Department of Veterans Affairs Veterans Health Administration Washington, DC 20420 VHA HANDBOOK 1601C.01 Transmittal Sheet February 22, 2012

REQUESTING AND VERIFYING INSURANCE INFORMATION FROM THIRD-PARTY PAYERS

- **1. REASON FOR ISSUE.** This Veterans Health Administration (VHA) Handbook updates Department of Veterans Affairs (VA) procedures for VA Health Care Facilities and Consolidated Patient Account Centers (CPAC) to verify health information of third-party users.
- **2. SUMMARY OF CHANGES.** This VHA Handbook updates current procedures for verifying insurance information.
- 3. **RELATED ISSUES.** None.
- **4. RESPONSIBLE OFFICE.** The Chief Business Office (10NB) is responsible for the contents of this VHA Handbook. Questions may be addressed to (202) 461-1589.
- **5. RESCISSION.** Handbook 1601C.01, dated August 28, 2006, is rescinded.
- **6. RECERTIFICATION.** This VHA Handbook is scheduled for recertification on or before the last working day of February 2017.

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REQUESTING AND VERIFYING INSURANCE INFORMATION FROM THIRD-PARTY PAYERS

1. PURPOSE

This Veterans Health Administration (VHA) Handbook provides information on the mandated procedures for requesting and verifying insurance information of third-party payers.

2. AUTHORITY

Title 38 United States Code (U.S.C.), § 1729 authorizes the Department of Veterans Affairs (VA) to recover or collect for care or services, reasonable charges (as determined by the Secretary of Veterans Affairs) for care and services, provided for a non-service connected disability in or through a VA facility to a Veteran who is also a beneficiary under a third-party payer's insurance plan. VA's right to recover or collect is limited to the extent that the Veteran or a non-government provider of the care or services would be eligible to receive reimbursement or indemnification from the third-party payer, if the care or services had not been furnished by a department or agency of the United States. VA implements this authority under title 38 Code of Federal Regulations (CFR) §§ 17.101 and 17.106.

3. BACKGROUND

- a. Requesting and verifying insurance information is vital to the success of the VA revenue collection process because accurate information is required to effectively bill and collect reimbursements from third-party payers for services to Veterans. It is important to contact the third-party payer and verify the Veteran's specific policy coverage and other information before submitting claims to the third-party payer.
- b. With implementation of the Health Insurance Portability and Accountability Act of 1996, new requirements for the request and verification of insurance information were impacted for the registration and insurance verification processes. This Handbook outlines the appropriate information the third-party payer may require from VA before providing Protected Health Information (PHI) in line with 38 CFR Part 17.106(g).
- c. VA Health Care Facilities (HCF) and Consolidated Patient Account Centers (CPAC) must use the Patient Information Collection Management (PICM) processes to update the Veteran's complete address, home and work telephone numbers, insurance information, next-of-kin, emergency contact, and employer information.
- d. VA HCFs and CPACs must use the following electronic means available to request and verify insurance information gathered during the PICM processes.
- (1) The Insurance Capture Buffer (ICB) is an insurance card scanning and Veterans Health Information Systems and Technology Architecture (VistA) Buffer File update management system designed to enhance insurance data collection and verification processes.

- (a) The ICB is integrated with several VistA components, including Appointment Scheduling and the Patient Insurance File, meaning that the transfer of information between the two systems is real-time.
- (b) The ICB does not have a separate Patient Insurance File; rather it integrates with VistA, the system of record, and pulls the information directly to populate the ICB views.
- (c) The ICB electronically captures a scanned image of the front and back of the insurance card, which is immediately available to the verification clerk in the Insurance Buffer File.
- (2) Electronic Insurance Verification (eIV) software provides VA facilities with the ability to automatically send and receive electronic inquiries in real time to third-party payers through the VA Financial Service Center (FSC). Insurance information placed in the Insurance Buffer File through the ICB is electronically sent immediately, allowing VA to obtain current information regarding a Veteran's health insurance coverage and benefits. After receiving insurance information from third-party payers, updates are automatically sent directly from VA FSC to the VistA Patient Insurance File (bypassing the Insurance Buffer). VistA stores and displays the eligibility and benefit information received from insurance companies.

4. **DEFINITIONS**

- a. <u>Coinsurance</u>. Coinsurance is the specified percentage of the cost of services the patient must pay the health care provider.
- b. <u>Coordination of Benefits (COB).</u> COB is a clause written in an insurance policy, or stipulated by state law, that requires insurance carriers to coordinate the reimbursement of benefits when a policyholder has two or more medical insurance policies. *NOTE:* The benefits from the combined policies may pay up to, but may not exceed, 100 percent of the covered benefits of the combined policies for all medical expenses submitted.
- c. <u>Copayment (Copay).</u> Copay is a specific monetary charge for either medical services or medications provided by VA to Veterans.
 - d. **Coverage.** The coverage is the extent of benefits provided under a health care policy.
- e. <u>Covered Person.</u> A "covered person" is any person entitled to health care benefits under an insurance policy.
- f. <u>Deductible.</u> The deductible is the specified amount of annual out-of-pocket expense for covered medical and/or prescription services that the insured must incur and pay each policy year to a health care provider before the insurance company will pay benefits.
- g. **<u>Dependent.</u>** A dependent is a person who, by virtue of the financial support provided by the policyholder, meets the legal requirements for inclusion in a policy or program.

- h. Effective Date. The effective date is the date on which insurance coverage begins.
- i. <u>Filing Time Frame.</u> Limited amount of time to submit insurance claims determined by third-party payer.
- j. <u>Group Name and Number.</u> The group name and number is the name and numerical identification assigned to a specific group of insured patients.
- k. <u>Insurance Carrier</u>. The insurance carrier is the insurance company (insurer) that sells the policies and administers the contract.
- 1. <u>Insurance Plan.</u> An insurance plan refers to a type of coverage offered by an insurance carrier.
- m. <u>Insured</u>. The insured is the policyholder; the subscriber; the person who contracts with an insurance company for insurance coverage.
- n. <u>Policy</u>. The policy is the legal document issued by a company to the policyholder that outlines the conditions and terms of the insurance, also called a policy contract or contract.
- o. **Policyholder.** The policyholder is the party who applies for, and is issued, an insurance policy.
- p. <u>Protected Health Information (PHI).</u> PHI is individually-identifiable health information (IIHI) maintained in any form or medium. *NOTE: PHI excludes employment records held by a covered entity in its role as an employer (see VHA Handbook 1605.)*
- q. <u>Subscriber</u>. The subscriber is the insurance policyholder; the individual who pays for the insurance plan.
- r. <u>Subscriber Identification (ID) Number.</u> The subscriber ID number is the unique identifier assigned by the insurance carrier, and can sometimes be the cardholder's Social Security number (SSN).
- s. <u>Third-party Payer.</u> The term third-party payer means an entity responsible for the payment of medical expenses on behalf of a Veteran through an insurance agreement or contract. A third-party payer is not the person who received the medical care or services at issue (first-party), or VA who provided the care or services at issue (second-party). Third-party payers include, but are not limited to:
 - (1) State and local governments that provide insurance plans other than Medicaid.
 - (2) Insurance underwriters or carriers.
- (3) Employer or employee groups offering self-insured or partially self-insured insurance plans.

- (4) Automobile liability insurance underwriter or insurance carrier.
- (5) No-fault insurance underwriter or carrier.
- (6) Worker's compensation program or plan sponsor, underwriter, carrier, or self-insurer.
- (7) Any other plan or program that is designated to provide compensation or coverage for expenses incurred by a beneficiary for healthcare services or products.
 - (8) A third-party administrator.

5. SCOPE

- a. This VHA Handbook provides details on VHA procedures for requesting and verifying insurance information from third-party payers.
- b. All VHA personnel verifying insurance provide third-party payers with only the minimum amount of appropriate PHI necessary to verify insurance, and request only the minimum amount of information necessary from third party payers in order to effectively bill and collect for services to Veterans.

6. RESPONSIBILITIES OF THE VETERANS INTEGRATED SERVICES NETWORK (VISN) DIRECTOR

In order to timely identify and update Veteran's insurance information, the VISN Director is responsible for ensuring all health care facilities and CPACs:

- a. First use the following electronic tools to verify a patient's insurance eligibility with third-party payers from which VA can seek reimbursement:
- (1) The ICB must be utilized by intake staff to capture insurance information directly from a Veteran. It must also be used in conjunction with eIV as the primary tool to perform insurance verification processing. *NOTE:* For additional information regarding ICB see: http://vaww.vistau.med.va.gov/vistau/e-bp/default.htm. This is an internal VA link not available to the public.
- (2) The eIV VistA software must be utilized as the preferred insurance verification tool, as it transmits electronic inquires to the third-party payers and receives current eligibility benefit information about a Veteran's insurance coverage. *NOTE:* For additional information regarding eIV see: http://vaww.vistau.med.va.gov/vistau/e-bp/default.htm. This is an internal VA link not available to the public.
- b. Utilize the following methods to assist in identifying additional insurance information only when use of eIV in conjunction with ICB cannot provide adequate benefit information.

- (1) Utilize third-party payer online database and/or telephone access to obtain new or updated insurance information.
 - (2) Send a letter to the Veteran to obtain new or updated insurance information.
 - (3) Contact the Veteran via telephone to obtain new or updated insurance information.
 - (4) Employ a third-party vendor to obtain new insurance policy information.
- (5) Perform the Remote Query option in VistA to import potential insurance information from other VA HCF VistA databases.
 - c. Maintain the following minimum insurance verification time frames:
 - (1) For all active patient policies (patients with appointments): 180 days.
 - (2) For all active patients with no previously identified insurance: 90 days.

NOTE: This Handbook does not provide any procedures for inactive patient verification actions. As each patient is scheduled for an appointment, the patient becomes "active" and is thereby covered under one of the preceding scenarios.

7. PROTECTED HEALTH INFORMATION (PHI)

This Handbook describes the minimum necessary information required by health plans to be assured that VHA has a legitimate right to the PHI requested, as required by HIPAA. VHA personnel requesting and verifying insurance information must possess a certain amount of information prior to contacting a third-party payer for verification. Third-party payers may refuse to provide information to VHA personnel if the minimum necessary information for insurance verification is not provided. The required information may vary by health insurance plan, and may be negotiated if the third-party payer requires additional data. *NOTE:* For more information on PHI, see Public Law (Pub. L.) 104-191, and 45 CFR Part 164.

8. GENERAL INFORMATION REQUIRED BY VHA PERSONNEL TO REQUEST AND VERIFY INSURANCE INFORMATION

- a. VHA personnel must have the following information <u>prior</u> to initiating a third-party payer contact: *NOTE:* This is the minimum necessary information which must be disclosed to the third-party payer to verify insurance.
 - (1) When the patient is the policy holder or subscriber:
 - (a) VA medical center Tax ID number;
 - (b) Facility ID number (VA specific);

(c) Name of patient;
(d) SSN; and
(e) Date of birth.
(2) When the spouse is the policy holder or subscriber, additional information must be obtained:
(a) Spouse's name;
(b) Spouse's SSN; and
(c) Spouse's date of birth.
(3) When a parent is the policy holder or subscriber, additional information must be obtained:
(a) Parent's name;
(b) Parent's SSN; and
(c) Parent's date of birth.
b. VHA personnel must request the following information from the third-party payer: NOTE: This is the minimum information required from the third-party insurer necessary for V to continue the insurance verification process:
(1) Code and the a ID
(1) Subscriber ID.
(1) Subscriber ID.(2) Group name and number.
(2) Group name and number.
(2) Group name and number.(3) Effective date of policy:
(2) Group name and number.(3) Effective date of policy:(a) Pre-existing time frame; and
(2) Group name and number.(3) Effective date of policy:(a) Pre-existing time frame; and(b) Expiration date (if applicable).
 (2) Group name and number. (3) Effective date of policy: (a) Pre-existing time frame; and (b) Expiration date (if applicable). (4) Policy type.
 (2) Group name and number. (3) Effective date of policy: (a) Pre-existing time frame; and (b) Expiration date (if applicable). (4) Policy type. (5) Filing time frame.

- (8) Mailing address for claims.
- (9) Pre-certification requirement for inpatient care and inpatient pre-cert phone number.
- (10) Pre-certification/pre-authorization requirements for outpatient services and outpatient pre-cert phone number(s).
- c. Based on the information provided by the third-party payer (as requested in subpar. 8b), VHA personnel request other insurance information during the insurance verification process. This additional information is instrumental when submitting claims to the third-party payer for reimbursement. Additional information collected from the third-party payer is:
 - (1) Inpatient and Outpatient coverage, to include:
 - (a) Deductible and copay amounts;
 - (b) Reimbursement percentage;
 - (c) Out-of-pocket or stop loss (dollar amount); and
 - (d) Lifetime maximum.
 - (2) Skilled nursing facility, to include:
 - (a) Pre-admissions requirement;
 - (b) Reimbursement percentage; and
 - (c) Daily or dollar maximums.
 - (3) Prescription health, to include:
 - (a) Medical or prescription network;
 - (b) Name and address of the network administering the prescription benefit;
 - (c) Reimbursement percentage;
 - (d) Deductible and copay amounts; and
 - (e) Maximum limitations.
 - (4) Home Health, to include:
 - (a) Reimbursement percentage; and

- (b) Maximum limitations.
- (5) Hospice, Rehabilitation, and Intravenous Management, to include:
- (a) Lifetime maximum; and
- (b) Maximum number of days.
- (6) Dental, to include:
- (a) Medical plan or network administering the benefit;
- (b) Name and address of the network administering the benefit;
- (c) Reimbursement percentage;
- (d) Deductible and copay amounts;
- (e) Level of benefits;
- (f) Reimbursement percentage; and
- (g) Maximum limitations.
- (7) Mental Health inpatient and outpatient, to include:
- (a) Medical plan or network administering the benefit;
- (b) Name and address of the network administering the benefit;
- (c) Reimbursement percentage;
- (d) Deductible and copayment amounts; and
- (e) Maximum limitations.
- (8) Vision, to include:
- (a) Medical plan or network administering the benefit;
- (b) Name and address of the network administering the benefit;
- (c) Reimbursement percentage;
- (d) Deductible and copay amounts; and

- (e) Frequency of visits.
- (9) Long-term Care, to include:
- (a) Medical plan or network administering the benefit;
- (b) Name and address of the network administering the benefit;
- (c) Reimbursement percentage;
- (d) Deductible and copay amounts; and
- (e) Maximum limitations.