

CHAMPVA POLICY MANUAL

CHAPTER: 3
SECTION: 1.1
TITLE: CLAIMS PROCESSING - GENERAL

AUTHORITY: 38 CFR 17.270(a) and 17.272-17.275

RELATED AUTHORITY: 32 CFR 199.7 and PPI 98-1

I. DEFINITIONS

A. Claim. A request for payment or reimbursement for one type of service, on one date, by one provider, for one beneficiary.

B. Current Procedural Terminology (CPT). An American Medical Association copyrighted numerical classification system used primarily for classifying and recording physicians services. The CPT contains information regarding outpatient services and procedures rendered by physicians.

C. Explanation of benefits (EOB). A summarization of the action taken on the claim.

D. HCFA Common Procedure Coding System (HCPCS). A standard coding system developed by HCFA that is used for processing claims for outpatient services. It includes additional codes for non-physician, non-office services beyond the outpatient codes used in the CPT. (See Current Procedural Terminology)

E. Health insurance claim, Form HCFA 1500. Form HCFA 1500 is a national standard claim form designed for use by individual professional providers of medical care (psychologists, dentists, pharmacists, marriage counselors, suppliers, etc.) or by institutions billing professional services, or for ambulatory surgical services (for both facility and/or professional charges) performed in authorized freestanding ambulatory surgical facilities or hospital outpatient settings.

F. International Classification of Diseases (ICD). An internationally used standard numerical coding system to classify diagnoses, procedures and operations.

G. Other health insurance (OHI). This term refers to double coverage, i.e., when a CHAMPVA beneficiary is also enrolled in another insurance, medical service, or health plan that duplicates all or part of beneficiaries CHAMPVA benefits. Double coverage plans do not include Medicaid, coverage designed to specifically supplement CHAMPVA benefits, or coverage under a State Victim of Compensation Program.

H. Primary payer. The plan or program whose medical benefits is payable first in a double coverage situation.

I. Secondary payer. The plan or program whose medical benefits are payment in double coverage situations only after the primary payer has adjudicated the claim.

J. Submission. The contents of one package/envelope. These documents may result in multiple claims.

K. Third party liability (TPL). When another insurer has the legal obligation to assume primary payer status e.g. personal injury protection (PIP) under automobile insurance and workers compensation.

L. Uniform billing form (UB-92). This national standard claim form is to be used by institutional providers of care for the billing of inpatient and outpatient institutional services and some home health care agencies.

M. United States. For purposes of this chapter, the term "United States" includes the 50 States, the District of Columbia, American Samoa, Guam, Puerto Rico, and the Virgin Islands. [PPI 98-1, January 22, 1998]

II. POLICY

A. General. 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. All claims reviewed must include sufficient information to determine:

1. eligibility of the beneficiary,
2. the service/supply is a CHAMPVA benefit,
3. the service/supply is medically necessary, and
4. the beneficiary is legally obligated to pay for the service or supply.

B. Timely Filing:

1. Prior to January 1, 1994, claims were required to be received no later than December 31st following the year in which the services/supplies were provided.

2. For services on or after January 1, 1994, claims must be received within one year from the date of service or one year from the date of discharge from an inpatient facility.

3. The provider cannot seek payment from the beneficiary when the provider fails to meet the timely filing requirements and a waiver is not granted.

4. Exceptions to timely filing requirements may be granted when:

a. There is medical documentation of beneficiary incompetence and the beneficiary did not have a legal guardian.

b. There is evidence of an administrative error. An administrative error is one where the beneficiary has been prevented from timely filing due to misrepresentation, mistake or other accountable action of an HAC employee acting within the scope of that individual's authority. Necessary evidence must include:

(1) A written statement describing how the error caused failure to file within the usual time limit, and

(2) Copy of an agency letter or written notice reflecting the error.

c. 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:

(1) The claim was originally sent to the primary health insurer prior to the CHAMPVA claim filing deadline or must have been filed with CHAMPVA prior to the deadline but returned or denied pending processing by the other health insurer.

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

C. Claim filing requirements. Claims from providers should be submitted on a standard billing form, or if submitted electronically, utilizing the national standard format as determined under the Health Insurance Portability and Accountability Act.

1. Acceptable paper formats for billing are the UB-92 (institutional) and Form HCFA 1500 (professional outpatient services).

2. At a minimum, the following information is required on all billing forms:

a. Patient identification.

(1) full name (as it appears on identification card),

(2) social security number (SSN),

(3) address,

(4) date of birth, and

(5) provider identification.

- b. full name and address of hospital or physician,
 - (1) remittance address,
 - (2) physical location where services were rendered,
 - (3) individual provider's professional status (M.D., PhD., R.N., etc),
 - (4) provider tax identification number (TIN) noting whether it is the employee identification number (EIN) or SSN, and
 - (5) Medicare provider number (inpatient institutions only).
 - (6) Other health insurance (OHI). If there is OHI, which is not Medicaid, a supplemental CHAMPVA policy or State Victims of Crime Compensation Program insurance, an OHI explanation of benefits must be submitted.

3. Inpatient treatment. In addition to the information in 2 above, the following information is required for inpatient treatment claims:

- a. dates of services (specific and inclusive),
- b. summary level itemization of billed charges (by revenue codes),
- c. dates for all absences from a hospital or other approved institution during the period for which inpatient benefits are being claimed,
- d. principal diagnosis (ICD code and description) established, after study, to be chiefly responsible for causing the patients hospitalization,
- e. all secondary diagnoses (ICD codes and descriptions),
- f. all procedures performed (ICD codes and descriptions), and
- g. discharge status of the patient.

4. Ancillary outpatient services. Claims for individual providers (including claims for ambulatory surgery) usually require more detailed itemization than inpatient institutional claims. In addition to the information in 2 above, the following information is required for ancillary outpatient claims (UB-92 or Form HCFA 1500):

- a. specific dates of service,
- b. diagnoses (ICD codes and descriptions),
- c. procedure codes (CPT, HCPCS, ADA) and descriptions for each procedure, service or supply for each date of service, and

d. individual billed charges for each procedure, service or supply for each date of service.

5. Prescription drugs and medicines. In addition to the information in 2 above, a pharmacy receipt is required for prescription drug and medicine claims to include:

- a. name and address of pharmacy,
- b. drug name and National Drug Code (NDC),
- c. strength and quantity, and
- d. date dispensed.

D. Preauthorization.

1. The beneficiary and/or provider must ensure advance approval is received from CHAMPVA for the following treatment/services.

- a. Dental care (see [Chapter 2, Section 5.1](#), *Adjunctive Dental Care*).
- b. Durable medical equipment (DME) (see [Chapter 2, Section 17.1](#), *Durable Medical Equipment and Supplies*).
- c. Non-emergent mental health/substance abuse treatment including admission of emotionally disturbed children and adolescents to residential treatment centers (see [Chapter 2, Section 17.2](#), *Preauthorization for Residential Treatment Center (RTC) Care*).
- d. Admissions to a partial hospitalization program, including alcohol rehabilitation (see [Chapter 2, Section 18.18](#), *Psychiatric Partial Hospitalization Programs-Preauthorization and Day Limits*).
- e. Outpatient mental health visits in excess of 23 per calendar year and/or more than two sessions per week (see [Chapter 2, Section 18.3](#), *Psychotherapy*).
- f. Organ transplants (see Chapter 2, Sections 31.2 thru 31.10).

2. In the case of care provided under the CHAMPVA Inhouse Treatment Initiative (CITI) program, the responsibility for obtaining preauthorization rests with the VA medical facility.

E. Retroactive authorizations. When either a claim for CHAMPVA eligibility or claim for benefits has been denied, such denial may be overturned with the submittal of additional information or evidence in support of the claim. When a retroactive authorization has been made, claims must be received:

1. 180 days following notification to the beneficiary of an approved retroactive authorization date.

2. 180 days following beneficiary notification of the approval of a covered service that had previously been denied.

F. Other health insurance (OHI). CHAMPVA is always the secondary payer of benefits when there is other health insurance except when the beneficiary has entitlement to Medicaid, State Victims of Crime Compensation Programs, and CHAMPVA supplemental insurance.

G. Allowable charge and prevailing charge. See [Chapter 3, Section 5.1. Outpatient and Inpatient Professional Provider Reimbursement](#), for definition of allowable charge and prevailing charge.

H. Payment of benefits.

1. Inpatient and CITI claims. All inpatient and CITI claims will be paid to the provider regardless of whether there is indication that the beneficiary requests payment.

2. Outpatient claims. Payment will be made to the provider unless the billing is accompanied by a completed and signed CHAMPVA Claim Form (VA Form 10-7959A). ONLY when a CHAMPVA Claim Form is received with the billing will payment be made to the beneficiary.

I. Payment under \$1.00. If the CHAMPVA benefit payment is under \$1.00, payment will not be issued although the catastrophic cap and deductible will be credited.

J. Claim disposition. Upon completion of claim processing, an explanation of benefits (EOB) will be sent to the beneficiary and the provider if benefits were assigned. For claims resulting in a payment, a check or electronic funds transfer (EFT) will be issued by the U. S. Treasury.

1. An EOB will be issued to the beneficiary whether or not an actual payment is involved.

2. Procedures codes for claims involving abortion, AIDS, alcoholism, drug abuse, psychosexual dysfunction or venereal disease will not be included on beneficiary EOBs.

K. Reopened claims. A claim may be reopened based on new information or a finding of administrative error. A reopened claim may result in increased or decreased allowable charges.

1. The new or relevant information will be appended to the original claim.

2. The reopened claim will be computed using the payment methodology applicable on the date of service.

3. If there was an underpayment, the claim will be reprocessed for additional payment through regular procedures.

4. If there was an overpayment, a recoupment action will be issued by the Debt Collection Unit (DCU).

L. Fraud. Falsifying information, e.g., providing an incorrect residence address, modifying claim forms, billing for services not provided, etc. is considered fraud.

III. POLICY CONSIDERATIONS

A. Claims receipt and control.

1. Each submission (paper and electronic) receives an internal control number called a primary document identifier (PDI) number. This is a 13-digit number that uniquely identifies each submission and consists of the last two digits of the current year, the Julian date, a two-digit identifier for the digitizer (scanner) and a six-digit sequential numerical identifier.

2. Claims are processed in the order received. The only exception to this is when claims must be suspended for program integrity or other reasons.

B. Claims for newborns.

1. Separate claims are required for the mother and newborn, even if the newborn care is considered routine.

2. In the case of multiple births, separate claims are required for each newborn.

C. Duplicate payment prevention.

1. With the exception of inpatient claims, exact duplicates will be denied.

a. An exact duplicate of an outpatient, travel, durable medical equipment or dental claim occurs when the following data points match:

- (1) type of service,
- (2) date of service,
- (3) provider tax identification number (13 digits),
- (4) total billed charges,

- (5) other health insurance dollar amount, and
- (6) procedure codes, modifier and each line item.

b. An exact duplicate of a pharmacy claim occurs when the following data points match:

- (1) type of service,
- (2) date of service,
- (3) total billed charges for each line item,
- (4) other health insurance dollar amount, and
- (5) national drug code (NDC).

2. Potential duplicate claims will be reviewed for a determination of appropriate disposition.

a. A potential inpatient or outpatient duplicate claim occurs when the following data points match:

- (1) beneficiary,
- (2) provider, and
- (3) dates of service (overlapping).

b. A potential pharmacy duplicate claim occurs when the following data points match:

- (1) beneficiary,
- (2) date of service, and
- (3) national drug code (NDC).

c. A potential duplicate durable medical equipment (DME), dental, or travel claim occurs when the following data points match:

- (1) beneficiary, and
- (2) date of service.

D. Provider agreements with third-party billers. A provider may enter into an agreement with a third party to act on its behalf in the submission and monitoring of claims. Such arrangements may be honored on a case-by-case basis and may be permissible as long as the third party is not acting simply as a collection agency.

E. Right to information. CHAMPVA may request from the provider of the services/supplies or the beneficiary any information necessary for the accurate and efficient administration of the requested benefits.

1. Failure to provide the information may result in denial of claimed benefits.
2. CHAMPVA will hold the information confidential except when:
 - a. disclosure is specifically authorized by the beneficiary,
 - b. disclosure is necessary to permit authorized government officials to investigate and prosecute criminal actions, or
 - c. disclosure is specifically authorized or required under the terms of the Privacy Act or Freedom of Information Act.
3. CHAMPVA may, without consent or notice to a beneficiary, release to or obtain from any provider, organization, insurance company, or government agency, any information when such release constitutes a routine use in accordance with the Privacy Act (5 USC 522a).

F. Audit trail and file integrity. HAC is responsible for ensuring the history file accurately reflects all transactions pertaining to payments including cost share, deductibles, and adjustments. The integrity of the audit trail must be maintained, and the confidentiality and integrity of the files must be protected.

END OF POLICY