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complex claims revenue solutions

MAPAM
Massachusetts Association of Patient Account Management
An affiliate of
AAHAM
American Association of Healthcare Administrative Management

Working with the VA:

Expectations, Updates, and Appeals

October 24th, 2022

Who We Are

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Folds of Honor

- A nonprofit organization dedicated to providing educational scholarships to families of soldiers wounded or killed while on active duty in the US military
- More than 29,000 scholarships have been awarded totaling over $145 million since 2007

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Company Overview

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complex claims revenue solutions

Comprehensive Suite of Reimbursement Solutions

- Workers' Compensation
- Veterans Administration
- Motor Vehicle Accident/TPL
- Out-of-State Medicaid
- A/R Resolution Services
- Denials Prevention and Resolution
- Denials "SafetyNet" All Payers
- Zero Balance Review

Solutions Across Reimbursement Lifecycle

Team of revenue specialists dedicated solely to your facility to ensure each claim is sent to the correct payer, the first time, for the maximum allowed reimbursement

Claims designated as zero balance are reviewed for underpayment and appealed for correct payment

Revenue specialists and litigators manage aged accounts once placed with us. Claims are analyzed, resubmitted and if necessary, appealed on behalf of your facility.

Specifically focused on situations where organization is presented with a prompt pay request by a payer to assure proper payment.

Agenda

1. Historical Review of the Department of Veteran Affairs
2. The 21st Century: A New Culture Shift
3. The MISSION Act
4. The Modernization of the VA
5. VA Pain Points: Authorization, Denials, Reimbursement, and Appeals
6. Wolfe Cases (#18-6091 and #2020-1958)
7. Questions

History of the Dept. of Veteran Affairs

- From World War II to 1988, the Department of Veteran Affairs operated as an independent government agency.
  - Over the course of six decades, the VA grew in both scope and size.
    - GI Bill, Health Insurance, and Nursing Homes
- The Department of Veterans Affairs Act of 1988
  - Promoted the VA to a cabinet level position. It also broke down the VA into three separate parts
    - **Veterans Health Administration**
    - **Veterans Benefits Administration**
    - **National Cemetery Administration**
- The Department has not substantially changed since 1988

The 21st Century – Present Day Dept.

Department of Veterans Affairs

- Secretary of Veterans Affairs – Denis McDonough
  - The Department has three central responsibilities
    1. **Veterans Benefits Administration**
       - Veteran registration, eligibility determination, and the five business lines: Home Loan, Insurance, Vocational Rehab, GI Bill, and Pension.
    2. **National Cemetery Administration**
       - Responsible for memorial benefits and Veteran cemeteries.
    3. **Veterans Health Administration (the VA)**
       - Providing health care in all forms, biomedical research, and healthcare network maintenance.

The 21st Century – Claims Process

❖ Original Claim Processing

- Authorization / Non-Authorized
- Claim sent to VA Fee Basis
- Manually, the VA Fee Basis would go through the following three steps:
  1) Is the Patient a Veteran?
     - Stolen Valor / Registered Veteran / Expired Veteran
  2) Is the Patient's Injury related to Service?
     - Service Related (Full Medicare) or Non-Service Related (Millennium Bill [75th Percentile of Medicare])
  3) Is the Patient's claim authorized correctly?
     - Claim procedures, stay, correct individual.
- If the claim met a certain dollar threshold, the claim then went to Washington D.C. for confirmation scoring.
- Once the VA made a determination, they would either approve or deny the claim.
  - This entire process was manual with minimal technological impact as there was only one A/R system in existence (VistA). VistA is a 1970's system that has been franken-upgraded for the past five decades.
- VA payment came from the Department of Treasury.
- VA denial comes from the local with limited Appeal rights.

The 21st Century – PC3 Program

- PC3 Claim Processing – Veterans Choice Program / 2014

  - Eligibility
    - Most near VA Medical Center (VAMC) or Community Based Outpatient Clinic (CBOC) with a full-time Primary Care Manager is greater than 40 miles from their home, or
    - They are, or will be, on a wait list of 30 days or more with a VAMC, or
    - Services are not available at VAMC, or
    - The closet VAMC is not easily accessible from their home or there are significant geographic barriers.
  - Authorization (Two Paths)
    1. Veteran calls TriWest to confirm VCP eligibility (**40-mile exception**) OR VA sends a referral to TriWest (**PC3, Choice First, or 30-Day exceptions**),
    2. PSR locates VCP / PC3 Provider,
    3. PSR makes appointment on behalf of Veteran, and
    4. TriWest sends authorization to provider via Fax.
  - Claim Submission
    - Claim (UB, Itemized Statement, and Medical Records) go to TriWest within 180 days of date of discharge. Medical records can trail a UB / Itemized Statement by 30 days (no less and the claim is denied).
  - Claim Processed within 30 days remitting payment or denial.
  - Appeal Right – 90 Days from date of denial, not date of receipt of denial.

The MISSION Act

- On May 23, 2018, the Senate passed an act introduced by Senators McCain, Akaka, and Johnson. The Act was the **M**aintaining **I**nternal **S**ystems and **S**trengthening **I**ntegrated **O**utside **N**etworks Act, also known as the MISSION Act, in response to the VA scandals throughout the decade. The Act became active on June 6, 2019.
- What changed on June 6, 2019?
  - Established the Veterans Community Care Program, which has different eligibility criteria for Veterans so they have an "easier" time of going out of network.
    - This was meant to allow Veterans another remedy to receive treatment that the VA could not provide in a timely manner or they lack the resources to provide.
    - Eligibility criteria significantly changed.
  - Terminated the Veteran's Choice Program, which exhausted the VA's resources in adjudicating.

The MISSION Act – Veteran Eligibility

- How veteran eligibility changed under the MISSION Act:
  - The Veteran, in order for the VA to furnish care, must meet at least one of more of the conditions listed below;
    - A. The covered veteran required hospital care, medical services, or extended care services and:
      1. No VA facility offers the care, services, or extended services the veteran requires, OR
      2. The VA does not operate a medical facility in the State in which the veteran resides, OR
      3. The veteran was eligible to receive care under the VACA Act of 2014, OR
      4. The veteran has contacted an authorized VA official to request the care required, but the VA has determined that they cannot furnish it, OR
      5. **The veteran and their referring clinician determined it is in the best medical interest of the veteran, to access care or services from an eligible entity based on the following factors:**
         - a. Distance, Nature, Frequency, Timeliness, Improved Continuity of Care, Quality of Care, or if the Veteran faces an unusual burden:
           - i. Excessive driving distance, Whether care at the VA is reasonably accessible, Whether a medical condition of the veteran affects the ability to travel, Whether there is a compelling reason the veteran needs to receive care and services from a non-VA facility, The need for an attendant, and The VA facility would not furnish the type of care that meets the VA quality standards.

The MISSION Act – Claims Submission

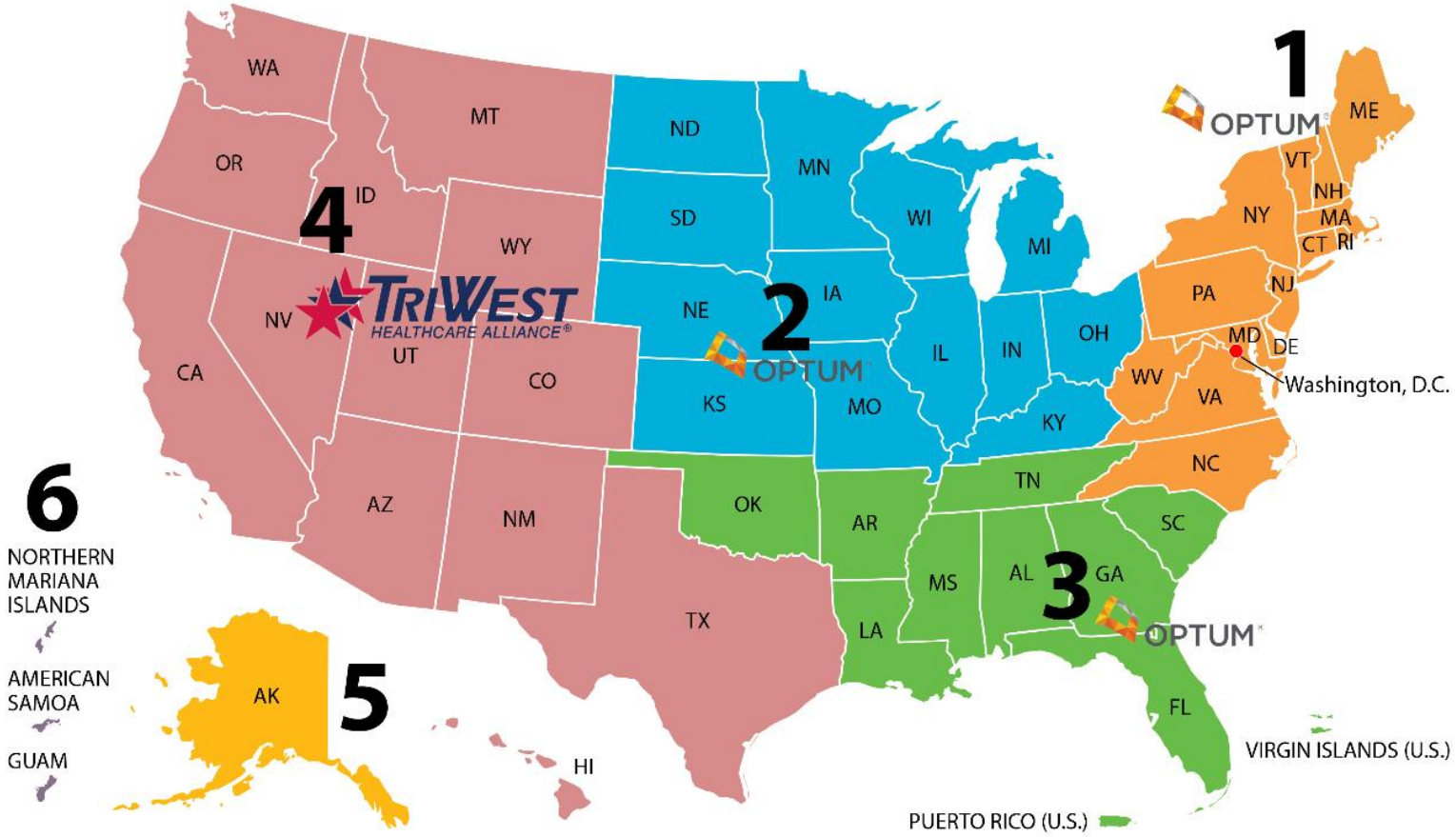
- Under MISSION, the claim submission process changed.
  - How the MISSION changed Claim Submission
    - Claims are now divided by authorization.
    - AUTHORIZED
      - If the hospital received authorization from TriWest, either a planned admission or an ER admission that was authorized within 72 hours, the Uniform Bill (UB) goes to TriWest.
      - The VA receives the medical records (along with a copy of the claim to accelerate processing) to confirm that services rendered match the authorization.
        - If authorization matches, TriWest will process and pay the claim.
        - If authorization does not match, TriWest will deny.
    - NOT AUTHORIZED
      - All non authorized claims should be submitted with the UB and Medical Records to the local VA that houses the Veteran.

The MISSION Act – A New Game

❖ Once the MISSION Act became effective, the days of VCP were numbered.

- The VCP program effectively terminated on June 5th, 2019, and PC3 and MISSION became the programs of choice.
- At the same time, the PC3 Program began a new initiative through the Community Care Network (CCN)
- The CCN is a network of 6 Regions, which do not mirror the regions of the PC3.
- The CCN is also managed by two companies at this time;
  1) OptumServe
  2) TriWest
- The CCN replaces the old TriWest Regions that existed and serve to focus on transparency, accountability, quality, and increased communications between the VA and Veterans.
- The Authorization process does not change, just the carrier.
- The only one change with Optum
  - Hospitals must agree to work with Optum Serve via contract. Please communicate with your Managed Care departments to determine if a contract is in the works, executed, or they declined to work with them.

The MISSION Act – A New Game



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The MISSION Act – Changes?

- Differences between VCP / PC3 and CCN
  - VCP / PC3 – Two programs that worked in "harmony"
    - VCP – 40-mile exception
    - PC3 – Wait list is longer than 30 days for services
    - PC3 – Services Not available in State
    - PC3 – Closet is not easily accessible
  - CCN – Rolled both programs and added fifth option
    - Services not available in State
    - VA does not operate in that State
    - Veteran eligible to receive benefits under VACA Act of 2014
      - Grandfather – AK, ND, SD, MT, or WY
    - VA cannot furnish those services in a timely manner
    - Best Medical Interest of the Veteran

The Modernization of the VA

- Upgrades – Headlines
  - The PACT Act
  - MISSION Act Utilization
  - MISSION Act Market Analysis – Massachusetts Market

- Upgrades – Standardization
  - Notice – Centralized
  - Health Share Referral Management
  - Submission – Physical Address

VA – The PACT Act (H.R. 3967)

- Promise to Address Comprehensive Toxics Act
  - Signed into law on August 10, 2022
  - Added more than 20 new Medical Conditions that result in **PRESUMPTIVE** eligibility for service-connected conditions.
    - Expanded and extended VA health care for Veterans with Toxic exposure from Vietnam, Gulf War, and post 9/11.
  - The VA is required to provide Toxic exposure screening to every Veteran enrolled in VA health care.
    - Due to conditions created by Burn Pits and other Toxic exposures (Agent Orange)

VA – The PACT Act

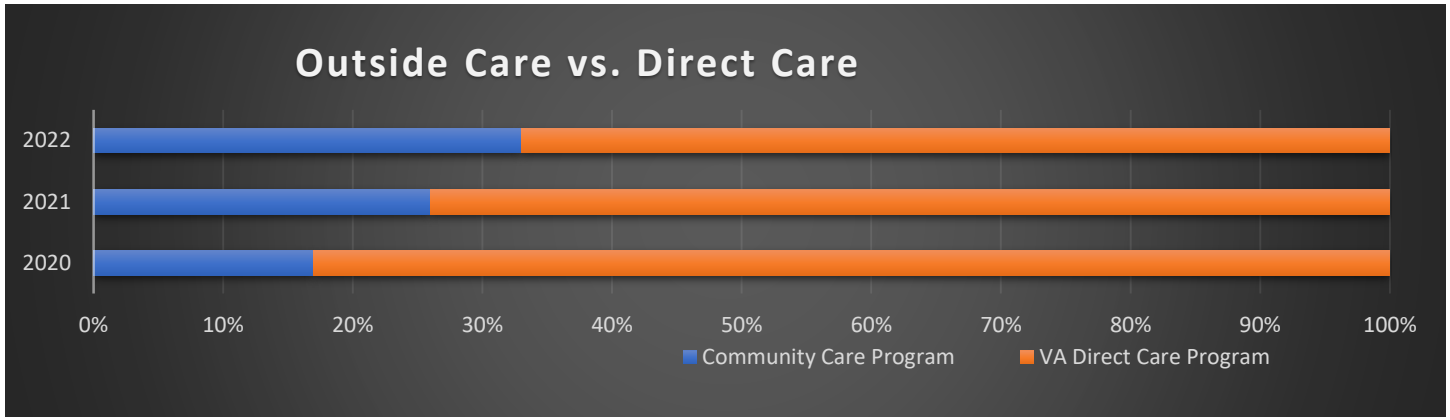
- Coverage extended by conditions created from Burn Pits and other Toxic exposures (Agent Orange)
  - Several Forms of Cancer are now considered covered and paid by the VA under 38 U.S.C. § 1728
    - Service-Connected Conditions are paid by the VA at 100% of the Medicare Allowable
    - These are paid by the VA regardless of medical coverage by another payer.
  - Several Cancers and new Chronic illnesses added to the Presumptive Condition Listing.

VA – The PACT Act

- Impact to Community Providers
  - New Cancer coverage include
    - Brain, Gastrointestinal, Gliobastoma, Head, Kidney, Lymphatic, Lymphoma, Melanoma, Pancreatic, Reproductive, and Respiratory.
  - New Illnesses
    - Asthma (after service), Bronchitis, COPD, Rhinitis, Sinusitis, Emphysema, Granuolmatous, Interstital Lung Disease, Pleuritis, Pulmonary Fibrosis, and Sarcoidosis.
  - Coupled with MISSION Act CCN coverage, CCN providers should expect an increase of usage of their facilities for Veterans with the above noted conditions.

VA – MISSON Act Impact

- Community Provider Utilization
  - MISSION passed in 2019 and was fully implemented in 2020.



  - Utilization of CCN resources continues to increase at an accelerated pace.
  - Anticipated Usage for 2023 is at 40% (Pre PACT Act)

VA – Market Analysis Report

- Ordered in 2018, and released in March 2022, the VA put together a comprehensive report showing their projected road map for the next 10 years.
- Enrollment Shift – Based on Estimates from Census

Market Area	**2019**	**2029**
East Market – East MA & RI	132,367	113,835
West Market – West MA & CT	90,881	75,431
TOTAL	223,248	189,266

VA – Market Analysis Report

East Market

- Constructing a replacement VAMC in the vicinity of Bedford, MA, and closing the current facility.
- Modernize the facility at West Roxbury as it is part of the Boston Health Care System.
- Form a strategic partnership regarding the Jamaica Plain VAMC and keep the Million Veteran Program in the VA buildings.
- Modernize Providence and Brockton VAMCs

West Market

- Relocating services provided at Central Western MA VAMC and close that VAMC.
- Relocating services at West Haven VAMC to current or future VA facilities.

https://www.va.gov/AIRCOMMISSIONREPORT/docs/VISN01-Market-Recommendation.pdf

Cost?

- ❖ Estimates run around $3.4 billion
- ❖ Under advisement and review with VA Committee

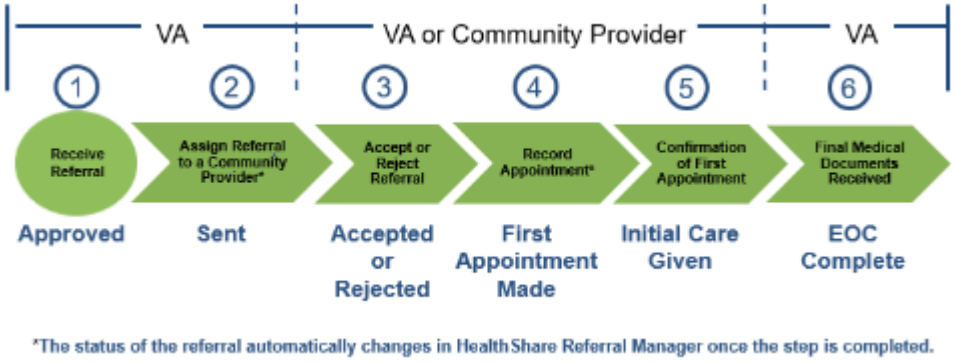
Modernization of the VA - Notice

Case Specific Information	
Veteran Information	Treating Facility Information
Name	NPI
Social Security Number	Name
Date of Birth	Address
Address	Point of Contact (POC) Name
Date Presenting to Facility	POC Phone #
Date of Discharge	POC Email Address
Admitted? (YES/NO)	Note: POC will receive VA authorization decision info
Chief Complaint/Admission DX and/or Discharge DX	

- Notification
  - Prior to June 8th, 2020,
    - Emergency claims, hospitals would have to locate the local VAMC , contact their case management department, and begin the process of notification and authorization.
    - This process was time consuming, highly unreliable, and generally mismanaged.
  - As of June 8th, 2020
    - The VA moved to centralized Notification Center. 1 Center, Phone Number, and Email Address.
    - Phone 1-(844) 724-7842 / Email VHAEmergencyNotification@va.gov
    - Providers are expected to utilize VA Form 10-10143g for case specific information.
  - December 21st, 2020
    - After several issues developed at the time of go live for the email, the VA relaunched this process as a Portal. (PHI in email and inability to send Secure Emails)
    - Portal address → https://emergencycarereporting.communitycare.va.gov/#/request
    - Users can also call with Urgent Requests at (844) 724-7842

Modernization of the VA - HSRM

- HealthShare Referral Management
  - During the course of 2019, the VA rolled out the HSRM program.
  - This program is meant to alleviate and accelerate Referrals and Approvals
    - The lifecycle example;



  - In order to utilize this program, a hospital must opt in with the VA, undergo 2 hour training (every Tuesday at noon EST), and submit an End User form to the HSRM.
  - Once approved, your hospital can schedule referrals online, upload medical records for review, and access approved / denied authorization documentation.

Modernization of the VA - Submission

- Centralization of Submission
  - Prior to May 1st, 2020,
    - Hospitals had to submit claims to the local VAMC. The hospital may not know who the VAMC is if the hospital straddled region lines.
    - This would lead to significant delays in getting claims submitted, processed, and paid.
  - After May 1st, 2020,
    - At this time, the VA would like to move away from physical submission as they continue to push the Change Healthcare clearinghouse (as they are partnered with them).
    - For any physical submission, the information would need to go to;

      VHA Office of Community Care

      P.O. Box 30780

      Tampa, FL 33630-3780

VA Pain Points – Medicare

- When Is Medicare Primary?
  - 38 U.S.C. § 1725 Reimbursement for Emergency Treatment [Medicare > VA]
    - The VA is primary if in cases where;
      - The veteran is enrolled and received care within the past 24 months AND
      - The veteran is enrolled with VA coverage (per § 1705 of this chapter)
    - Medicare is primary is the patient possesses Medicare at the time services were rendered.
      - VA will pay as a secondary payer in these instances now (see ***Wolfe vs. Wilkie***)
  - 38 U.S.C. § 1728 Reimbursement of Certain Medical Expenses [VA > Medicare]
    - The VA is primary if the patient presents with the following;
      - An adjudicated service-connected disability,
      - A nonservice connected disability associated with and held to be aggravating a service-connected disability,
      - Any disability of a veteran if the veteran has a total disability permanent in nature from a service-connected disability,
      - Any illness, injury, or dental condition of a veteran who
        - A participant in a vocational rehabilitee program; and
        - Medically determined to have been in need of care or treatment to make possible the veteran's entrance into a course of training or prevent interruption of course of training.
    - Even if the patient possesses Medicare, the VA is primary.
      - VA will process and pay this claim at 100% of the Medicare allowable

VA Pain Points – Who is the Payer Scenarios

- Who is Primary
  - Scenario A
    - Veteran presents to the ER complaining of a broken arm. Patient has Medicare and VA benefits. Arm was not broken during deployment or active duty.
    - Who is the Primary Payer?
  - Scenario B
    - Veteran appears at the hospital for their cancer infusion therapy. Patient has Medicare and VA benefits. Infusion therapy previously authorized under VA Choice.
    - Who is the Primary Payer?
  - Scenario C
    - Veteran presents the ER complaining of chest pains. Patient has Medicare and VA benefits. Chest pains are a symptom of condition acquired while deployed.
    - Who is the Primary Payer?

VA Pain Points - Ambulance Claims

- Authorized Ambulance Transport – Conditions
  - Veterans must meet the following administrative requirements for authorized transport:
    - Have a service-connected disability or combined rating of 30% or more, OR
    - Be in receipt of a VA pension, OR
    - Previous calendar year income does not exceed maximum VA pension rate, OR
    - Projected income in travel year does not exceed maximum VA pension rate, OR
    - Travel is in connection with care for a service-connected disability, OR
    - Travel is for a Compensation and Pension exam, OR
    - Travel is to obtain a service dog, OR
    - Travel relates to VA transplant care, AND
    - ***A VA clinician determines and documents that special mode transportation is medically required***.
  - Per Policy 32 CFR 199.4(d)(3) there are a few requirements:
    - HCPCS Level II Codes → A0225 – A0384, A0390 – A0398, A0420 – A0436, and A0999
    - §§ III. POLICY → In all service areas where suppliers routinely bill a mileage charge for ambulance services in addition to a base rate, an allowable amount will be calculated based upon the POP (Point of Pickup) zip code of the beneficiary at the time he or she is placed on board the ambulance to the final destination.
    - The above policy is silent to the POP requiring additional Value Codes.

VA Pain Points – Auth vs Notification

- How do you review a patient encounter?
  - Registration
  - Notification (ER) or Prior Authorization (Planned)
  - Transfer (VA Facility) or Episode of Care Occurs
  - Discharge
  - Claim Submission
  - Follow Up
  - Review
  - Appeal

VA Pain Points – Authorization Denials

- When working a Veteran claim
  - Authorizations
    - If the patient presents for ER services, they must be authorized (exception to EMTALA). The timeline is 72 hours from start of treatment and the call is whether a bed or bay is available.
    - You have two options with this denial.
      - **OPTION #1 (Authorization on file)**
        - Under TriWest → If there is an authorization on file, see if a Secondary Authorization Request ("SAR")is appropriate.
        - Under VA → If there is an authorization on file, did you attempt a Request for Service extension?
      - **OPTION #2 (Appeal)**
        - Utilizing the Standard of Care as noted in the VA statute, if the patient feels their life is in danger and a **reasonable person** would conclude that services are needed, the VA will not deny the claim.

VA Pain Points – Denials

- When working a Veteran claim
  - Denials
    - The most common denials are:
      - Untimely filing [90 Days for Mil Bill],
      - Lacking an authorization (did not meet criteria),
      - Patient not enrolled (Veteran did not enroll in 24 months),
      - The responsibility of TriWest / Optum Serve (CCN claim), and
      - Coding (hybrid of Medicare coding).

VA Pain Points - Reimbursement

- How does the VA process and pay your claims?
  - Based on the Veteran's Injury
- Non-Service Related Injury versus Service-Related Injury
  - Under the Millennium Act of 2001, Non-Service related Injuries are covered by the VA at a discounted rate
  - Discounted Rate equals to the 75th Percentile of Medicare (which is 69.5% to 70.5%)
- Service-Related Injuries are paid at 100% of the Medicare allowable.
  - 38 U.S.C. § 1728 – Any injury that occurs while deployed or on active duty

VA Pain Points - Reimbursement

- New Reimbursement Rule as of January 1st, 2021
  - VA updated their fee schedule to base their reimbursement based on the location where the care is provided not the location of the referring facility.
  - Prior to 1/1/2021, the VA processed, and paid claims based on a difficult formula. [Locality code versus Rendering code]
    - The VA would look at where the Veteran was housed (locality of the referring VA Medical Center).
    - Once the Veteran received treatment, the VA would pay the Rendering facility based on the Location code of the referring VA.
  - This would lead to slight discrepancies in reimbursement where rendering facilities would think they were underpaid.

VA Pain Points - Reimbursement

- New Reimbursement Rule as of January 1st, 2021
  - After 1/1/2021, the VA processes and pays claims based on the Locality of the Rendering facility.
    - This change has two effects
      1. Rural Facilities will see a slight increase in reimbursement as they accept referrals from Urban VA facilities.
      2. Urban Facilities will see a slight decrease in reimbursement as they accept referrals from Rural VA facilities
    - This change has NO effect on the following;
      - Rural Facilities that accept referrals from Local Rural VA facilities.
      - Urban Facilities that accept referrals from Local Urban VA facilities.
- Updated Fee Schedule can be found here
  - https://www.va.gov/COMMUNITYCARE/revenue_ops/Fee_Schedule.asp

VA Pain Points – Appeal Roadmap

❖ Veteran Health Administration Appeal Map

- Appeal landscape is difficult
- Timeline;
  - 90 Days for VA appeal
  - 1 Year for Court Appeals
  - Must go through each step
  - If you skip a step, will be dismissed
  - Various Admin Law Standards
- Success
  - Not a great overturn rate
  - Board of VA Appeals
  - Goes to Veteran's Benefit File
- Roadblocks
  - Will not get a copy of the Veterans Benefit file. Hospital does not have standing to sue on this issue.
  - Significant language barrier → Standards continue to shift, no established standard such as "Arbitrary and Capricious". Mostly "De novo" or "clearly erroneous"

VA Pain Points – Appeals

- How to write an appeal?
  - Format – Issue, Rule, Analysis, and Conclusion
    - **Issue** – Clearly Identify the reason for the denial
      - Examples; Authorization, Timely Filing, Responsibility
    - **Rule** – Layout the rule per statute or policy
      - Authorization – 72 hours when treatment starts
    - **Analysis** – Show your actions
      - Give detailed notes that you took to follow the procedure
    - **Conclusion** – Demand that the VA review
      - Request the VA overturn their previous decision after a de novo review

Wolfe vs. Wilkie (USCAVA #18-6091) & Wolfe vs. McDonough (USCFC #2020-1958)

- Wolfe vs. Wilkie
  - VA Coordination of Care
    - Previously, the VA was known as a Payer of Last resort and would never work as a secondary payer.
    - The Court of Veteran Appeals approved and directed the VA to act as a secondary payer for Emergent Claims paying only Deductible and Co-Insurance at the Medicare rates.
  - Wolfe vs. McDonough
    - Court reviewed the prior ruling and reviewed the definitions of Co-Insurance and Deductible.
    - Court modified the ruling by allowing Co-Insurance to continue coverage, but denying deductibles as clearly part of the ban.
  - VAMC Fee Basis payments resumed as of 7/17/2022.
    - VA will only pay for co-insurance for Emergent Care claims.
    - Wolfe is looking into potential appeals.

Questions?

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Thank You!