The State of VA & Workers' Comp Claims:

Strategies to Maximize Your Revenue Right Now

September 26th, 2024

enablecomp™
complex claims revenue solutions

Who Are We? – The Bad Boys of Complex Claims

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We take on old and new claims across the reimbursement lifecycle. Whether you choose to outsource some or all of your complex claims, you get intelligent automation, seamless implementation, ongoing client engagement, and expertise that goes above and beyond.

Veterans Administration

Workers' Compensation

Motor Vehicle Accident / Third-Party Liability

Out-of-State Medicaid

Denials for All Payer Classes

Folds of Honor

- A nonprofit organization dedicated to providing educational scholarships to families of soldiers wounded or killed while on active duty in the US Military
- More than 29,000 scholarships have been awarded totaling over $145 million since 2007

Agenda

Workers' Comp

1. Why is this complex?
2. Validation/registration challenges
3. Fee Schedule overview
4. Oregon FS Overview
5. Contracting

Veterans Administration

1. The 21st Century (where we started and where we are)
2. Legislative Impact (MISSION, COMPACT, and PACT)
3. VA Pain Points: Denials & Authorizations
4. VA Notification / Authorization Timeline
5. VA Appeals
6. AIR Report Recommendations – Oregon State Markets (VISN 20)

Questions & Answers

EnableComp is committed to continuing education.
You will receive a copy of this presentation after the conclusion of the webinar.

Workers' Compensation

Why is Billing Work Comp Complex?

- Complicated and complex billing rules and regulations
- Validation/Registration/Verification of coverage
- Document requirements
- Complicated Fee Schedule math
- Pre-auth and utilization review
- Timely filing requirements
- Compensability and presumption
- Higher denial rate
- Complicated appeal process
- Complicated contracting considerations

- ***Billing work comp is like flying an airplane. Make sure you have safety checks during take off and landing (Front and back end of the bill)***

Validation and Registration Challenges/Solutions

Challenges:

- Most injured workers do not know who their employer used for workers compensation insurance
- Numerous phone calls can be required to determine claim destination (potentially to patient/employer/payer)
- Company must file first report of injury
  - No matter what the situation, it is not a work comp claim until this happens

Solutions:

- Ask the right questions at registration
  - Do you know who your employer uses for work comp? (just in case but they probably won't know ☺)
  - Who is my point of contact at your employer (risk management/HR/etc.)
- Catalogue everything!
  - Keeping a database of all insurance/employer relationships can save you time. (example: *Enforcer360*)
  - Always verify but do in one phone call instead of 5!

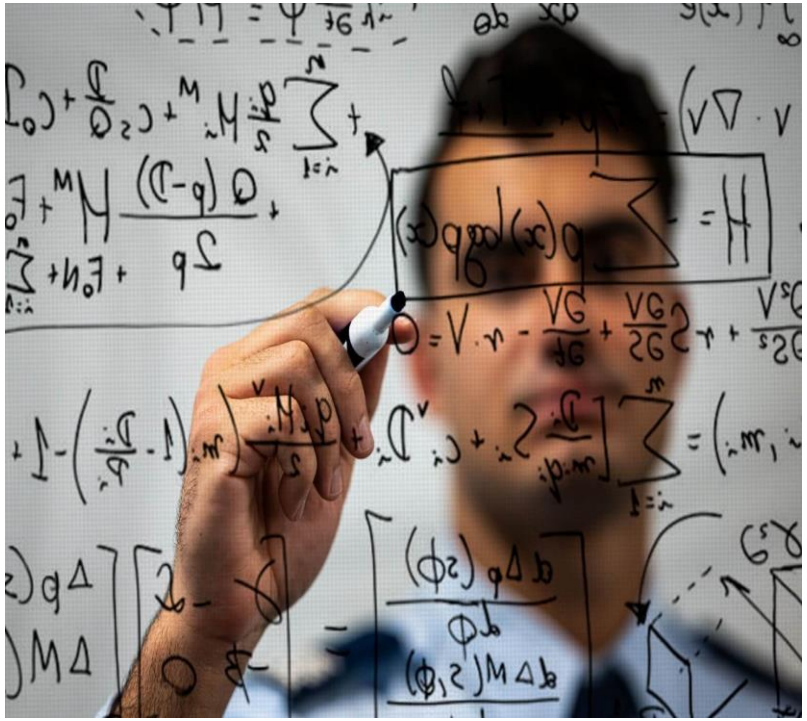
Employer Inventory Example

- Reviewed GA client
- Over 400 claims for over $1.5m in charges
- 7 random employers chosen
- Employer information removed
- Excluded obvious large employers ie Walmart

	Employer A	Employer B	Employer C	Employer D	Employer E	Employer F	Employer G	Total	
Claims	20	6	9	13	63	21	55	187	43% total claim count
Charges	$71,567	$43,987	$15,409	$65,478	$51,009	$74,153	$163,547	$486,150	32% total charges

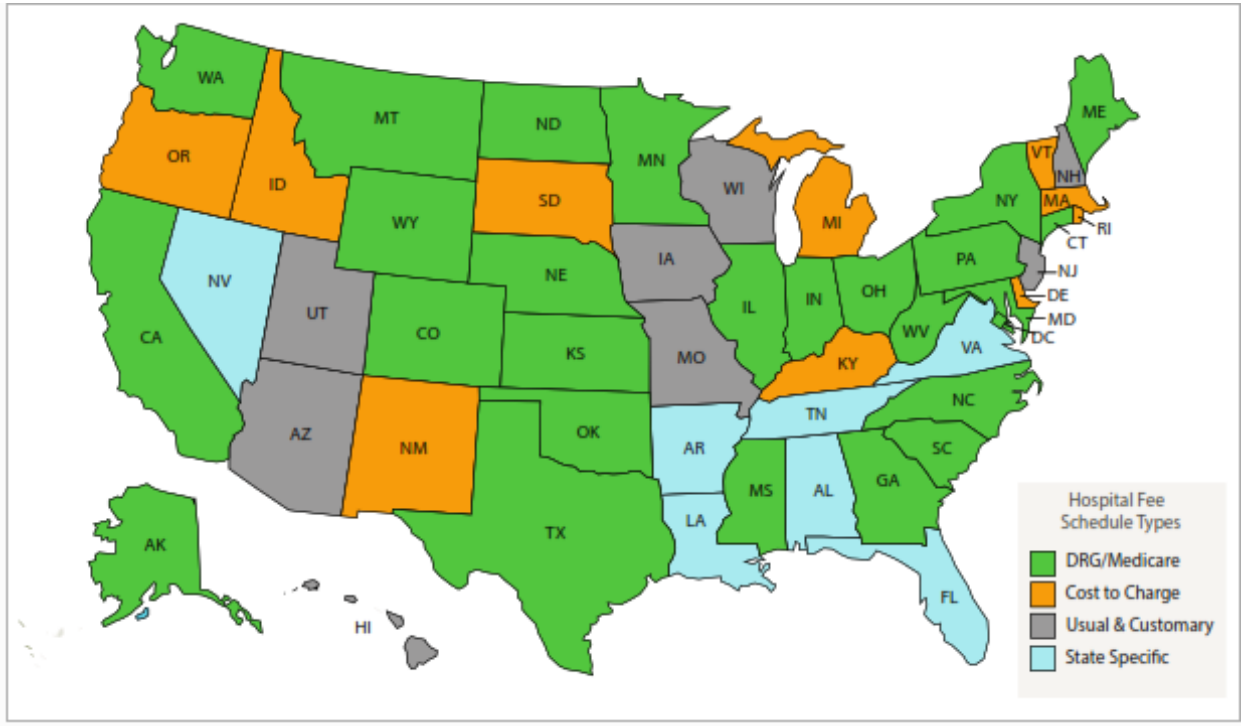
Complicated Fee Schedule Math

- Math problems are rarely simple and require information from multiple sources (i.e. DRG weights/Hospital cost to charge information/locality/etc.)
- Not only do state have different Fee Schedules but they have different methodologies (examples on next slide)
- A lot of hospital systems are not able to quantify some of the complicated Fee Schedule math/nuance
  - Example: Florida OP Fee Schedule contains clinical nuances that can't be built in
- Knowing the expected reimbursement before billing a claim can help with planning/appeals



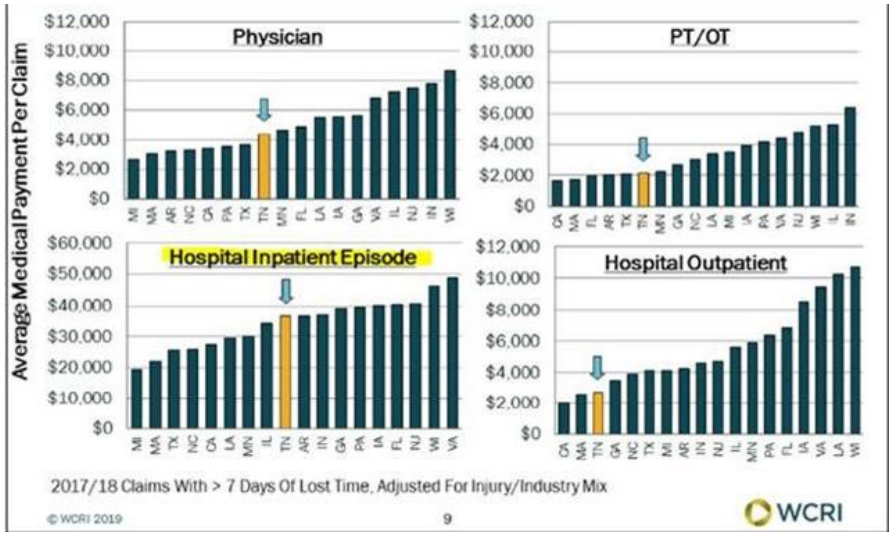
Work Comp FS Types

- Medicare (or Medicaid) based
  - Most common
  - Lower margins. Lower average reimbursement
  - NC/WV are Medicare based
- State Specific
  - Usually more streamlined easier to navigate
  - Higher reimbursement averages
  - KY/VA have state specific FS
- Usual and Customary
  - No formal work comp rules/Fee Schedule in place
  - Claims must not pay more than other providers in area
  - Difficult to work
  - Contracts a plus!
- State run (Ohio)
  - Work comp division processes and pays claims
  - Typically, through approved managed care groups
  - Consistent reimbursement
  - Low appeal opportunity



Medicare and Work Comp

- Preferred model of payers across the county
- Consistent with other claim types
  - Work comp not considered by CMS when rates are set causing states to add sometimes up to 200% uplifts to account for higher cost in treating work comp patients
- When CMS rates change so do work comp Fee Schedules
  - 2023 spending bill impact/example
- Typically, some the lowest reimbursement averages nationally



Oregon Fee Schedule Overview

- Bulletin 290 is houses the Oregon FS rates
  - Oregon Workers' Compensation Division : Medical fee schedules : Medical : State of Oregon
- IP
  - Amount charged X Hospital CCR (listed in Bulletin 290)
  - Hospitals not listed in Bulletin 290 are paid at 80% of BC
- OP
  - Amount charged x Hospital CCR (listed in Bulletin 290) *with some exception
  - Hospitals no listed in Bulletin 290 paid at 80% of BC
- Out of state
  - OOS hospitals paid at charges x CCR 1.00
- Timely
  - 60 days to bill
  - No timely to appeal
  - 45 days to pay with a reasonable delay service charge penalty

Contracting in Work Comp

- Complicated!
- Some states have PPO rules in place for workers' compensation
- Most states have FS in place that posses many of the benefits of contracts
  - Set rates
  - Escalation methods
- Patient traffic generated organically (to an extent and with caveats)
- Many bad work comp agreements get rolled into group health contracts
  - Smaller PT volume allows this to fly under the radar

Contracting in Work Comp

PPO	Claims	Charges	Total Payment	Percent Below Fee Schedule	PCR	Percent of Total Revenue
Prime Health	371	$3,689,320	$1,565,807	-10%	41%	13%
Novanet	332	$2,876,346	$1,232,895	-8%	43%	11%
Coventry	292	$1,762,352	$884,082	-12%	50%	8%
Multiplan	272	$727,000	$480,047	-12%	66%	4%
Corvel	54	$659,632	$225,100	-13%	34%	2%
USA MCO	72	$225,193	$144,051	-11%	64%	2%
VHN	56	$194,169	$138,027	-10%	71%	1%
Fee Schedule	4,188	$16,552,500	$6,938,516	1%	44%	59%
Total	**5637**	**$26,686,512**	**$11,608,525**	-9%	**43%**	**100%**

PPO	Claims	Charges	Total Payment	Percent Below Fee Schedule	PCR	Percent of Total Revenue
Emergency	123	$615,192	$295,357	-8%	48%	19%
Imaging	45	$156,970	$81,968	-12%	52%	5%
Inpatient	24	$1,070,064	$473,971	-10%	44%	30%
Lab	8	$49,821	$29,996	-36%	60%	2%
OP Surgey	48	$1,458,929	$542,939	-6%	37%	35%
Other OP	12	$136,049	$57,130	-5%	42%	3%
PT	114	$233,995	$94,135	-28%	40%	6%
Total	**374**	**$3,721,020**	**$1,575,496**	-10%	**42%**	**100%**

Veterans Administration

THE 21ST Century – Where We Are Today

Department of Veterans Affairs

- Secretary of Veterans Affairs – Denis McDonough
  - The Department has three central responsibilities
    - **Veterans Benefits Administration**
      - Veteran registration, eligibility determination, and the five business lines: Home Loan, Insurance, Vocational Rehab, GI Bill, and Pension.
    - **National Cemetery Administration**
      - Responsible for memorial benefits and Veteran cemeteries.
    - **Veterans Health Administration (the VA)**
      - Providing health care in all forms, biomedical research, and healthcare network maintenance.

THE 21ST Century – Old vs. Current State

Original Claim Processing
Highly Manual Process

1. Authorization / Non-Authorized
2. Provider would mail the claim to VA Fee Basis with attachments.
3. Claim received by VA Fee Basis (Fee Basis would review three questions)
   A. Is the patient a registered and eligible Veteran?
   B. Is the patient's injury related to Service?
   C. Did the hospital perform the authorized services?
4. If the processor found all three elements were in the affirmative, the VA would approve the claim for payment.
5. Payment would come from the Department of Veteran Affairs

Claim Processing After MISSION
Electronic Process

Authorized (HSRM / ER Notification)

1. Provider sends claim and medical records to CCN regional carrier
2. CCN regional carrier processes the claim in conjunction with VA data.
3. Claim paid / denied by regional carrier.

Non-Authorized

Follows the same procedure as previously known, but it is electronic.

VA will look to see if there are extenuating circumstances and process accordingly.

Legislative Changes– MISSION, COMPACT, AND PACT

Three Major Acts reshaped Veteran Benefits in the past six years:

1) **"MISSION" Act** – Maintaining Internal Systems & Strengthening Integrated Outside Networks
   - Passed on June 6, 2018
   - Eligibility Expansion and Creation of the Community Care Network (CCN)

2) **"COMPACT" Act** – Comprehensive Prevention, Access to Care, & Treatment Act of 2020
   - Passed on December 5, 2020
   - Veteran Administration initiative to combat Veteran Suicide

3) **"PACT" Act** – Promise to Address Comprehensive Toxics Act
   - Passed on August 10, 2022
   - Expanded on March 14, 2024
   - Medical Coverage expansion for Toxic exposure

Legislative Changes– MISSION ACT

- MISSION Merged two programs (Patient Community Center Care "PC3" and Veteran Choice Program "VCP") into Community Center Network ("CCN")
- Differences between VCP / PC3 and CCN
  - VCP / PC3 – Two programs that worked in "harmony"
    - VCP – 40-mile exception
    - PC3 – Wait list is longer than 30 days for services
    - PC3 – Services Not available in State
    - PC3 – Closet is not easily accessible
  - CCN – Rolled both programs and added fifth option
    - Services not available in State
    - VA does not operate in that State
    - Veteran eligible to receive benefits under VACA Act of 2014
      - Grandfather – AK, ND, SD, MT, or WY
    - VA cannot furnish those services in a timely manner
    - **Best Medical Interest of the Veteran**
- Ended the VCP Program, but extended due to COVID

Expected Veteran usage of CCN facilities for 2023 is approximately 45% of Veterans receive care outside the VA network

Legislative Changes– COMPACT ACT

- COMPACT addresses issues due to the public health crisis associated with Veteran Suicide
- As of 2020, 17 Veterans commit suicide every day.
  - 16.8 Veterans for every 100,000 Veterans
- The VA Created multiple programs and initiatives
  - Improved transitional phase resources and support networks
  - Launched a pilot program to educate Veteran families for better advocacy and identification
  - Tasked the VA with developing and enacting protocols to assist those Veterans in danger
- On January 17, 2023, the VA implemented the last program change which directly affects hospitals
  - If a Veteran presents to a hospital in an acute suicidal crisis, the Veteran can receive care at any Provider
  - The government defines an "acute suicidal crisis" under 38 U.S.C. § 1720J(h)(1) as an individual that was determined to be at imminent risk of self-harm by a trained crisis responder or health care provider.
  - If an enrolled Veteran presents in this condition, the Veteran is entitled to 30 days of inpatient care and 90 days of outpatient therapy / treatment at no cost to the Veteran

The process for COMPACT notification follows the same procedure as Emergency Notifications.

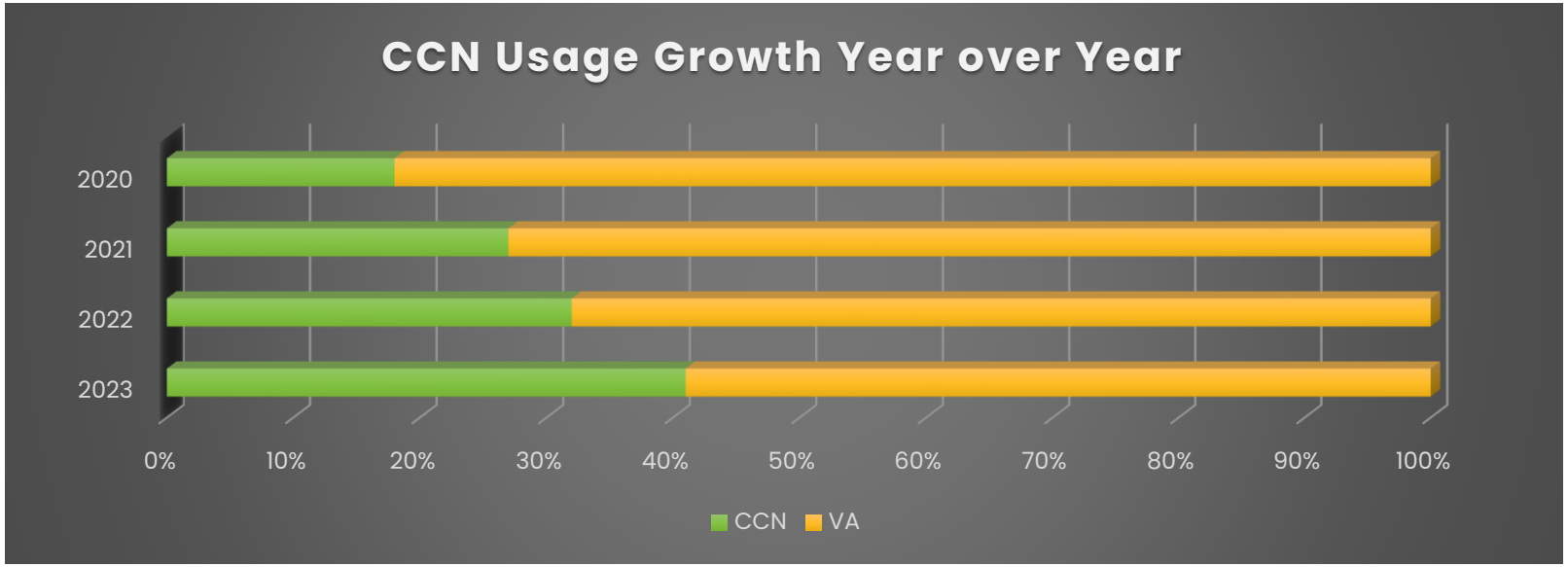
Legislative Changes – PACT ACT

- PACT Act addressed a growing issue amongst Veterans exposed to Toxic chemicals from the battlefield and burn pits.
  - Added more than 20 new Medical Conditions that result in **PRESUMPTIVE** eligibility for service-connected conditions.
    - Expanded and extended VA health care for Veterans with Toxic exposure from Vietnam, Gulf War, and post 9/11.
  - Several Forms of Cancer are now considered covered and paid by the VA under 38 U.S.C. § 1728
    - Service-Connected Conditions are paid by the VA at 100% of the Medicare Allowable
    - These are paid by the VA regardless of medical coverage by another payer.
  - New Cancer coverage include
    - Brain, Gastrointestinal, Gliobastoma, Head, Kidney, Lymphatic, Lymphoma, Melanoma, Pancreatic, Reproductive, and Respiratory.
  - New Illnesses
    - Asthma (after service), Bronchitis, COPD, Rhinitis, Sinusitis, Emphysema, Granuolmatous, Interstital Lung Disease, Pleuritis, Pulmonary Fibrosis, and Sarcoidosis.

Coupled with MISSION Act CCN coverage, CCN providers should expect an increase of usage of their facilities for Veterans with the above noted conditions.

Legislative Changes– Year over Year

- Community Provider Utilization
  - MISSION passed in 2019 and was fully implemented in 2020.



General usage percentages 2000 through 2010 > 5%

2010 through 2013 ≈ 6%

2014 through 2018 ≈ 10%

- Utilization of CCN resources continues to increase at an accelerated pace.
- Usage for 2023, came in just at 41%
- Secretary has not released their projection for 2024

Legislative Updates – PACT Act Expansion and Budgets

VA finds itself in an unusual position as of July:

1) VA Budget Shortfalls 2024 & 2025
   - Secretary McDonough informed Congress of a potential funding gap of $15 Billion
   - 2024 - Veteran Health and Veteran Benefit - $2.88 Billion
   - 2025 – Estimated $12.12 Billion
   - VHA – driven by PACT Act / VBA – driven by disability claims
   - VA will eliminate 20,000 positions to make up the difference plus other cost containment policies.

2) VA Budget 2025
   - VHA requested $20 Billion (down from $34 Billion) to purchase CCN care
   - VHA requested $14 Billion (up from $4 Billion) to purchase care related to PACT Act Claims
   - VA requested approval for $5 Billion in facility upgrades, but did not tackle the AIR Report.

3) Promise to Address Comprehensive Toxics Act ("PACT")
   - Expanded Medical Coverage to additional 1.2 million Veterans on March 14, 2024
   - Total enrolled Veterans increased from 9 million to approximately 10.4 million.

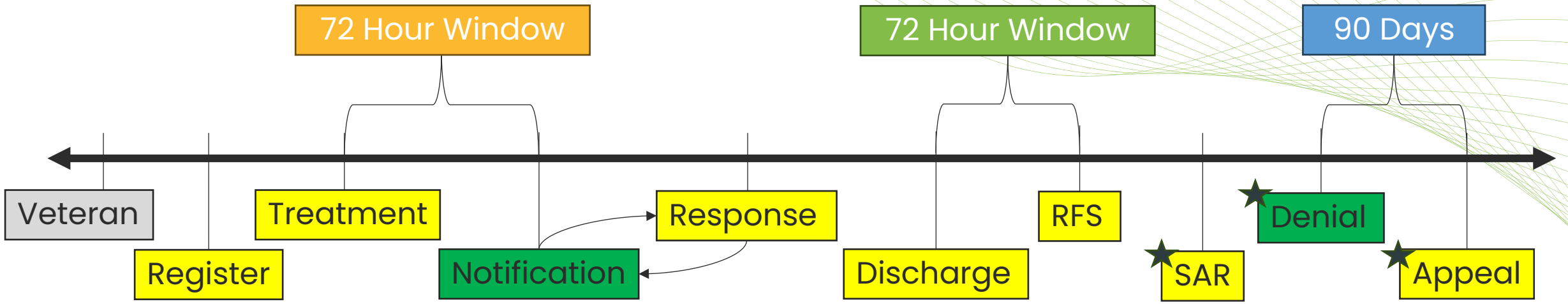
VA Pain Points– Top 5 Denials

- The most common denials are:
  1. Untimely filing [90 Days for Mil Bill],
     - Service Connected – 2 Years
     - Non-Service Connected Millenium Bill – 90 days
     - CCN Carrier (Authorized Referral) – 180 days
  2. Lacking an authorization (did not meet criteria or process),
  3. Patient not enrolled (Veteran did not enroll in 24 months),
  4. Another carrier is responsible (Medicare or Commercial), and
  5. Coding (hybrid of Medicare coding).
     - https://www.va.gov/COMMUNITYCARE/providers/SEOC-Code-User-Agreement.asp

VA Pain Points– Other Insurance (MEDICARE)

- When Is Medicare Primary?
  - 38 U.S.C. § 1725 Reimbursement for Emergency Treatment [Medicare > VA]
    - The VA is primary if in cases where;
      - The veteran is enrolled and received care within the past 24 months AND
      - The veteran is enrolled with VA coverage (per § 1705 of this chapter)
    - Medicare is primary is the patient possesses Medicare at the time services were rendered.
      - VA will pay as a secondary payer in these instances now (see ***Wolfe vs. Wilkie*** & ***Wolfe vs. McDonough***)
  - 38 U.S.C. § 1728 Reimbursement of Certain Medical Expenses [VA ≥ Medicare]
    - The VA is primary if the patient presents with the following;
      - An adjudicated service-connected disability,
      - A nonservice connected disability associated with and held to be aggravating a service-connected disability,
      - Any disability of a veteran if the veteran has a total disability permanent in nature from a service-connected disability,
      - Any illness, injury, or dental condition of a veteran who
        - A participant in a vocational rehabilitee program; and
        - Medically determined to have been in need of care or treatment to make possible the veteran's entrance into a course of training or prevent interruption of course of training.
    - Even if the patient possesses Medicare, the VA is primary.
      - VA will process and pay this claim at 100% of the Medicare allowable
      - Per the MSP, if VA approves the claim, they are responsible for that claim.

VA Pain Points– Authorization Denials



- When working a Veteran Authorization Denial, you have two options available.
  - **<u>OPTION #1 (Authorization on file)</u>**
    - Under CCN → If there is an authorization on file, see if you can use Secondary Authorization Request ("SAR").
    - Under VA → If there is an authorization on file, did you attempt a Request for Service extension?
  - **<u>OPTION #2 (Appeal)</u>**
    - Utilizing the Standard of Care as noted in the VA statute, if the patient feels their life is in danger and a **<u>reasonable person</u>** would conclude that services are needed, the VA will not deny the claim.
    - You must show why an authorization was not obtained, examples include; patient unconscious at the time at presentation, mental confusion, other insurance was provided…

VA Pain Points– Notice / Authorizations

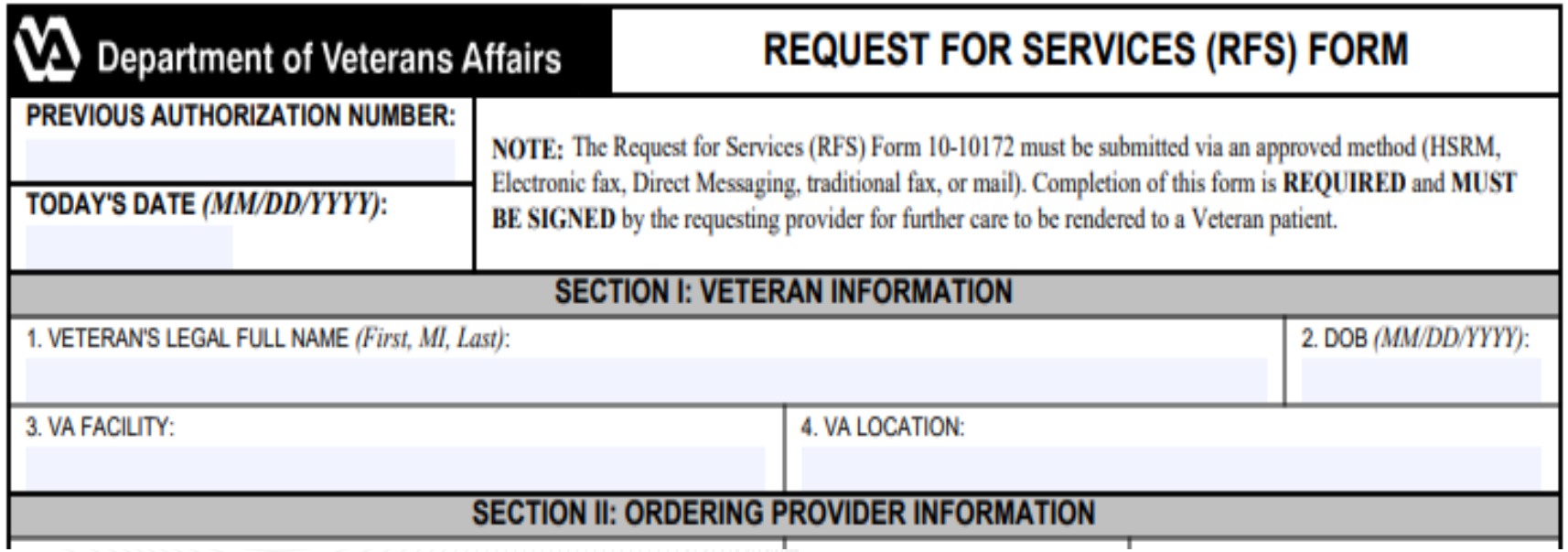
- Form 10-10143g

Case Specific Information	
Veteran Information	Treating Facility Information
Name	NPI
Social Security Number	Name
Date of Birth	Address
Address	Point of Contact (POC) Name
Date Presenting to Facility	POC Phone #
Date of Discharge	POC Email Address
Admitted? (YES/NO)	Note: POC will receive VA authorization decision info
Chief Complaint/Admission DX and/or Discharge DX	

- The Point of Contact (POC) will receive follow up emails and communications from the VA regarding approval, denial, transfer request, or conditional approval.
- The VA utilizes InterQual as their utilization management standard (VHA Directive 1117 October 8th, 2020) and the "reasonable person" standard for emergency treatment.

VA Pain Points – Request For Service

- Form 10-10172 - https://www.va.gov/vaforms/medical/pdf/va_form_10-10172.pdf



Department of Veterans Affairs

REQUEST FOR SERVICES (RFS) FORM

PREVIOUS AUTHORIZATION NUMBER:

TODAY'S DATE *(MM/DD/YYYY)*:

NOTE: The Request for Services (RFS) Form 10-10172 must be submitted via an approved method (HSRM, Electronic fax, Direct Messaging, traditional fax, or mail). Completion of this form is **REQUIRED** and **MUST BE SIGNED** by the requesting provider for further care to be rendered to a Veteran patient.

SECTION I: VETERAN INFORMATION

1. VETERAN'S LEGAL FULL NAME *(First, MI, Last)*:

2. DOB *(MM/DD/YYYY)*:

3. VA FACILITY:

4. VA LOCATION:

SECTION II: ORDERING PROVIDER INFORMATION

- The RFS form is utilized when a hospital discharges a Veteran and that Veteran provides information pertaining to their VA coverage at the time of discharge.
- Hospitals have 72 hours from the time of discharge to contact the VA with the relevant information to initiate a Request For Service, which is essentially a retro-authorization.

Legislation presented to extend the window to 96 hours in Congress

VA Pain Points – Reimbursement Rates

- How does the VA process and pay your claims?
  - Based on the Veteran's Injury
  - Non-Service Related Injury versus Service-Related Injury
    - Non-Service Related Injuries
      - Under the Millennium Act of 2001, Non-Service related Injuries are covered by the VA at a discounted rate
      - Discounted Rate equals 70% of Medicare (38 C.F.R. §17.1005)
    - Service Related Injuries
      - Service-Related Injuries are paid at 100% of the Medicare allowable. (38 C.F.R. §17.4035)
  - Community Care Providers **DO NOT** have an appeal right regarding "underpaid" claims. You must appeal with an actual issue that supplies you an appeal right.

VA Appeals – Appeal Roadmap

❖ Veteran Health Administration Appeal Map

- Appeal landscape is difficult
- Timeline;
  - 90 Days for VA appeal
  - 1 Year for Court Appeals
  - Must go through each step
  - If you skip a step, will be dismissed
  - Various Admin Law Standards
- Success
  - Not a great overturn rate
  - Board of VA Appeals
  - Goes to Veteran's Benefit File
- Roadblocks
  - Will not get a copy of the Veterans Benefit file. Hospital does not have standing to sue on this issue.
  - Significant language barrier → Standards continue to shift, no established standard such as "Arbitrary and Capricious". Mostly "De novo" or "clearly erroneous"

VA Appeals – Appeal Drafting

- How to write an appeal?
  - Format – Issue, Rule, Analysis, and Conclusion
    - **Issue** – Clearly Identify the reason for the denial
      - Examples; Authorization, Timely Filing, Responsibility
    - **Rule** – Layout the rule per statute or policy
      - Authorization – 72 hours when treatment starts
    - **Analysis** – Show your actions
      - Give detailed notes that you took to follow the procedure
    - **Conclusion** – Demand that the VA review
      - Request the VA overturn their previous decision after a de novo review

  - If you don't have much, you still have the **Kitchen Sink**
    - Throw everything you have in your first appeal, because if you don't mention it in your first level appeal, you can't bring it up in your second level appeal without timely evidence.

VA Appeals – Example

Department of Veteran Affairs
Attn 11FB
P.O. Box 5005
Bay Pines, FL 33744

Client Name:	XX
Patient Name:	XX
Patient ID #:	XXX-XX-XXXX
Date of Service:	XX/XX/XXXX
Billed Amount:	$XX,XXX.XX
Claim #:	XXXXXXX

PROVIDER APPEAL

To Whom It May Concern,

Upon review of the above reference patient account, we believe that the claim should be reconsidered for payment. Specifically, we disagree with how the Fee Basis denied the entire claim for lacking medical necessity. In reviewing the medical records, the hospital was duty bound to accept the patient, the patient believed that he was in serious jeopardy, and the events qualify under the reasonable person standard. As outlined below, we will show why the hospital was bound to treat the patient, why the patient's condition warranted immediate medical attention, and why the VA should fulfill their obligation under 38 U.S.C. §1728 (a).

REIMBURSEMENT FOR EMERGENCY TREATMENT

Under 38 U.S.C. § 1725, Reimbursement for Emergency Treatment, Congress laid out the basis requirements for payment of Emergency Room claims. Specifically, a veteran referred to in this section is an individual who is an active Department health-care participant who is personally liable for emergency treatment furnished the veteran in a non-Department facility. A veteran is considered an active Department health care participant if the veteran is enrolled in the health care system established under section 1705 and received care under this chapter within the last past 24 months preceding the furnishing of such emergency.

REIMBURSEMENT OF CERTAIN EXPENSES

Second, when reviewing 38 U.S.C. § 1728, we believe that the Department of Veteran Affairs is skirting liability for this claim as it approved this encounter under authorization number XXXXXX after speaking with Bay Pines. In reviewing such cases, if the VA authorized the claim and then denies the claim for lacking medical necessity, the VA has created a false promise for coverage, when in fact the VA never meant to cover this episode of care.

Specifically, the emergency treatment rendered to the Veteran falls into one of the follow categories. First, an adjudicated service-connected disability. Second a non-service-connected disability associated and held to be aggravating a service-connected disability. Third, any disability of a veteran if the veteran has a total disability permanent in nature from a service-connected disability. Finally, any illness, injury, or dental condition of a veteran who is a participant in a vocational rehab program and is medically determined to have needed care or treatment to make possible the veteran's entrance into another rehab program.

As the patient clearly falls into one of the outlined categories, the patient's XXX, and the VA is clearly aware of this issue, we demand that the authorization be honored, and the claim processed.

GOALS

1) Organization
2) Clarity
3) Specific citations
4) Attention to Detail

AVOID

1) Chaos
2) Generalities
3) Some statutes
4) One sentence

AIR Report – Oregon (VISN#20)

- **Per AIR Report and 2020 Census**
  - Enrollees

Market	2019	2029	Shift
South Cascades	156,287	152,379	- 2.5%
Inland South Idaho	39,294	40,354	+ 2.7%
Inland North	71,630	70,985	- 0.9%
Totals	**267,211**	**263,718**	**- 1.3%**

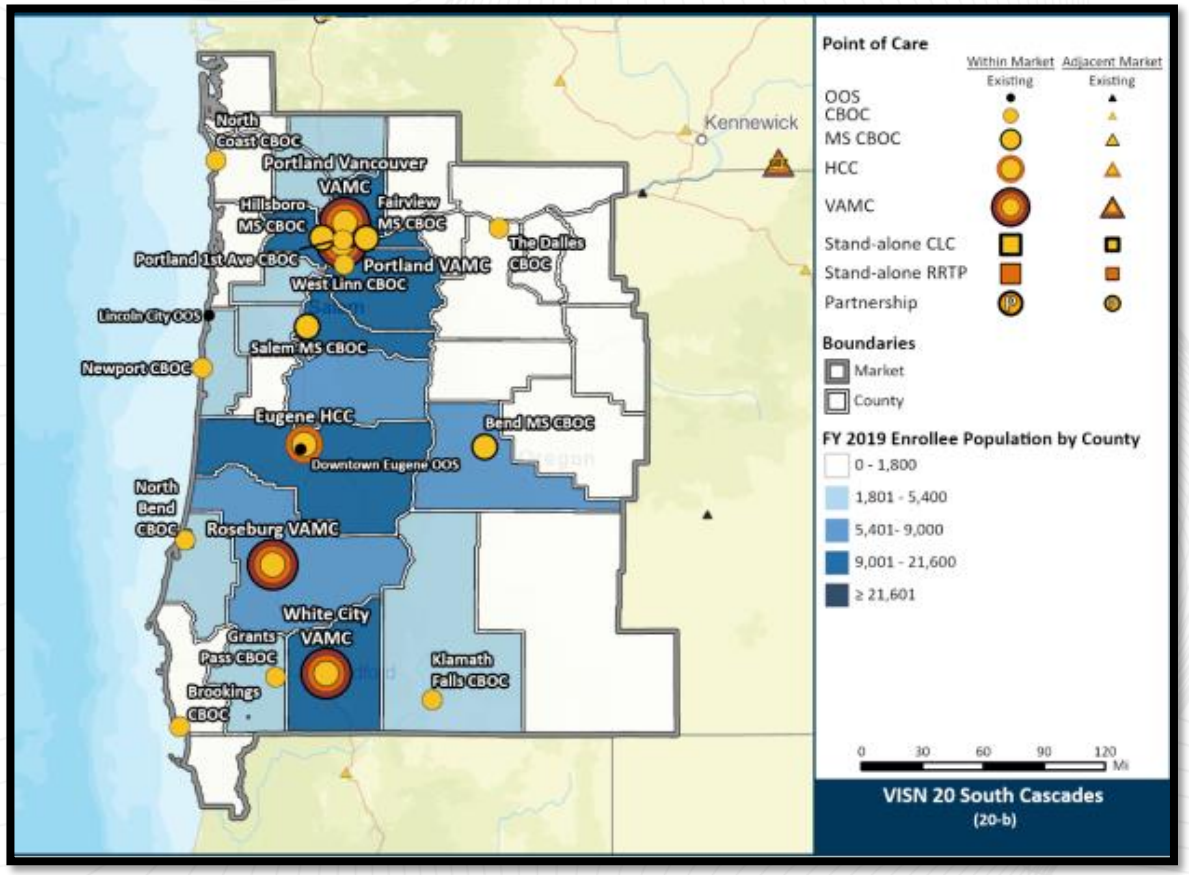
These are recommendations from the AIR Committee, Congress has yet to adopt them.

- **Demand Change next 10 years**
  - Inpatient Medical / Surgical Services will increase by **8.7%**
  - Inpatient Mental Health Services will increase by **4.5%**
  - Long Term Care will increase **42.6%**
  - Demand for Outpatient Medical Services reported to increase all markets.

- Cost to Implement Changes → **$771 Million**

VISN 20 – South Cascades Market

Current



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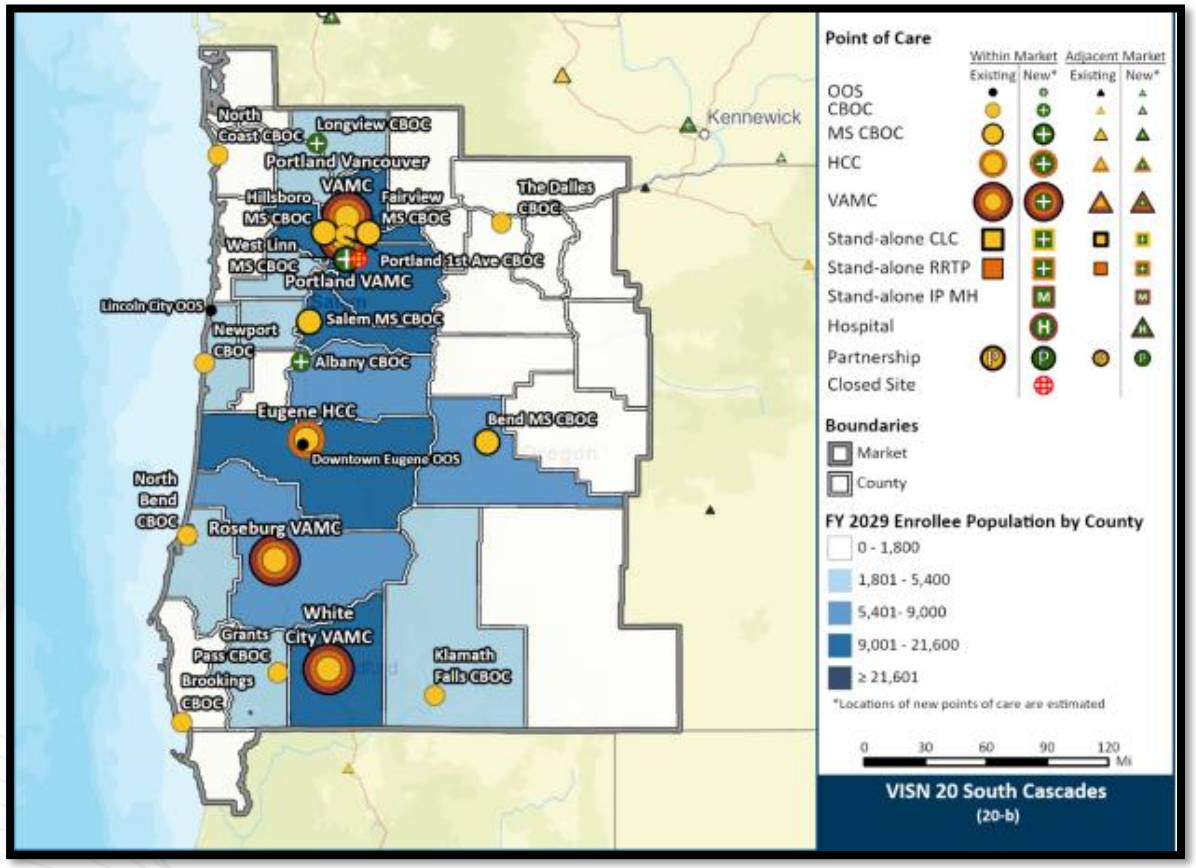
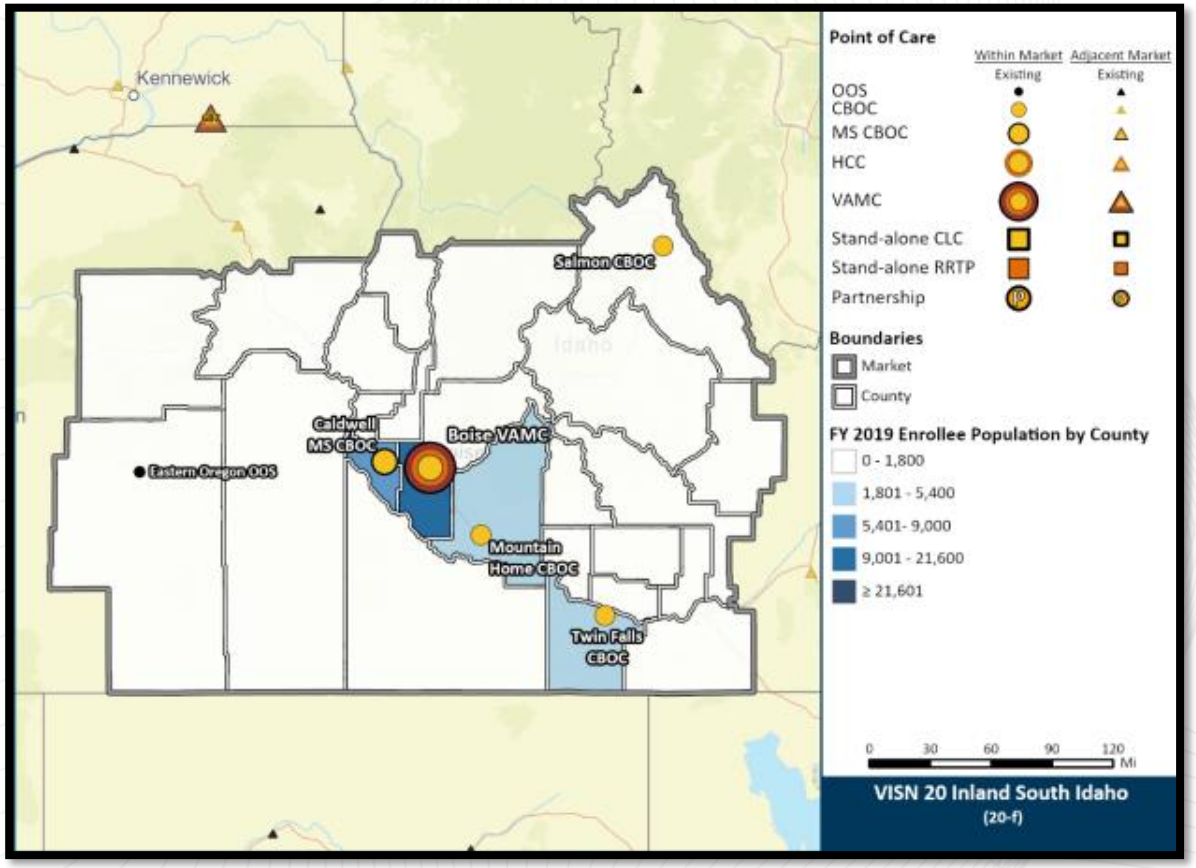


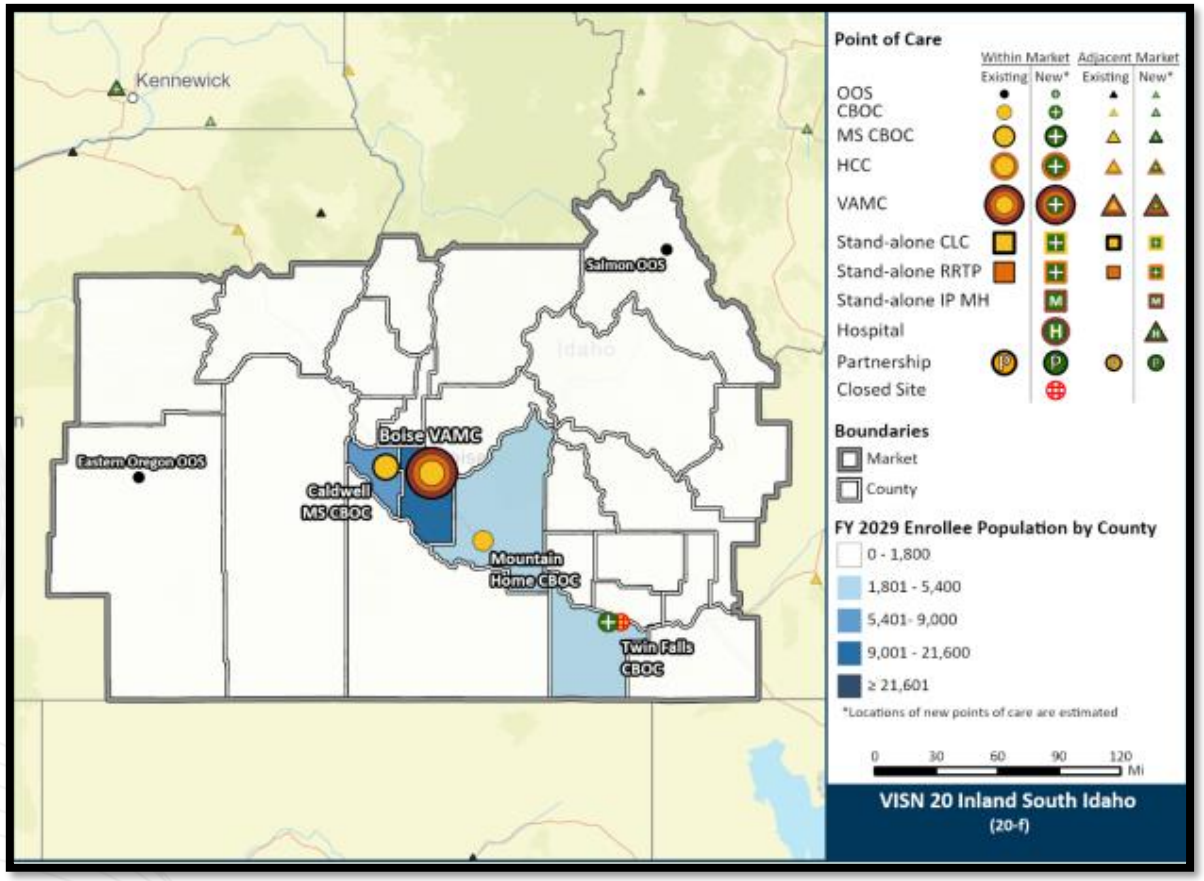
1) Modernize and realign the Roseburg VAMC – relocating outpatient surgery and RRTP
2) Modernize and realign the Portland VAMC – relocate to academic affiliate
3) Relocate 1 facility and build 2 new facilities

VISN 20 – Inland South Idaho Market

Current



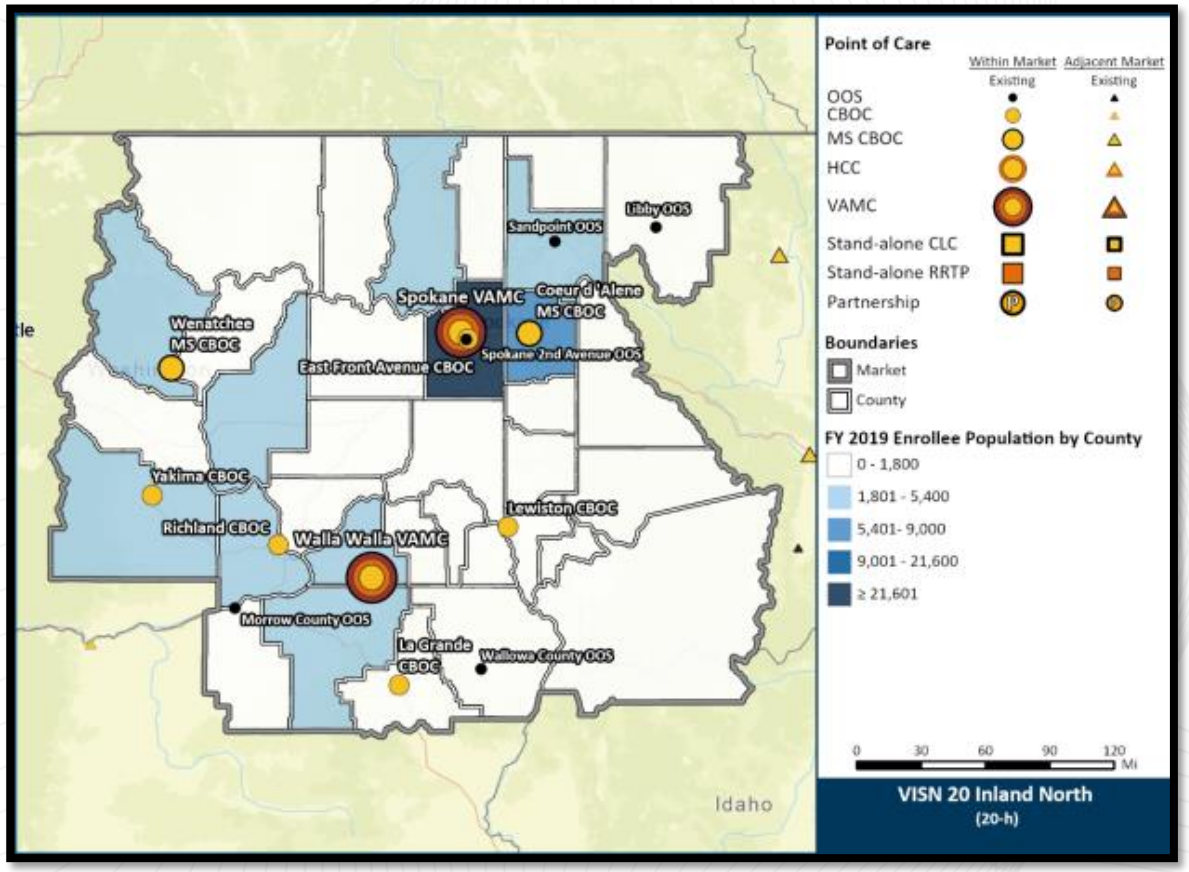
Optimized



1) Relocating the Twin Falls CBOC to a new site in the vicinity and close the current facility.

VISN 20 – Inland North Market

Current



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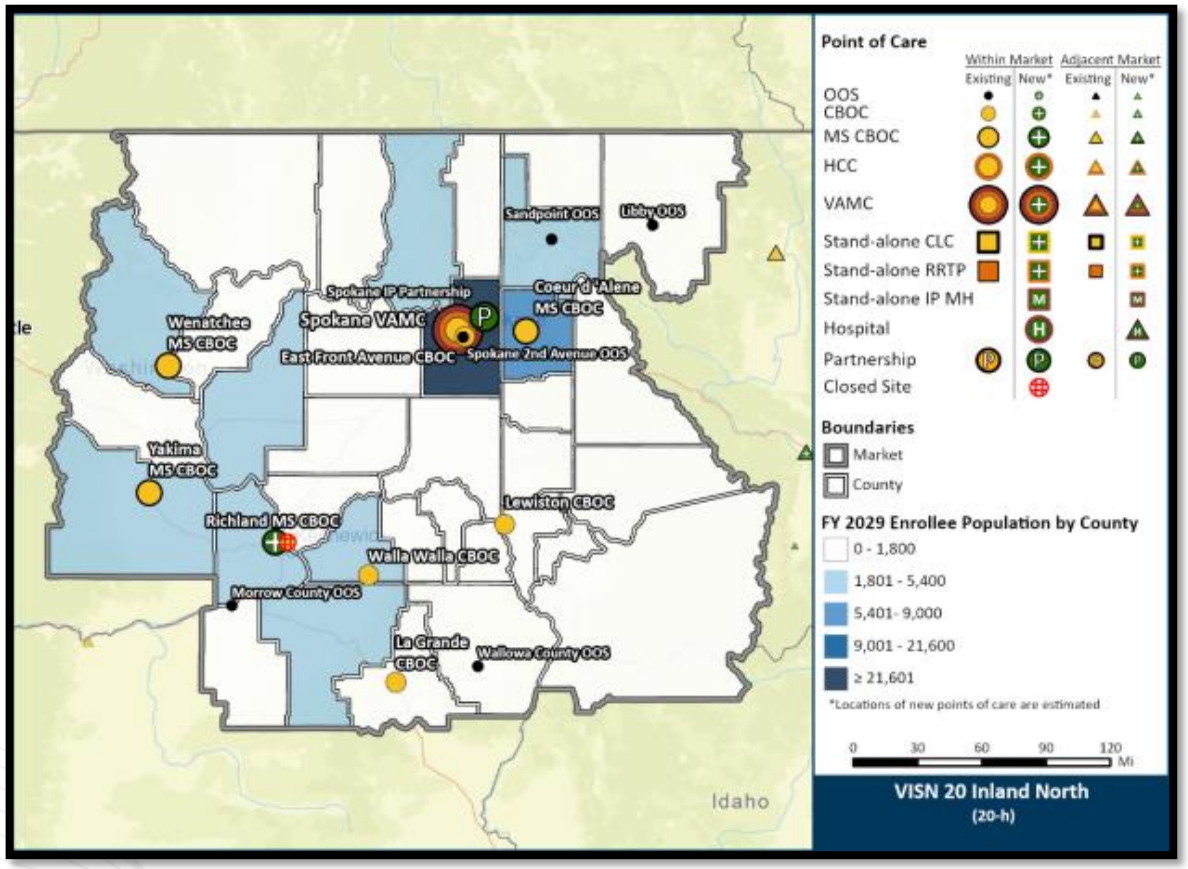

1) Modernize and realign the Spokane VAMC – strategic collaboration and build RRTP
2) Modernize and realign the Walla Walla VAMC – specialty care relocation
3) Relocate the CBOC in Richland, WA

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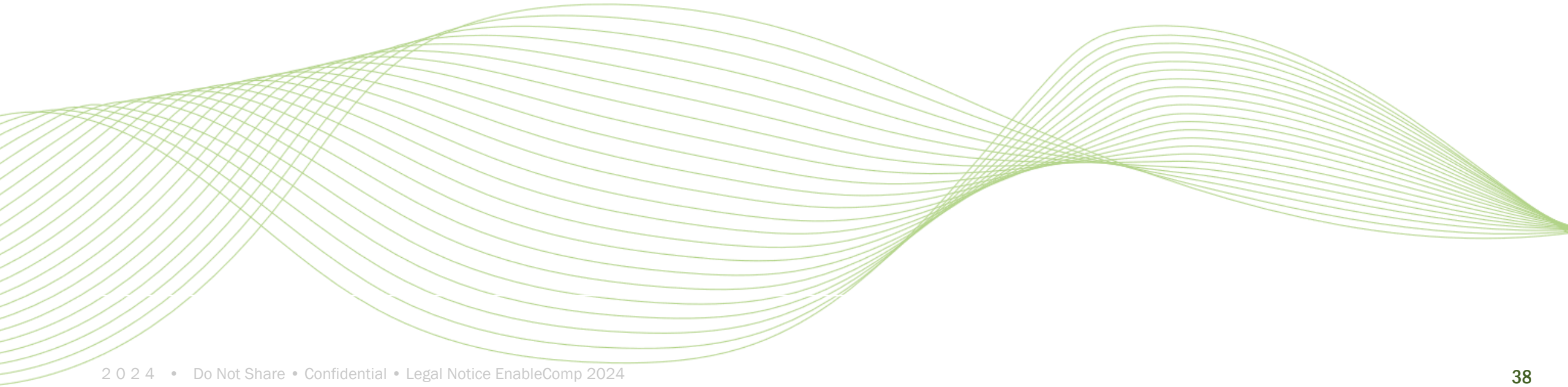
Questions?



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Thank You!