VA Choice/Non-VA Care

Felissa Koernig
Assistant Director
Charleston VA Medical Center

Sharon Holloman
Chief, Purchased Care
Consolidated Business Office, VISN 7
1. Overview of VA Community Care (VACC) Today

2. VACC Claims and Payment Today

3. Claims Processing Hot Topics and Updates

4. Questions
Overview of VA Community Care (VACC) Today
## Legislation Supporting VACC

Several legal authorities and laws exist to pay for VA Community Care.

<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>&quot;Authorized&quot;</td>
<td>&quot;Unauthorized&quot;</td>
</tr>
</tbody>
</table>

### Contracts for hospital care and medical services in non-Department facilities
- Inpatient and outpatient medical services on a preauthorized basis by contract or individual authorization
- Preauthorized claims must be submitted within 6 years of treatment date
- Reimbursement for emergency treatment furnished to service-connected Veterans
- Unauthorized claims must be submitted within 2 years of treatment date

### Reimbursement of certain medical expenses

### Reimbursement for emergency treatment

### Reimbursement for emergency treatment of non-service connected conditions
- Mill Bill claims must be submitted within 90 days of treatment date

### Care for newborn children of women Veterans receiving maternity care
- Claims filing deadline is 6 years

### Public Law 113-146 “Choice Act”
- Reimbursement for preauthorized medical services furnished to eligible Veterans
- Claims must be submitted within 120 days of treatment date

### Reimbursement for Veterans who are eligible for the Veterans Choice Program

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In all cases, VA must be notified of admission/treatment within 72 hours.
# Veterans Choice Program

## Eligibility, What’s Not Covered, What Is, Eligible Providers, TPA

<table>
<thead>
<tr>
<th>Distance, &amp; Specialty Care</th>
<th>Not Covered</th>
<th>What Is Covered</th>
<th>HealthNet</th>
<th>Eligible Providers</th>
</tr>
</thead>
</table>
| • Geoburden/hardship for Veterans requiring specific services, certain medical conditions  
• Veteran seeking other care, and care is not offered by VA facility  
• This rule is changing in the near future  
• Access not available in VA within 30 days | • Long term care services  
• Dialysis  
• Emergent Care  
• Durable Medical Equipment  
• Routine prescriptions | • Outpatient services  
• Homemaker Home Health Aid, Respite, Skilled Home Services  
• Inpatient services with appropriate notification  
• Dental based on Veteran eligibility | • HealthNet (HN) is our Third Party Administrator (TPA)  
• HN works with VA/Veteran and community providers to appoint Veterans who opt into Choice  
• If unable to appoint timely, VA schedules using Provider Agreements | • Community providers who sign up with HealthNet or a Provider Agreement with VA to furnish care, must be a Medicare participant  
• Possess similar credentials to VA providers  
• Agree to accept rates as outlined in Choice Act |

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For questions related to eligibility, services, authorizations, etc., please refer to contact numbers at the end of the presentation.
Across the legislation supporting VACC, there are four primary VA Community Care programs through which community providers receive authorizations from either VA or one of VA’s third-party contractors to provide health care to Veteran patients.

<table>
<thead>
<tr>
<th>VA Community Care Programs</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Veterans Choice Program (VCP)</td>
<td>The Veterans Choice Program provides primary, hospital, and outpatient medical services through eligible non-VA health care providers to eligible Veterans due to:</td>
</tr>
</tbody>
</table>
|                                                  | • Unavailable specialist  
• Wait time reduction  
• Travel ≥ 40 miles  
• Unusual travel burdens |
| VCP Provider Agreements                          | VCP Provider Agreements allow VA to partner directly with local community care providers in two circumstances:  |
|                                                  | • VCP contractors are unable to schedule  
• Specific services are not offered by contractors |
| Patient-Centered Community Care (PC3)           | PC3 is a VA nationwide program that provides Veterans access to medical care when local VA medical facilities cannot due to:  |
|                                                  | • Unavailable specialist  
• Wait time reduction  
• Geographic inaccessibility or other factors |
| Traditional VA Community Care                    | Traditional Community Care entails individual authorizations issued by local VA Health Care facilities to providers in the community. Individual authorizations are typically issued for authorized emergency care. |

Authorizations give community providers the authority to provide health care to Veterans and provides assurance of payment for those services.
Provider Agreements were established to provide facilities a scheduling alternative when HealthNet is unable to appoint Veterans timely while allowing VA’s to still utilize Choice fund.

Basically, a Provider Agreement is an agreement between the community provider and the VA in which the provider agrees to provide a service, and the VA agrees to pay based on Medicare rates.

The Choice/Provider Agreement budget for FY17 has now increased to $88 million.

If your facility is interested in participating in the Choice Program under a Provider Agreement, please contact the VACC Customer Service number at the end of the presentation for information and assistance.
## Non-VA Payment Methodologies

<table>
<thead>
<tr>
<th>Type of Service</th>
<th>Emergency care for Service Connected (SC) conditions (when no contract exists)</th>
<th>Emergency care for Non-Service Connected (NSC) conditions and NSC Veterans (when no contract exists)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Veterans Choice Program (VCP)</strong></td>
<td>No provision for payment unless care is preauthorized</td>
<td>No provision for payment</td>
</tr>
<tr>
<td></td>
<td>VCP retroactive authorizations are not permitted</td>
<td></td>
</tr>
<tr>
<td></td>
<td>(For preauthorized care, payment is the contracted percent of the Medicare rate. If no Medicare rate exists, payment is the VA Fee Schedule.)</td>
<td></td>
</tr>
<tr>
<td><strong>Physician and Non-Physician Professional Charges</strong></td>
<td>Pay Lesser of:</td>
<td>Pay Lesser of:</td>
</tr>
<tr>
<td></td>
<td>1) Medicare Physician Fee Schedule (MPFS) rate; or</td>
<td>1) 70% of MPFS rate; or</td>
</tr>
<tr>
<td></td>
<td>2) The amount the community provider bills the general public for the same service, i.e. – billed charges</td>
<td>2) The amount the community provider bills the general public for the same service; i.e. – billed charges</td>
</tr>
<tr>
<td></td>
<td>Note: Services provided in Alaska are paid using the Alaska Fee Schedule</td>
<td>Note: Services provided in Alaska are paid using the Alaska Fee Schedule</td>
</tr>
<tr>
<td></td>
<td>When NO MPFS rate exists, payment is the lesser of:</td>
<td>When NO MPFS rate exists, payment is:</td>
</tr>
<tr>
<td></td>
<td>1) Local VA Fee Schedule: or</td>
<td>Amount the Veteran is personally liable (usually billed charges)</td>
</tr>
<tr>
<td></td>
<td>2) The amount the community provider bills the general public for the same service, i.e. – billed charges</td>
<td></td>
</tr>
</tbody>
</table>
# Non-VA Payment Methodologies

<table>
<thead>
<tr>
<th>Type of Service</th>
<th>Emergency care for Service Connected (SC) conditions (when no contract exists)</th>
<th>Emergency care for Non-Service Connected (NSC) conditions and NSC Veterans (when no contract exists)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>OUTPATIENT</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Outpatient Facility</td>
<td>Pay Lesser of: 1) Medicare rate; or 2) The amount the community provider bills the general public for the same service; i.e.- billed charges</td>
<td>Pay Lesser of: 1) 70% of Medicare rate; or 2) Amount the Veteran is personally liable (usually billed charges)</td>
</tr>
<tr>
<td></td>
<td>When NO Medicare rate exists, or the provider is Medicare exempt, pay the lesser of: 1) Local VA Fee Schedule; or 2) The amount the community provider bills the general public for the same service; i.e.- billed charges</td>
<td>When NO Medicare rate exists, payment is: Amount the Veteran is personally liable (usually billed charges)</td>
</tr>
<tr>
<td><strong>INPATIENT</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Acute Inpatient Facilities paid under CMS IPPS</td>
<td>Pay: 1) MS-DRG amount</td>
<td>Pay Lesser of: 1) 70% of Medicare rate; or 2) Amount the Veteran is personally liable (usually billed charges)</td>
</tr>
<tr>
<td>Facilities exempt from payment under CMS IPPS</td>
<td>Pay: 1) VA cost-to-charge rate (48.3%)</td>
<td>Pay: 1) Amount the Veteran is personally liable (usually billed charges)</td>
</tr>
</tbody>
</table>
Emergency Care

• Emergency Care is handled differently than routine care furnished through one of the VA Community Care programs.

• Urgent/emergent hospital admissions should be reported to the nearest VA within 24 hours when possible; notification should not exceed 72 hours.

• Should the Veteran require a higher level of care that cannot be provided at the current non-VA facility, VA must be notified to facilitate admission to a VA Medical Center or to authorize the transfer to a second non-VA facility.

• If the VA has capacity and provides the appropriate level of service, a transfer to the VA hospital will be facilitated when the patient is stable to transfer.

• If the patient refuses transfer, VA payment will cease and the Veteran will be liable for additional physician and facility charges.

Providers are expected to verify Veteran eligibility for reimbursement of claims and identify the VA of jurisdiction for claims submission.
Claim filings for VCP and PC3 are routed through Health Net and TriWest, with contractor coverage separated by region.

### Where to File the Claim

<table>
<thead>
<tr>
<th>HealthNet</th>
<th>TriWest</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Payer Name:</strong> Health Net – VA Patient-Centered Community Care. <strong>Payer ID:</strong> (68021)</td>
<td>Step 2: Set up an EDI to submit electronic claims by calling Wisconsin Physicians Service (WPS) at 1-800-782-2680 and select Option 2 to register.</td>
</tr>
</tbody>
</table>

### Where to Mail a Claim

<table>
<thead>
<tr>
<th>Health Net</th>
<th>TriWest</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Veterans Choice Program – VACAA</strong></td>
<td><strong>Veterans Choice Program and PC3</strong></td>
</tr>
<tr>
<td>PO Box 2748 Virginia Beach, VA 23450</td>
<td>WPS-VAPC3 PO Box 981646 El Paso, TX 79998-1646</td>
</tr>
<tr>
<td><strong>Patient-Centered Community Care (PC3)</strong></td>
<td><strong>Note:</strong> Must use form CMS 1500 or UB04.</td>
</tr>
<tr>
<td>PO Box 9110 Virginia Beach, VA 23452</td>
<td></td>
</tr>
</tbody>
</table>

### For Detailed Instructions

<table>
<thead>
<tr>
<th>Health Net</th>
<th>TriWest</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Call</strong> 1-866-606-8198 <strong>Open</strong> 6:00am–7:00pm EST, Monday through Friday, excluding federal holidays</td>
<td><strong>Call</strong> 1-855-722-2838 <strong>Open</strong> 8:00am–10:00pm EST, Monday through Friday, excluding federal holidays</td>
</tr>
<tr>
<td><strong>OR</strong></td>
<td><strong>OR</strong></td>
</tr>
<tr>
<td>Visit <a href="#">Health Net claims submission provider page</a></td>
<td>Visit <a href="#">TriWest Claims and Reimbursement Quick Reference Guide</a></td>
</tr>
</tbody>
</table>
Claim Filing Instructions – Non VCP/PC3

Claim filings for Traditional VA Community Care and VCP Provider Agreements follow a specific process that differs from claims that are authorized through VCP or PC3.

**Where to File a Claim**


While registering you will need the VA Fee Program payer IDs which include:
- 12115 for submission of medical claims
- 12116 for submission of dental claims
- 00231 for submission of any inquiry transaction

**Where to Mail a Claim**

Submitting claims electronically may help community providers receive payment faster and reduce administrative costs.

If you are unable to file a claim electronically, please complete the appropriate form (original CMS 1500 and/or CMS 1450 (UB-04)) and provide the codes for the treatment rendered just as you would when completing a Medicare claim. Contact the facility indicated in the authorization for further instruction on where to mail paper submissions.

**For Detailed Instructions**

For information on authorizations, call the number indicated on your authorization letter/form.

OR


**Contact Information**

Contact local office. 334.725.2940
Electronic Claims

VA accepts and encourages electronic health care claims (i.e., EDI claims) that satisfy criteria established in the Health Insurance Portability and Accountability Act of 1996 (HIPAA), and claims will go through different clearinghouses depending on the VACC program for which care is authorized.

VCP/PC3 Claims

- VA contracts with Health Net and TriWest for claims adjudication, and the Choice Act requires both contractors to transmit all claims submitted by providers to VA via EDI

- Community providers must register with the Health Net and/or TriWest clearinghouse services to submit EDI claims to the contractors as outlined in the formal claim filing instructions for VCP and PC3

Non VCP/PC3 Claims

- VA contracts with Emdeon to provide clearinghouse services for electronic health care claims

- To register or submit an EDI claim to a local VA health care facility, please call 1-800-845-6592 or visit http://www.emdeon.com/payerlists/

- While registering, providers will need the VA Fee Program payer IDs which include:
  - 12115 for submission of medical claims
  - 12116 for submission of dental claims
  - 00231 for submission of any inquiry transaction
Paper Claims

• While electronic health care claims expedite payment to community providers, VA also allows providers to submit paper claims if EDI is not an option.

Non VCP/PC3 Claims

• Complete the appropriate form

• Provide the codes or the treatment rendered just as you would when completing a Medicare claim

• Submit the claim to the Fee Office of the VA facility that issued the authorization
Claims Processing Hot Topics and Updates
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
- 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 – To Be Determined
- Prompt Pay Act (PPA)
- October 2015: all preauthorized VACC, including individual authorizations, is subject to the PPA with the exception of intergovernmental and provider agreements
Emergency Services and PFRAR
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.nonvacute.va.gov](http://www.nonvacute.va.gov), to view information on the various Purchased Care Programs as well as information on how to file claims with VA.
How to Read Preliminary Fee Remittance Advice Report – CMS-1500

VA facility that processed the claim. All claims and questions should be directed to this location.

Information on file for your office. Please make sure this information is correct and current.

Patient identification information.

Claim information.

Total 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.

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**Initial Fee Remittance Advice Report**

Date: 2/6/2013

**Facility:** BUTLER

**Patient:** VACCK PATIENT

**SSN (last 4 digits):** ####

**Program:** Authorized

**Claim ID:** ####

**Claim Adj Codes:**

<table>
<thead>
<tr>
<th>DOS</th>
<th>POS</th>
<th>CPT</th>
<th>Diags</th>
<th>QTY</th>
<th>Billed</th>
<th>Paid</th>
</tr>
</thead>
<tbody>
<tr>
<td>10/31/2012</td>
<td>22</td>
<td>99214</td>
<td>722.83, 724.2, V45.89</td>
<td>1</td>
<td>135.00</td>
<td>$74.77</td>
</tr>
</tbody>
</table>

Claim Totals:

- **Total to be paid by VA:** $135.00
- **Paid:** $74.77

**Totals for Facility BUTLER**

- **Grand Total:**
  - **Total to be paid by VA:** $135.00
  - **Paid:** $74.77

Payment by VA constitutes payment in full. The veteran may not be billed for any services covered by VA’s authorization.

**Legend**
How to Read Preliminary Fee Remittance Advice Report – UB04

VA facility that processed the claim. All claims and questions should be directed to this location.

Information on file for your office. Please make sure this information is correct and current.

Patient identification information.

Claim information.

Claim adjustment codes.

Total 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:
- CR-10 = The Veteran was not treated for a service-connected disability or a condition to be adjunct to a service-connected disability.
- CR-161 = Our records indicate the veteran has other insurance.

CE-CW7001 = (50)(MN-LCD) Procedure is not medically necessary based on the primary diagnosis code selected. Procedure - 33880

CE-CW0001 = (50)(MN-LCD) Procedure is not medically necessary based on the primary diagnosis code selected. Procedure - 99065

CE-CW7001 = (50)(MN-NCD) Procedure is not medically necessary based on the primary diagnosis code selected. Procedure - 85610

CE-CW7001 = (50)(MN-NCD) Procedure is not medically necessary based on the primary diagnosis code selected. Procedure - 85730
Other Health Insurance (OHI) and Service Connected and Special Authority
What is OHI?

Some Veterans have Other Health Insurance (OHI) in addition to their health care coverage at VA. OHI is a contract between a policyholder and a third party payer to reimburse all or a portion of the cost of treatment or care.

Typical Covered Benefits

• Hospital care
• Surgical fees
• Physicians’ services
• Catastrophic coverage
• Preventive care
• Dental
• Disability income
• Long-term care
• Home health care

Typical OHI Sources

• Private Insurance
  • Commercial insurance policies purchased by an individual or provided through an employer

• Public Insurance
  • Medicare
  • Medicaid

• Government Plans
  • TRICARE
  • CHAMPVA

Each type of OHI has its own policies and procedures for coverage hierarchy, and Veteran OHI policies are unique with varying levels of benefits.
VA Care and Other Health Plans

- **VA has specific guidance about paying for care in coordination with other payers.**
- When VA purchases health care for a Veteran from the community, VA cannot share costs with any other health plan (as an 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 for Veterans who have other health insurance (e.g., Medicare, Medicaid, Tricare, etc.) or third party liability
- VA payment for any authorized period of care is considered payment in full
- VA payment for emergent health care costs of non-service connected events is 70% of the Medicare allowable amount, and payment for the authorized period of care is considered payment in full, unless the provider returns the payment within 30 days of receipt
- Inpatient Prospective Payment System (IPPS) exempt facilities are paid at the Cost to Charge ratio, which is 48% of billed charges
Most types of private insurance are billable for VCP, while public insurance and government plans are generally considered non-billable.

<table>
<thead>
<tr>
<th>COB – Coordination of Benefits</th>
<th>Primary Insurance</th>
<th>Secondary Insurance</th>
<th>Considered Billable</th>
</tr>
</thead>
<tbody>
<tr>
<td>Care</td>
<td></td>
<td>Commercial policy or Medigap</td>
<td>No – VA Primary payer</td>
</tr>
<tr>
<td>Commercial Policy</td>
<td></td>
<td>Medicare</td>
<td>Yes – OHI primary payer</td>
</tr>
<tr>
<td>Spouse’s Commercial Policy</td>
<td></td>
<td>Medicare</td>
<td>Yes – OHI primary payer</td>
</tr>
<tr>
<td>Medicare Advantage</td>
<td>n/a</td>
<td></td>
<td>No – VA Primary payer</td>
</tr>
<tr>
<td>HMO</td>
<td>n/a</td>
<td></td>
<td>Yes – VA Primary payer</td>
</tr>
<tr>
<td>Special Class</td>
<td>n/a</td>
<td></td>
<td>Conditional</td>
</tr>
<tr>
<td>TRICARE</td>
<td>n/a</td>
<td></td>
<td>No</td>
</tr>
<tr>
<td>Regional Counsel</td>
<td>n/a</td>
<td></td>
<td>No – VA Primary payer</td>
</tr>
<tr>
<td>Medicaid</td>
<td>n/a</td>
<td></td>
<td>No – VA Primary payer</td>
</tr>
<tr>
<td>Pharmacy</td>
<td>n/a</td>
<td></td>
<td>No – VA Primary payer</td>
</tr>
<tr>
<td>Mental Health</td>
<td>n/a</td>
<td></td>
<td>Conditional</td>
</tr>
</tbody>
</table>

To determine if a Veteran’s OHI is billable, VA conducts an assessment to review the various OHI policies that may be active.
Contacts
For additional questions, the following contacts can respond to your questions:

- RHJ VAMC Community Care Customer Service (843) 789-6763
- HealthNet (866) 606-8198, select option #2 (for vendors and providers)
- Elene’ Kelleher, Chief Community Care, RHJ VAMC (843) 789-7425
- Kim Way, RN Choice Navigator (843) 371-4275
- Daniel Yzaguirre, RN Choice Navigator (843) 806-9688
- VACC Claims Customer Service (843) 789-7840
- David Neumayer, Veterans Integrated Service Network 7 VACC Manager (843) 789-7831