

**Outpatient Billing Guidance
For
Department of Defense/Veterans Affairs Direct Sharing Agreements for Health
Care**

This guidance is based on the 2003 memorandum of agreement signed by the Assistant Secretary of Defense for Health Affairs and the Under Secretary for Health, Veterans Health Administration for standardized billing rates. It replaces the previous implementation guidance for outpatient direct sharing agreements between the Department of Defense (DoD) and the Department of Veterans Affairs (VA). It does not apply to network agreements between VA medical facilities and DoD's managed care support contractors (MCSC) nor to outpatient services rendered under the auspices of the National MOA for Spinal Cord Injury, Traumatic Brain Injury and Blind Rehabilitation, which are billed through the MCSC.

1. Basic Methodology. DoD and VA medical facilities will bill outpatient clinical services provided under direct sharing agreements at the CHAMPUS Maximum Allowable Charge (CMAC) less 10 percent for the appropriate Current Procedure Terminology (CPT) code. If there is no CMAC rate for a particular CPT code, the facility may substitute an agreed upon rate. The facility providing care will bill the discounted rate and receiving facility will pay the amount billed. Rates are located at the TRICARE Management Activity website as shown: <http://www.tricare.mil/cmhc/>

2. CMAC Rate Tables. Facilities will use the rate table specific to their own zip code. DoD facilities should use the private sector care CMAC rates found in the TRICARE website for VA billing, not the CMAC rates loaded by the DoD Uniform Business Office (UBO) into the DoD outpatient billing system. UBO loaded CMAC rates are slightly different and are used for third party billing for DoD. If there is no CMAC rate available for a specific service, negotiate a local rate.

3. Outpatient Visits. DoD and VA medical facilities will use the non-facility rates (types two and four) for outpatient visits. Use type two for physicians and type four for non-physician providers. There will be no additional institutional fee for the outpatient visit because it is already included in the non-facility rate. Ancillary services should be billed in addition to the outpatient visit.

4. Ambulatory Procedure Visit. Each Department will follow its own business office guidance for ambulatory procedure billing for institutional costs. Facilities may negotiate discounts from either VA reasonable charges or DoD rates. CMAC less 10% should be used for professional fees. Prices should include appropriate follow-up.

5. Same Day Surgery. For procedures performed in an operating room, a procedure room or an ambulatory surgery center, sites may negotiate locally for the institutional cost, in keeping with the methodology used by each Department's business office, discounted to approximate the actual cost. For the professional fee, both DoD and VA should use the facility based CMAC rates less 10 percent. Surgical rates for services that are not part of the designated TRICARE or VA benefit (e.g. cosmetic, LASIK, PRK) will be locally negotiated. For procedures that require anesthesia, sites may use the Anesthesia Procedure Pricing from the TRICARE website, or follow their Department's internal business office guidance for the base anesthesia rate, discounted to approximate actual cost. Pricing for procedures wherein patients bring implants supplied by their referring facility will be negotiated locally.

6. Emergency Room visits. For the professional component, use the CMAC rate less 10 percent for the appropriate CPT code. For the institutional component, sites may negotiate a cost based rate as there is no CMAC rate table for this.

7. Observation Beds. For less than 24 hours, use the CMAC rate less 10 percent for the appropriate CPT code. The institutional component should be negotiated locally.

8. Physical and Occupational Therapy. DoD and VA medical facilities will use the global CMAC rate for the appropriate CPT code less 10 percent.

9. Radiology. Global CMAC rates should be used for radiology procedures which includes both institutional and professional fees for the appropriate CPT code less 10 percent. If the service provided is only the procedure and not the interpretation, use the technical rate only. If the service provided is only interpretation, use the professional rate only.

10. Pharmacy. There is no CMAC rate table for pharmaceuticals. The Departments have agreed to use the average wholesale price (AWP) less 60 percent with a \$9.00 dispensing fee. A calculator tool will be developed and maintained on DoD's Uniform Business Office website, the same website which hosts the inpatient CMAC calculator. In the event that AWP's become unavailable, sites will negotiate based on cost. This does not pertain to sharing agreements wherein VA participates as part of the TRICARE Retail Pharmacy.

11. Laboratory. Use the global CMAC rates less 10 percent. There are no CMAC rates for reference lab services. For agreements wherein one facility acts as a reference lab rates should be negotiated locally based on cost.

12. Dental Services. Due to the low volume of dental care shared between VA and DoD, activities may negotiate dental care locally.

13. Exemption from waiver: The eight official Joint Ventures, and certain other designated sites (listed on Appendix 1), may negotiate discounts greater than 10 percent of CMAC if needed to allow for shared staffing or space, etc. without requesting a waiver. Any other co-located medical facilities that share space, staffing and/or equipment are authorized to negotiate greater discount percentages as approved by their chain of command. If these conditions do not exist, medical facilities will not change the discount percentage unless approved by the waiver process.

14. Waivers:

a. Requests for waivers to change the discount rate will contain the following information:

- (1) VA and DoD Facility Name and Location
- (2) VA and DoD Point of contact (name, phone number and email address)
- (3) Date of request
- (4) Description of waiver requested and the proposed alternative rate
- (5) Reason for waiver request
- (6) Benefits derived – include significant tangible and intangible factors
- (7) Impact if waiver is disapproved
- (8) Calculations used to determine desired discount; include data source
- (9) Signatures of both facility's Director/Commander

b. Approval Process:

(1) VA facilities will forward waivers through their VISN Director, who has 10 working days to forward to the VA/DoD Sharing Office (10D2). The VA/DoD Sharing Office has 15 working days to review and forward the waiver to the VA/DoD Financial Management Working Group (FMWG).

(2) Military Treatment Facilities will forward waivers through their appropriate intermediate commands, who will have 10 working days to forward to medical headquarters. The Service Surgeon General, will have 15 working days to forward to the Deputy Assistant Secretary of Defense for Health Budgets and Financial Policy DASD (HB&FP), co-chair of the FMWG.

Joint Ventures/Federal Facilities/Joint Market Opportunity Sites

Anchorage – Alaska VA Health Care System/ 3rd Medical Group, Elmendorf AFB

Albuquerque – New Mexico VA Health Care System/ 377th Medical Group, Kirtland AFB

Chicago – North Chicago VA Medical Center/ Naval Medical Clinic, Great Lakes

El Paso - El Paso VA Health Care System/ William Beaumont Army Medical Center

Fairfield – Northern California VA Health Care System/ David Grant Medical Center, 60th Medical Group, Travis AFB

Honolulu – VA Pacific Islands Health Care System/ Tripler Army Medical Center

Key West – Miami VA Health Care System (CBOC)/ Naval Medical Clinic, Key West

Las Vegas – VA Southern Nevada Health Care/ Mike O’Callaghan Federal Hospital

Biloxi – Biloxi VA Medical Center/ Keesler AFB

Denver – Denver VA Medical Center/Buckley Air Force Base