and, if not, then at billed charges: transportation; prosthetics; orthotics; durable medical equipment; adjunctive dental care; home care; personal care attendants; and extended care (e.g., nursing home care).

3.1.4.4. Since this is care for ADSMs, normal TRICARE coverage limitations do not apply to services rendered for MOA care. As long as a service has been authorized by MMSO, it will be covered regardless of whether it would have ordinarily not been covered under TRICARE policy.

3.1.5. On January 1, 2007, the contractor will begin processing claims for care provided on and after this date. Claims for care provided prior to this date, will continue to be reimbursed by either MMSO or the Air Force. After 90 days, all claims -- regardless of dates of service -- will be processed by the contractor. All TED records for this care must include Special Processing Code 17 - VA medical provider claim.

3.1.6. Sixty to ninety days prior to the effective date, the contractor shall meet with MMSO to discuss the transition of claims processing responsibility (this meeting can be by telephone). Items to be discussed include: points of contact (including fax numbers) for authorizations; coordination of a process to forward claims received at the wrong location during the dual processing period; establish points of contact for transition issues; other items deemed necessary to facilitate a successful transition of these claims. The contractor will not be responsible for processing adjustments for any claims previously paid by MMSO or the Services.

3.2. Claims for Care Provided Under the National DoD/DVA MOA for Payment for Processing Disability Compensation and Pension Examinations (DCPE) in the Integrated Disability Evaluation System (IDES)

The contractor shall reimburse the DVA for services provided under the current national DoD/DVA MOA for "Processing Payment for Disability Compensation and Pension Examinations in the Integrated Disability Evaluation System" (IDES MOA; see Addendum D for a full text copy of the MOA for references purposes only). The contractor shall begin processing these claims with dates of

care January 1, 2011 and forward. Claims under the IDES MOA shall be processed in accordance with this chapter and the following:

3.2.1. *Claims submitted by the DVA on a Centers for Medicare and Medicaid Services (CMS) 1500 (08/05) for a service member's care with the Current Procedural Terminology (CPT[1]) code of 99456 (principal or secondary) shall be processed as a IDES MOA claim.*

3.2.2. *The contractor shall verify whether services provided under the IDES MOA have been referred and authorized by the MTF. The MTF will generate a single referral request in the Armed Forces Health Longitudinal Technology Application (AHLTA) and submit the referral to the contractor. The referral will specify the total number of Compensation and Pension (C&P) examinations authorized for payment by the contractor. It is not necessary for the referral to identify the various specialists who will render the different C&P examinations. The reason for referral will be entered by the MTF as* ***"DVA only: Disability Evaluation System (DES) C&P exams for fitness for duty determination - total __."*** *The MTF will complete the referral as described in Chapter 8, Section 5, paragraph 7.2.1. including Note 4.*

3.2.3. *The DVA will list one C&P examination (CPT[1] code 99456) per line in block 24 of the CMS 1500 (08/05) and indicate one unit such that there is a separate line item for each C&P examination. The DVA can list related ancillary services separately in block 24 of the CMS 1500 (08/05) using the appropriate CPT codes.*

3.2.4. *If an authorization is on file, the contractor shall process the claim to payment (see Section 2, paragraph 2.2.). One C&P examination fee will be paid for each referred and authorized C&P examination up to the total number of C&P examinations authorized. The contractor shall not deny claims for lack of authorization. Rather, if a required authorization is not on file, the contractor shall place the claim in a pending status and shall forward appropriate documentation to the MTF for determination (following the procedures in Section 3, paragraph 1.2.1.).*

3.2.5. *Claims for C&P exams shall be paid SHCP using the pricing provisions agreed upon in the IDES MOA. CPT[1] procedure code 99456 shall be used and will be considered to include all parts of each C&P examination, except ancillary services. Claims for related ancillary services shall be paid at the appropriate TRICARE allowable rate (e.g., CMAC) with a 10% discount applied.*

FIGURE 18-2-1 ***DISABILITY PAY SCHEDULE***

EFFECTIVE DATE	C&P DISABILITY EXAM (99456[1])	ANCILLARY SERVICES
01/01/2011	$515.00	CMAC - 10%

3.2.6. *All TED records for this care shall include Special Processing Code* ***DC*** *- Disability Compensation and Pension Examinations-DVA, Special Processing Code* ***17*** *- VA Medical Provider Claim, and Enrollment Health Plan Code* ***SR*** *- SHCP-Referred Care.*

3.2.7. *Claims for care provided prior to January 1, 2011 will be paid by TMA. The contractor shall pay all claims with dates of services on or after January 1, 2011. The contractor shall NOT be responsible for processing adjustments for any claims previously paid by TMA.*

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CHAPTER 18
ADDENDUM D

MEMORANDUM OF AGREEMENT (MOA) BETWEEN DEPARTMENT OF VETERANS AFFAIRS (DVA) AND DEPARTMENT OF DEFENSE (DOD) FOR PROCESSING PAYMENT FOR DISABILITY COMPENSATION AND PENSION EXAMINATIONS (DCPE) IN THE INTEGRATED DISABILITY EVALUATION SYSTEM (IDES)

The Departments of Veterans Affairs (VA) and Defense (DoD) have a shared responsibility to ensure the highest quality of service is delivered efficiently, compassionately, and with minimal inconvenience to our Service Members in the DoD and VA Disability Evaluation System (DES). The Service Member's experience when participating in the DoD and VA DES will be that the individual is dealing with one Federal health care system or agency. To facilitate these goals, this Memorandum of Agreement (MOA) establishes expected roles, procedures, and outcomes for VA and DoD regarding the processing of Compensation and Pension (C&P) disability examination requests. It also addresses the reimbursement procedures for these examinations.

1. Roles.

A. **VA will:**

1) Maintain those components of the VA Compensation and Pension examination system necessary to ensure objective assessment of disabilities of Service Members identified by Military Health System (MHS) personnel as requiring a Medical Evaluation Board (MEB) as part of the DES.

2) Conduct C&P examinations as requested in the DES for both medical conditions to be considered as the basis of fitness for duty determination, and for those claimed by the Service Member.

3) Bill the MHS via the appropriate Regional TRICARE Managed Care Support Contractors (MCSC), for those services which are related to medical conditions to be considered as the basis of fitness for duty determination.

B. **DoD will:**

1) Identify to VA those Service Members requiring a MEB, and the medical conditions which may render a Service Member unable to fully perform assigned duties or causes them to fall below Service medical retention standards

via completion of Section I of the VA Form 21-0819, VA/DoD Joint Disability Evaluation Board Claim.

2) Reimburse VA for C&P services related to DoD-identified medical conditions to be considered as the basis of evaluation for fitness for duty. The services covered will include a C&P General Medical Examination and other C&P examination services related to medical conditions in Section I of the VA Form 21-0819. Additional conditions may be found later in the DES process that may also be used for determination of fitness. Authorization process for conditions identified in Section I of VA Form 21-0819 is discussed in Attachment D.

2. Procedures.

A. A DES program oversight contact (POC) will be appointed at each TRICARE Regional Office (TRO), VA Regional Office (VARO), VA Medical Center/Facility and Military Treatment Facility (MTF). The DES oversight official duty may be a collateral duty.

B. The DoD DES health care provider will determine the conditions that may render the Service Member unable to meet Service medical retention standards or call into question the member's ability to continue military service. The DoD DES health care provider will annotate these conditions in Section I of VA Form 21-0819 (Attachment A), under "MEDICAL CONDITIONS TO BE CONSIDERED AS THE BASIS OF FITNESS FOR DUTY DETERMINATION."

C. The VA Military Services Coordinator (MSC) will coordinate with the Service Member and identify any additional conditions the member may wish to claim for purposes of VA compensation and/or pension. The MSC will annotate these conditions in Section III, Field 8 of the VA Form 21-0819, Additional Conditions. Upon completion of the VA Form 21-0819, the VA MSC will provide the completed form to the local VA medical center billing office.

D. VA will use the Compensation and Pension Record Interchange (CAPRI) examination request system when possible to transmit data regarding the request, scheduling, completion, and reporting of C&P examinations so that VA and DoD will have notice of C&P examination data and reports. VA and DoD will operate in a provider-to-provider relationship. Transmission of data which cannot be accommodated in CAPRI, such as photocopies of health care documentation, will be resolved on a facility-to-facility basis. All examination requests entered into CAPRI will, at a minimum:

1) State the examination is for a service member in the DES.
2) Identify specific C&P examination(s) required.
3) Identify specific condition(s) to be evaluated in each C&P examination.

E. VA will report to the DoD MTF representative the C&P examinations required by the Service Member for evaluation of conditions in Section I of VA Form 21-0819. DoD will use the Military Health System referral management system to transmit an authorization for the VA-reported C&P services to the appropriate Regional TRICARE MCSC as outlined in Attachment B. The MCSC will in turn transmit the authorization to the appropriate VA medical facility billing office.

F. Based on findings at the time of the C&P examination and the instructions on the requested Automated Medical Information Exchange (AMIE) worksheet, the Service Member may need to undergo additional examinations. VA will conduct C&P examinations and those other ancillary services needed to complete the C&P examinations for the DES.

G. DoD and VA will promote the use of approved templates to provide the requested information.

H. Selected examinations may be conducted using tele-medicine technology (a telephonic contact with the Service Member and/or video contact with the Service Member) when clinically and administratively appropriate.

I. Billing. VA will bill the appropriate regional TRICARE MCSC for C&P examination health services related to medical conditions identified in VA Form 21-0819, section I. VA Billing Procedures are contained in Attachment B. Electronic billing is desired and should be used when practical.

J. Reimbursement. MHS (TRICARE) will reimburse VA for a C&P General Medical Examination, examinations provided for evaluation of medical conditions identified in VA Form 21-0819, Section I, and ancillary services.

K. VA and DoD, working cooperatively, will make every effort to process claims and resolve issues identified by the other agency in a timely manner. If VA and DoD cannot resolve the issue, it will be forwarded to the Health Executive Committee (HEC) Financial Management Workgroup for final resolution.

3. Outcomes.

A. Complete C&P examination reports will be available in CAPRI and the Bidirectional Health Information Exchange (BHIE). On average, these reports will be provided by VA and if available, in CAPRI/BHIE, 35 calendar days from the date VA registers as received a properly completed request for examination(s). Complete C&P examination reports include all necessary laboratory and ancillary test results. The C&P examination reports will, at a minimum:

1) Provide the required information from the requested AMIE worksheet(s) and the additional exams identified during the initially ordered C&P examinations.

2) Provide data that will meet DoD/VA DES requirements as documented in the C&P disability examination worksheets, provide results of any additional examinations identified later in the DES process, and adequately address any matters identified in the request for a medical opinion.

B. Reports. The following reports will be based on the claims submitted to the appropriate Regional TRICARE MCSC during the reporting time.

1) On a monthly basis, VA Compensation and Pension Examination Program (CPEP) will prepare C&P timeliness reports listing facility processing times. The C&P timeliness reports will be posted/shared with the MHS and TRO program officials.

2) On a quarterly basis VA will produce a data file of examinations and services provided to Service Members in the DES whose exams have been completed by VA. The file will be shared with the MHS and TRO program officials.

4. Accountability and Funding:

A. VA will submit a bill to MHS through the TRICARE managed care support contracts. VA will bill for C&P examinations and ancillary services associated with the medical conditions which may render a Service Member unable to fully perform assigned duties and/or are to be considered as the basis of fitness for duty determination as listed in Section I of the VA Form 21-0819.

B. Neither VA nor DoD will bill the Service Member for these C&P examinations and ancillary services as all examinations and services rendered in the DES are authorized and provided by either DoD or VA.

C. At the present time, the Current Procedural Terminology (CPT) code 99456 does not have a CHAMPUS Maximum Allowable (CMAC) rate. DoD will pay VA the national reasonable charges amount for each exam for CPT code 99456. Ancillary services will be reimbursed based on CMAC less ten percent. Upon agreement of the HEC Financial Management Working Group, and with a minimum 2-month advance notification to the Managed Care Support Contractors (MCSC), billing procedures may be changed effective annually, on or about 1 January.

D. VA and DoD will audit services provided and billed quarterly to ensure all C&P examinations and services for which DoD paid were for conditions annotated in Section I of VA Form 21-0819.

E. C&P examinations and services for conditions claimed in Section III of VA Form 21-0819 will be funded by VA appropriations.

5. **Effective Date, Terms of Modification and Termination:**

A. This agreement provides a framework for VA facilities and MTFs to develop local agreements that will address more specific information on operations to implement this program. All local agreements addressing the DoDNA DES shall refer to this MOA.

B. Requests for modification of this agreement will be submitted in writing from one party to the other, not less than 60 days prior to the desired effective date of such modification.

C. An annual review of this agreement, including rate structure, will be conducted by both parties to ensure compliance with each Departments' policies.

D. This agreement will be renewed automatically on its anniversary date unless either party gives a written 90-day notice of termination or a new agreement is implemented. The provisions are in effect until it is superseded by a new MOA or terminated.

E. The provisions of this agreement are effective 30 days from the date both approving signatures have been affixed.

6. **Authority:** This MOA is entered into under the authority of titles 10 and 38, United States Code, including sections 513 and 8111 of title 38 and chapters 55 and 61 of title 10.

7. **Associated Memoranda of Understandings (MoU):** A separate MoU exists and must be consulted regarding processing of Benefits Delivery at Discharge (BDD) exams.

8. **Approvals:**

Department of Veterans Affairs	**Department of Defense**
W. Scott Gould Deputy Secretary	William J. Lynn, III Deputy Secretary
Date: JAN 12 2010	Date: JUN 16 2010

Attachments:
A) VA Form 21-0819
B) VA Billing Guidance
C) CMS -1500 Example
D) DoD Referral Guidance

ATTACHMENT A: VA Form 21-0819 (June 2009)

OMB Approved No. 2900-0704
Respondent Burden: 30 minutes

Department of Veterans Affairs

VA DATE STAMP
(DO NOT WRITE IN THIS SPACE)

VA/DOD JOINT DISABILITY EVALUATION BOARD CLAIM

IMPORTANT - Please read the Privacy Act and Respondent Burden on the back before completing the form.

Section I: To be completed by Military Treatment Facility referring Service member to Disability Evaluation System *(DES)*

SERVICE MEMBER NAME *(First, middle, last)*		GRADE
COMPONENT	UNIT ADDRESS	
SOCIAL SECURITY NUMBER	DATE OF BIRTH (MM,DD,YYYY)	SEX ☐ MALE ☐ FEMALE
NAME AND PHONE NUMBER OF ASSIGNED PHYSICAL EVALUATION BOARD LIAISON OFFICER *(PEBLO)* *(First, MI, Last)* / *Include Area Code*	NAME OF REFERRING MILITARY TREATMENT FACILITY *(MTF)*	DATE OF REFERRAL TO MEDICAL EVALUATION BOARD *(MEB)* (MM,DD,YYYY)

MEDICAL CONDITIONS TO BE CONSIDERED AS THE BASIS OF FITNESS FOR DUTY DETERMINATION *(List only conditions referred by physician):*

PREPARED BY	DATE PREPARED

Section II: Tell us about yourself. Please provide a contact name and address. If you are on Temporary Duty, please indicate that on the VA Form 21-4138, Statement in Support of Claim available on the internet at www.va.gov/vaforms

1. WHAT IS YOUR ADDRESS?
Street address, rural route, or P.O. Box — Apt. number
City — State — ZIP Code — Country

2. WHAT ARE YOUR TELEPHONE NUMBERS? *(Include Area Code)*
Daytime _____
Evening _____
Cell phone _____

3. WHAT IS YOUR E-MAIL ADDRESS *(If applicable)*

4. HAVE YOU EVER FILED A CLAIM WITH VA?
☐ Yes ☐ No
(If "Yes," provide file number) _____ *(VA File Number)*

5. POINT OF CONTACT NAME AND ADDRESS

6a. DID YOU SERVE UNDER ANOTHER NAME?
☐ Yes *(If "Yes," go to Item 6b)* ☐ No *(If "No," go to Item 7)*

6b. PLEASE LIST OTHER NAME(S) YOU SERVED UNDER

7. I ENTERED THIS CURRENT PERIOD OF ACTIVE SERVICE ON
___ / ___ / ___
mo day yr

8. PLACE OF ENTRY

Section III: Tell us about your military service. Enter complete information for your service. Tell us about your reserve duty or National Guard Duty

9. ARE YOU CURRENTLY ASSIGNED TO AN ACTIVE RESERVE UNIT OR NATIONAL GUARD UNIT?
☐ Yes *(If "Yes," provide date of activation below)*
☐ No ___ / ___ / ___
mo day yr

10a. WHAT IS THE NAME AND MAILING ADDRESS OF YOUR CURRENT UNIT?

10b. WHAT IS THE TELEPHONE NUMBER OF YOUR CURRENT UNIT? *(Include Area Code)*
( )

VA FORM OCT 2009 **21-0819** SUPERSEDES VA FORM 21-0819, JUN 2009, WHICH WILL NOT BE USED.

11. ADDITIONAL CONDITIONS - *(Do you have any disabling conditions, other than those referred for the fitness for duty determination, that you feel were incurred in or aggravated by, your active military service? Please list those disabilities below.) (If you need additional space, please use VA Form 21-4138, Statement in Support of Claim available at www.va.gov/vaforms)*

12. DO YOU HAVE DEPENDENTS?

☐ YES ☐ NO *(If "Yes," please complete VA Form 21-686c, Declaration of Status of Dependents, available at www.va.gov/vaforms)*

Section IV: MILITARY RETIRED PAY

IMPORTANT - Unless you check the box in Item 13 below, you are telling us that you are choosing to receive VA compensation instead of military retired pay, if it is determined you are entitled to both benefits. If you are awarded military retired pay prior to compensation, we will reduce your retired pay by the amount of any compensation that you are awarded. VA will notify the Military Retired Pay Center of all benefit changes. If you receive both military retired pay and VA compensation, some of the amount you get may be recouped by VA, or in the case of Voluntary Separation Incentive (VSI), by the Department of Defense.

13. ☐ No I do not want VA compensation in lieu of military retired pay.

Section V: DIRECT DEPOSIT INFORMATION

Generally, all Federal payments are required to be made by electronic funds transfer (EFT) also called Direct Deposit. Please attach a voided personal check or deposit slip or provide the information requested below in Items 14, 15 and 16 to enroll in Direct Deposit. If you do not have a bank account we will give you a waiver from Direct Deposit, just check the box below in Item 14. The Treasury Department is working to make bank accounts available to you. Once these accounts are available, you will be able to decide whether you wish to sign-up for one of the accounts or continue to receive a paper check. You can also request a waiver if you have other circumstances that you feel would cause you a hardship to be enrolled in Direct Deposit. You can write to: Department of Veterans Affairs, 125 S. Main Street Suite B, Muskogee, OK 74401-7004, and give us a brief description of why you do not wish to participate in Direct Deposit.

14. ACCOUNT NUMBER *(Please check the appropriate box and provide the account number, if applicable)*

☐ Checking _____ ☐ Savings _____ ☐ I certify that I do not have an account with a financial institution or certified payment agent

15. NAME OF FINANCIAL INSTITUTION *(Please provide the name of the bank where you want your direct deposit)*	16. ROUTING OR TRANSIT NUMBER *(The first nine numbers located at the bottom left of your check)*

Section VI: CERTIFICATIONS AND SIGNATURE

I certify and authorize the release of information.
I certify that the statements in this document are true and complete to the best of my knowledge.

17. YOUR SIGNATURE *(Do NOT print)*	18. DATE SIGNED

Section VII: WITNESSES TO SIGNATURE

19a. SIGNATURE OF WITNESS *(If claimant signed above using an "X")*	19b. PRINTED NAME AND ADDRESS OF WITNESS
20a. SIGNATURE OF WITNESS *(If claimant signed above using an "X")*	20b. PRINTED NAME AND ADDRESS OF WITNESS

PRIVACY ACT NOTICE: The form will be used to determine allowance to compensation benefits (38 U.S.C. 5101). The responses you submit are considered confidential (38 U.S.C. 5701). VA may disclose the information that you provide, including Social Security numbers, outside VA if the disclosure is authorized under the Privacy Act, including the routine uses identified in the VA system of records, 58VA21/22/28 Compensation, Pension, Education, and Vocational Rehabilitation and Employment Records - VA, published in the Federal Register. The requested information is considered relevant and necessary to determine maximum benefits under the law. Information submitted is subject to verification through computer matching programs with other agencies. VA may make a "routine use" disclosure for: civil or criminal law enforcement, congressional communications, epidemiological or research studies, the collection of money owed to the United States, litigation in which the United States is a party or has an interest, the administration of VA programs and delivery of VA benefits, verification of identity and status, and personnel administration. Your obligation to respond is required in order to obtain or retain benefits. Information that you furnish may be utilized in computer matching programs with other Federal or state agencies for the purpose of determining your eligibility to receive VA benefits, as well as to collect any amount owed to the United States by virtue of your participation in any benefit program administered by the Department of Veterans Affairs. Social Security information: You are required to provide the Social Security number requested under 38 U.S.C. 5101(c)(1). VA may disclose Social Security numbers as authorized under the Privacy Act, and, specifically may disclose them for purposes stated above.

RESPONDENT BURDEN: We need this information to determine your eligibility for compensation. Title 38, United States Code, allows us to ask for this information. We estimate that you will need an average of 30 minutes to review the instructions, find the information, and complete this form. VA cannot conduct or sponsor a collection of information unless a valid OMB control number is displayed. You are not required to respond to a collection of information if this number is not displayed. Valid OMB control numbers can be located on the OMB Internet Page at www.whitehouse.gov/omb/library/OMBINV.VA.EPA.html#VA. If desired, you can call 1-800-827-1000 to get information on where to send comments or suggestions about this form.

VA FORM 212-0189, JUN 2009

ATTACHMENT B: VA Billing Instructions For VA / DoD DES Program Agreement

1. Registration of DES Participants:

STEP 1: Facility eligibility staff will obtain list of DES participant names based on daily transmittal of disability examination requests (Form 2507) to Facility DES POC.

STEP 2: Eligibility staff will review each DES Participant's registration information to ensure all fields are correct. For additional guidance on how to register DES participants, refer to the CBO TRICARE Procedure Guide, Chapter 2: Registration; located at http://vaww1.va.gov/CBO/policy/policyguides/index.asp?mode=contents&id=IV.

NOTE — If VA staff is unable to access the above link, please go to the VHA CBO Home page, CBO Resources, Policy Procedure Guides, and click on Series 1601D: Non-Veteran Beneficiaries and the TRICARE Policy Procedure Guide, click on Chapter 2 as above.

STEP 3: Eligibility staff will notify the DES POC and other appropriate staff that the DES participant's registration has been reviewed, and corrected as required.

2. Billing related to DES Participants:

After notification of completion of exam(s) and ancillary services by DES POC, VA billing staff will initiate a claim for payment. Notification method and frequency will be established by local facilities.

STEP 1: Facility needs to ensure that the Patient Insurance File contains the appropriate TRICARE Regional Managed Care Support Contractor/Fiscal Intermediary information, especially the EDI parameters.

STEP 2: TRICARE Authorization, along with VA Form 21-0819, will be sent / faxed to the VA Billing Supervisor. Please provide appropriate Billing POC information to the DoD / TRICARE POC. VA staff will use Claims Tracking to document Authorization number by DES participant.

STEP 3: Initiate the claim related to DES Exam (s) using the CMS 1500 (ATTACHMENT C) for ONLY those exams related to the "Referred" conditions listed in Section I on VA Form 21-0819.

Use Rate Type — "TRICARE," this will allow for the funds to be placed in the correct Revenue Source Code (RSC).

Some of the information in Blocks 1-13 should autopopulate based on the registration and insurance information in the system.

In Block 1 — For DES Program, enter "TRICARE"
In Block 1a — enter the Active Duty Service Member's (ADSM) SSN
In Block 2 - enter the ADSMs Name
In Block 3, Block 4, Block 5, Block 7 - as appropriate
In Block 6 — enter "Self'
In Block 8 — enter as appropriate
In Block 9d —TRICARE
In Block 10a — enter "Yes"
10b — enter "No"
10c — enter "No"
In Block 11 — enter ADSMs SSN
11a — enter ADSM DOB
11b — leave BLANK
11c — enter "DoD DES Program"
11d — enter "No"
In Block 14 — enter date of original 2507
In Block 15 — leave BLANK
In Block 16— if possible, enter date of 2507 as date FROM, and Date of exam release as date TO
In Block 18 — enter date of original 2507
In Block 19 — enter "DES"
In Block 21 — enter "V68,01" (for Disability Examination)
In Block 23 — enter the TRICARE Authorization number
In Block 24a — enter "Date exam released"
24d — enter "99456" (CPT Code for "Medical Disability Examination by OTHER than Treating Physician"); **NOTE**: a separate line item will be required for each authorized exam performed.
TEXT: enter the TYPE of DISABILITY EXAM performed (e.g. PTSD, Audio. Gen Med, etc.)
In Block 24f — Reasonable Charges for 99456 will auto-populate (base charge is $382.56 in FY 2009) ***NOTE***: If your facility has **NOT** converted to Reasonable Charges for the TRICARE rate types you will have to manually enter the national Reasonable Charges base rate above (in FY09 rate is $382.56); or contact VA Help Desk to assist in establishing the correct rate to this Rate Type.
In Block 24g — enter number of exams completed as unit = 1; Again, a separate line item will be required for each authorized disability exam performed.
In Block 28 — total charges for all procedures (99456) will appear here.
Other Blocks, not otherwise identified are to be completed as for any other 3rd party Insurer.

STEP 4: Initiate the claim for fees related to DES Exam (s) and ancillary services using the CMS 1500 for ONLY those items related to the **"Referred"** conditions listed in Section I, on VA Form 21-0819.

Use Rate Type — "TRICARE", this will allow for the funds to be placed in the correct Revenue Source Code (RSC).

Using the instructions, as above for CMS 1500 for DES exams, complete the CMS 1500 for ancillary services associated with the exams.

Rates: Reimbursement for ancillary services will be based on CMAC less 10 percent.

For additional guidance on how to bill for DES participants, refer to the CBO TRICARE Procedure Guide,
http://vaww 1.va.gov/CBO/policy/policyguides/
index.asp?mode=contents&id=IV.01.4.B

NOTE — If VA staff are unable to access the above link, please go to the CBO Home page, CBO Resources, Policy Procedure Guides, and click on Series 160 ID: Non-Veteran Beneficiaries and the TRICARE Policy Procedure Guide, click on Chapter 4B as above.

Where to Submit Claims: The appropriate TRICARE Regional Managed Care Support Contractor (MCSC) / Fiscal Intermediary (FI) information, especially the EDI parameters.

Disputes: TBD

CONTACTS: VHA for Billing Issues - Ms. Felicia A. Lecce, Lead Program Specialist/HSS CBO, Business Policy Division Ms. Lecce can be reached at 202-461-1588, or by email at Felicia.Leccegva.gov.

ATTACHMENT C: CMS 1500 Example

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA

1. MEDICARE (Medicare #) MEDICAID (Medicaid #) TRICARE CHAMPUS [X] (Sponsor's SSN) CHAMPVA (Member ID#) GROUP HEALTH PLAN (SSN or ID) FECA BLK LUNG (SSN) OTHER (ID)

1a. INSURED'S I.D. NUMBER (For Program in Item 1): enter member's SSN

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): enter member's name (Last, First, MI)

3. PATIENT'S BIRTH DATE MM DD YY SEX M F

4. INSURED'S NAME (Last Name, First Name, Middle Initial): enter member's name (Last, First, MI)

5. PATIENT'S ADDRESS (No., Street): enter address

6. PATIENT RELATIONSHIP TO INSURED: Self [X] Spouse Child Other

7. INSURED'S ADDRESS (No., Street): enter address

CITY: enter city STATE

8. PATIENT STATUS: Single Married Other

CITY: enter city STATE

ZIP CODE: enter zip code TELEPHONE (Include Area Code): (fill in)

Employed [X] Full-Time Student Part-Time Student

ZIP CODE: enter zip code TELEPHONE (Include Area Code): (fill in)

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous): [X] YES NO

a. INSURED'S DATE OF BIRTH MM DD YY SEX: enter DOB and gender M F

b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. AUTO ACCIDENT? YES [X] NO PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME: DoD

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES [X] NO

c. INSURANCE PLAN NAME OR PROGRAM NAME: DoD DES Program

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES [X] NO *If yes*, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED DATE

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED

14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE 17a. 17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY

19. RESERVED FOR LOCAL USE: DES (add additional AMIE numbers which will not fit on line 24

20. OUTSIDE LAB? YES NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line)
1. V68.01 2. 3. 4.

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER: enter TRICARE authorization number

24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1 enter release date	22		AMIE # e.g., 0505, 0410, 0910 99456		1	$382.56			NPI	
2									NPI	
3									NPI	
4									NPI	
5									NPI	
6									NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES NO

28. TOTAL CHARGE $ extended price

29. AMOUNT PAID $

30. BALANCE DUE $

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION a. NPI b.

33. BILLING PROVIDER INFO & PH # ( ) a. NPI b.

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

NUCC Instruction Manual available at: www.nucc.org **PLEASE PRINT OR TYPE** APPROVED OMB-0938-0999 FORM CMS-1500 (08-05)

SAMPLE

ATTACHMENT D: Guidance for DoD Military Treatment Facilities on DoD Referrals

1. Referrals from the DoD to VA for Service Members in DoD/VA DES should be generated by a DoD provider trained on the DES. Based on review of the Service Member's medical documentation, DoD providers referring Service Members into the DoD/VA DES will ensure all "potentially unfitting, or medically disqualifying conditions" are designated in VA Form 21-0819, Section I, "Medical Conditions to be Considered as the Basis of Fitness for Duty Determination," before referring the DES case to the VA Military Services Coordinator (MSC).

2. After VA MSC completes the VA Form 21-0819 with the Service Member, and requests the Compensation and Pension (C&P) examinations associated with both the DoD referred and the Service Member claimed conditions, the DoD will be provided a completed copy of VA Form 21-0819, VA/DoD Joint Disability Evaluation Board Claim with the list of requested C&P examinations for each condition.

2.1. The DoD will generate a referral request to the Military Treatment Facility (MTF) Referral Management section for the conditions listed in Section I of VA Form 21-0819. The DoD will follow the MTF specific guidance regarding referral requests.

2.1.1. AHLTA Generated Referral Request. Referrals for C&P examinations must be from the FEDB, FEDC, or FEDD MEPRS for DoD/VA billing and auditing purposes.

2.1.2. For the DoD/VA DES, it is not necessary to identify the various specialists who will be doing the different C&P examinations. Enter only the total number of DES C&P examinations derived from Section I, "Medical Conditions to be Considered as the Basis of Fitness for Duty Determination," of VA Form 21-0819. In "Reason for request" enter:

"VA only: DES C&P exams for fitness for duty determination - total"

Example:
VA only: DES C&P exams for fitness for duty determination - total 6.

3. The MTF Referral Management Section will forward the information to the Managed Care Support Contractor who will provide VA with the applicable referral number for all the DES related services (e.g.,VA DES C&P exams, necessary laboratory and radiology studies) for the specific Service Member. C&P examination referrals should come from the FEDB, FEDC, and FEDD MEPRS for auditing purposes between DoD and VA.