

January 27, 2010

TIMELINESS STANDARDS FOR PROCESSING NON-VA PROVIDER CLAIMS

1. PURPOSE: This Veterans Health Administration (VHA) Directive establishes policy standards for the processing of non-VA health care claims from non-Department of Veterans Affairs (VA) providers.

2. BACKGROUND

a. Timely processing of claims for hospital care and medical services ensures improved provider relations and increased Veteran access to supplemental community health care services. This policy applies to the traditional fee program as well as any claim for service provided to a Veteran outside a VA medical facility, including Community-based Outpatient Clinics (CBOC).

b. Non-VA health care claims are submitted for services purchased in accordance with the Federal Acquisition Regulation (FAR) and Veterans Affairs Acquisition Regulation (VAAR) (including individual authorizations and sharing agreements) and authorized under Title 38, United States Code (U.S.C.) §§ 1703, 1720, 1720C, 1725, 1728, 7409, or 8153. **NOTE:** *Non-VA health care claims authorized by 38 U.S.C. §§ 1720 and 1720C include community nursing home, community adult day health care, home health care services, respite care, and hospice care.*

c. For the purposes of this policy, a claim is considered processed upon the date:

- (1) The batch is finalized;
- (2) The claim is denied or disapproved; or
- (3) The claim is returned to the provider as incomplete.

3. POLICY: It is VHA policy that 90 percent of all non-VA health care claims are processed within 30 days of the date the claim is received by the facility.

4. ACTION

a. **Veterans Integrated Service Network (VISN) Director.** The VISN Director is responsible for:

(1) Ensuring that standards are met without regard to where the claims for purchased non-VA health care are processed. For example, the VISN Director must ensure that standards are met by the centralized network function when claims processing has been centralized in a VISN, or by staff processing claims in a clinical service line (e.g., radiology).

(2) Ensuring development of claims processing tracking tools are used within the VISN.

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(3) Submitting VISN specific data for all non-VA health care claims in a monthly performance tool housed on the National Fee Program Office Intranet Web site at: <http://vhahacnonva.vha.med.va.gov/default/default.asp>.

(4) Ensuring that a copy of any VA facility or VISN contract for the payment or purchase of non-VA health care services from health care vendors in a VISN facility, geographical area, or patient referral area is given to all managers at the appropriate facility assigned responsibility for the payment of those purchased non-VA health care services.

b. **Facility Director.** The facility Director is responsible for ensuring that:

(1) Each employee in the facility who processes non-VA health care claims for payment receives VHA Chief Business Office (CBO) standardized mandatory Veterans Health Information Systems and Technology Architecture (VistA) Fee and claims processing training, including application of contracted care rates to accurately pay services purchased by contract.

(2) A copy of any VA facility or VISN contract for the payment or purchase of non-VA health care services from health care vendors in a VISN facility geographical area or patient referral area is given to all managers at the appropriate facility assigned responsibility for the payment of those purchased non-VA health care services.

(3) All non-VA health care claims, including claims that are denied for administrative or clinical reasons, are processed using the VistA Fee system, unless it is not possible to process the claim within VistA Fee due to system limitations. Exceptions made to processing claims within VistA Fee software must be documented in writing and approved by the facility Director. Workload capture for payments processed out of the VistA Fee system must be accomplished through other credible VA workload applications, such as the VistA Scheduling package.

(4) Claims processing timeliness standards are met without regard to where the medical facility chooses to process the non-VA health care claim.

(5) Non-VA health care claims requiring transfer to another fee site for processing are forwarded within 3 business days of receipt of the claim.

(6) Ninety percent of all non-VA health care claims are processed within 30 days of receipt of the claim at the fee claims processing site. All claims are to be date stamped with the date the claim is received at the facility and in those instances when the date of claim receipt is unknown, the postmark date or date of invoice, whichever is later, is to be used as the receipt date.

(7) Claims processing and status data, i.e., monthly performance reports, are submitted by using the monthly performance tool housed on the VHA National Fee Program Office Intranet Web site at: <http://vhahacnonva.vha.med.va.gov/default/default.asp>. The monthly report includes the following:

(a) All non-VA health care claims, including pending and denied claims, are counted in the statistics for claims processing timeliness reports.

(b) Claims requiring additional information must be set to incomplete status in VistA Fee. These claims are considered pended. The time from date of receipt to date additional information is requested for pended claims are to be included in the Stoplight Report. The time awaiting additional information from the claimant for pended claims is not to be included in the claims processing statistics. Upon receipt of the requested information, the processing cycle for the claim begins anew.

1. For example: The claim is received on July 1. On July 6, it is determined that the Veteran meets administrative eligibility for VA payment; however, additional information is needed to adjudicate the claim. The claim is pended, set to incomplete status, and a letter is mailed to the claimant on July 8 requesting the needed information. The provider submits the requested information, which is received at the VA facility on August 1. The claim is processed and dispositioned on August 15.

***NOTE:** If the VistA system site parameters are properly set, the system automatically begins tracking the timeliness of pended unauthorized claims. The system will display an alert message identifying claims due to be abandoned so that appropriate follow-up action may be taken. The system is also designed to automatically disposition the claim and print an abandonment letter when a claim entered under 38 U.S.C. 1725 is pended 90 days or 365 days for claims pended under 38 U.S.C. 1728.*

2. The claim would be counted as follows:

Action	Date	Calendar Days Elapsed	Processing Days for Reporting Purposes	Stoplight Report
Claim Receipt	July 1	1		Counted as <u>New Claim Received</u>
Claim Pended and Closed	July 8	9	9	Claim Counted as Processed
Claim Receipt (Requested Information Received)	August 1	32		Counted as <u>New Claim Received</u>
Claim Dispositioned and Closed	August 15	46	15	Claim Counted as Processed

3. When a claim is forwarded by another VA facility, the receiving facility must date stamp the date the claim is received as the start date for counting claims processing timeliness.

(8) Non-VA health care claims, including Electronic Data Interchange (EDI) claims, received in the Fee Site Fee Payment Processing System (FPPS), are opened and initial adjudication action begins within 3 business days of receipt of the claim at the Fee claims processing site.

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(9) A non-VA health care claim is not considered for payment until all the information needed to make a decision is received by the processing VA facility. Claims requiring additional information must be returned to the claimant with a request for the additional information within 30 days from the date of VA receipt of the claim at the Fee claims processing site. Such claims returned to the claimant are considered "pending," and the following applies:

(a) A pending claim is neither a denial of the claim nor abandonment of the claim. Reasons for return may include, but are not limited to, the need for additional supporting documentation, or correction and explanation of medical coding discrepancies on the claim. Processing of a pending claim in accordance with established regulations resumes upon receipt of the requested information.

(b) VA medical facility correspondence notifying claimants of pending non-VA health care claims considered under 38 U.S.C. § 1728 (payment for emergency treatment not authorized by VA in advance for certain service-connected Veterans) must advise the claimant that the claim has not been denied, but that failure to submit requested information within 1 year from the date of request will result in the claim being abandoned.

(c) VA medical facility correspondence notifying claimants of pending non-VA health care claims considered under 38 U.S.C. § 1725 (payment of emergency treatment not authorized by VA in advance for non-service connected conditions) must advise the claimant that the claim has not been denied, but that failure to submit requested information within 30 days from date of receipt will result in the claim being abandoned, unless the claimant has requested, in writing, an extension within the 30-day period. In that case, an extension may be granted for what VA deems a reasonable time period.

5. REFERENCES

- a. Title 38 U.S.C. §§ 1703, 1720, 1720C, 1725, 1728, 7409, and 8153.
- b. Title 38 CFR §§ 17.52 – 17.56, 17.120 - 17.142, and 17.1000-17.1008.
- c. MP-4 Part III, Chapter 2.
- d. MP-4 Part III, Chapter 3.
- e. M-1 Part I, Chapter 18, Appendix A Section VI b (1) b.
- f. M-1 Part I, Chapter 19, Section 19.14C.

6. FOLLOW-UP RESPONSIBILITY: The Chief Business Officer (16) is responsible for the contents of this Directive. Questions should be referred to the National Fee Program Office at (303) 398-5160.

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7. RECISSIONS: VHA Directive 2007-010 is rescinded. This VHA Directive expires January 31, 2015.

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