Provider Brief – HFMA Webinar
Veterans Health Administration
VA Community Care

Cindy Heaton – Deputy Director, Claims Adjudication and Reimbursement
Benjamin Altose – Regional Officer R4 & R5 (Acting)

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Agenda

1. Consolidation Overview
2. Overview of VA Care in the Community (VACC)
3. Purchased Care Programs
4. Authorities for VHA to Reimburse for VACC
5. Process for Referral and Filing a Claim
6. VACC Claims Processing Timeliness
7. Process of Filing An Appeal
8. VISN 16 & VISN 17 and Region 3 & Region 4 Performance Metrics
9. Hot Topics
10. Veterans Choice/PC3
11. POCs
12. Questions
Consolidation Overview

- As a result of the Veterans Access, Choice, and Accountability Act of 2014 signed into law by President Obama on August 7, 2014, the authority to pay for hospital care, medical services, and other health care through community care providers was formally transferred to Chief Business Office on October 1, 2014.
- Consolidating is a legal requirement and is also the most impactful way to enhance Veteran service with the least amount of change for staff. For frontline staff, there was no change to duty station.
- A new regional supervisory structure has been implemented.
- Combining VACC into one organization is projected to enhance performance by streamlining and standardizing processes.

Overview of VACC

- Pre-authorized VACC is health care VA purchases for Veterans when services are not available at a VA facility
  - VACC is an augmentation of in-house capabilities and capacity
- Reasons VHA Purchases Care from Community Providers
  - Inability to access VA health care facilities
  - Demand exceeds VA health care facility capacity
  - Need for diagnostic support services for VA clinicians
  - Need for scarce specialty resources (e.g., obstetrics, hyperbaric, burn care, oncology) and/or when VA resources are not available due to constraints (e.g., staffing, space)
  - Ensure cost-effectiveness for VA (whereby outside procurement vs. maintaining and operating like services in VA facilities and/or infrequent use is more appropriate)
  - Satisfying patient wait-time requirements
- Emergency Unauthorized Service Connected/Non-Service Connected Care
Emergency Care

- When a Veteran seeks emergency care at a community facility, the community provider should contact the closest VA facility promptly (within 72 hours):
  - Notify VA of Veteran treatment/admission
  - Verify eligibility of Veteran for reimbursement of claim and identify the VA of jurisdiction to submit claims
  - Obtain instructions for transfer of VA patient to VA

Purchased Care Programs

- VHA Chief Business Office for Purchased Care (CBOPC) business line supports and augments the delivery of health care benefits through enterprise program management and oversight of Purchased Care services.

  - **Civilian Health And Medical Program of VA (CHAMPVA):** health benefits for spouse/dependents of certain Veterans
  - **Spina Bifida (SB):** health benefits to the children of Vietnam Veterans diagnosed with Spina Bifida
  - **Children of Women Vietnam Veterans (CWVV):** health benefits to children of female Vietnam Veterans when the children are diagnosed with a covered birth defect
  - **Caregiver Support Program:** Calculates and processes the stipend payments for eligible Primary Care Family Caregivers and Determines the Caregivers CHAMPVA eligibility
Purchased Care Programs

- **Foreign Medical Program (FMP):** health benefits for service connected Veterans residing or traveling overseas.
- **Camp Lejeune Family Member Program:** Veterans and their family members who served on active duty or resided at Camp Lejeune for 30 days or more between Jan. 1, 1957 and Dec. 31, 1987 may be eligible for medical care through VA for 15 specific contamination related health conditions.
- **VACC Program:** enterprise management of the purchase of health services when unavailable at VA facilities.
- **State Home Program:** partnership with State governments to provide long-term care to Veterans; managed by State governments with some financial assistance from VA.
- **The Veterans Choice Program:** a new program to provide improved access and meet the short-term health care needs of our Nation’s Veterans. This is a new, temporary benefit allowing some Veterans to receive health care in their communities rather than waiting for a VA appointment or traveling to a VA facility.

Authorities Governing the VACC Program

- **38 USC 1703:** The authority to pay for preauthorized inpatient and outpatient emergency, routine, and diagnostic medical care for certain veterans.
- **38 USC 1728:** The authority to pay for emergency care provided to service-connected veterans that was not preauthorized.
- **38 USC 1725:** The authority to pay for emergency community care provided to non-service connected veterans enrolled in VA health care.
- **38 USC 8153:** Provides the authority for a VA facility to enter into a contract or other form of agreement with VACC health care entities to secure health care services that are either unavailable or not cost-effective at the VA facility.

REGULATION SPECIFIC TO WOMEN VETERANS

- Women veterans are eligible for preauthorized hospital care for any condition under the Code of Federal Regulations (38 CFR) 17.52(a)(4).
Process for Referral and Filing a Claim

- Clinical Decision on Health Care Needs
- Treatment/Diagnostic Testing Available in VA vs. Community
- Consult Prepared
- Approved by Delegated Official
- Community Care Coordination Staff Prepares Authorization
- Patient Appointment Made with Community Provider
- Provider Submits Claim via EDI - with Return of Clinical Information for Inpatient, Emergency Room, Unauthorized, and Non-Service Connected Claims
- Health care claim paid

VA Care and Other Health Plans

- When VA purchases health care for a Veteran from the community – VA cannot share costs with any other health plan. 38CFR17.56e
  - Exception: VA may share costs for some emergency events partially covered by automobile liability coverage under PL 111-137
- VA is not authorized to reimburse emergency health care costs of non-service connected events of Veterans who have other Health Plans (Medicare, Medicaid, Tricare, etc.) or third party liability. 38CFR17.1002
- VA payment for authorized period of care is payment in full
- VA payment for emergent health care costs of non-service connected events is 70% of the Medicare allowable, and payment for the authorized period of care is payment in full, unless the provider returns the payment within 30 days of receipt
Reconsideration and Appeal Rights

What is a reconsideration request?
• If you receive an initial determination of denial and you disagree with the decision made, you may request reconsideration of the denial. An initial determination can be the Explanation of Benefits (EOB) or a letter denying benefits, commonly referred to as the Preliminary Fee Remittance Advice Report (PFRAR). An appeal can be initiated by the provider, Veteran, legal guardian on their behalf or a representative appointed in writing by the Veteran or provider. The reconsideration request should be submitted to the site which made the original determination.

• The reconsideration request must be:
  • Submitted within one year of the date of the initial determination, and in writing.
  • Identify why you believe the decision is in error.
  • Include new and relevant information not previously submitted.

• After reviewing the request for reconsideration and supporting documentation, NVC staff will send you a letter advising of the reconsideration decision.
• If the decision is upheld the reconsideration will become a formal appeal.

VACC Claims Processing Timeliness

• Continue to see tremendous growth in the volume of VACC claims since implementation of Accelerating Access to Care Initiative (ACI)

• VA made over 2.1 million authorizations for Veterans to receive care in the private sector. This represents a 45% increase in authorizations, when compared to the same period in the previous years.

• Claims processing timeliness is currently on an upward trend.
  — Nationally:
    • October 1, 2015: Total inventory was 1,739,983 with 72.30% current.
    • April 15, 2016: Total inventory is 1,612,596 with 78.57% current.

• For FY15, days to pay on average for Authorized Care is 30 and Unauthorized is 35
VETERANS HEALTH ADMINISTRATION

Regional Map

VISN 16 & VISN 17 Performance Improvement

October 1, 2015
V16 had 108,102 total claims and was at 90.5% current.
V17 had 143,024 total claims and was at 46.1% current.

April 15, 2016
V16 has reduced their inventory to 85,540 claims and is up to 95.9% current.
V17 has reduced their inventory to 88,394 claims and is up to 70.9% current.

Collectively that is a reduction of over 77,000 claims!
Regional Performance Improvement

**October 1, 2015**
R3 had 416,458 total claims and was at 68.4% current.  
R4 had 401,081 total claims and was at 70.2% current.

**April 15, 2016**
R3 has reduced their inventory to 325,168 claims and is up to 80.1% current.  
R4 has reduced their inventory to 351,353 claims and is up to 78.4% current.

Collectively that is a reduction of over 141,000 claims!

VACC Claims Processing Timeliness

- Update on CBOPC actions taken to improve timeliness:
  - Expanded use of overtime
  - Added Staffing
  - Expedited recruitments
  - Increased reliance on external support units and their resources
  - Established a “Command Center” and Dashboard to monitor claims status with much more detail
  - Increased system functionality to improve automated claims adjudication
Increased Efficiencies: Command Center

Hot Topics

- Receipt/mailing of Preliminary Fee Remittance Advice Reports (PFRARs)
  - Standard processes and expectations remain in place to include daily receipt, scanning and mailing of correspondence
  - Emergency system patch is currently in testing to increase PFRAR generation, tracking and delivery

- Processing of claims prior to records being scanned and indexed
  - Implementation of a 14 day hold policy (1725/1728) and queue micromanagement to prevent premature adjudication.

- Reviewing numbers/rejecting claims
  - Increased auditing established to detect and review adjudication decisions of all claims processors.

- EDI 45 day hold
  - Extending to a 90 day hold. Patch release scheduled for July 2016.

- Prompt Pay Act
  - October 2015: all preauthorized VACC, including individual authorizations, is subject to the PPA with the exception of intergovernmental and provider agreements
Veterans Choice Program (VCP) Overview

• The Department of Veterans Affairs strives to ensure quality, timely care for all Veterans.

• In an effort to increase Veterans’ access to health care, VA implemented the Veterans Choice Program (VCP) – a program that allows eligible Veterans to use approved health care providers outside of the VA network.

• The Veterans Choice Program was implemented as part of the Veterans Access, Choice, and Accountability Act of 2014 (VACAA).

Veteran Eligibility

A Veteran must be enrolled in the VA health care system and must meet at least one of the following criteria:

✓ A Veteran is told by their local VA medical facility that they will not be able to schedule an appointment for care either:
  o Within 30 days of the date the Veteran wants to be seen, or
  o Within 30 days of the date the Veteran's provider determines they need to be seen, or
  o By the date the Veteran's provider determines they need to be seen, if that date is less than 30 days away.

✓ The Veteran's home is more than 40 miles driving distance from the closest VA medical facility.

✓ The Veteran needs to travel by plane or boat to the VA medical facility closest to your home.

✓ The Veteran faces an unusual or excessive burden in traveling to the closest VA medical facility based on geographic challenges, environmental factors, or a medical condition. Staff at your local VA medical facility will work with you to determine you are eligible for any of these reasons.
Patient-Centered Community Care (PC3) and/or VCP Network of Providers

- Providers in VISN 16 and VISN 17 fall under Tri-West.
- All PC3 providers are automatically eligible to participate in the VCP
  - If a provider is interested in becoming a PC3 provider, they must establish a contract with Health Net
- If a provider is not interested in becoming a PC3 provider, but wants to become a VCP provider, they must establish a provider agreement with Health Net
  - Provider must accept Medicare rates
  - Meet all Medicare Conditions of Participation and Conditions for Coverage
  - Be in compliance with all applicable federal and state regulatory requirements
  - Have a full, current, and unrestricted license in the state where the service(s) are delivered
  - Have same or similar credentials as VA staff
  - Any provider on the Centers for Medicare and Medicaid Services (CMS) exclusionary list are prohibited from network participation

Other Health Insurance and VA Copayments

- For all service-connected care, VA is the primary payer and a Veteran would have no out-of-pocket costs
- If the care is non-service-connected and the Veteran has other health insurance (excluding government health benefit plans, i.e. Medicaid, Medicare, TRICARE, etc.) the provider will bill the other insurance.
  - If the Veteran’s other health insurance requires a copayment or cost share, the Veteran may have to pay it at the visit if the provider requires it
- VA 1st party copayments will be determined by VA after the services are provided and Veterans should not pay a VA copayment at the time of their visit
Contact Information for TriWest

- Provider Customer Service Number: **1-866-284-3743**
- Hours: 8:00am – 10:00pm, EST Monday through Friday, excluding Federal Holidays
- Email: TriWestDirectContracting@triwest.com
- Website: joinournetwork.triwest.com/

Contact Information for Health Net

- Provider Customer Service Number: **1-866-606-8198**
- Hours: 6:00am – 7:00pm, EST Monday through Friday, excluding Federal Holidays
- Email: HNFSProviderRelations@Healthnet.com
- Website: www.hnfs.com
**Additional Information**

In addition to the Choice Program call center (866-284-3743), if you have a question about the Choice Program, there are a number of places where you can get more information!

- Visit [www.va.gov/opa/choiceact](http://www.va.gov/opa/choiceact) - You can visit the “For Provides” tab for additional information.
- Reach out to the local Choice Champion.
  - Choice Champions are designated persons of contact who have the most up-to-date information on the VCP and can assist program inquiries from Veterans.
  - Each VA Medical Center has a designated primary and alternate Choice Champion.

**Point of Contacts**

- Joe Enderle: Director, Chief Business Office Purchased Care, Operations – (303) 370-5088 – [Joseph.Enderle@va.gov](mailto:Joseph.Enderle@va.gov)
- Cindy Heaton: Deputy Director, Operations – (406) 461-5971 – [Cindy.Heaton@va.gov](mailto:Cindy.Heaton@va.gov)
- Benjamin Altose: VACC Regional Officer – Region 4 – (216) 701-7944 – [Benjamin.Altose@va.gov](mailto:Benjamin.Altose@va.gov)
- Provider Relations email group: [Provider.Response@va.gov](mailto:Provider.Response@va.gov)
Resources

• Chief Business Office Purchased Care Website: http://www.va.gov/purchasedcare/
  • Provider Fact Sheets and Guidebooks can be located at http://www.va.gov/PURCHASEDCARE/programs/providerinfo/provider_info_nvc.asp

• Veterans Choice Program Website: http://www.va.gov/opa/choiceact/
  – For more information on how to become a Choice Program and/or Patient-Centered Community Care (PC3) provider: http://www.va.gov/PURCHASEDCARE/programs/veterans/nonvacare/pccc/index.asp

Questions
Background Information

Medical services that are necessary on an emergency basis should be reported as soon as possible (within 72 hours) of treating the Veteran. Please submit notification of emergent medical care to the nearest VA Healthcare Facility (VA HCF) by phone or fax. The information provided will enable VA to determine Veteran eligibility and the appropriate payment authority. Veterans are reminded that they should go to the nearest emergency room if they are experiencing an injury or illness that threatens their life or health and requires immediate treatment.

Once VA has received all relevant documentation, they will determine what charges are eligible to be paid based on the individual Veteran’s specific circumstances and eligibility. Claims for emergency services are reviewed and verified by the VA prior to payment. Please notify your local VA HCF regarding the need for emergency medical services. The claims and the emergency department report should contain sufficient information to enable the VA review to:

- Properly identify the Veteran
- Confirm the need for the emergency treatment
- Determine the condition treated and medical necessity of the treatment rendered
- Determine whether the Veteran could have been discharged, transferred to the local VA HCF, or needed to remain at the community hospital

Visit the website, www.nonvacare.va.gov, to view information on the various Purchased Care Programs as well as information on how to file claims with VA.

Emergency Medical Services

Contact Information:
Please visit www.va.gov/directory to find the nearest VA HCF.

When VA is notified about emergency care for a Veteran they will request the following information (at a minimum):
- Patient name, ID, demographics
- Hospital ID, name, address
- Hospital point of contact
- Provider name and NPI
- Patient chief complaint
- Clinical presentation of patient
- Stabilization for transfer
- Care coordination information

Claims Process for Emergency Care:

- Veteran receives emergency medical care
- Veteran notifies local VA HCF of medical emergency within 72 hours
- “Veteran is transferred to a VA facility”
- Veteran remains at community hospital
- Claim is submitted
- VA determines Veteran eligibility and claim payment authority
- Veteran discharged
- Claim is denied
- Claim is paid
What is a Preliminary Fee Remittance Advice Report (PFRAR)

As the VA claims examiners process claims for payment, rejection, or denial, the claims system automatically builds customized, vendor-specific correspondence, or the PFRAR. The PFRAR is patterned after the standard Medicare Remittance Advice Report. The document supplies claim data to identify claim dates and services, reasons for disapproval and/or payment amounts. The PFRAR is designed to allow display of multiple claims and their respective disposition data on each page. Additionally, a Veteran-specific letter with claim specific information is created for the patients.

On the following page you will find two examples of a PFRAR. The first is an example of a PFRAR generated in response to a claim submitted on a CMS-1500 form. Charges submitted on the CMS-1500 form are generally associated with outpatient care, professional services, or ancillary services for inpatient care.

The second image is a sample of a PFRAR generated in response to a claim submitted on a UB. The UB is the official HCFA/CMS form used by hospitals and health care centers when submitting bills to Medicare and other 3rd-party payers for reimbursement for health services provided to patients for: inpatient care, dialysis, emergency room care, etc.

How to Read Preliminary Fee Remittance Advice Report –

- Patient identification information.
- Claim information.
- Totals to be paid by VA for claims listed on this PFRAR.
- Explanation of claim adjustment codes used by VA that are particular to this claim.

Legend:
- Total for Facility
- Grand
- Payment by VA constitutes payment in full. The Veteran may not be billed for any services covered by VA's authorization.
# How to Read Preliminary Fee Remittance Advice Report – UB04

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<th>Description</th>
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<td>Information on file for your office. Please make sure this information is correct and current.</td>
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<td>Patient identification information</td>
<td>The patient identification information is used for billing purposes. It includes the patient's name, address, and other identifying details.</td>
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<tr>
<td>Claim information</td>
<td>The claim information includes the provider's name, address, and the services provided.</td>
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<tr>
<td>Claim adjustment codes</td>
<td>Claim adjustment codes are used to adjust the claim amount based on specific conditions or circumstances.</td>
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<tr>
<td>Total to be paid by VA</td>
<td>The total amount to be paid by the VA is listed, which is the amount the VA will pay for the services billed by the provider.</td>
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### Preliminary Fee Remittance Advice Report

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**Payment to VA:**

- The veteran was not treated for a service-connected disability or a condition that is similarly ranked by VA.

**Diagnosis Codes:**

- **E0100**: The diagnosis is a service-connected disability.
- **E0200**: The claimant is a veteran who is eligible for benefits.
- **E0300**: The claimant is a veteran who is not eligible for benefits.
- **E0400**: The claimant is a non-veteran who is eligible for benefits.
- **E0500**: The claimant is a non-veteran who is not eligible for benefits.

**Explanation of adjustment codes used by VA:**

- **E0100**: A service-connected disability.
- **E0200**: Eligible veteran.
- **E0300**: Non-veteran, eligible for benefits.
- **E0400**: Non-veteran, not eligible for benefits.
- **E0500**: Non-service-connected disability.