

## PROVIDERS OF CARE

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### 1.0. GENERAL

1.1. The SHCP payment structure applies to inpatient and outpatient medical claims submitted from civilian institutions, individual professional providers, and uniformed service members for civilian health care received within the 50 United States and the District of Columbia. Most patients covered by this chapter will have undergone medical care prior to any contact with the *Service Point of Contact (SPOC)* (Chapter 19, Addendum A) or the MCS contractor. However, when the patient initiates contact prior to treatment and the SPOC has authorized the care being sought, the Managed Care Support Contractor (MCSC) will make referrals to network providers; if a network provider is not available, the referral will be made to a TRICARE authorized provider. *When a SPOC referral directs evaluation or treatment of a condition, as opposed to directing a specific service(s), the MCSC shall use its best business practices in determining the services encompassed within the Episode of Care (EOC), indicated by the referral. The services may include laboratory tests, radiology tests, echocardiograms, holter monitors, pulmonary function tests, and routine treadmills associated with that EOC. A separate SPOC authorization for these services is not required. If a civilian provider requests additional treatment outside the original EOC, the MCSC shall contact the SPOC for approval. The contractor shall not communicate to the provider or patient that the care has been authorized until the SPOC review process has been completed.*

1.2. For service determined eligible patients other than active duty (e.g., ROTC, Reserve Component, foreign military, etc.), the contractor, upon receiving an authorization from the SPOC, will document the authorization with a network provider or TRICARE-authorized provider (if available).

### 2.0. DEPARTMENT OF VETERAN'S AFFAIRS

In addition to receiving claims from civilian providers, the contractors may also receive SHCP claims from the Department of Veteran's Affairs (DVA). The provisions of the SHCP will not apply to services provided under any local Memoranda of Understanding between the Department of Defense (including the Army, Air Force and Navy/Marine Corps facilities) and the Department of Veteran's Affairs. Claims for these services will continue to be processed by the Services or MTF as outlined in the MOU. However, any services not included in the MOU shall be paid by the MCSC in accordance with the requirements in this chapter.

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

2.1.1. The contractor shall reimburse for services under the current national DoD/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.

**2.1.2.** 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.

**2.1.3.** The contractor shall verify whether the MOA 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).

**2.1.4.** MOA claims shall be reimbursed as follows:

**2.1.4.1.** Claims for inpatient care shall be paid using 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 TMA (including period 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 VA-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 rates. (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.)

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

**2.1.4.3.** 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).

**2.1.4.4.** Since this care is 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.

**2.1.5.** 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.

**2.1.6.** 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 claim previously paid by MMSO or the Services.

