

PROVIDERS OF CARE

1.0. GENERAL

1.1. The *Supplemental Health Care Program (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 *Managed Care Support Contractor (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. 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 (RC), 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 (DVA)

2.1. In addition to receiving claims from civilian providers, the contractors 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 (MOU) 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 processed by the Services or *Military Treatment Facility (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 *to include claims for MTF-referred care for beneficiaries on the Temporary Disability Retirement List (TDRL)*.

2.2. Claims for Care Provided Under the National DoD/DVA Memorandum of Agreement (MOA) for Spinal Cord Injury (SCI), Traumatic Brain Injury (TBI), Blind Rehabilitation, and Polytrauma

2.2.1. *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 C for a full text copy of the MOA for references purposes only).*

2.2.2. *Claims received from a DVA health care facility for service members care shall be processed as an MOA claim based upon the TRICARE Management Activity (TMA)/Military Support Office (MMSO) authorization number. As determined by the 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.*

2.2.3. *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 Chapter 19, 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.*

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

2.2.4.1. *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 TMA (including periodic updates as needed). 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 rates. (For example, a stay for SCI may include days billed 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.*

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2.2.4.2. 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.*

2.2.4.3. The following *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 (PTRP)
- Home care
- Personal care attendants
- Conjoint family therapy
- Ambulatory surgeries
- Cognitive rehabilitation
- Extended care/nursing home care

2.2.4.4. 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.

2.2.4.5. If paid at per diem rates, the provisions of Chapter 8, Section 2, paragraph 4.2., apply when enrollment changes in the middle of an inpatient stay. If enrollment changes retroactively, prior payments will not be recouped.

