

Providers Of Care

1.0 GENERAL

1.1 The Supplemental Health Care Program (SHCP) payment structure applies to inpatient and outpatient medical claims submitted by civilian institutions, individual professional providers, suppliers, pharmacies and uniformed service members for Civilian Health Care (CHC) received within the 50 United States and the District of Columbia. For **Military Treatment Facility (MTF)**-referred care, the Managed Care Support Contractor (MCSC) will make referrals to network providers as required by contract.

1.2 For care that is not MTF referred (including care for MTF enrollees), most patients covered by this chapter will have undergone medical care prior to any contact with the Service Points of Contact (SPOC) ([Addendum A](#)) or the MCSC. However, when the patient initiates contact prior to treatment and the SPOC has authorized the care being sought, the MCSC will make referrals to network providers; if a network provider is not available, the referral will be made to a TRICARE authorized provider.

1.3 For service determined eligible patients other than active duty (e.g., Reserved Officer Training Corps (ROTC), Reserve Component (RC), foreign military, etc.), the contractor, upon receiving an authorization from the SPOC, will record and enter the authorization to enable appropriate claims processing, and, if necessary, will assist the patient with referral to a network provider or TRICARE-authorized provider (if available).

1.4 Claims for active duty dental services will be processed and paid by a single, separate active duty dental program contractor. Claims for adjunctive dental care will be processed and paid by the MCSC (or the TOP contractor for overseas care).

2.0 UNIFORMED SERVICES FAMILY HEALTH PLAN (USFHP)

2.1 In addition to receiving claims from civilian providers, the contractor may also receive SHCP claims from certain USFHP designated providers. 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 the TRICARE Management Activity (this includes care for a USFHP enrollee). 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 local Memoranda of Understanding between the Department of Defense (DoD) (including the Army, Air Force and Navy/Marine Corps facilities) and the DVA. Claims for these services will continue to be paid by the Services as outlined in the individual MOUs. However, any services not included in the Memorandum of Understanding (MOU) shall be paid by the MCSC in accordance with the requirements in this chapter **to include claims for MTF-referred care for beneficiaries on the Temporary Disability Retirement List (TDRL).**

3.1 Claims for Care Provided Under the National DoD/DVA Memorandum of Agreement (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/DVA 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." MOA claims shall be processed in accordance with this chapter and the following.

3.1.2 Claims received from a DVA health care facility for Active Duty Service Member (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 DVA-provided care has been authorized by the Military Medical Support Office (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

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MMSO for determination (following the procedures in [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 DVA 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. All TRICARE Encounter Data (TED) records for this care must include Special Processing Code 17 - DVA medical provider claim.

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 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.

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