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* 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/*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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