

October 1, 2003

## INSURANCE VERIFICATION

**1. PURPOSE:** This Veterans Health Administration (VHA) Directive establishes a new policy concerning the minimum necessary requirements for requesting insurance verification information and the minimum information required to provide when seeking to verify insurance from a third-party payer.

### 2. BACKGROUND

a. As a result of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), there are new requirements for insurance verification that impact the registration and insurance verification processes in VHA. Some Department of Veterans Affairs (VA) facilities have been refused protected health information (PHI) when contacting health plans to verify insurance. Many of the health plans have been citing HIPAA as the reason they cannot share information that they previously shared with VA facilities.

b. This Directive outlines the appropriate information to request from a health plan when verifying insurance and what information may be required from VA facilities before giving out PHI. The matrix in Attachment A captures the required elements that ensure VHA has the proper information needed to provide to payers when seeking to verify insurance.

c. Insurance verification is vital to the success of the VA revenue collection process. It is important to contact the third-party payer and verify exactly what the veteran's policy covers before submitting claims. Accurate information is needed to effectively bill and collect claims from third-party payers for services to veterans.

d. This Directive includes the minimum necessary information required by health plans in order for them to be assured that VHA has a legitimate right to the PHI being requested, as required by HIPAA. VHA personnel verifying this information must possess a certain amount of information prior to contacting a health plan for verification. Health plans may refuse to provide information to VHA personnel if the minimum necessary information for insurance verification is not provided to the plan. The required information may vary by health plan, and may be negotiated if the health plan requires additional data to that outlined in this Directive.

**3. POLICY:** It is VHA policy that all VHA personnel verifying insurance provide third-party payers with only the minimum amount of appropriate PHI necessary to verify insurance, and that they request only the minimum amount of information necessary from the third-party payers in order to effectively bill and collect for services to veterans.

**THIS VHA DIRECTIVE EXPIRES OCTOBER 31, 2008**

**VHA DIRECTIVE 2003-055**  
**October 1, 2003**

**4. ACTION:** The medical center Director is responsible for ensuring that:

a. VHA personnel, prior to contacting third-party payers, must have:

(1) At least the following:

(a) VA medical center Tax Identification (ID) number,

(b) (VA specific) and/or facility ID number,

(c) Name of patient,

(d) Social Security Number (SSN),

(e) Date of birth,

(f) Policy holder or subscriber's name,

(g) Policy or subscriber's number, and

(h) Group number and/or group name.

(2) If the spouse is the policy holder or subscriber, the following additional information must be obtained:

(a) Spouse's name,

(b) Spouse's date of birth,

(c) Group name and number (if known),

(d) Spouse's SSN,

(e) Primary or secondary insurance.

b. VHA personnel identifying insurance, have obtained from the insurance company the:

(1) Effective date of policy,

(2) Policy type,

(3) Filing timeframe,

(4) Coverage and/or benefits (see Att. A), and

(5) Mailing address for claims.

**5. REFERENCES**

- a. Title 38 United States Code (U.S.C.) 1729.
- b. Public Law 104-191.
- c. Title 45 Code of Federal Regulations (CFR) Parts 160 and 164.
- d. VHA Handbook 1605.1.
- e. VHA Handbook 1605.2.

**6. FOLLOW-UP RESPONSIBILITY:** The Chief Business Officer (16) is responsible for the contents of this Directive. Questions may be directed to 202-254-0324.

**7. RESCISSIONS:** None. This VHA Directive expires October 31, 2008.

S/ Louise Van Diepen for  
Robert H. Roswell, M.D.  
Under Secretary for Health

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**ATTACHMENT A**

**COVERAGE AND/OR BENEFITS MATRIX**

This is additional information Veterans Health Administration (VHA) personnel may capture during insurance verification with the health plans. The additional information may be instrumental when submitting claims for reimbursement. This information may only be captured if applicable to the treatment or payment of a specified claim. VHA personnel should only ask for information that is applicable to the treatment of the patient to satisfy the minimum necessary requirements outlined in the regulations resulting from the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

<p><b>1. Effective Date</b></p> <ul style="list-style-type: none"> <li>a. Pre-existing Timeframe</li> <li>b. Expiration Date (if applicable)</li> </ul> <p><b>2. Policy Type.</b> Filing Timeframe</p> <p><b>3. Group Name and Number</b></p> <p><b>4. Inpatient and Outpatient Coverage</b></p> <ul style="list-style-type: none"> <li>a. Deductible and/or Co-payment Amounts</li> <li>b. Reimbursement Percentage</li> <li>c. Out-of-Pocket or Stop Loss (Dollar Amount)</li> <li>d. Lifetime Maximum</li> </ul> <p><b>5. Skilled Nursing Facility</b></p> <ul style="list-style-type: none"> <li>a. Pre-Admissions Requirement</li> <li>b. Reimbursement Percentage</li> <li>c. Daily or Dollar Maximums</li> </ul> <p><b>6. Prescription Health</b></p> <ul style="list-style-type: none"> <li>a. Medical or Rx Network</li> <li>b. Network Name and Address administering Rx</li> <li>c. Reimbursement Percentage</li> <li>d. Deductible and/or Co-payment Amounts</li> <li>e. Maximum Limitations</li> </ul> <p><b>7. Dental</b></p> <ul style="list-style-type: none"> <li>a. Deductible and/or Co-Payment Amounts</li> <li>b. Level of Benefits</li> <li>c. Reimbursement Percentage</li> <li>d. Maximum Limitations</li> </ul>	<p><b>8. Mental Health.</b> Inpatient and/or Outpatient</p> <ul style="list-style-type: none"> <li>a. Deductible and/or Co-payment Amounts</li> <li>b. Reimbursement Percentage</li> <li>c. Maximum Limitations</li> </ul> <p><i>NOTE: If Mental Health is Not Through Health Plan</i></p> <p><b>9. Home Health</b></p> <ul style="list-style-type: none"> <li>a. Reimbursement Percentage</li> <li>b. Maximum Limitations</li> <li>c. Pre-certification Requirement</li> </ul> <p><b>10. Vision.</b> Percentage and/or Frequency  <i>NOTE: If Vision is Not Through Health Plan</i></p> <p><b>11. Hospice, Rehabilitation, and IV Management</b></p> <ul style="list-style-type: none"> <li>a. Lifetime Maximum</li> <li>b. Maximum Number of Days</li> </ul>
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