

Veteran Administration (VA) and Indian Health Services (IHS)

Policy Number: MCS103.02
Approval Date: June 14, 2021

[Instructions for Use](#)

Table of Contents	Page
Coverage Guidelines	1
• VA Eligible Members	1
• Non-VA Eligible Members in a VA Facility	2
• Services Provided by Indian Health Services	3
Definitions	4
Policy History/Revision Information	4
Instructions for Use	4

Related Policies
None

Coverage Guidelines

Services involving Veteran Administration (VA) eligible members and/or Veteran Administration (VA) facilities are only covered when Medicare coverage criteria are met.

VA Eligible Members (i.e., Veterans, Retired Military Personnel and Eligible Dependents)

Services at a VA Facility

UnitedHealthcare is not responsible for emergency items or services directed, furnished, authorized, or paid for by the VA or the member elected to use his/her medical benefits through the VA.

Note: The law provides an exception to the above listed emergent/urgent services exclusion when:

- The VA facility is determined to be providing services to the public generally as a community institution or agency (VA hospitals that have sharing agreements with non-VA participating hospitals, under which the VA hospitals furnish end-stage renal disease services to non-veterans, may be considered community hospitals with respect to any otherwise covered service rendered to ESRD beneficiaries)

Services at a Non-VA Facility

Emergency Services

Note: Services must meet definition of [Emergency Services](#).

- VA is responsible for all charges when the VA authorizes the items or services provided.
- UnitedHealthcare is responsible as a secondary payer when the VA authorizes only a portion of the items or services provided and these items or services are covered under the member's UnitedHealthcare Medicare plan.
- UnitedHealthcare is responsible for all charges covered under the UnitedHealthcare Medicare Advantage (MA) plan when the VA does not authorize the items or services provided.

Non-Emergency Services

Services provided by a UnitedHealthcare Medicare Advantage plan provider for military service related injuries are covered only when the member is eligible for such services under his/her UnitedHealthcare Medicare Advantage benefit plan.

Skilled Nursing Facility (SNF) Care

Continued SNF care is covered when the member exhausts his/her VA SNF benefit and when both of the following are met:

- Criteria for SNF care are met
- The skilled level determination is made by the member's physician or UnitedHealthcare Medical Director and the care is directed, furnished and authorized by the member's physician or UnitedHealthcare.

VA SNF days do not count against the UnitedHealthcare Medicare Advantage plan SNF benefit. Members who exhaust the UnitedHealthcare Medicare Advantage plan SNF benefit may qualify for continued SNF coverage through VA.

Note: The UnitedHealthcare plan may reimburse VA-eligible members for VA copayment amounts charged for:

- Charges for services that exceed the VA copayment;
- Services rendered in a non-VA facility that are not authorized by the VA; or
- Services rendered after VA benefits are exhausted in a non-VA facility

These services must be reasonable and necessary and Medicare or the UnitedHealthcare Medicare Advantage plan covered benefits.

Refer to:

- [Medicare Benefit Policy Manual, Chapter 16, §50 – Items and Services Furnished, Paid for or Authorized by Government Entities – Federal, State or Local Governments.](#)
- [Medicare Managed Care Manual, Chapter 8, §130 – Special Rules for MA Payments to Dept. of VA Facilities.](#)

(Accessed June 3, 2021)

Non-VA Eligible Members in a VA Facility

The UnitedHealthcare Medicare Advantage plan will cover emergency, urgent and post-stabilization care provided by a VA facility in accordance with the member's emergency services benefits (such services are considered to be out-of-network).

Note: Medicare law prohibits CMS from paying a Federal provider of services, but the statute provides two exceptions as outlined in the [Medicare Managed Care Manual, Chapter 8, §130 – Special Rules for MA Payments to Dept. of VA Facilities](#). Section 1814(c) of the Social Security Act (the Act) sets forth the general rule that Medicare payments may not be made to any Federal provider of services for any item or service that such provider is obligated by law, or contract with the United States, to render at public expense. The Department of Veteran Affairs (VA) is a federal provider of services that is obligated by law to render services to veterans at public expense. The CMS has clarified that an MA organization is an entity that “stands in the shoes” of Medicare, and is considered a federal provider of services for purposes of this general rule. This means that an MA organization may not use Medicare funds to pay the VA Healthcare System for VA-covered services rendered to veterans who are also MA organization members. This rule prevails for both elective services and the emergency services rendered by the VA to veteran MA members. (Accessed June 3, 2021)

An MA enrollee who is enrolled in the VA Medical Benefits Plan has dual entitlement to separate government-funded health care systems. This means that the individual may elect to receive his or her health care either through the VA system or through his or her MA plan. If the individual elects to receive routine or non-emergency services through the VA system, the VA would be obligated by law to pay for those services and the MA organization would not be permitted to reimburse for such services under the same law.

Similarly, the MA organization is not permitted by law to pay the VA system for emergency services rendered by the VA to veterans who are MA enrollees. This holds true regardless of the circumstances underlying the enrollee's presentation to the VA. Thus, the prohibition against payment to the VA prevails whether the enrollee self-presented to the VA (e.g., walk-in patient), was directed there by a treating physician, or was brought to the VA by ambulance. However, refer to Chapter 7 (forthcoming) for a discussion of the situation where an MA plan enrollee with VA coverage is assessed cost sharing by the VA for receipt of emergency services and this cost sharing exceeds MA plan levels of cost sharing.

Refer to the [Medicare Managed Care Manual, Chapter 8, §130 – Special Rules for MA Payments to Dept. of VA Facilities](#).

(Accessed June 3, 2021)

Non-Veteran MA Enrollees

The rules governing MA organizations' responsibility for payment differs for services rendered by the VA to non-veteran MA enrollees. The rule at §1814(c) of the Act prohibiting payment has no application to non-veterans. Non-veteran enrollees are covered under §1814(d), which permits payment to be made to hospitals not contracted with Medicare for emergency services rendered to Medicare beneficiaries. Under 42 CFR 422.100 and 422.113, MA organizations are responsible for covering emergency and post-stabilization care services rendered to enrollees. MA organizations are obligated to reimburse the VA for such services, and would be expected to coordinate care of non-veteran enrollees who are in a VA hospital due to an emergency as it would in any other non-contracted or out-of-network hospital.

Exception Under Section 1814(h) of the Act

The rules governing MA organizations' responsibility for payment for services rendered by the VA to non-veteran MA enrollees also contain a provision at §1814(h) of the Act for circumstances in which a non-veteran is admitted to a VA hospital when both the individual and the VA mistakenly believe that the individual is entitled to VA benefits when in fact they are not. The §1814(h) exception only applies to the unusual situation in which an MA Organization enrollee who is a non-veteran is mistakenly admitted to a VA hospital for a service that does not require pre-authorization by their MA Organization plan. The CMS expects that this situation would be very rare.

Refer to the:

- [Medicare Managed Care Manual, Chapter 8, §130 – Special Rules for MA Payments to Department of VA Facilities.](#)
- Medicare regulations at [Medicare Managed Care Manual, Chapter 17, §5 – Special Rules for HMO/CMP Payments to Department of Veteran Affairs Facilities.](#)

(Accessed June 3, 2021)

Services Provided by Indian Health Services (IHS)

CMS does not have a specific requirement for Medicare Advantage Health Plan to pay for routine services provided by Indian Health Services. However, a Medicare Advantage Organization (MAO) must make timely and reasonable payment to, or on behalf of, plan enrollees for the following services obtained from a provider or supplier that does not contract with the MAO (including Indian Health Services) for the following:

- Ambulance services dispatched through 911 or its local equivalent where other means of transportation would endanger the beneficiary's health; refer to the Coverage Summary titled [Ambulance Services](#).
- Emergency and urgently needed services; refer to Coverage Summary titled [Emergent/Urgent Services, Post-Stabilization Care and Out-of-Area Services](#).
- Maintenance and post-stabilization care; refer to Coverage Summary titled [Emergent/Urgent Services, Post-Stabilization Care and Out-of-Area Services](#).
- Medically necessary dialysis from any qualified provider selected by an enrollee when the enrollee is temporarily absent from the plan's service area and cannot reasonably access the plan's contracted dialysis providers. An MA plan cannot require prior authorization or notification for these services. However, the MA plan may provide medical advice and recommend that the enrollee use a qualified dialysis provider if the enrollee voluntarily requests such advice because (s)he will be out of area. The MA plan must clearly inform the beneficiary that the plan will pay for care from any qualified dialysis provider the beneficiary may independently select. Furthermore, the cost-sharing for out-of-network medically necessary dialysis may not exceed the cost-sharing for in-network dialysis; and
- Services for which coverage has been denied by the MAO and found (upon appeal under subpart M of 42 CFR Part 422) to be services the enrollee was entitled to have furnished, or paid for, by the MAO.
- Regardless of the MA plan type being offered (e.g., HMO, PPO), arrange for specialty care outside of the network, but at in-network cost-sharing, in order to provide all Medicare Part A and Part B benefits. That is, if an enrollee requires a very specialized covered service that is not provided by the physicians in the network, the plan must arrange for that service to be provided by a qualified non-contracted provider.

Note: Other circumstances that could possibly apply include, but not limited to:

- A contracting provider refers a member to an IHS provider
- An IHS provider is contracted with MAO to provide services within the member's network.
- Member has a PPO or HMO-POS Plan which allows them to obtain routine care from non-network providers.

Refer to the following Medicare references:

Veteran Administration (VA) and Indian Health Services (IHS)
UnitedHealthcare Medicare Advantage Coverage Summary

Page 3 of 4
Approved 06/14/2021

- [Medicare Managed Care Manual, Chapter 4, §110.1.3 – Services for Which MA Plans Must Pay Non-contracted Providers and Suppliers.](#)
- [Medicare Managed Care Manual, Chapter 4, §110.4 – Preferred Provider Organization \(PPO\) Coverage and Access.](#)
- [Medicare Managed Care Manual, Chapter 4, §20 – Ambulance, Emergency, Urgently Needed and Post-Stabilization Care Services.](#)
- [Medicare Claims Processing Manual, Chapter 19 – Indian Health Services.](#)

(Accessed June 3, 2021)

Definitions

Emergency Services: A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, with an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in (1) Serious jeopardy to the health of the individual or, in the case of a pregnant woman, the health of the woman or her unborn child; (2) Serious impairment to bodily functions; or (3) Serious dysfunction of any bodily organ or part. Refer to [Medicare Managed Care Manual, Chapter 4, §20.2 – Definitions of Emergency and Urgently Needed Services.](#) (Accessed June 3, 2021)

Urgently Needed Services: Covered services that are not emergency services but are medically necessary and immediately required as a result of an unforeseen illness, injury or condition. Refer to [Medicare Managed Care Manual, Chapter 4, §20.2 – Definitions of Emergency and Urgently Needed Services.](#) (Accessed June 3, 2021)

Policy History/Revision Information

Date	Summary of Changes
06/14/2021	<p>Coverage Guidelines</p> <p><i>Services Provided by Indian Health Services (IHS)</i></p> <ul style="list-style-type: none"> • Added reference link to the <i>Medicare Claims Processing Manual, Chapter 19 – Indian Health Services</i> <p>Supporting Information</p> <ul style="list-style-type: none"> • Archived previous policy version MCS103.01

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The benefit information in this Coverage Summary is based on existing national coverage policy; however, Local Coverage Determinations (LCDs) may exist and compliance with these policies are required where applicable.

There are instances where this document may direct readers to a UnitedHealthcare Commercial Medical Policy, Medical Benefit Drug Policy, and/or Coverage Determination Guideline (CDG). In the absence of a Medicare National Coverage Determination (NCD), Local Coverage Determination (LCD), or other Medicare coverage guidance, CMS allows a Medicare Advantage Organization (MAO) to create its own coverage determinations, using objective evidence-based rationale relying on authoritative evidence ([Medicare IOM Pub. No. 100-16, Ch. 4, §90.5](#)).

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