

ELECTRONIC CLAIMS PROCESSING FOR CONTRACT FEE SERVICES

1. PURPOSE: This Veterans Health Administration (VHA) Directive provides policy to Department of Veterans Affairs (VA) medical centers, VA outpatient clinics (OPCs), Vet Centers, and Community-based Outpatient Clinics (CBOCs) on the management of contracts, sharing agreements, purchase orders, and other acquisition tools used to obtain services for veterans outside of a VA medical facility. *NOTE: This Directive does not apply to non-clinical services (e.g., supplies).*

2. BACKGROUND

a. Medical facility Directors obtain services for veterans from non-VA sources on a routine basis. Many tools are used to obtain these services. With the advent of the Health Insurance Portability and Accountability Act (HIPAA) and the availability of an electronic claims portal (Claims Processing System-Fee) for VHA, it is appropriate for VHA to offer guidance on other methods contract vendors may use to bill the medical center for services provided.

b. Implementation of this policy eliminates billing to the VA medical center with roster billing, i.e., one bill for a large sum of money that lists a number of veterans treated. Contract vendors are required to submit one claim per patient using a HIPAA compliant transaction set.

c. Small contract providers who cannot generate HIPAA compliant electronic claims may continue to submit paper claims. According to the Centers for Medicare and Medicaid Services (CMS) HIPAA Frequently Asked Questions (FAQ) website: The term “small providers” originates in the Administrative Simplification Compliance Act (ASCA). HIPAA requires those providers/submitters who bill Medicare to begin submitting only electronic claims to Medicare on October 16, 2003 in the HIPAA format. However, ASCA provides an exception to the Medicare electronic claims submission requirements to “small providers.” This exception also applies to small providers who submit claims to VA. ASCA defines a small provider or supplier as: a provider of services with fewer than 25 full-time equivalent (FTE) employees, or a physician, practitioner, facility or supplier (other than a provider of services) with fewer than 10 FTE employees.

d. When a veteran is being treated over a long period of time (e.g., nursing home), the contract needs to stipulate that the vendor is to bill periodically (i.e., monthly).

e. Vendors who are not contracted with VA to provide non-VA care may also submit electronic health care claims.

NOTE: This Directive does not apply to VA-Department of Defense (DOD) sharing agreements under Title 38 United States Code (U.S.C.) §8111.

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June 27, 2006

3. POLICY: It is VHA policy that contract vendors who bill electronically using the HIPAA-compliant claims transactions must submit claims through the VA clearinghouse, Emdeon, using payer ID number 12115 for medical claims and 12116 for dental claims. *NOTE: Notification will be provided if more clearinghouses are made available in the future.*

4. ACTION: The Veterans Integrated Service Network (VISN) Directors are responsible for:

a. Establishing procedures to review existing contracts with vendors to determine whether these vendors are able to use HIPAA compliant claims transactions. Vendors who are able to submit the transactions are to be contacted for possible modification of their contract (or other similar changes to the acquisition tool being used), or if more practical, at the time the contract or sharing agreement is renewed, but not later than June 30, 2007.

b. Establishing procedures ensuring any new acquisition of clinical services by a contract, sharing agreement or purchase order for veterans outside a VA medical center includes a requirement to use HIPAA-compliant claims transactions to obtain vendor payment, but only if the vendor is able to use the HIPAA-compliant transactions. *NOTE: Vendors who are not able to use the HIPAA-compliant transactions are not required to do so.*

c. Establishing procedures to ensure local use of the Veterans Health Information System and Technology Architecture (VistA) Fee Software package to process electronic health care claims for contract medical care when the workload cannot be credited through Computerized Patient Record System (CPRS) and Patient Encounter systems.

d. Ensuring timely review of a new report produced from data stored in the Austin Automation Center Central Fee database. This report, generated twice each fiscal year (end of March and end of September) for each Fee Site, provides information about the number of contractual community care providers.

(1) Designated VA medical center and VISN Managers need to analyze the report within 30 days of publication to determine if contract vendors, who are HIPAA-complaint transaction capable and whose contract stipulates the use of these transactions, are participating in the submission of electronic claims based on contract billing requirements.

(2) Appropriate action needs to be taken to address non-compliance with the contract requirement to submit electronic health care claims by the Contracting Officer's Technical Representative (COTR) when necessary.

5. REFERENCES

a. Health Insurance Portability and Accountability Act of 1996 (Public Law 104-191).

b. Title 38 U.S.C. §8153.

c. Title 38 U.S.C. §7409.

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6. FOLLOW-UP RESPONSIBILITY: The National Fee Program Manager (162) is responsible for the contents of this Directive. Questions may be addressed to 720-889-2349.

7. RESCISSIONS: None. This VHA Directive expires June 30, 2011.

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