

February 16, 2007

## TIMELINESS STANDARDS FOR PROCESSING NON-VA PROVIDER CLAIMS

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

### 2. BACKGROUND

a. Processing is the issuance of payment, decision to disapprove payment, or rejection and return of a claim as incomplete. It applies to the traditional Fee program as well as any claim for any service provided to a veteran outside a VA medical facility. Claims from Community-based Outpatient Clinics (CBOC) are also included.

b. Contracted care claims are those submitted pursuant to a contract that VA awarded under Title 38 United States Code (U.S.C.) §§1703, 7409, or 8153 to a private institution or physician in accordance with the Federal Acquisition Regulations (FAR). They are subject to Federal Prompt Payment Act standards, and are processed through the Veterans Health Information Systems and Technology Architecture (VistA) Fee software, when not subject to the Financial Service Center "On-Line Certification" process, or when patient care encounters are not captured in other VA creditable workload applications, such as the VistA Scheduling package.

c. Non-contracted care claims are those submitted pursuant to an individual authorization issued under 38 U.S.C. §§1703 to a private institution or physician. Non-contracted care claims include individual authorizations issued after the care is given under 38 U.S.C. §§1728 or 1725. Such non-contracted care claims, subject to the Money Management Standards under the Federal Prompt Payment Act, are processed through VistA Fee software, when not subject to the Financial Service Center "On-line Certification" process, or when patient care encounters are not captured in other VA creditable workload applications, such as the VistA scheduling package.

**3. POLICY:** It is VHA policy that 95 percent of all non-VA Provider claims are processed within 30 days of receipt and that production data is submitted monthly using the nationally standardized report.

### 4. ACTION

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

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**VHA DIRECTIVE 2007-010**  
**February 16, 2007**

(1) Ensuring that standards are met without regard to where the medical facility chooses to process the claim for non-VA care. For example, staff processing Fee claims in a clinical service line (e.g., Radiology) must also meet the standards outlined in this policy.

(2) Developing claims processing tracking tools that incorporate cost, quality, and access data elements. *NOTE: Where claims payment processing has been centralized in the VISN, the VISN Director must ensure that standards are met by the centralized network function.*

(3) Submitting specific data in a monthly performance tool housed on the Health Administration Center (HAC) National Fee Program Office Intranet Web site at: <http://vhahacnonva.vha.med.va.gov/default/default.asp>.

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

(1) Claims are opened and initial adjudication action has begun within 3 working days of receipt at the Fee claims processing site.

(a) Day of receipt refers to the day the claim is received at the Fee claims processing site. It is not the day the claim was entered into the VistA Fee system.

(b) Claims may be received at the Fee site via mail, in person delivery, or electronic transmission. *NOTE: Electronic Claims received in the Fee Site CPS-Fee Electronic Data Interchange (EDI) claims system must be placed "In Process" within 3 business days of receipt.*

(2) Claims requiring transfer to another Fee Site for processing are forwarded within 2 business days from being opened or placed "In Process." The Fee site receiving the transferred claim must utilize the original date VA received the claim for reporting claims processing timeliness.

(3) Standards are met without regard to where the medical facility chooses to process the claim for non-VA care.

(4) Ninety-five percent of all Fee claims are processed within 30 days of receipt.

(5) All claims (100 percent) processed under 38 U.S.C. §§1703, 1725, and 1728 are processed in the VistA Fee system.

(6) A claim is not considered for payment until all the information required to make a decision is received by the processing VA facility.

(7) Claims considered for payment under 38 U.S.C. §§1703, 1725, and 1728 that require additional information are returned to the provider within 30 days from the date of VA receipt.

(a) Reasons for return may include the need for additional supporting documentation, or correction, or explanation of medical coding discrepancies on the claim. Claims returned are considered "rejected." *NOTE: VA does not consider this as either a denial of the claim, or abandonment of the claim.*

(b) VA medical facility correspondence notifying claimants of rejected claims considered under 38 U.S.C. § 1728 (payment for emergency treatment of service-connected conditions not authorized by VA in advance) must advise the claimant 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 rejected claims considered under 38 U.S.C. § 1725 (payment of emergency treatment for non-service connected conditions) must advise the claimant 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. Rejected claims may be re-submitted by the claimant for consideration.

(8) Rejected claims statistics are included in claims processing timeliness reports.

(9) Re-submitted claims are counted as new claims for processing purposes.

(10) Specific data is submitted in a monthly performance tool that is housed on the HAC National Fee Program Office Intranet Web site at:  
<http://vhahacnonva.vha.med.va.gov/default/default.asp>.

## 5. REFERENCES

- a. M-1 Part I, Chapter 18, Appendix A Section VI b.(1)b.
- b. M-1 Part I, Chapter 19 Section 19.14C.
- c. MP-4 Part III, Chapter 2.
- d. MP-4 Part III, Chapter 3.
- e. Title 38 U.S.C. §§1703, 7409, and 8153.
- f. Title 38 Code of Federal Regulations (CFR) 17.131 and 17.1004(e).

**6. FOLLOW-UP RESPONSIBILITY:** The Chief Business Officer (16) is responsible for the contents of this Directive. Questions should be referred to (303) 331-7500.

**VHA DIRECTIVE 2007-010**  
**February 16, 2007**

**7. RECISSIONS:** None. This VHA Directive expires February 28, 2012.

Michael J. Kussman, MD, MS, MACP  
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