

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 other TRICARE authorized providers for Civilian Health Care (CHC) rendered to uniformed service members and other SHCP-eligible individuals. 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., Reserve 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 in the 50 United States, the District of Columbia, and U.S. territories and commonwealths 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 (DPs). The provisions of the SHCP will not apply to services furnished by a USFHP DP if the services are included as covered services under the current negotiated agreement between the USFHP DP and the TRICARE Management Activity (TMA) (this includes care for a USFHP enrollee). However, any services not included in the USFHP DP agreement shall be paid by the contractor in accordance with the requirements in this chapter.

2.2 The USFHP, administered by the DPs 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 Memorandum of Agreement (MOA) for sharing between the Department of Defense (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 MOA 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/DVA MOA for Spinal Cord Injury (SCI), Traumatic Brain Injury (TBI), Blind Rehabilitation, and Polytrauma

3.1.1 Effective August 4, 2009, the contractor shall process DVA submitted claims for service members' treated under the MOA in accordance with this chapter and the following (SCI, TBI MOA; see Addendum D for a full text copy of the MOA for references purposes only).

3.1.2 Claims received from a DVA health care facility for Active Duty Service Member (ADSM) care shall be processed as an MOA claim based upon the TMA/Military Medical Support Office (MMSO) authorization number. As determined by TMA/MMSO, all medical conditions shall be authorized and paid under this MOA if a condition of TBI, SCI, Blindness, or Polytrauma exists for the patient. The authorization shall clearly indicate that the care has been authorized under the SCI, TBI, Blindness, and Polytrauma MOA. The authorization shall specify type of care (inpatient, outpatient, etc.) to be given under the referenced MOA and limits of the authorization (inpatient days, outpatient visits, expiration date, etc.). Suggested authorization language to possibly include all care authorized under the SCI, TBI, Blindness, and Polytrauma MOA for inpatient, outpatient and rehabilitative care. TMA/MMSO shall send authorizations to the contractor either by fax or by other mutually agreed upon modality.

3.1.3 The contractor shall verify whether the DVA-provided care has been authorized by the TMA/MMSO. If an authorization is on file, the contractor shall process the claim to payment. The contractor shall not deny claims for lack of authorization. If a required authorization is not on file, the contractor shall place the claim in a pending status and forward the appropriate documentation to the TMA/MMSO identifying the claim as a possible MOA claim for determination (following the procedures in Addendum B for the TMA/MMSO SPOC referral and review procedures). Additionally, any DVA submitted claim for a service member with a TBI, SCI, blindness, or polytrauma condition that does not have a matching authorization number shall be pending to the TMA/MMSO for payment determination.

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, published in the Federal Register. 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 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 TBI care. Blind rehabilitation and SCI care each have their own separate interagency rate. Additionally, it is possible that two or more separate rates may apply to one inpatient stay. All interagency rates except the outpatient interagency rate in the Office of Management and Budget (OMB) Federal Register Notice provided by TMA will be applicable. 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 SCI may include days paid with the SCI rate and days billed at a surgery rate.) MCSCs shall verify the DVA billed rate on inpatient claims matches one of the interagency rates provided by TMA. DVA claims for inpatient care submitted with an applicable interagency rate shall not be developed any further (i.e., for revenue codes, diagnosis, etc.) if care has been approved by the TMA/MMSO. Claims without an applicable interagency rate shall be denied and an Explanation of Benefits (EOB) shall be issued to the DVA, but not the beneficiary. The claim will need to be resubmitted for payment.

3.1.4.2 Claims for outpatient and ambulatory surgery professional services shall be paid at the appropriate TRICARE allowable rate (e.g., CHAMPUS Maximum Allowable Charge (CMAC)) with a 10% discount applied. For those services without a TRICARE allowable rate, DVA shall be reimbursed at billed charges.

3.1.4.3 The following care services, irrespective of health care delivery setting require authorization from MMSO and are reimbursed at billed charges (actual DVA cost) separately from DVA inpatient interagency rates, if one exists:

- Transportation
- Prosthetics
- Non-medical rehabilitative items
- Durable Medical Equipment (DME)
- Orthotics (including cognitive devices)
- Routine and adjunctive dental services
- Optometry
- Lens prescriptions
- Inpatient/outpatient TBI evaluations

- Special diagnostic procedures
- Inpatient/outpatient polytrauma transitional rehabilitation program
- Home care
- Personal care attendants
- Conjoint family therapy
- Ambulatory surgeries
- Cognitive rehabilitation
- Extended care/nursing home care

3.1.4.4 On August 4, 2009, the contractor shall process all claims received on or after this date using the guidelines established under the updated MOA regardless of the date of service. All TRICARE Encounter Data (TED) records for this care shall include Special Processing Code **17** - DVA medical provider claim.

3.1.4.5 If paid at per diem rates, the provisions of Chapter 8, Section 2, paragraph 7.2, apply when enrollment changes in the middle of an inpatient stay. If enrollment changes retroactively, prior payments will not be recouped.

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 C](#) for a full text copy of the MOA for reference 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 (CPT¹) 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 6.1](#) including Note 4.

3.2.3 The DVA will list one C&P examination (CPT¹ 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.

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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. If no authorization is 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. CPT² 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 17.2-1 DISABILITY PAY SCHEDULE

EFFECTIVE DATE	C& P DISABILITY EXAM (99456 ²)	ANCILLARY SERVICES
01/01/2011	\$515.00	CMAC - 10%

3.2.6 All TED records for this care shall include Special Processing Code **DC** - 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 care from that date forward. The contractor shall NOT be responsible for processing adjustments for any claims previously paid by TMA.

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