Department of Veterans Affairs
Health Administration Center
CHAMPVA

2007

newsletter

Summer 2007
Volume 1, Number 1

The HAC Would Like to Thank Our Providers

Thank you for providing medical services and supplies to CHAMPVA program beneficiaries. As you know, these beneficiaries are the spouses, children, and survivors of veterans who have either a permanent and total service-connected disability, or those veterans who have died as a result of their service-connected disability. We sincerely appreciate your willingness to help serve the family members of our nation's veterans.

Denied Claims Tips for Providers

We have a denied claims service on the CHAMPVA web site. Visit us at **www.va.gov/hac**, and click on "For Providers." You will find a quick link to this important information advertised at the beginning of the "For Providers" page.

The tip for this issue is understanding denial code "78 –EOB FROM OTHER INSURANCE REQUIRED–CHAMPVA SECONDARY PAYER."

If you receive this notice, it means that our records indicate that the patient you treated has insurance through Medicare or a commercial health plan that is primary to CHAMPVA. Your patient will also receive a copy of this notice.

If you are certain that your office has the most up to date information on the patient, then it will be necessary to have that individual contact us to update their insurance status. This can either be done by completing and mailing in a VA Form 10-7959c "CHAMPVA Other Health Insurance (OHI) Certification," or by having the patient contact us by phone (1-800-733-8387). This type of claim denial normally occurs when your patient informs you that they are dropping their primary coverage, but fails to inform us. It can also occur when they start a new health plan without providing us with information on the plan.

A less frequent reason for denying claims under code 78 is that the information you provided with your bill was not sufficient for us to understand the decision of the primary insurance plan. Many commercial insurers only show a denial code on the front of their Explanation of Benefits (EOB) form and describe the meaning of the code on the back side of the page. If we do not receive the description of their denial or payment decision, we will not be able to adjudicate the claim for secondary payment. Some health plans do not provide a paper EOB form, but make this information available on a web site or other service. It is necessary for you to print a copy of the EOB form and include it with a paper claim.

We will accept an electronic bill (837) for secondary payment as long as the request accurately and completely describes the decision of the primary health insurance plan.

inside

Having Problems Contacting Us?

We understand how frustrating it can be when you call 800-733-8387 and you get a busy signal because our phone lines have reached capacity, or when you are on hold waiting to speak to a Customer Service Representative. It is our desire to always provide you with excellent service and we are working to improve our level of service to you. We have a solid plan in place and we expect that you will soon begin to see gradual improvements in service. We are increasing our phone staff by 15%. With each newly trained staff member, we will be able to answer 50-70 more calls per day. With the addition of this staff over the summer, it is our goal to reduce call hold times to five minutes or less by the fall.

We appreciate your patience and sincerely apologize for any inconvenience the wait times have caused you. When you reach a Customer Service Representative, our objective is to provide courteous, accurate, and professional service. We will do everything possible to fully answer your questions or resolve your concerns the first time you call.

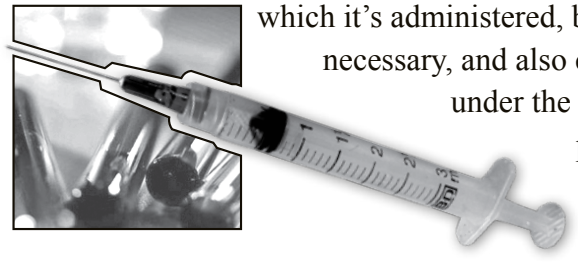
Also, we have information available through options other than speaking to a Customer Service Representative. If the information you would like is available through any of these sources, consider giving these options a try:

- Interactive Voice Response System. This is available to you 24 hours a day, 7 days a week by calling 1-800-733-7387 and then pressing 1 to use this self-service system.
- Use our website **www.va.gov/hac** to view the handbook, policy manual, fact sheets, and frequently asked questions.
- Your questions can be answered on-line 11:00 a.m. to 6:30 p.m. Eastern Time, Monday through Friday (excluding holidays) by using our chat line. To access it, go to **www.va.gov/hac/contact/contact.asp** and select "Chat Live!"
- You can contact us via email by logging on to our website **www.mychampva.com** and clicking on the Inquiry Routing and Information System (IRIS) link.
- You can also write us for information. Make sure you include your name, the patient's name and CHAMPVA Member Number (which is the Social Security number), and your phone number. Correspondence should be sent to:

  VA Health Administration Center
  CHAMPVA
  PO Box 65023
  Denver, CO 80206-9023

Billing and Reimbursement of Injectables

The CHAMPVA Program compensates health care providers for covered drugs (injectables, infusables, pharmaceuticals, and chemotherapy agents) rendered during the course of an outpatient treatment. The drug must be FDA approved for the treatment of the condition to which it's administered, be medically necessary, and also covered under the program provisions.



To assist you in expediting the processing of your claim, as well as ensure appropriate payment, we advise that both the HCPCS "J" code and the appropriate National Drug Code (NDC) for each drug with the appropriate quantity or units be provided on the claim for adjudication. This will eliminate erroneous denials for specific drug information particularly when a drug does not have an applicable code resulting in the use of a miscellaneous or non-specific HCPCS code.

CHAMPVA reimbursement of covered medical drugs is limited to the CMAC (CHAMPVA Maximum Allowable Charge) for Outpatient Injectables and the Average Wholesale Price (AWP) plus a $3 dispensing fee for medical drugs billed with a NDC.

Payment is contingent upon the appropriate pharmacy coding conventions and billing guidelines. When billing CHAMPVA, please ensure that pricing of these drugs are comparable to that of the CMAC and/or AWP reimbursement methodology according to the appropriate dosage and quantity of the drug.

In providing you with these billing guidelines, we hope to reduce the number of claim denials and decrease the possible overpayments that would be collected retrospectively.

Dental Care–is it a covered benefit under CHAMPVA?

In most cases the answer is no.

The regulations that govern the CHAMPVA program limit dental coverage to those procedures that are necessary in the treatment of an otherwise covered medical condition, that is an integral part of the treatment of such medical condition, and is essential to the control of the primary medical condition. What does that mean in plain English? It means that if your patient has a medical condition that has nothing to do with the teeth, but the patient's teeth must be treated or the non-dental medical condition will not improve, then the dental care may be covered.

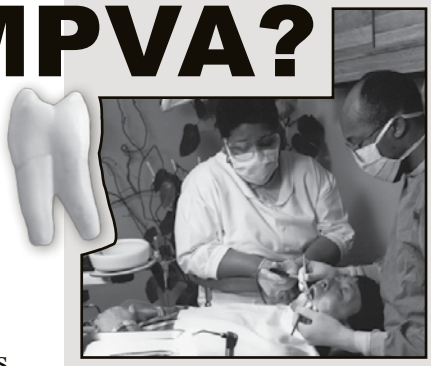
Here are a couple scenarios that may help to make this clearer.

Let's say the patient's jaw is fractured (a non-dental condition) and tooth fragments need to be removed (a dental condition) in the repair of the fractured jaw. The removal of the tooth fragments would be a covered benefit.

On the other hand, if the patient fell, broke a leg, and knocked a couple teeth loose, the repair of the loose teeth would not be a covered benefit. The repair of the loose teeth was not necessary to treat the medical condition resulting from the fall—a broken leg. The loose teeth are solely a dental condition and the repair of the loose teeth would not be considered necessary to treat the broken leg.

Needless to say, the list of what is not covered is much longer than what may be covered. We do not cover routine dental care, cleanings, fillings, dentures, crowns, root canals, etc. related to usual and customary dental hygiene.

There is one condition that is often treated by dentists for which we do provide limited coverage, and that is temporomandibular joint syndrome (TMJ) or myofascial pain dysfunction syndrome. The extent of the authorization



CHAMPVA can provide is for the initial x-rays, no more than four office visits, and the construction of an occlusal splint.

To obtain preauthorization for any dental procedure, please contact us at 1-800-733-8387, or send written requests or inquiries to:

VA Health Administration Center
CHAMPVA
Attn: Preauthorization
PO Box 65023
Denver CO, 80206-9023

CHAMPVA & Other Health Insurance

Some of our CHAMPVA beneficiaries have other health insurance coverage plans from their employment or Medicare and Medicare supplements. CHAMPVA is secondary or tertiary payer. As a result, please be aware that we will not make payment on a claim for medical services until we have received the Explanation of Benefits (EOB) from all other payers on the claim.

For example, we must be provided both the Medicare and Medicare supplemental insurance EOBs if applicable for your CHAMPVA patient before we can consider payment for any additional amounts on the claim for services.

Additionally, please be aware that in most cases we also do not cover services and supplies that Medicare has determined not to be a benefit under their program, such as custodial care. If you disagree with Medicare's denial, you must appeal the denial to Medicare.

Preauthorization Requirements

Certain types of care/services require advance approval. When preauthorization is not obtained, it may result in denial of the claim. Preauthorization is required for

- Durable medical equipment (please call us for more information).
- Hospice services.
- Mental health/substance abuse services.
- Transplants.

Exceptions:
When Medicare is the primary payer and has authorized the care, mental health services do not require preauthorization.

Dental care is not a covered benefit in most cases. As a result, any dental care your dentist believes meets the criteria for coverage under CHAMPVA must be preauthorized. Please see the separate article in this newsletter regarding dental care.

If you have questions about the items that require preauthorization for our programs, the coverage criteria or the medical documentation needed for a particular item or service you may access the policy manuals for our programs from our website at **www.va.gov/hac** or contact customer service:

CHAMPVA 1-800-733-8387

When preauthorization is not required, but medical documentation still must be submitted

There are items and services that do not require preauthorization, but do require medical documentation with the claim. The following is a list that provides examples of services that, if provided, the physician should send the medical records/notes with the bill:

- allergy testing
- biofeedback
- home health services
- laser surgery
- outpatient diabetes self-management training
- oxygen and oxygen supplies
- physical therapy services
- skilled nursing services (you may want to request preauthorization to ensure the care is covered–custodial care is NOT covered)
- surgery for morbid obesity (gastric bypass, gastric stapling or gastroplasty)

Claims Auditing Update

We use a claims auditing/editing product for the purpose of evaluating and clarifying professional billing for Current Procedural Terminology (CPT)® coding. The product eliminates overpayment(s) on professional and outpatient hospital (non-institutional) claims. In other words, the benefits consist of:

- Paying claims more accurately,
- applying consistent payment policies for providers,
- enabling prospective claims audits to educate physicians on coding inaccuracies,
- decreasing claim suspensions while increasing productivity.

We are upgrading the current claims auditing/editing version. The anticipated time for the new service will occur this summer. The updated version has more auditing options and will be updated annually with new coding based on current industry standards.

The claims auditing/editing product identifies coding errors in the following categories:

- **Age and Gender Conflicts**–Procedure codes that are in conflict with the age and gender information entered on the claim.
- **Assistant Surgeon**–Only certain procedures include routine use of an assistant surgeon. It screens claims for assistant surgeon charges and determines if the procedure normally requires an assistant surgeon's services.

- **Bilateral/Unilateral Procedures**–A unilateral CPT® code is used to identify a procedure performed on a single anatomical part. A bilateral code identifies a set of procedures performed on similar anatomical parts. If both the bilateral and related unilateral codes are submitted on the same date of service and a single comprehensive (all-inclusive) code exists that describes the procedure(s) performed, the services will be identified as rebundled services. The editing product rebundles (replaces) the procedure codes to the single comprehensive procedure code.
- **Cosmetic Procedures**–Procedures, which are performed to enhance the beneficiary's appearance, are considered cosmetic.
- **Duplicate Procedures**–Services that have been previously processed or are currently in progress. The editing product will search for duplicate services in the patient's history.
- **Evaluation & Management (E&M) Medical Visits**–Billing for medical visits when a substantial diagnostic or therapeutic procedure is performed. The E&M visit will not be reimbursed separately.
- **Incidental Procedures**–Procedures that require little additional physician resources and/or are integral to the primary procedure performed. The incidental procedure will not be reimbursed separately.
- **Mutually Exclusive Procedures**–Two or more procedures that are usually not performed during the same session for the same patient on the same day. This includes different procedure code descriptions for the same types of procedures where only one code should be billed.
- **Procedure Unbundling**–Two or more CPT codes are used to describe a procedure when a single, more comprehensive code exists that describes the entire procedure performed. The editing product will delete any extra (unbundled) codes and replace them with the proper single code (rebundle).

The process for appeals has not changed. Providers should submit their appeals in writing, with supporting documentation to:

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

Providers, are you submitting claims electronically?

The Health Administration Center (HAC) receives thousands of hospital and medical claims daily for processing from our trading partner clearinghouse Emdeon™ (formerly known as WebMD). Emdeon™ is capable of receiving and sending electronic transactions as required by the Health Insurance Portability and Accountability Act of 1996 (HIPAA). Other available transactions from the HAC include electronic eligibility, claim status and remittance advice.

Submitting your claims electronically is an easy, cost effective solution to significantly shorten adjudication time and speed your payment. If you have the capability at your hospital or office of submitting electronic health care claims via your billing office, an electronic claim network or another clearinghouse, please contact your software vendor to insure our Payer IDs are set up for EDI transmission. No additional enrollment is required to submit claims to the HAC.

Payer ID 84146
Hospital/Medical Claims

Payer ID 84147
Dental Claims

www.emdeon.com

National Provider Identifier (NPI)

What is an NPI?

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires the adoption of a standard unique identifier for providers. The National Provider Identifier (NPI) Final Rule was issued on January 23, 2004 and adopted the NPI as this standard. The compliance date for implementation of this new identifier is May 23, 2008.

The NPI is a ten digit intelligence free numeric identifier. Intelligence free means that the numbers do not carry information about health care providers, such as the state they practice or the provider type or specialization. The NPI will replace other health care provider identifiers used in HIPAA standard electronic transaction that they conduct with health plans. Those transactions include but are not limited to the electronic claim (837), eligibility inquiry and response (270/271), claim status inquiry and response (276/277), payment and remittance advice (835), prior authorization/referral (278) and all coordination of benefit transactions. Some examples of the identifiers that will be replaced by the NPI are: Medicare legacy IDs, UPIN, BCBS numbers and OSCAR. The NPI does not replace the Tax Identification Number (TIN) which is also needed to process and pay claims.

NPI Requirements for CHAMPVA

We are currently accepting NPIs in electronic transactions received at our clearinghouse for medical, dental and pharmacy transactions. Also include your Tax Identification Number with the entity that will be paid on all electronic 837 claim transactions.

If you are a HIPAA covered health care provider who electronically bills for services to us, or submits other electronic transactions to us through our clearinghouse, you need an NPI. NPIs that should be sent include rendering, referring and prescriber NPIs.

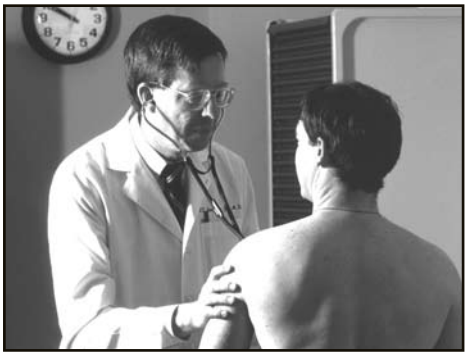
If you are submitting your claims via the new paper forms UBO4, CMS 1500 (08/05) or the ADA J400 form, there are fields that allow entry of the NPI. Please include your NPIs on your paper submissions as well as the Tax Identification Number in the appropriate locations.

When is the use of the National Provider Identifier Required?

The Health Administration Center, as a HIPAA compliant health plan, is establishing a contingency plan for a period of 12 months after the NPI deadline of May 23, 2007. We will allow the continued use of legacy identifiers in HIPAA transactions until May 23, 2008 through our clearinghouses, for medical, dental and pharmacy claims. After May 23, 2008 legacy identifiers will not be allowed on any inbound or outbound HIPAA electronic transactions.

Who can apply for an NPI?

Health care providers such as physicians, dentists, opticians, chiropractors, medical equipment suppliers, hospitals, pharmacies and other providers of medical services are eligible for NPIs and can apply for an NPI. Health care providers are individuals or organizations that render health care. All health care providers that are HIPAA covered entities, whether they are individuals or organizations must obtain an NPI to identify themselves in all HIPAA covered electronic transactions.



How can I apply for my NPI?

Providers can apply for an NPI in one of three ways:

1 Apply via the Internet through the National Plan and Provider Enumeration System (NPPES) website at: **https://nppes.cms.hhs.gov**

2 Health care providers can agree to have an Electronic File Interchange (EFI) Organization submit application data on their behalf or,

3 Providers can obtain a copy of the paper NPI application/update form (CMS-10114) and mail the completed, signed application to the NPI Enumerator. A request for a paper application should be made at 1-800-465-3203.

Regardless of how you obtain your NPI, it is important that you retain the notification document that National Plan and Provider Enumeration System (NPPES) sends to you that contains your NPI. You will need to share this information with other health care partners who may provide electronic billing services to you or your organization.

Once you obtain your NPI, it is estimated that it will take 120 days to do the remaining work to use it. This includes working on your internal billing systems, coordinating with billing services, software vendors, and clearinghouses, and testing with payers. As outlined in the federal regulation, (The Health Insurance Portability and Accountability Act of 1996 [HIPAA]) you must also share your NPI with other providers, health plans, clearinghouses, and any entity that may need it for billing purposes. If you delay applying for your NPI, you risk your cash flow and that of your health care partners as well.

To date over 1.6 million providers have obtained their NPI from the NPPES. A recent survey of the health care industry, conducted by the Workgroup for Electronic Data Interchange (WEDI), indicates that providers should have already applied for an NPI and be focusing on implementation with health plans and clearinghouses. If you have not obtained your NPI, you should do so immediately so that you can begin implementation and testing. Your NPI is critical for health plans and health care clearinghouses to aid in the transition to the NPI.

Additional Information on NPI is Available

If you need more information and/or education on the NPI, it can be found at the CMS NPI page at **www.cms.hhs.gov/nationalprovidentstand** on the CMS website.

Professional & Technical Component Modifiers

Would you like to receive the appropriate reimbursement for certain procedural codes requiring the use of modifiers–26 (professional component) and–TC (technical component) without having to retrospectively reconcile numerous accounting records to identify potential overpayments? If so, please read on, as this notice may have a financial impact to you.

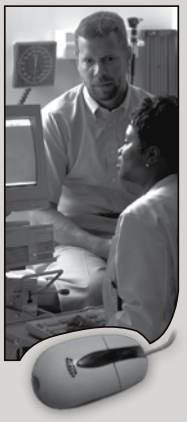
We will be conducting quality assurance reviews to proactively identify scenarios where the billing of both modifiers–26 and–TC resulted in an inappropriate payment. Inappropriate reimbursement would be defined as billing for the global reimbursement of a service when in fact, only one of the components, (either the professional or the technical portion) was provided by you.

What follows are informative coding tips in the appropriate application of modifiers –26 and–TC:

Modifier–26 should be appended to certain CPT codes when a physician is billing for the professional component or physician interpretation of the procedure. Reimbursement is based on the CHAMPVA allowed amount for the professional relative value unit. Documentation of the service must be accessible in the patient's medical record. The written documentation must include the physician's diagnostic procedure findings, relevant clinical issues, and the signature of the physician.

Modifier –TC should be appended to certain CPT codes when the service represents the technical component of the procedure. Reimbursement is based on the CHAMPVA allowed amount for the technical relative value unit. Technical services represent the actual performance of the diagnostic test or study.

Certain procedures without appended modifiers represent a combination of both the technical and professional component resulting in a global reimbursement for both services. Certain procedures allow for global reimbursement when rendered by the same provider.



Please ensure that the appropriate applications of these modifiers are being used in your billing process. In some instances, services may be inappropriately reported resulting in either an under or overpayment. In the event that either of these situations has occurred in your billing process, please report these findings in writing to us.

Notice of Payment Changes

In February 2007, we implemented the Department of Defense TRICARE fee schedule for anesthesia and drugs administered during office visits.

- TRICARE CMAC rates for services billed for injectable drugs. A rate schedule is available at: **www.tricare.mil/cmac/procedurepricing/procpricing.aspx**
- TRICARE CMAC rates for anesthesia professional service when not provided in an inpatient setting. A rate schedule is available at: **www.tricare.mil/anesthesia**

We will be implementing other fee schedules and Prospective Payment Systems (PPS) based on the TRICARE PPS. Skilled Nursing Facility payment will be implemented this year. The HAC will send additional notices as changes are made.

Information on payment procedures for each health plan can be obtained on our web site at **www.va.gov/hac**, by selecting the "For Providers" menu option. Details are also available on the web in the CHAMPVA Policy Manual.

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 Newsletter
ATTN: HAC Communications
PO Box 65020
Denver, CO 80206-9020

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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Health Administration Center
CHAMPVA

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