Department of Veterans Affairs (VA) and Department of Defense (DoD) Memorandum of Agreement (MoA) Regarding 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

1. PURPOSE: This document establishes procedures regarding active duty military personnel with spinal cord injury (SCI), traumatic brain injury (TBI), or blindness treated at VA medical facilities under direct resource sharing agreements under the authorities noted in paragraph 2. Active duty military personnel will receive timely and high quality specialty care within a continuum of health care dedicated to the needs of persons with SCI, TBI, and blindness. ***NOTE:*** *This MoA does not pertain to the transfer of active duty military personnel to VA facilities for care or treatment related to alcohol or drug abuse or dependence in accordance with Title 38 U.S.C, Section 620A(d)(l). This MoA pertains to direct resource sharing agreements only, and* ***not*** *to agreements between the VA and TRICARE Managed Care Support Contractors.*

2. AUTHORITIES:

a. Department of Veterans Affairs and Department of Defense Health Resources Sharing and Emergency Operations Act (Title 38 U.S.C. Section 8111) (Public Law 102-40, Section 402 (b)(1) renumbered Section 5011(d) [Section 3 of Public Law 97-174 (enacted May 4, 1982)].

b. Section 3-105 of the VA/DoD Health Care Resource Sharing Guidelines of July 29, 1983.

c. VA/DoD Health Executive Council Memorandum of Agreement Health Care Resource Sharing Reimbursement Methodology dated November 2002 (Appendix A).

3. BACKGROUND: There has been a long-standing Memorandum of Agreement between the Department of Defense (DoD) and the Department of Veterans Affairs (VA) associated with specialized care for active duty sustaining SCI, TBI, and blindness. VA is known for its integrated system of health care for these conditions. The VA/DoD Health Executive Council has identified the need for referral procedures governing the transfer of active duty military inpatients from military or civilian hospitals to VA medical facilities, and the treatment of active duty military patients at such facilities. This MoA supersedes the VA/DoD Memoranda of Understanding dated June 10, 1986, pertaining to TBI, and December 1, 1999, pertaining to SCI.

4. DoD RESPONSIBILITIES

a. The referring Military Treatment Facility (MTF) will identify and contact the VA TBI (Appendix B), SCI (Appendix C), or Blind Rehabilitation Center (Appendix D) as soon as possible to begin the referral process, to present the case, and to gain admission approval. The medical and administrative personnel of the MTF must establish immediate contact with their counterparts at the designated VA Center to discuss and make specific arrangements. Whenever possible the VA Center closest to the active

duty member's home of record or location selected by the active duty member, guardian, conservator, or designee should be contacted first. The referring MTF in conjunction with the service member's commander ordinarily determines whether the circumstances associated with injury and/or condition will bar the member from medical benefits, and is subject to provisions of Title 38 Code of Federal Regulations (CFR) Part 17.

b. The referring MTF will provide all pertinent patient medical record documentation requested by the VA Center needed to make a medical decision. This includes the patient's history and physical, diagnostics, laboratory findings, hospital course, daily documentation of progress, etc.

c. Pre-requisites for transfer, in addition to identifying an accepting staff physician at the VA Center, are stabilization of the patient's injuries and the acute management of the medical and physiological sequelae associated with the SCI, TBI, or blindness. Stabilization is an attempt to prevent additional impairments while focusing on prevention of complications. The criteria for the transfer of patients with SCI, TBI, or blindness require:

(1) Attention to airway and adequate oxygenation;

(2) Treatment of hemorrhage, no evidence of active bleeding;

(3) Adequate fluid replacement;

(4) Maintenance of systolic blood pressures ($\geq$90 mm mercury hydrargyrum (Hg));

(5) Foley catheter placement, when appropriate, with adequate urine output;

(6) Use of a nasogastric tube, if paralytic ileus develops;

(7) Maintenance of spinal alignment by immobilization of the spine, or adequate stabilization to prevent further neurologic injury (traction, tongs and traction, halo-vest, hard cervical collar, body jacket, etc.); and

(8) Approval by the SCI Center Chief, TBI Center Medical Director or Designee, or Blind Rehabilitation Chief in consultation with other appropriate VA specialty care teams.

d. The referring MTF must notify the VA Center of any changes in medical status. Patients are <u>not</u> to be transferred if there is:

(1) Deteriorating neurologic function,

(2) An inability to stabilize the spine, especially if the neurologic injury is incomplete,

(3) Bradyarrhythmias are present,

(4) An inability to maintain systolic blood pressure >90 mm Hg,

(5) Acute respiratory failure is present, or

(6) New onset of fever, infection and/or change in medical status (e.g., deteriorating physiological status).

e. Following the VA Center's agreement to accept the patient, the MTF commander or designee will notify and submit a patient movement request to the Global Patient Movement Requirements Center (GPMRC), or when overseas, to the Theatre Patient Movement Requirement Center (TPMRC), without regard to weekend or holiday, to schedule the transport of the patient from either an MTF or a civilian hospital. If the patient is moved by other than an Air Force aircraft or is an emergency patient, information reported to GPMRC will be the minimum required to allow GPMRC to develop referral patterns [please refer to Chapter 4, Joint Regulation, dated June 10, 1986, titled "Medical Regulating to and Within the Continental United States (CONUS)]. This notification may be made after the fact for emergency patients.

f. The MTF commander and GPMRC are responsible for coordination with the receiving VA facility for ground transportation from the airfield to the VA facility. Whenever possible, the originating MTF should arrange with any MTF within a reasonable distance to provide needed transportation. If that is not possible, the receiving VA Medical Center shall obtain appropriate local transportation. For CONUS transfers and transfers from Outside the Continental United States (O-CONUS), the VA facility designated to receive the patient shall arrange local transportation of patients from the local airfield to the VA facility. ***NOTE:*** *DoD will be responsible for payment of any costs incurred by VA for the transport of active duty personnel.*

g. To ensure optimal care, active duty patients are to go directly to a VA medical facility without passing through a transit military hospital.

h. In emergencies, GPMRC will expedite transfers from MTFs or civilian hospitals to VA facilities through telephone communications. MTFs will report directly to the GPMRC for CONUS transfers, but MTFs will report to the TPMRC at Ramstein Air Base, or to the TPMRC at Yokota Air Base for O-CONUS transfers. The TPMRC will then coordinate with the GPMRC for transportation. An after-the-fact report will be made to GPMRC within 48 hours.

i. DoD will ensure meeting the goal of transfer within three days (four days from overseas), whenever the patient's medical condition permits, but not exceeding twelve days. The ability to complete medical review board processing is not a prerequisite for transfer to a VA medical facility.

j. DoD will assure that each Surgeon General's office or her/his designee provides necessary assistance to VA facilities in the preparation and transmittal of the patient's medical boards or as a point of contact should problems arise.

k. DoD will assure that the appropriate Service provide telephone and written notification to VA facilities when active duty members are discharged or released from active duty. This notification shall be made before the separation date and will include the date, type of separation, and the periods of active duty served. The DD214 will be provided to VA in a timely manner.

5. VA RESPONSIBILITIES:

a. The Rehabilitation Strategic Healthcare Group (SHG) Chief Consultant and the Spinal Cord Injury and Disorders SHG Chief Consultant will provide annually to DoD, a list of VA Spinal Cord Injury Centers, Traumatic Brain Injury Lead Centers, and Blind Rehabilitation Centers including their telephone numbers and points of contact. These lists will be updated if changes occur.

b. The Veterans Integrated Service Network (VISN) Directors will adhere to policies in this MoA.

c. The designated VA facility with an SCI Center, TBI Center, or Blind Rehabilitation Center will assist military authorities in the following manner:

(1) Respond (following receipt of necessary medical records) to requests for admission from military medical authorities or their designees without regard to weekends or holidays. ***NOTE:*** *Concurrent notification of the GPMRC will be provided.*

(2) Accept appropriate active-duty patients without regard to hour of the day, day of the week, or holidays. ***NOTE:*** *The acceptance of local transfers from MTFs to VA facilities should be mutually agreed.*

(3) Coordinate the transfer of active duty patients to VA Centers with the MTFs and GPMRC. ***NOTE:*** *Concurrent notification of the GPMRC will be provided.*

(4) Coordinate with civilian hospitals and GPMRC so that active duty patients, who are ready for transfer to a VA specialty care center are transported directly from a civilian hospital to the appropriate VA facility.

(5) Assist the MTF in identifying the most appropriate VA SCI, TBI, or Blind Rehabilitation Center. Active duty patients need to be referred to the designated VA medical facility closest to the active duty member's home of record or location selected by the active duty member, guardian, conservator, or designee, subject to availability of beds. If the preferred Center is unable to accept the patient, that VA medical facility will

assist in locating an appropriate placement. ***NOTE:*** *The Chief Consultant, Rehabilitation SHG, or Chief Consultant, SCI&D SHG, VA Central Office, 810 Vermont Avenue, NW, Washington, DC 20420, will assist when necessary.*

(6) The accepting VA staff physician will review military transportation arrangements and make recommendations if it is believed that the patient's care will be compromised due to delays or other clinical considerations. VA will assist referring military authorities and GPMRC in coordinating the medically indicated mode of transportation and arranging local ground transportation to VA facilities, such as from local airfields.

(7) Provide immediate notification to the appropriate MTF Case Manager, when an active duty member is admitted.

(8) Coordinate the hospital discharge of an active duty member with the appropriate MTF or the Military Medical Support Office (MMSO).

(9) Assist with medical boards when requested by the military authority having cognizance over the member.

(10) Notify DoD of the active duty member's absences, medical discharge, and change of location.

6. PROGRAM DESCRIPTIONS:

a. **Spinal Cord Injury and Disorders:** The mission of the Spinal Cord Injury and Disorders Program within VA is to promote the health, independence, quality of life, and productivity of individuals with spinal cord injury and disorders. There are twenty SCI Centers available throughout VA to provide acute rehabilitative services to persons with new onset SCI (see Appendix B). VA offers a unique system of care through SCI Centers, which includes a full range of health care for eligible persons who have sustained injury to their spinal cord or who have other spinal cord lesions. Persons served in these centers include those with: stable neurological deficit due to spinal cord injury, intraspinal, nonmalignant neoplasms, vascular insult, cauda equina syndrome, inflammatory disease, spinal cord or cauda equina resulting in nonprogressive neurologic deficit, demyelinating disease limited to the spinal cord and of a stable nature, and degenerative spine disease.

b. **Traumatic Brain Injury:** VA offers a full range of traumatic brain injury rehabilitation to ensure that military and veteran personnel with brain injuries receive coordinated, comprehensive care. The goal is to return the brain injury survivor to the highest level of function and to educate family and caregivers in the long-term needs of the patient. VA has four lead Traumatic Brain Injury Centers (see Appendix C). These facilities provide comprehensive assessment, medical care, TBI specific acute rehabilitation,

access to state of the art treatment, clinical trials, and leadership for a nationwide system of TBI care through case management. Each participating medical center has a designated TBI case manager who facilitates patient participation in the program and expedites facility transfers and community placement.

c. **Blind Rehabilitation:** Blind Rehabilitation Service offers a coordinated educational training and health care service delivery system that provides a continuum of care for veterans with blindness that extends from their home environment, to the local VA facility, to the appropriate rehabilitation setting. These services include adjustment to blindness counseling, patient and family education, benefits analysis, assistive technology, outpatient programs, and residential inpatient training. There are ten residential, inpatient VA Blind Rehabilitation Centers (BRCs) (see Appendix D). The mission of each BRC program is to educate each veteran on all aspects of Blind Rehabilitation and address the expressed needs of each veteran with blindness so they may successfully reintegrate back into their community and family environment. To accomplish this mission, BRCs offer a comprehensive, individualized adjustment-training program along with those services deemed necessary for a person to achieve a realistic level of independence. BRCs offer a variety of skill courses including: orientation and mobility, communication skills, activities of daily living, manual skills, visual skills, leisure skills, and computer access training. The veteran is also assisted in making an emotional and behavioral adjustment to blindness through individual counseling sessions and group therapy meetings. Each VA medical center has a Visual Impairment Services Team Coordinator who has major responsibility for the coordination of all services for visually impaired veterans and their families. Duties include arranging for the provision of appropriate treatment modalities (e.g. referrals to Blind Rehabilitation Centers and/or Blind Rehabilitation Outpatient Specialists) and being a resource for all local service delivery systems in order to enhance the functioning level of veterans with blindness. Referrals can be directed to the Program Analyst in the Blind Rehabilitation Program Office in the VA Central Office at 202-273-8482.

7. DURATION:

a. This MoA will remain in force unless terminated at the request of either party after thirty (30) days written notice. In event this MoA is terminated, DoD shall be liable only for payment in accordance with provisions of this agreement for care provided before the effective termination date.

b. This agreement supersedes all local resource sharing agreements.

8. REIMBURSEMENT:

a. Both VA and DoD will use CHAMPUS Maximum Allowable Charge (CMAC) rates less 10 percent (CMAC-10%) or Diagnosis Related Group (DRG) code rates less 10 percent (DRG-10%) as the reimbursement methodology for health care reimbursement between medical facilities for institutional and professional charges consistent with

VA/DoD Health Executive Council Memorandum of Agreement Health Care Resource Sharing Reimbursement Methodology (see Appendix A). In no case should reimbursement rates be below the incremental cost, resulting in interdepartmental subsidies. The two Departments are allowed to charge for outlier days as currently allowed under CMAC business rules. VAMCs will provide all documentation required for billing medical claims. At a minimum, this will include an itemized bill for each member on the Form HCFA 1500 for outpatient services and Form UB 92 for inpatient services. ***NOTE:*** *The costs of transportation, prosthetics, durable medical equipment, dental services, ambulance, home care, some separate professional fees, and personal care attendants are not included in the CMAC-10 percent rates and will be billed at the interagency rate, if a rate is available. If an interagency rate is not available, reimbursement will be at the actual charge. When patients are released from hospital care and the hospital discharge plan requires assistance in the home, the military will reimburse VA for the cost of any personal care attendant services incurred by VA, if the service member is still an eligible DoD beneficiary at the time the services are provided. The discount rate will be reviewed annually to maximize resource sharing.*

b. VA health care facilities providing care to active duty members in accordance with national VA-DoD agreements will be paid by the respective Service as outlined:

(1) **Army**: Military Medical Support Office (MMSO). Address: Military Medical Support Office, ATTN: Army VA Claims, P.O. Box 886999, Great Lakes, IL, 60088-6999. Telephone number 888-647-6676. ***NOTE:*** *Claims will include the Transportation Command Regulating and Command and Control Evacuation System (TRAC2ES) authorization number and approval of transfer documentation from GPMRC.*

(2) **Air Force**: Send bills to referring Air Force Military Treatment Facility (MTF). Point of contact (for other than billing): Financial Management, Headquarters, USAF Surgeon General, Bolling AFB at (202) 767-5424.

(3) **Navy & Marine Corps**: Military Medical Support Office (MMSO). Address: Military Medical Support Office, P.O. Box 886999, Great Lakes, IL, 60088-6999. Telephone number 888-647-6676.

William Winkenwerder, Jr., M.D.
Assistant Secretary for Health Affairs
Department of Defense
Date: 4-20-04

Robert H. Roswell, M.D.
Under Secretary for Health
Department of Veterans Affairs
Date: 3.9.04

VA/DoD Health Executive Council
Memorandum of Agreement
Health Care Resource Sharing
Reimbursement Methodology

This document establishes the reimbursement methodology for direct sharing of health care resources between facilities of the Department of Veterans Affairs (VA) and the Department of Defense (DoD). It replaces reimbursement guidelines issued in 1983 and 1989. This document pertains to direct sharing agreements only, not to agreements between the VA and TRICARE Managed Care Support Contractors.

1 BACKGROUND

During previous agreements between VA and DoD, flexibility was given to establish locally developed rates for medical sharing agreements. This resulted in the proliferation of rate setting mechanisms, introduced unnecessary complexity in the billing process and called in question the financial efficacy of such agreements. Facilities focused their attention on the negotiation of rates rather than collaborating together. Once the rates were set, they were often not reviewed for several years.

The Financial Management Work Group, under the direction of the VA/DoD Health Executive Council, proposed a national rate structure be implemented that is regionally adjusted, and discounted to encourage further resource sharing. Use of the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS) Maximum Allowable Charge rate structure will ensure that rates are regionally adjusted, updated yearly, and are easily accessible via website.

2. AUTHORITY

A. Department of Veterans Affairs and Department of Defense Health Resources Sharing and Emergency Operations Act (38 U.S.C. 8111)

3. POLICY

A. Both the VA and DoD will use CHAMPUS Maximum Allowable Charge (CMAC) rates less 10% as the reimbursement methodology for health care reimbursement between medical facilities, for institutional and professional charges. The discount rate will be reviewed annually to maximize resource sharing levels.

B. The two Departments will use this reimbursement methodology for all clinical services and specialty programs such as spinal cord injury, traumatic brain injury and

blind rehabilitation, but will not use these rates for non-clinical services such as laundry and food service, which should be negotiated independently.

C. The two Departments will use this reimbursement methodology for joint venture agreements where a discrete episode of clinical care is provided that can be assigned ICD9, CPT or DRG codes. Joint ventures and co-located facilities are allowed flexibility to account for unique circumstances involving shared space, staffing or other arrangements. Joint ventures and co-located facilities may adjust the discount percentage to reflect the value of these non-monetary contributions. It is recommended that non-clinical services agreements are negotiated separately (e.g. laundry, food service, etc.). The VA/DoD Financial Management Workgroup is available to answer questions regarding the rate structure and adjustments.

D. The two Departments will be allowed to charge for outlier days as currently allowed under CMAC business rules. The Departments will not bill for Graduate Medical Education or Capital Expense Equipment.

E. This reimbursement methodology will apply to both existing and new agreements. Existing agreements will be modified to reflect this policy change.

F. A CMAC billing guide will be developed to assist facilities in preparing claims under this methodology.

G. As required by law, reimbursements will be credited to the facility that provided the services.

H. The implementation will be phased in to coordinate with DoD's introduction of itemized billing within the Military Health System.

4. REVIEW

Each Department will monitor the VA/DoD sharing agreements and track reimbursements to ensure that they are in accordance with the guidelines set forth in this Memorandum of Agreement. This MOA will be reviewed annually and may be amended by mutual consent of both Departments.

5. WAIVER PROCESS

Although waivers are generally discouraged, there are two scenarios under which a waiver from the standardized rate may be requested: 1) if the standardized rate does not cover marginal costs or 2) if the standardized rate is higher than local market rates and both parties desire a larger discount from CMAC. In either instance, documentation must be provided to the VA/DoD Financial Management Work Group co-chairs for determination. Both co-chairs must agree for a waiver to be granted.

6. EFFECTIVE DATE

Outpatient billing using CMAC less 10% will begin in the first quarter of fiscal year 2003. It is anticipated that inpatient care will be billed using this methodology during the third quarter of fiscal year 2003, as DoD implements itemized inpatient billing. This memorandum may be amended by mutual consent of the participating entities. Either party upon 60 days notice in writing may terminate of the agreement.

William Winkenwerder, Jr.

Honorable William Winkenwerder, Jr., M.D.
Assistant Secretary for Health Affairs
Department of Defense

Robert H. Roswell

Honorable Robert H. Roswell, M.D.
Under Secretary for Health
Department of Veterans Affairs

TRAUMATIC BRAIN INJURY (TBI) CENTERS ACCEPTING DEPARTMENT OF DEFENSE REFERRALS

1. Minneapolis VA Medical Center (117), One Veterans Drive, Minneapolis, NM 55417, Telephone 612-467-3562.
2. VA Palo Alto HCS (117), 3801 Miranda Avenue, Palo Alto, CA 94304, Telephone 650-493-5000 Extension 65118.
3. HH McGuire VA Medical Center (117), 1201 Broad Rock Boulevard, Richmond, VA 23249, Telephone 804-675-5332.
4. James A. Haley VA Medical Center (117), 13000 Bruce B. Downs Blvd., Tampa, FL 33612-4798, Telephone 813-972-2000 Extension 6185

SPINAL CORD INJURY (SCI) CENTERS ACCEPTING DEPARTMENT OF DEFENSE REFERRALS

1. Department of Veterans Affairs (VA) New Mexico Health Care System (HCS) (128), 1501 San Pedro Southeast, Albuquerque, NM 87108, Telephone 505-256-2849.
2. Augusta VA Medical Center (128), One Freedom Way, Augusta, GA 30904-6285, Telephone 706-823-2216.
3. VA Boston HCS (128), 1400 VFW Parkway, West Roxbury, MA 02132, Telephone 617-323-7700 Extension 5128.
4. VA Medical Center (128), 130 West Kingsbridge Road, Bronx, NY 10468, Telephone 718-584-9000 Extensions 5423.
5. Louis Stokes VA Medical Center (128W), 10701 East Boulevard, Cleveland, OH 44106, Telephone 216-791-3800 Extension 4731.
6. VA North Texas HCS (128), 4500 South Lancaster Road, Dallas, TX 75216, Telephone 214-857-1757.
7. Edward Hines, Jr. VA Medical Center (128), Fifth Avenue and Roosevelt Road, Hines, IL 60141-5000, Telephone 708-202-2241.
8. Houston VA Medical Center (128), 2002 Holcombe Boulevard, Houston, TX 77030-4298, Telephone 713-794-7128.
9. VA Long Beach HCS (128), 5901 East 7th Street, Long Beach, CA 90822, Telephone 562-826-5701.
10. VA Medical Center (128), 1030 Jefferson Avenue, Memphis, TN 38104, Telephone 901-577-7373
11. VA Medical Center (128), 1201 Northwest 16th Street, Miami, FL 33125, Telephone 305-324-3174.
12. Clement J. Zablocki VA Medical Center (128), 5000 West National Avenue, Milwaukee, WI 53295, Telephone 414-384-2000 Extension 41230.
13. VA Palo Alto HCS (128), 3801 Miranda Avenue, Palo Alto, CA 94304, Telephone 650-493-5000 Extension 65870.
14. HH McGuire VA Medical Center (128), 1201 Broad Rock Boulevard, Richmond, VA 23249, Telephone 804-675-5282.
15. South Texas Veterans HCS (128), 7400 Meront Minter Blvd., San Antonio, TX 78284, Telephone 210-617-5257.
16. VA San Diego HCS (128), 3350 La Jolla Village Drive, San Diego, CA 92161, Telephone 858-642-3117.
17. VA Medical Center (128), 10 Casia Street, San Juan, PR 00921-3201, Telephone 787-641-7582 Extension 14130.
18. VA Puget Sound HCS (128), 1660 South Columbian Way, Seattle, WA 98108-1597, Telephone 206-764-2332
19. Saint Louis VA Medical Center (128JB), One Jefferson Barracks Drive, St. Louis, MO 63125, Telephone 314-894-6677.
20. James A. Haley VA Medical Center (128), 13000 Bruce B. Downs Blvd., Tampa, FL 33612-4798, Telephone 813-972-7517.

BLIND REHABILITATION CENTERS (BRC) ACCEPTING DEPARTMENT OF DEFENSE REFERRALS

1. Augusta VA Medical Center (324), One Freedom Way, Augusta, GA 30904-6285, Telephone 706-733-0188 Extension 6660.
2. Birmingham VA Medical Center (124), 700 South 19th Street, Birmingham, AL 35233, Telephone 205-933-8101.
3. Edward Hines, Jr. VA Medical Center (124), Fifth Avenue and Roosevelt Road, Hines, IL 60141-5000, Telephone 708-202-8387.
4. Olin E. Teague Veterans Center (124), Central Texas VA Health Care System, 1901 Veterans Memorial Drive, Temple, TX 76504, Telephone 254-752-6581 Extension 7835.
5. San Juan VA Medical Center (124), 10 Casia Street, San Juan, PR 00921-3201, Telephone 787-641-8325.
6. Southern Arizona VA Health Care System (3-124), 3601 South 6th Avenue, Tucson, AZ 85723, Telephone 520-629-4643.
7. VA Connecticut Health Care System (124), West Haven Campus, 950 Campbell Avenue, West Haven, CT 06516, Telephone 203-932-5711 Extension 2247.
8. VA Palo Alto HCS (124), 3801 Miranda Avenue, Palo Alto, CA 94304, Telephone 650-493-5000 Extension 64358.
9. VA Puget Sound HCS (124), 1660 South Columbian Way, Seattle, WA 98108-1597, Telephone 253-582-8440 Extension 76203.
10. West Palm Beach VA Medical Center (124), 7305 North Military Trail, West Palm Beach, FL 33410-6400, Telephone 561-882-8262.