

Department Of Veterans Affairs (DVA) And Department Of Defense (DoD) Health Care Resources Sharing

Issue Date: June 1, 1999

Authority: 38 United States Code (USC) Section 8111, Title II P.L. 102-585

1.0 DESCRIPTION

Agreements between the Department of Veterans Affairs (DVA) and the Department of Defense (DoD) to enable DoD beneficiaries to use certain Veterans Affairs Medical Centers (VAMCs) on a space available basis are authorized by 8111 of 38 United States Code (USC) and Title II of Public Law (PL) 102-585.

1.1 General

Only VA hospitals with signed agreements will be included as network providers. See [Chapter 11, Section 2.1](#), which includes the Memorandum Of Understanding (MOU) for the policy concerning this program. Contractors processing claims submitted from the VAMCs shall continue to use the usual claims processing procedures to include medical necessity, Explanation of Benefits (EOB), Other Health Insurance (OHI) and Third Party Liability (TPL). VAMCs shall be subject to the same Utilization Management and Quality Assurance requirements applicable to other network providers. The contractor shall ensure that all DVA Health Care Finders (DVAHCFs) institutional and individual professional providers are properly trained in and comply with the provisions of TRICARE quality and utilization management programs. The effective date for TRICARE coverage of service provided by a network VAMC is determined by the agreement between the contractor and the VAMC. Only services furnished on or after the effective date will be considered for TRICARE payment.

1.2 Certification Of VAMCs

VAMCs participating as network providers shall be recognized as authorized TRICARE providers, dependent upon their being Joint Commission approved or meeting the waiver criteria of the Managed Care Support Contractors (MCSCs) for network providers. The contractor shall assign the VAMC a TRICARE unique provider number which will identify the claim as a TRICARE claim and the provider as the VAMC.

1.3 Certification Of Individual Professional Providers

Individual providers shall not be certified since all claims will be submitted by the VAMC. Individual providers who meet VA requirements will be deemed to meet TRICARE requirements. When billing for professional services, the VAMC will furnish the specialty of the providers. The contractor shall create provider records in accordance with the TRICARE Systems Manual (TSM).

TRICARE Policy Manual 6010.57-M, February 1, 2008

Chapter 1, Section 9.1

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1.4 Claims Processing

All claims will be submitted by the VAMC and shall be processed as participating claims even if not so indicated on the claim form. Any beneficiary submitted claims for care received at the VAMC shall be denied using the EOB message: "Claims must be filed by the VA Medical Center."

1.5 Reimbursement

Reimbursement shall be based on a percentage discount off the CHAMPUS Maximum Allowable Charge (CMAC), the state prevailing, Diagnostic Related Group (DRG), or other methodology such as per diems for all types of services. Cost-shares and deductibles will be withheld prior to payment being made directly to the VAMC. The MCSC will negotiate reimbursement rates with the VAMC.

1.6 Pharmacy Drug Claims

1.6.1 Pharmacy drug claims will be processed in accordance with the guidelines in [Chapter 8, Section 9.1](#), however, there will be no discount applied to pharmacy drugs. The VAMC shall bill for outpatient prescriptions and prescription refills written for each 30 day supply (or fraction thereof) at VAMC's costs for the prescription items plus a reasonable fee to cover VAMC's dispensing costs. The VAMC will be reimbursed based on:

- The billed charge or,
- The TRICARE allowable charge, whichever is less.

1.6.2 In addition, the VAMC shall collect copayments consistent with TRICARE requirements. The amount of copayment shall be deducted from the lower of the billed charge or the TRICARE allowable charge.

Note: Inpatient prescriptions, including those filled at discharge, will be included in the DRG bill and, as such, are not subject to a separate prescription reimbursement or copayment.

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