VA MINUTES
July 18, 2016 RIC/RAC Meeting

VA REPRESENTATIVE PRESENT:
Ms. Traci Solt
Ms. Jackie Lewis

FACILITATORS PRESENT:
Mr. Wesley Ashmore
Ms. Debbie Rubio

MR. ASHMORE: I'm happy to say we have the VA here for the first time. And we have Traci Solt and Jackie Lewis with us today. Do you want to go ahead and introduce yourselves?

MS. SOLT: Yes. Good afternoon. My name is Traci Solt. I'm the associate director for patient care services and the chief nursing officer at Central Alabama Veterans Healthcare System. My role in Central Alabama Veterans Healthcare System is to oversee the VA community care, which does the authorizations for the care that we give in the community.

And then I'm going to let Jackie introduce herself.

MS. LEWIS: My name is Jackie Lewis, and I'm the chief of purchase care, so I'm responsible for paying for the claims that get submitted to us.

(Laughter)

MS. LEWIS: And I get blamed for everything the crazy staff doesn't do.

(Laughter)

MS. SOLT: I thought I came here to protect you.

1. Providers are being asked to mail a copy of the paper claim along with the medical record even after submitting the electronic claim.
    a) If we have to resend a paper claim each time with the medical records, what is the point of sending electronic claims?

        <u>Response:</u> Providers often send bundles or stacks of medical documentation. This makes it difficult for personnel scanning the records into our system to determine where one record ends and another begins. Submission of a paper claim along with each record ensures that our medical records department has the necessary information needed to properly index the records.

    b) Would the paper claim sent with the medical records not be considered as a duplicate claim?

        <u>Response:</u> No. Further, if a paper claim is adjudicated incorrectly, the claim can be reopened. Electronic claims cannot be reopened if denied, and can only be reopened within 45 days after being rejected.

c) Are there any plans for VA to develop a method for providers to do electronic transmission of the medical record instead of using snail mail?

Response: **The short answer is yes. However, there are no specific dates of implementation at the present time.**

Discussion at meeting

MS. LEWIS: Okay. Part A was that if we send a paper claim each time with the medical records, what's the point of sending electronic claims?

Well, providers often send us bundles and stacks of medical records, and it makes it difficult for the people who are scanning in the medical records to know where one medical record ends and the other begins. So it helps when a paper claim is attached, and it just makes it easier for the medical records department to ensure that those records are indexed to the proper veteran or patient.

And no, the paper claim that's sent with the medical record isn't a duplicate claim because when we reject a claim for not having medical records, that claim is no longer active in our system. We rescan the medical record and the claim, and the claim is visible again in our system and we don't have to reopen anything. So it makes it easier, even though it may make it more difficult for you.

And, yes, there are plans for the VA to develop a method for providers to do electronic transmission of medical records, but I don't have any specific dates. But they're looking at seeing how that can be done.

MS. SOLT: And I was just going to add not necessarily for the billing but for the sending medical records, probably within the next month or two, Central Alabama is starting something called Stream, it's through Xerox, where we'll be able to receive medical records. And we're going to be working with CBO. Instead of having to mail them or fax them, we'll be able to receive them and they'll be indexed, and we'll be able to use them like that.

Before, what was happening is if we got emailed or faxed records, even if we got something emailed, we had to print them out, scan them into the machine, and then index them, because it has something to do with our security system in the VA. But probably within the next I would say two months, I think we'll be able to implement that system, it's called Stream. So I'm hoping that that will make some things easier for you guys.

2. Please explain the difference between Authorized vs Eligible claim and also provide information on how they are processed.

Response: **An 'Authorized' claim is a claim presented for preauthorized care. Veterans sent directly from the VA for emergent care fall in this category.**

Unauthorized care is when a Veteran obtains care outside the VA health care system without prior authorization. Depending on the Veterans 'eligibility,' VA may pay all, some or none of the charges.

Discussion at meeting

MS. LEWIS: Okay, preauthorized - we send them to you, we set them on the inside, we know they're going; and we don't require medical records for those particular claims to be processed for payment.

So in other words, the veteran has to meet administrative eligibility criteria. And that can't be determined until we get the claim and the medical records and it goes through a clinical review. Because there are a lot of what-ifs.

I mean, the veteran sometimes is not service-connected for whatever he presented for or it wasn't a pre-emergency. There's just a number of variables. And we can't tell you up front if we're going to be able to process that claim for payment or not. And all those what-ifs are governed by law or regulation. It's not something that we make up just to make life difficult for everybody.

MS. SOLT: Another thing, too, sometimes you can get an authorization if you have a patient that admits to your emergency department or to your hospital if you notify us within 72 hours of them being there.

And when we were at the Alabama Hospital Association, one of the things that we found with the round table was that a lot of people didn't have the right phone numbers. Their complaint was, I call and nobody answers the phone. And so we gave the Alabama Hospital Association a list of just the people that you would need to contact for getting an authorization or notifying us that you had one of our patients that was admitted. And so I don't know if you guys have shared that with these guys?

MR. ASHMORE: I'm not sure because I wasn't at that meeting, but I'm sure we could, if it hasn't already been.

MS. SOLT: If you guys are interested in that list, I can get that to you. So I will send you that list.

MS. CARSTENS: Please, send it to me. Because if it got distributed, it may have gone to the administration level and it may not have cycled to the people in this group. So if you'll send that to me, I'll be glad to distribute that to the group.

MS. SOLT: We worked real closely I know with Baptist Health. And they had a lot of outstanding claims, and we were able to work with them. But now that they have the right phone numbers and the right people to call, I think we're doing a lot better with them. It's getting better. But having the right phone number and somebody to contact I think is the first step. So I'll get that to you guys.

AUDIENCE: You have the phone numbers that you're going to get to them. Can you also do that or obtain those in a matrix for those of us on the Gulf Coast, like in Mobile County? Because we don't necessarily deal with you ladies. We have to deal with the people in Mississippi.

MS. SOLT: Yeah. I know those guys in Biloxi, and I'll call them and see if they have a list.

AUDIENCE: A lot of us are aware of the people. But as we get new employees and all, if we had a matrix that we could just hand to someone.

MS. SOLT: Absolutely. I think we did it by position.

AUDIENCE: Position is great.

MS. SOLT: Right. And so we also did it on the weekend and night hours. You know, the bed management folks are there Monday through Friday, but we have a nurse of the day and an administrative officer of the day that cover the other hours, and they're the people that you probably need to get in touch with, but you guys probably don't have those numbers. I know the guys in Biloxi real well, so I'll try to get that for you.

AUDIENCE: So I just wanted to share this because we're trying to partner up with VA and trying to figure out how we can get things better. The other thing that we did with regards to authorization is we created a group email on the VA side as well as on our side for our registration people to use to send emails if it's on a weekend and they can't get to somebody.

AUDIENCE: That's a good idea.

MS. SOLT: Yeah. And so I can get that distribution list out to you guys too.

AUDIENCE: And while you're following up on the Gulf Coast, they don't let us email at all. So if you have a way to be able to let us do that without us having to call them, that would be great.

MS. SOLT: I can reach out to their director and ask him. But, you know, here, I oversee the department, so I can make sure that we communicate.

MS. LEWIS: I like emails.

MS. SOLT: I do too. And I don't know if you guys know this, but Jackie works for CBO, which is part of VA, but she didn't work for the medical center. And so we've had to make sure that we partner. Because when you guys hear VA, you just think VA. You don't know that there's so many different silos. And that's all you should see.

But historically, we've been very silo. They're bureaucratic. You guys know that. And we're working really hard here in Central Alabama to change that. So that's why Jackie and I are here together. We work for different agencies, but we're on the same team, and we have the same mission that you guys do. We want to take care of veterans.

3. Please confirm if 10-583 form for “Non-authorized” claims is a requirement. Providers have been told that it is not taken into consideration for payment and that if clinical review of medical records determines that the services were “eligible”, payment is processed by VA.

   <u>Response:</u> VA Form 10-583 has not been required since the implementation of the FBCS (Fee Basis Claims System). CAVHCS implemented FBCS processing 5/22/2009. No claims have been denied or rejected for VA Form 10-583 since implementation.

a) If the presence or non-presence of 10-583 form is not a factor for payment, is there a need to attach the 10-583 form on claims that are deemed "eligible" by VA Authorization staff.
Response: **Again, VA Form 10-583, is no longer required.**

b) If the "Non-authorized" claims are always going to get denied, what is the point of attaching a 10-583 form with those? It is an unnecessary administrative burden if there is no purpose of attaching the form.

Response: **VA Form 10-583 is no longer required. (Unauthorized claims submitted for eligible Veterans are for payment.)**

Discussion at meeting

MS. LEWIS: For Part B, well, the form is not required, but unauthorized claims can be processed for payment if that particular patient is eligible. So they're not always denied if it's unauthorized.

4. Providers have been informed that VA cannot process payment unless there is a Prior Authorization # from VA prior to services or within 72 hours of Emergency visit, or a Post Authorization internal number updated in the VA system by relevant VA staff based on eligibility confirmation and clinical review. Since we don't have access to the internal Post Authorization #, how are Providers supposed to follow up on our claims for payment status?

Response: **Claims status lines are provided on ALL PFRAR's (Preliminary Fee Remittance Advice Reports) and may differ by the claim, vendor, and veteran . . . each instance.**

The two (2) claims status lines are:

(800) 214-8387 Ext 2940 for claims processed under the Authorized Program
(205) 212-3192 for claims processed under the two Unauthorized Programs (Unauthorized & Mill Bill)

Discussion at meeting

MS. LEWIS: Okay. We provide claim statuses on a letter. And this letter is called the Preliminary Fee Remittance Advice Report, and it differs depending on the claim type or the provider or veteran in each instance. And on those forms are phone numbers. So I don't use the authorization number when we're statusing a claim. You just need to give me the veteran's name and his or her social security number and the date of service, and we can let you know. But also on that letter you get, it should provide a status.

And I know that sometimes people complain that they'll only status three claims for you, but that's in Birmingham for the unauthorized Mill Bill unit. But you have to understand, we don't have dedicated customer service representatives, so the same people that are answering the phone are the same people that are processing the claims. And if they spend all day on the phone, then they won't be able to get the claims processed. So they do the best they can.

And I'm happy to tell you that the VA is working on a dedicated customer service department. And it was supposed to roll out in September for this area, but it may be a little bit delayed because we've been working a lot of overtime getting claims paid, and they've run out of money. So probably in October or November we'll get a better status. And I'll be excited because that means that we won't have to accept any more phone calls, that they'll do it 24/7. And it will be much easier for you, I'm sure, because that will be that person's only job, to answer the phone.

5. What is the established timeframe for VA to adjudicate claims and release payment? Please provide the established protocol within VA to process Mill Bills, claims for Out of State Veterans, claims that don't have an Authorization but are deemed "Eligible" for payment and require a clinical review before payment is released, etc.

Response: **Adjudication of claims does not differ whether the veteran is in or out of state.**

Authorized Program claims have a 30-day processing timeframe
Unauthorized Programs Claims have a 45-day processing timeframe

Discussion at meeting

MS. LEWIS: The time frame can be interrupted if there is something wrong with the claim and the claim isn't clean. And each time we reject or deny the claim, the process starts all over again when that claim is corrected or resubmitted. So if I reject a claim because it doesn't have medical records or because the codes are wrong, I'm done. I mean, as soon as I reject it or deny it and send you a letter, then, for all practical purposes, I'm done until you resubmit it again. It doesn't stay open like I know it does on your AR until it's taken care of. As soon as I look at it and determine whether or not I can pay it for some reason or not, I'm done when I send the letter.

MS. SOLT: You know, the other part to that I think, Jackie, that we probably should make clear is that sometimes what we've found is some organizations we work with, they start their timer the day the patient leaves the hospital. We may not get that bill until 20 days later. That's when our time stops. So the time from the patient being discharged from the hospital, a lot of times people will call us and say, well, this claim has been out there since this date but we didn't receive it until maybe 20 days after that date.

And I think the other thing that sometimes is challenging is a lot of times, the ancillary services, the docs for the hospitals send us bills before we get the hospital bill and we have to pay them all together. So when they're not together, I think it causes some time delays.

MS. LEWIS: Sometimes we get bills for inpatient claims when the patient is still in the hospital, and we can't pay that claim until the patient has been discharged and we receive the medical records from the facility.

AUDIENCE: With regards to the clock starting back up again every time, there have been claims, as you know, for years together. So how does it affect the whole timely filing stuff and all of that? Because it keeps in that loop of starting back over all over again.

MS. LEWIS: Well, as long as you submit whatever information we ask for within 30 days of us asking for it, it's fine. And if you need an extension, all you have to do is let me know.

AUDIENCE: Because it happens multiple times - so if it comes to that, you're saying there's going to be a waiver on the timely filing, correct?

MS. LEWIS: Right. Right.

AUDIENCE: I'd like to add to that. On the Gulf Coast, again, we're under a little bit different constraints. So maybe the next meeting I would even ask, if you guys do come back, maybe there could be representatives from there. Because one of the things we run into, we can have confirmation that the records were delivered with the claim, and we can still get a rejection, and they just say, well, we just didn't get the records.

AUDIENCE: That happens to us too.

AUDIENCE: And so it's not always that we haven't billed a clean claim. We've billed a clean claim, we've also submitted records, and we've billed the claim electronically. So we sort of get in that cycle of, well, we just didn't get the records or we've misplaced. You know, so I think that might be something we would like to see addressed in the long term, when it really was not the provider's fault, it was just where it was handled when it was received.

MS. LEWIS: And I know that does happen. So when that does happen, I hope that you can let us know. Because I mean, another department scans in those records. And so everything, like Traci said, is silo. We have a way of going in and looking. We can see when that record was scanned in. We can see. And so if you raise a ruckus about it, someone should look and be able to tell you that you are correct, that those records were submitted timely.

MS. SOLT: I think what she's saying is they're not communicating with her at the other station.

AUDIENCE: And that was really directed more so at the process on the Gulf Coast.

MS. LEWIS: No. It happens with us also. I know it does happen.

AUDIENCE: Right.

MS. LEWIS: Because we'll go back and we'll look sometimes and we'll see, well, those records were here, why did the clerk say that it wasn't.

MS. SOLT: And, you know, I think the STREAM process of allowing us to accept electronic records that are indexed already, I think that's going to help that. I mean, we've got a long way to go, but I think we've made a lot of improvements. So I'm sorry that that's happening, but I'll relay those messages to the Gulf Coast system.

AUDIENCE: And, Jackie, with regards to just clarification so everybody is on the same page, with regards to authorized claims, you said you do not need the medical records to be sent, or do we need to send it regardless?

MS. LEWIS: We would like to have them, but I don't need them to pay.

MS. SOLT: And from a clinical care coordination point of view, in order to provide the care that maybe the doctors or the community providers have recommended, we have to have that to go to the next step, but it's not a requirement to pay. Does that make sense?

AUDIENCE: Yes.

MS. SOLT: But please send the records, because we need them.

AUDIENCE: The Stream process you were talking about, will it give us a confirmation number or a reference number? A lot of carriers do that, and that gives us a reference number to go back to when they say they didn't get the records.

MS. SOLT: I don't know. I think it does, but I don't want to lie. I want to be accurate. I'll follow up, and that will be one of my to-do's.

AUDIENCE: I have two questions. One, when you said when somebody tells you that they don't have records but we have evidence that they do, you said let us know. Who should we let know?

MS. LEWIS: Well, there should be a phone number on the PFRAR you can call or you can email me.

AUDIENCE: These reports that you're referring to, we're not getting them.

MS. LEWIS: They go to the billing address on the claim that you submit. What facility are you with?

AUDIENCE: Cullman Regional Medical Center.

MS. LEWIS: I don't think I do much business with Cullman Regional.

AUDIENCE: Yes, you do.

MS. LEWIS: No, I'm talking about from Tuskegee. It's probably with Birmingham.

AUDIENCE: It's the Birmingham office.

MS. LEWIS: Okay. I'm not Birmingham. I'm Montgomery/Tuskegee, so you're out of my area. But I mean, we may every now and then, I'm sure.

MS. SOLT: You know, what I can do is I'll follow up with the Gulf office. I'll follow up with the Birmingham office also.

AUDIENCE: Okay. So both of you guys are from the Montgomery?

MS. LEWIS: Yeah. So I can find out. I know Cindy Bland is the chief there, and I can let her know.

AUDIENCE: The other question is, is there such a thing as a VA provider billing manual?

MS. LEWIS: I happen to have right here in my trusty little bag a guide for providers.

AUDIENCE: Not a guide. A billing manual.

MS. LEWIS: No. No, there's no billing manual.

MS. SOLT: You mean like a directive, rules of how to bill?

AUDIENCE: Yeah, something like that.

MS. LEWIS: Well, this just tells you what we require. There's no billing manual that I'm aware of. That's something I can check.

MS. SOLT: So we do have to follow a set of rules. And we'll find out what those set of rules are to be able to share them. And I think what Jackie is saying is it's broken down into laymen's terms in this manual.

MS. LEWIS: Claims and payments. How to file a claim. But what are you referring to when you're saying a billing directive or guidance?

AUDIENCE: Like a provider manual that has all the details like Medicaid has.

AUDIENCE: Blue Cross has one, Medicaid has one, Humana has one, Health Springs has one. You know, it says like revenue code 450, you have to go with this set of CPT codes.

MS. LEWIS: Well, we bill according to Medicare.

AUDIENCE: Not all the time.

MS. LEWIS: Most of the time.

AUDIENCE: Okay. Having a list of exceptions would be what would be listed in a provider manual.

MS. LEWIS: I don't have one.

MS. SOLT: Well, one of our billing is under United States Code. So in this guide, there is some references to 38 USC 1703, 38 USC 1728. And it talks about unauthorized emergency care for service-connected claims, unauthorized emergency care for nonservice- connected claims, and it talks about filing deadlines. I think that might be kind of what you're looking for. But a lot of what we do is based on law. It would be nice. A lot of the things we do we wish we could change sometimes, but it's the legislators that make a lot of the rules that we have to follow.

MS. LEWIS: He's asking about revenue codes like CPT codes and those things.

MS. SOLT: You know what? We'll look at that and see if we can find something other than this. But I think that this would help. I don't know if all of you guys have this.

AUDIENCE: I need one. Can I have that one?

AUDIENCE: Where do we get them?

MS. LEWIS: I have 25 copies right here, and I sent it electronically to Peggy already.

MS. CARSTENS: They did provide the handout that she's referring to here. I can post it on the AlaHA website next week. Will that be helpful?

AUDIENCE: Yes.

6. Some providers are having issues with inpatient VA claims where the patient came through the Emergency Room. Seems as if the VA is inaccurately counting the ED visit charge as an inpatient room. Please provide some clarity on this issue.

   Response: **As phrased, this is an issue we are unaware of. Authorized Inpatient claims are processed by episode of care. To process an Authorized Inpatient Ancillary Provider's claim the facility's claim must be received in order to generate an Inpatient 'payment window'. If the facility does not follow-up timely in providing their claim/exact episode of care dates to the NVCC staff, a delay in payment may occur to those providers rendering services to the facility and the facility as well. Once an Inpatient Authorization is set and if any claim is processed against the authorization, it CANNOT BE CHANGED. Therefore, the need for the exact veteran, vendor, and episode of care is pertinent to processing all inpatient claims.**

   Discussion at meeting

   MS. LEWIS: So in other words, we need to know the from and to dates before we can process any of the ancillary claims. Because if I pay a claim and it is outside that window, then no other claims can be paid. So that's why we have to wait until we get the claim from the facility first.

AUDIENCE: Jackie, I'm from Tuscaloosa. And the billing supervisor that gave me this, I can get you an example and show it to you, where the patient came through the ED, and was an inpatient two days; and when the claim was submitted, they sent it back, rejected it saying it was a three day. Well, it was never a three day. It was a two-day inpatient admission, but they came through the ED.

And so basically, I am understanding that when they talked to the VA, their contact person there in Tuscaloosa, they were told that it was a three-day stay because of the revenue code 450. And the only thing that I can do is just send you an example.

MS. LEWIS: Well, please do that, and we'll see if we can get it cleared up. Because it shouldn't matter.

AUDIENCE: And it's not just one claim. She's had several of them the same way.

MS. LEWIS: Maybe someone is not understanding on the other side. Because we can pay the ED charge as well as the admission charge. I mean, you can bill it on the same claim.

AUDIENCE: Right. And that's what we're doing is billing it on one claim.

MS. LEWIS: So I don't understand why they're rejecting it.

AUDIENCE: I'll get you some examples.

MS. LEWIS: Okay. Please do. There hasn't been a supervisor there at the Tuscaloosa site for a little while.

AUDIENCE: Right.

MS. LEWIS: I think someone just came on board last week.

AUDIENCE: Okay. Thank you.

MS. LEWIS: Okay.

MR. ASHMORE: All right. Well, that sums it up for the VA. I want to thank Traci and Jackie for being here today.

MS. SOLT: Thank you for having us and inviting us here today.