Moved? Tell Us!

If your office is moving, or has recently moved, please write or type your new address below, cut out this section and mail it to:

CHAMPVA
PO Box 469060
Denver CO 80246-9060

Write your office/practice name and new address here:

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What articles would you like to see in the next newsletter?

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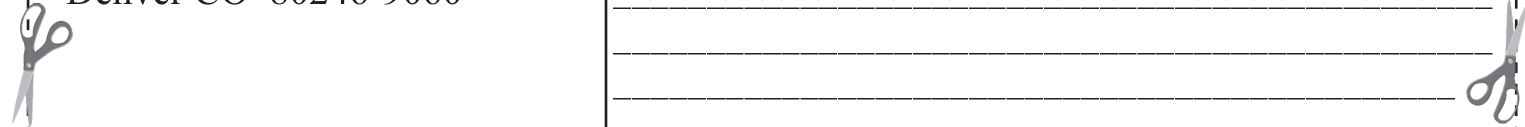

Department of Veterans Affairs
Health Administration Center
CHAMPVA

2008 Provider newsletter

Volume 1, Number 2, Summer 2008

CHAMPVA
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Department of Veterans Affairs
Health Administration Center
CHAMPVA

2008 Provider newsletter

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Moved? Tell Us!

CHAMPVA Beneficiaries Need Your Help

Mary Lou raised seven children and worked as a nurse for 36 years. Now she is 87 years old and lives in an assisted living home in Colorado.

Like many of the greatest generation, her husband, Vince, served in the Army Air Corps during WWII. As a bombardier, Vince was shot down and taken prisoner by the Germans. Because of his sacrifice, Mary Lou is being provided health care through the Civilian Health and Medical Program of the Department of Veterans Affairs. You many know it as CHAMPVA.

Mary Lou and 300,000 other CHAMPVA beneficiaries like her need your help!

Because CHAMPVA is such a small health care program, many health care providers have not heard of the program and do not accept assignment for its beneficiaries.

Oftentimes CHAMPVA beneficiaries like Mary Lou have to pay full medical costs up front, settling for reimbursement from the government after filing their claims. This can be a huge financial burden to seniors on a fixed income. In other cases, doctors simply refuse to treat a CHAMPVA beneficiary, making the burden of finding a health care provider a daunting task.

Sometimes health care providers simply do not know what the CHAMPVA program is, or they confuse it with other programs. Here are some quick facts about the program:

- CHAMPVA is *not* related to TRICARE or the older version of the TRICARE program, CHAMPUS.
- Claim payment is based on Medicare reimbursement rates.
- CHAMPVA is not an HMO—so a referral for specialty care or diagnostic testing is not required.
- CHAMPVA does not contract with providers to see CHAMPVA patients or accept assignment.
- You can file claims on behalf of your patient electronically, and the payment will be electronically transferred to your account. If you are interested in electronic filing, call our clearing house, Emdeon™, at 1-800-444-4336 ext. 2239.

Please continue to accept CHAMPVA assignment. If you need more information on CHAMPVA, please call us at 1-800-733-8387.

Mary Lou with her husband, Vincent.

Thank You Providers

You are an important part of our nation's commitment to veterans.

Since the end of the Civil War, our nation has pledged care and support for the veterans that have fought and sacrificed for our ideals and freedoms and for their families. In fact, the Department of Veterans Affairs' motto, "...to care for him who shall have borne the battle and for his widow, and his orphan..." taken from Abraham Lincoln's Gettysburg Address, punctuates the nation's collective resolve and commitment to veterans.

An important part of that commitment is health care for both veterans and their families. Veterans primarily receive their care at VA medical centers or outpatient clinics, however, for most veteran dependents, health care is received through nongovernmental providers such as yourself. You may not have always thought of yourself as a part of our country's commitment to our veterans, but as a health care provider who treats a CHAMPVA beneficiary, you play a vital role in fulfilling the promise we have made to veterans and their families.

I would first like to express my deep gratitude for your compassion and caring for our CHAMPVA beneficiaries. Supporting their health and well-being is the sole reason that we at the HAC exist, and through you, we make that happen.

Secondly, I would like to sincerely thank you for billing on behalf of the beneficiary. In many cases our more elderly or infirm beneficiaries have a hard time filling out the paperwork and including all of the required documentation. Your billing on their behalf ensures that they receive the vital medical care they need and can enjoy the peace of mind that comes with not having to worry about possibly filing claims wrong.

Finally, I would strongly encourage you and your financial staff to submit claims to us electronically. Not only will this mean that you get your money faster, but it ensures a more accurate claim payment and saves taxpayers hundreds of thousands of dollars in processing expenses.

Once again, thank you for all that you do for our beneficiaries and for helping us fulfill our promise to our veterans and their loved ones.

Mary Beth Saldin, Director
Health Administration Center

We Have New PO Box Numbers & Zip Codes Due to a Post Office Relocation

If you want to file a claim with CHAMPVA, the new address is:

VA Health Administration Center
CHAMPVA
PO Box 469064
Denver CO 80246-9064

If you have general correspondence for the CHAMPVA program, the new address is:

VA Health Administration Center
CHAMPVA
PO Box 469063
Denver CO 80246-9063

The address for filing an appeal has not changed and remains:

VA Health Administration Center
CHAMPVA
ATTN: Appeals
PO Box 460948
Denver CO 80246-0948

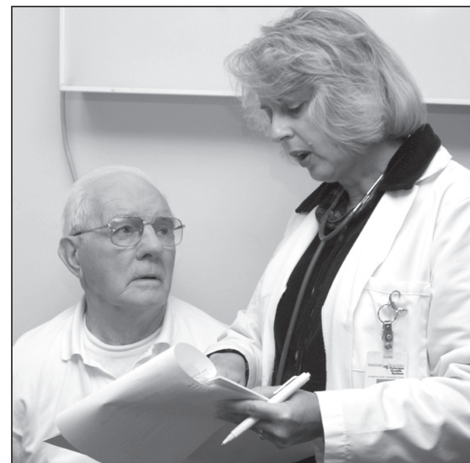
What Is CHAMPVA?

The Civilian Health and Medical Program of the Department of Veterans Affairs (CHAMPVA) is a federal health care benefits program established for the dependents of permanently and totally disabled veterans, survivors of veterans who died from service-connected conditions, or who at the time of death, were rated permanently and totally disabled from a service-connected condition. Under CHAMPVA, the Department of Veterans Affairs (VA) shares the cost of covered medical services and supplies with eligible beneficiaries worldwide.

The CHAMPVA program is administered by the director, Health Administration Center (HAC), located in Denver, Colorado. HAC administers all CHAMPVA activities, including the verification of eligibility for benefits, authorization of benefits and services, vendor certification and approval, payment methodologies, and the authorization of medical services and supplies. CHAMPVA is one of four programs administered by the HAC, the others being the Spina Bifida Program, the Foreign Medical Program, and the Children of Women Vietnam Veterans Program.

Although CHAMPVA is similar to TRICARE, the two programs are not identical. Differences exist in the coverage of some medical services, payment methodologies, and constituent populations.

Can Your CHAMPVA Eligible Patients Appeal a Medical Necessity Denial Made by Their Other Health Insurance (OHI) to CHAMPVA?



When one of your patient's OHI denies one of their claims based on a medical necessity determination, CHAMPVA benefits cannot be extended.

The appeal of the medical necessity decision should be made to the OHI (not CHAMPVA).

If, after review of the appeal, the OHI overturns the original decision and determines the service that you have provided is medically necessary, CHAMPVA will then process the claim as secondary payer and reimburse up to the CHAMPVA allowable amount.

What Requires Preauthorization?

There are five types of care or services that require preauthorization. Getting preauthorization, when required, is extremely important and failure to do so may result in the denial of a claim.

CHAMPVA requires preauthorization for the following:

1. Durable medical equipment (DME) in excess of $2,000

Durable medical equipment is equipment that can withstand repeated use, is used primarily for medical purposes, is generally not useful in the absence of an illness or injury, and is appropriate for use in the home.

It is important to keep in mind that DME must be ordered by a physician and authorized by CHAMPVA if the total cost exceeds $2,000, which would be for either the purchase of the equipment or rental cost up to VA allowable purchase price.

Below is a list of examples of DME that require preauthorization (this is not an all-inclusive list):

- BiPap Devices
- Insulin Pumps
- Patient Lifts
- Power Wheelchairs and Scooters
- Specialty Mattresses

2. Organ Transplants

If an organ transplant is needed, the facility must be Medicare certified or TRICARE authorized. An evaluation from the transplant team is required.

3. Hospice Care

If hospice care is required, please contact us at 1-800-733-8387, and we will send you a list of items that need to be completed prior to authorization. The Hospice provider must be Medicare certified for services to be covered under CHAMPVA.

4. Dental Care

Generally, dental care is NOT a covered benefit. There are rare circumstances and conditions when dental care is covered, but in all cases, preauthorization is required. When submitting requests for preauthorization for dental care, please include a statement from both your physician and dentist specifying what treatment is required, why the treatment is required, how it relates to a CHAMPVA covered medical condition, and the estimated cost.

5. Mental Health Care

The mental health programs that require preauthorization are:

- Mental Health Inpatient Care
- Psychiatric Partial Hospitalization Program (PHP)
- Residential Treatment Center (RTC)
- Substance Abuse Detox and Rehabilitation Services (Inpatient and PHP)
- Psychological Testing (in excess of six hours)
- Outpatient Psychotherapy (exceeding 23 visits in a fiscal year)

Outpatient Substance Use Rehabilitation exceeding 60 sessions in a benefit year. (A benefit year is defined as 365 days from the start of treatment.)

Please contact our mental health partner, Magellan, at 1-800-424-4018 (24 hours day) for additional preauthorization questions.

Currently, the preauthorization process may take up to three to five business days. During this time, your request will be thoroughly researched and a determination will be made. Once the determination is made, we will send you a letter to indicate our decision.

CHAMPVA preauthorization staff are located in the Health Administration Center in Denver, Colorado. We can be reached at 1-800-733-8387. You can also fax your requests to 303-331-7807, or mail them to:

CHAMPVA
PO Box 469063
Denver CO 80246-9063

Common Questions CHAMPVA Receives from Our Providers

1. Is there a group number or a network of doctors?

CHAMPVA is a federal benefit and does not have contract providers or a group number. You must be properly licensed in your state to receive payment from CHAMPVA and cannot be on the Medicare exclusion list.

2. Are you able to accept crossover claims with Medicare?

At this time we do not accept Medicare crossover claims directly from the Centers for Medicare and Medicaid Services. If your patient is a Medicare beneficiary, we will process the claim as a secondary payer if you submit it to us on paper or electronically through our clearing house, EMDEON. Just add the other health insurance information to the 873 transaction. We request that you send us the bill, along with the Explanation of Benefits (EOB) from Medicare, prior to collecting any cost shares or deductibles from our CHAMPVA beneficiaries. We expect to be able to accept Medicare crossover claims in the future.

3. How does a beneficiary's other health insurance (OHI) status affect how claims are processed or denied with CHAMPVA?

With the exception of State Victims of Crime Compensation, Medicaid, and Indian Health Service, CHAMPVA is, by law, always the second payer. For us to comply with federal law, we need to know if the beneficiary has other coverage so we can calculate payments correctly. EOBs from all OHI for a CHAMPVA beneficiary must be submitted with a claim. We will review every submitted health care claim to verify that OHI information is present, if needed. If OHI EOB information is missing, we will deny the claim, using a reason code of 78—"EOB from other insurance required CHAMPVA secondary payer."

4. What's the difference between TRICARE, CHAMPVA, and CHAMPUS?

TRICARE beneficiaries are not eligible for CHAMPVA. Although the programs are similar, TRICARE (formerly CHAMPUS—which is administered by the Department of Defense) should not be confused with CHAMPVA. TRICARE provides coverage to the families of active duty service members, families of service members who died while on active duty, and military retirees and their families, whether or not the veteran is disabled.

5. How does balance billing work with CHAMPVA?

Under 38 CFR, section 272(b) (3) and (4), providers who agree to accept the beneficiary must accept the CHAMPVA allowable charges and cannot balance bill the beneficiary. The sole exception is when you notify the beneficiary prior to any services being rendered that you do not accept CHAMPVA and that the beneficiary must pay the entire billed amount up front and file a claim to CHAMPVA.

6. What are the requirements for timely filing?

The objective of CHAMPVA claims processing procedures is to ensure that all claims are processed in a timely and consistent manner and that government funds are expended only for those services or supplies authorized by regulation. Claims must be received within one year from the date of service, or one year from the date of discharge from an inpatient facility. Exceptions to timely filing requirements may be granted when:

- There is medical documentation of beneficiary incompetence and the beneficiary did not have a legal guardian.
- There is evidence of an administrative error. An example of an administrative error is where the beneficiary has been prevented from timely filing because of misrepresentation. Necessary evidence must include:
  - A written statement describing how the error caused inability to file within the usual time limit
  - A copy of an agency letter or written notice reflecting the error
- The claimant submitted the claim to a primary health insurer, and the primary insurer delayed adjudication past the CHAMPVA deadline. In this case, the following must be established:
  - The claim was originally sent to the primary health insurer prior to

Continued on Page 6

Continued from Page 5

the CHAMPVA claim filing deadline. The claimant must submit with the claim a statement indicating the original date of submission to the other health insurer, the date of adjudication, any relevant correspondence, and an EOB.

7. Is long-term care a covered benefit?

Long-term care and any other service provided to assist a person with eating, dressing, bathing, or performing other activities of daily living are not covered benefits under CHAMPVA, regardless of where the care is performed, whether in a nursing home, assisted living facility, or at a beneficiary's home.

Additional information is available online at **www.va.gov/hac/factsheets**

Meds by Mail

Meds by Mail is a cost free way for beneficiaries to receive maintenance medications! Please help us ensure they take advantage of this benefit.

Are your CHAMPVA eligible patients (who do not have other health insurance with a prescription plan) aware of the benefits of the Meds by Mail pharmacy program?

CHAMPVA offers these patients a safe, convenient way to get maintenance medications free of charge delivered directly to their home! As long as your CHAMPVA eligible patients meet all of the requirements, you, the health care provider, simply write a new prescription for a 90 day supply, plus refills not to exceed one year.

Your patient will need to send this prescription, along with a Meds by Mail order form (VA form 10-0426, available online at **www.va.gov/vaforms/medical/pdf/vha-10-0426_fill.pdf**) to the correct servicing center in either Cheyenne, Wyoming (West), or Dublin, Georgia (East). Patients can determine which office they will need to submit their prescription to by going to our Meds by Mail website at **www.va.gov/hac/forbeneficiaries/meds/meds.asp** and clicking on the state in which they live.

Please note that CHAMPVA eligible patients needing antibiotics or controlled substances should still use their local pharmacy, where they will incur a minimum charge of 25%.

CHAMPVA and Routine Medical Exams

Some of the inquiries we receive in the Customer Service Center are about routine medical exams. We believe there may be some confusion about the definition of *routine medical exam*. This term may mean one thing to you, the provider, and something different to the CHAMPVA program.

For the most part, providers view routine care as follow-up to a patient's medical condition, such as high blood pressure; review and adjustment of medications; other diagnostic tests for monitoring high cholesterol or diabetes; or even a visit for the flu. This is because the care provided to the patient is routine in nature and does not require an extensive physical examination or medical history workup.

CHAMPVA views routine medical examinations as those exams that are not a part of follow-up care to a medical condition. Some examples of routine medical examinations include: an annual routine physical examination, to assess your general health without having a specific health care-related need; pre-employment physicals; and smoking cessation or weight loss programs.

There are, however, many routine procedures and diagnostic tests that are covered by CHAMPVA. Health care benefits include, but aren't limited to: screenings for breast, colorectal, and prostate cancer; pap smears, mammograms, and immunizations that are recommended by the Centers for Disease Control.

Understanding benefits is important for determining which health care services may be covered under the CHAMPVA program. You can find answers to many of your questions about covered benefits in the CHAMPVA Handbook, on the Internet at: **www.va.gov/hac/forproviders**, or call the HAC Customer Service Center at 1-800-733-8387.

Timely Filing of Appeals

The largest percentage of reconsideration/appeals received by the HAC relates to timely filing. To ensure that a claim is submitted in a timely manner, it must be received by the HAC:

- Within one year from the date of service;
- In the case of inpatient care, within one year after the date of discharge;
- In the case of retroactive authorization, within 180 days following notification to the beneficiary of an approved retroactive authorization date; or
- In the case of retroactive authorization, within 180 days following beneficiary notification of the approval of a covered service that had previously been denied.

You cannot seek payment from the patient when you fail to meet the timely filing requirements and a waiver has not been granted.

Some exceptions that could allow a waiver of the timely filing requirements are:

- There was a delay with the primary health insurance, as indicated on their EOB. You must include supporting documentation verifying that the claim was originally sent to the primary health insurer prior to the CHAMPVA claim filing deadline;
- There is sufficient medical documentation of patient incompetence and the patient does not have a legal guardian; or
- There is evidence of an administrative error that occurred when the beneficiary or provider was misinformed by a representative of the HAC. Supporting documentation must accompany the appeal before the HAC can begin to research and validate the error through historical records.

In the case of late filing, you or the patient may submit to the Director, in writing, reasons for the late filing and documentation to support these reasons. Exceptions to timely filing are determined by the HAC Director. Each appeal received regarding an untimely filing denial will be reviewed on a case-by-case basis and judged on its own merit.

HAC Customer Service Center Improvements

HAC's Customer Service Center has been working on several improvements to help ensure that every interaction with us is as pleasant and efficient as possible.

You now have the option to obtain claim information using our Integrated Voice Response (IVR) system. When you call us at 1-800-733-8387, you will be offered the option of hearing claim information without having to speak with a customer service representative (CSR). For anyone in a busy office environment, this feature is a real time-saver.

We've also increased our staff, for those times when you do need to speak with a CSR. The additional staff means your wait time will be much shorter than it has been in the recent past. Our goal is that your hold time be no more than 1–2 minutes on a typical day.

To further reduce call wait times, a new feature called Virtual Hold has been added. This is a new technology that allows you to request a return call instead of waiting on hold. When hold times are greater than three minutes, callers are given the choice of either continuing to hold for the next available representative or letting the system call them back when a representative becomes available.

Another area of focus is training for our CSRs. Our training program has been enhanced to help ensure that every person who calls us receives the same high level of service in a friendly and professional manner and our responses are always complete and correct.

In reviewing our planned improvements, we are considering several additional ways to better help you receive the information you need. One initiative is a secure website that would be available 24 hours a day, 7 days a week, where you would be able to retrieve all the information you now receive by talking with a live representative. We are also working toward the ability to offer "live chat" customer service. This is another web-based and secure way to very quickly get the answers to questions you may have.