Department of Veterans Affairs Billing Guidelines for Health Care Provided to Veterans and Beneficiaries

Chief Business Office Purchased Care
Department of Program Integrity (DPI)

July 2013
The Department of Veterans Affairs would like to take this opportunity to thank you, the healthcare provider, who ensures our Veterans and their families receive the best level of care and we hope that level of care continues throughout the healthcare community.
Applicable Laws

- 18 U.S.C §1031 Major fraud against the United States
- 18 U.S.C §1035 False statements relating to health care matters
- 18 U.S.C §1342 Fictitious name or address
- 18 U.S.C §1346 Definition of “scheme or artifice to defraud
- 18 U.S.C §1347 Health care fraud
- 31 U.S.C.§3729 False Claims Act
- 42 U.S.C. §1320a-7b Health Care Programs
- 42 U.S.C. §1320a-7b(b) Anti-Kickback Statute
Applicable Laws

- Improper Payments Elimination and Recovery Act (IPERA)
- The Federal Managers Financial Integrity Act codified in 31 U.S.C § 3512
- The Affordable Care Act
- Health Insurance Portability and Accountability Act of 1996
- Presidential Executive Order 13520 Reducing Improper Payments
- OMB Cir No. A-123 Management’s Responsibility for Internal Controls
Target Audience

- New Health Care Professionals
- Existing Health Care Professionals
- Medical Coders
- Billing Departments
- Any Entity Who Submits Medical Claims to the Veterans Affairs
Training Objectives

- Convey The Department of Veterans Affairs commitment to excellence
- Provide the basics of how claims should be billed
- Assist providers on how to bill correctly
- Provide practical examples
Claims Coding Guidance

- Non VA care is like or similar to Medicare

- Very seldom will the VA accept Blue Cross Blue Shield or Medicaid codes

- AMA coding guidelines
Claims Coding Guidance

- National Correct Coding Initiative (NCCI) and Medically Unlikely Edits (MUE)
- Prospective Payment System (PPS)
- Excessive charges
- Reimbursement
Program Integrity Claims Reviews

- Program Integrity Tools

- Delay in claims processing

- Utilize Medicare’s Claims Processing Manual CMS 100-04 at:

# CMS-1500

**HEALTH INSURANCE CLAIM FORM**

**1500**

**APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05**

1. **MEDICARE**
   - Medicare #: [Box]
   - Medicaid #: [Box]

2. **PATIENT’S NAME** (Last Name, First Name, Middle Initial)
   - **PATIENT’S COMPLETE NAME**

3. **PATIENT’S BIRTH DATE**
   - **SEX**
     - M [Box]
     - F [Box]

4. **INSURED’S NAME** (Last Name, First Name, Middle Initial)

5. **PATIENT’S ADDRESS** (No., Street)

6. **PATIENT’S COMPLETE ADDRESS**

7. **PATIENT’S CITY**

8. **PATIENT’S STATE**

9. **PATIENT’S ZIP CODE**

10. **PATIENT’S PHONE**

11. **INSURED’S SSN**

12. **INFORMATION**

13. **SIGNATURE**

**READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.**

**VETERANS HEALTH ADMINISTRATION**

9
### CMS-1450 (UB-04)

#### Patient Information
- **Name:** [Patient Name]
- **Address:** [Patient Address]
- **City:** [Patient City]
- **State:** [Patient State]
- **Zip Code:** [Patient Zip Code]

#### Admission Information
- **Date of Admission:** [Admission Date]
- **Time of Admission:** [Admission Time]
- **Type of Admission:** [Admission Type]
- **Diagnosis:** [Diagnosis]

#### Procedure Information
- **Procedure Code:** [Procedure Code]
- **Procedure Name:** [Procedure Name]
- **Description:** [Procedure Description]

#### Charges Information
- **Place of Service:** [Place of Service]
- **Non-Covered Charges:** [Non-Covered Charges]
- **Total Charges:** [Total Charges]
- **Cost:** [Cost]
- **Value Codes:** [Value Codes]

#### Payment Information
- **Facility Assigned Patient #:** [Facility Assigned Patient #]
- **Statement Covers Period From:** [Statement Covers Period From]
- **Statement Covers Period Through:** [Statement Covers Period Through]
- **Claimant ID:** [Claimant ID]

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**Note:** The table above is an example of how a CMS-1450 (UB-04) form could be filled out. The actual form would have specific fields for each piece of information and would require specific data entry for each patient and service detail.
# CMS-1450 (UB-04)

**Page 1 of 2**

<table>
<thead>
<tr>
<th><strong>Creation Date</strong></th>
<th><strong>TOTALS</strong></th>
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<tbody>
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<td>00/00/0000</td>
<td>100.00</td>
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<thead>
<tr>
<th><strong>Payer Name</strong></th>
<th><strong>Health Plan ID</strong></th>
<th><strong>Bill Info</strong></th>
<th><strong>Prior Payments</strong></th>
<th><strong>Est. Amount Due</strong></th>
<th><strong>NPI</strong></th>
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<td>Y</td>
<td>000.00</td>
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<tr>
<th><strong>Insured's Name</strong></th>
<th><strong>Insured's Unique ID</strong></th>
<th><strong>Group Name</strong></th>
<th><strong>Insurance Group No.</strong></th>
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**Insured's Name or Patient's Name**

<table>
<thead>
<tr>
<th><strong>Patient's SSN or Insured's ID #</strong></th>
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**Treatment Authorization Codes**

<table>
<thead>
<tr>
<th><strong>Authorization Numbers If Applicable</strong></th>
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<table>
<thead>
<tr>
<th><strong>Admit</strong></th>
<th><strong>PatientReason</strong></th>
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<tr>
<td>296.53</td>
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<tr>
<th><strong>Principal Procedure Code</strong></th>
<th><strong>Other Procedure Code</strong></th>
<th><strong>Other Procedure Code</strong></th>
<th><strong>Other Procedure Code</strong></th>
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<td>00/00/00</td>
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<tr>
<th><strong>Remarks</strong></th>
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**NPI**

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<th>187654320</th>
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</table>

**Attending**

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<tr>
<th><strong>NPI</strong></th>
<th><strong>Qual</strong></th>
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<tbody>
<tr>
<td>DOE</td>
<td>FIRST</td>
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</tbody>
</table>

**Last and First Name**

<table>
<thead>
<tr>
<th><strong>Last</strong></th>
<th><strong>First</strong></th>
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<tbody>
<tr>
<td>DOE</td>
<td>JOHN</td>
</tr>
</tbody>
</table>

**Other Information**

<table>
<thead>
<tr>
<th><strong>Last</strong></th>
<th><strong>First</strong></th>
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<tbody>
<tr>
<td></td>
<td>LAST</td>
</tr>
<tr>
<td>76 OTHER</td>
<td>NPI</td>
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**Certifications**

The certifications on the reverse apply to this bill and are made a part hereof.
The Qui Tam (aka Whistleblower Law) provisions of the False Claims Act, stipulates that a private party (employee of a health care organization) may file a complaint on behalf of the government (Federal & State) to prosecute alleged false claims.

Report allegations to:

VA Office of Inspector General (VA OIG)
VA Inspector General Hotline (53E)
P.O. Box 50410
Washington, DC 20091-0410
Telephone: 1-800-488-8244
Fax: 1-202-565-7936

vaoighotline@va.gov
Summary

- Ensure that the codes reflect the level of care provided
- Valid use of modifiers
- Align your medical coding with Medicare’s billing guidelines
- Correct and accurate claims will not be suspect to Program Integrity and will not be delayed
Helpful Web Resources

- Form CMS 1500 processing manual

- Form CMS 1450 processing manual

- Medicare Claims Processing Manual
Veterans Affairs manages several health care programs that reimburse private health care providers for caring for our Veterans and their eligible family members. Unfortunately, these health care programs have a different statutory and regulatory authority, which creates diverse payment methodologies. The majority of VA health care programs utilize Medicare’s payment methodologies or something very similar.

Therefore, providers and facilities that utilize Medicare’s billing and coding guidelines will greatly minimize claim delays or rejections as a result of the Program Integrity Tools Improper Payment Review.

The following Medicare link is an excellent source of billing and coding guidance for all providers and facilities:

Medicare Claim Processing Guide