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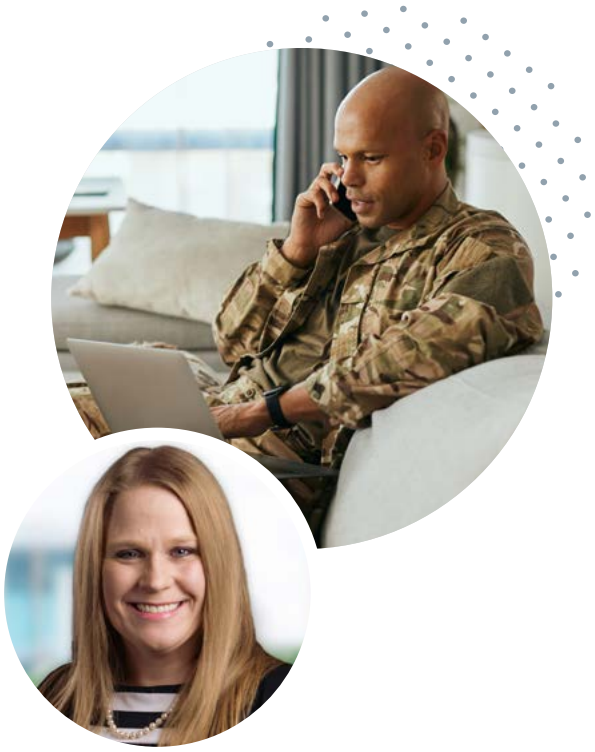
Preventing Top Barriers to VA Claim Payment: Notifications and Authorizations



With a proactive strategy, your organization can more effectively manage VA claims and protect revenue.

by Janice Matthews

VA claim denials are a common and highly complex challenge for healthcare revenue cycle, and it's easy to understand why: Just when revenue cycle teams think they have a handle on VA claims, the rules change. It's hard to stay current on changes and figure out how to adjust how teams pursue VA accounts.

The best defense is a good offense. For revenue cycle leaders, a key place to start is to tackle two of the top barriers to VA claim payment: breakdowns in notification and authorization processes.

Strengthening Your Team's Response

Nearly 90 percent of hospitals report a rise in denials over the past three years, according to a report from the American Hospital Association. Failure to notify and/or obtain authorization drives most denials—and VA claims are no exception.

Although the Mission Act allows veterans to receive care from non-VA providers in specific circumstances—such as when veterans live too far away from a VA facility, appointment/wait times are too long, or VA internal resources are limited—in most instances, veterans must receive approval from the VA in advance. Without an authorization to provide care, the claim will be denied.

Six Community Care Eligibility Criteria for Non-Urgent Care

In an urgent or emergency situation, veterans can seek care at non-VA facilities, but notification is critical. As soon as staff members know a patient is a veteran, they should submit a notification to the VA, as notification must be made within 72 hours of admission. A provider's status in the VA network will determine whether the VA or CCN TPA should be notified to obtain authorization.

It's important to note that when authorization for emergency care is granted, it applies only to immediate emergency treatment. As soon as the patient's condition stabilizes, the VA will determine whether the veteran will be transported to a VA Medical Center or continue their care at the non-VA hospital. If continued care or inpatient admission is required, staff must call the VA (or CCN if contracted with TriWest or Optum) to ensure the authorization obtained covers the additional days necessary to deliver this care.

Identifying—and Overcoming—Authorization and Notification Challenges

The requirement that all non-urgent care be preauthorized and that the VA be notified of all emergent care—with authorization required beyond stabilization—makes the VA unique from other payers. Although the Mission Act allows veterans to step outside of the VA for treatment, preauthorization is still necessary for any and all treatment outside of emergent care. This includes the initial start of care as well as reauthorization for a new episode of care.

Too often when faced with a VA denial, healthcare revenue cycle teams may not invest time in appeals. Some assume that denials for lack of authorization or failure to notify the VA upon admission cannot be overturned, anyway, so they direct resources elsewhere. Others choose to focus on bigger sources of missed revenue, like commercial denials, given that VA denials comprise a smaller portion of overall revenue.

But at a time when hospitals experience increased margin pressures, every dollar captured matters.

Here are five tips for avoiding and overcoming VA authorization denials.

1 Seek authorization even when the patient has already been discharged.

If your patient has been discharged before your team has sent the notification to receive authorization of emergency care, you can still obtain an authorization. The VA requires notification of emergent care within 72 hours of the start of care by submitting through the ECR portal at https://EmergencyCareReporting.CommunityCare.va.gov or by calling (844) 724-7842. *(Note: The same phone number and email apply whether you are contracted with a CCN or not.)*

2 Understand that the notification number is not the authorization number.

This can be confusing for revenue cycle staff because both the authorization number and the notification number are found on the same notification form received from the VA. See the exhibit below for an example.

From: VHA Emergency Notification <VHAEmergencyNotification@va.gov
Sent: Wednesday, June 16, 2022 3:59 PM
To: Sample Hospital
Subject: VA Eligibility Decision for Emergent Care - Approval - A1234567890000

Dear Community Provider,

Thank you for notifying VA of the emergent event referenced below. The emergent episode of care has been approved for payment. This approval is for care until discharge, transfer to another community facility or until such a time that the Veteran refuses to transfer to VA. Please submit claims to the VAs Third Party Administrator (TPA). All authorized claims submitted to VA and VAs TPA must include the corresponding Referral ID.

Notification ID: A-1234567890000 **Notification #**

Provider Name: Sample Hospital
Episode of Care Start Date: 6/16/2022
Episode of Care End Date: 6/23/2022
Referral ID: VA 0123456789 **Authorization #**

Third Party Administrator: Optum

In-network providers seeking authorization numbers may also refer to their TPA portal, https://provider.vacommunitycare.com for Optum and http://www.triwest.com/provider for TriWest. Providers may also call the centralized call center at 844-72HRVHA (844-724-7842) to check the status of the notification.

For more information on Emergency Care eligibility, please visit:
https://va.gov/COMMUNITYCARE/providers/info_EmergencyCare.asp

U.S. Department of Veterans Affairs
Veterans Health Administration
Office of Community Care

3 Make sure you're billing to the correct payer.

This is a common misstep: Sending a claim to the wrong payer for payment. Unsure of who to bill? For authorized emergency visits, the information can be found on the Approved Referral Notification. Also, don't forget that in some cases, the VA can be a secondary payer for unauthorized emergent care when balances left due are not tied to a copayment.

4 If emergency care was not authorized, submit claims and supporting documentation to the VA's Centralized Claims Intake Center.

Providers can submit claims and records to the VA in support of emergency department claims in two ways:

- **Electronically.** Electronic submission is highly encouraged and preferred. Submit the claim electronically via an 837 transaction (Electronic Data Interchange (EDI): Payer ID for medical claims is 12115) and the supporting documentation via a 275 transaction.
- **Postal delivery.** Include the claim or a copy of the claim on top of the supporting documentation that is mailed to the centralized intake office:

  VHA Office of Community Care
  PO Box 30780
  Tampa, FL 33630-3780

5 Don't take "No" for an answer.

Denials happen. If a claim is denied, explain the extenuating circumstances, and ask for reconsideration. Submit appeals within 90 days of denial to avoid missing timely filing. Appeals aren't easy, and with expert assistance, many authorization denials can be overturned.

Find Out More

Knowtion Health is an expert in VA complex claims, with more than 30 years of healthcare and VA claims experience. Each year, we process more than 196,000 VA denials and recover $423 million in VA claim payments. Some of our dedicated team of VA claim representatives are veterans themselves, and they understand the complexity of the VA rules around billing and reimbursement.

Want to continue the conversation around best practices for VA claim submission?
Contact us today.

About the author:

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