enablecomp™
complex claims revenue solutions

NAVIGATING VA AND WORK COMP CLAIMS:

CRITICAL UPDATES TO SUCCESSFULLY CAPTURE REVENUE

FEBRUARY 22, 2024

WHO ARE WE? – THE BAD BOYS OF COMPLEX CLAIMS

Zach Schultz
Sr. Dir, Complex Claims & Policy
EnableComp
ZSchultz@enablecomp.com
(615) 479-3328

Jason Smartt, Esq.
Associate General Counsel
and SVP, Complex Claims
EnableComp
JSmartt@enablecomp.com
(615) 846-9432

COMPANY OVERVIEW

COMPREHENSIVE SUITE OF REIMBURSEMENT SOLUTIONS

- VETERANS ADMINISTRATION
- WORKERS' COMPENSATION
- MOTOR VEHICLE ACCIDENT/TPL
- OUT-OF-STATE MEDICAID
- A/R RESOLUTION SERVICES
- DENIALS PREVENTION AND RESOLUTION
- "SAFETY NET" DENIALS
- ZERO BALANCE REVIEW

SOLUTIONS ACROSS REIMBURSEMENT LIFECYCLE

DAY ONE BILLING

Team of revenue specialists dedicated solely to your facility to ensure each claim is sent to the correct payer, the first time, for the maximum allowed reimbursement.

A/R RESOLUTION

Revenue specialists and litigators manage aged accounts once placed with us. Claims are analyzed, resubmitted, and if necessary, appealed on your behalf.

ZERO BALANCE

Claims designated as zero balance are reviewed for underpayment and appealed for correct payment.

NEGOTIATED SETTLEMENTS

Specifically focused on situations where organization is presented with a prompt pay request by a payer to assure proper payment.

enablecomp
complex claims revenue solutions

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' Compensation

1. Workers' Compensation Billing Challenges
2. Workers' Compensation Fee Schedule Types
3. Contracting in Workers' Compensation

Veterans Administration

1. The 21st Century (where we started and where we are)
2. Legislative Impact (MISSION, COMPACT, and PACT)
3. VA Pain Points: Authorizations, Denials, and Reimbursement
4. VA Appeals
5. AIR Report Recommendations – Kentucky State

Questions & Answers

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

WORKERS' COMPENSATION

enablecomp
complex claims revenue solutions

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:

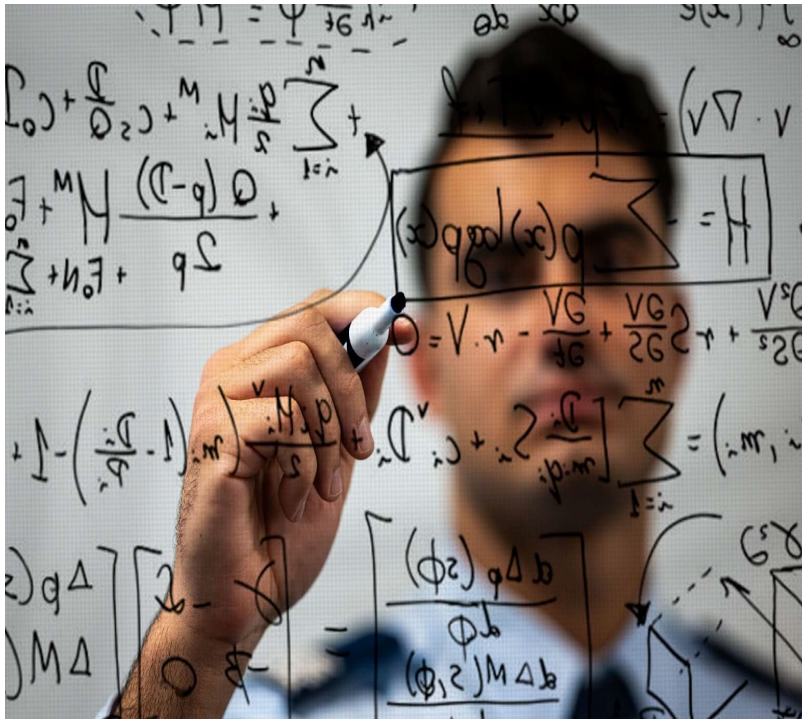
- Most injured workers do not know who their employer used for workers compensation insurance
- Numerous phone calls can be required to determine claim destination (potentially to patient/employer/payer)
- Company must file first report of injury
  - No matter what the situation, it is not a work comp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

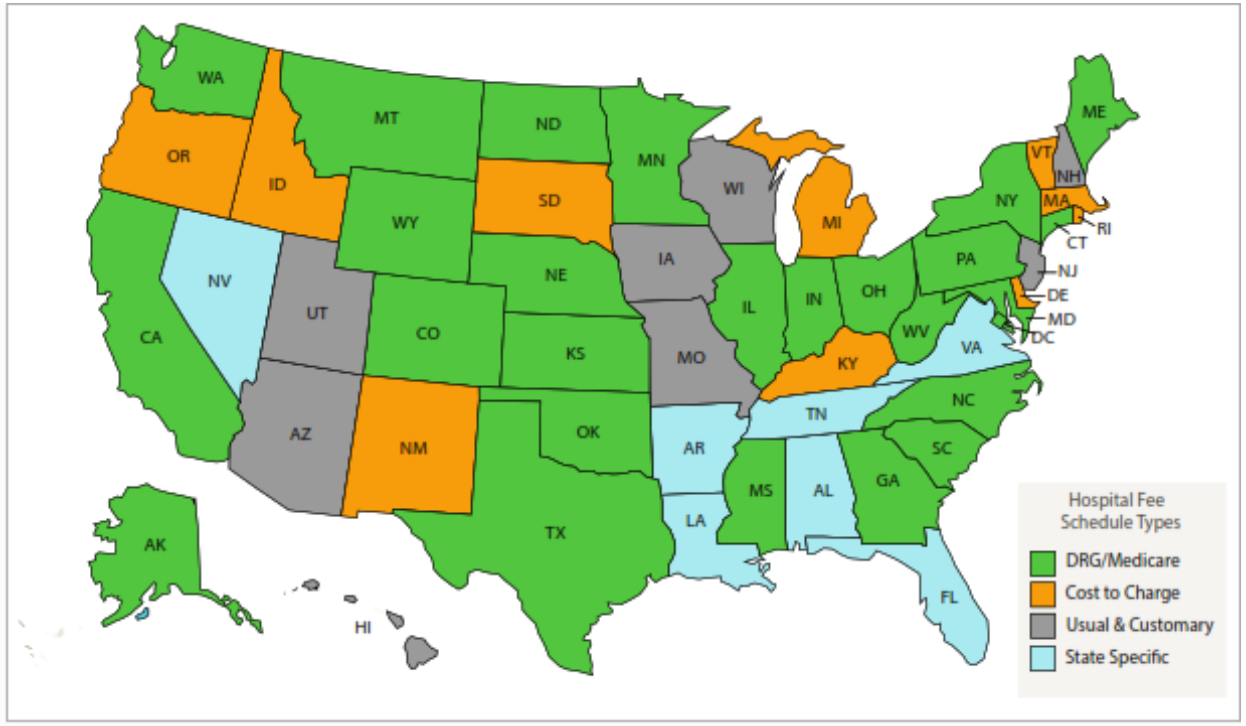
COMPLICATED FEE SCHEDULE MATH

- 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
- KY uses the follow FS logic
  - CCR for Hospitals
  - OOS Fee Schedule for non-KY Providers
  - A hospital's base cost-to-charge ratio shall be based on the latest cost report, or HCFA-2552, which has been supplied to the Cabinet for Health and Family Services, Department of Medicaid Services, pursuant to 907 KAR 1:815 and utilized in 907 KAR 1:820 and 1:825 on file as of October 31 of each calendar year.



WORK COMP FS TYPES

- Medicare (or Medicaid) based
  - Most common
  - Lower margins. Lower average reimbursement
- State Specific
  - Usually more streamlined easier to navigate
  - Higher reimbursement averages
  - KY is a fee Schedule state (cost to charge)
- 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



enablecomp
complex claims revenue solutions

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 ANALYSIS EXAMPLE

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

enablecomp
complex claims revenue solutions

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 – PREVIOUS CLAIM PROCESSING

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.

TriWest Healthcare Alliance

OPTUM Serve™

enablecomp complex claims revenue solutions

LEGISLATIVE CHANGES – MISSION, COMPACT, AND PACT

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

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

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

3) Promise to Address Comprehensive Toxics Act ("PACT")
   - Passed on August 10, 2022
   - 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.

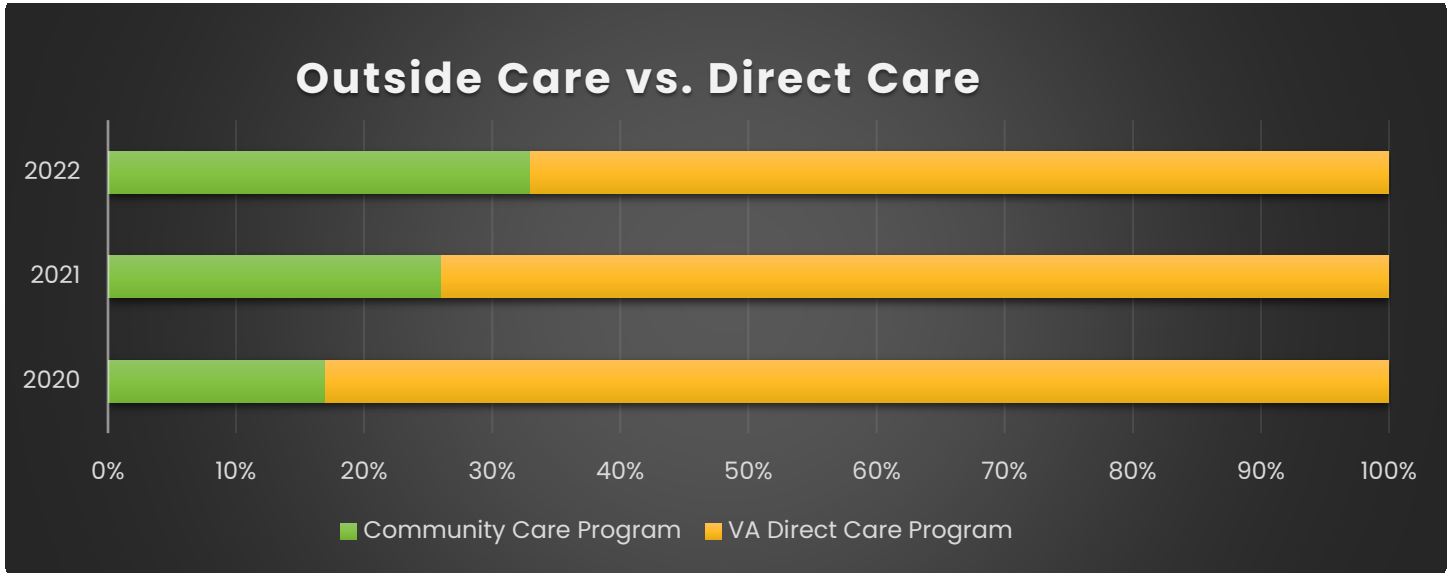
LEGISLATIVE CHANGES – PACT ACT

- 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 IMPACTS – YEAR OVER YEAR

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



  - Utilization of CCN resources continues to increase at an accelerated pace.
  - Anticipated Usage for 2023 is at 40% (Pre PACT Act)

VA PAIN POINTS - 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 VS. NOTIFICATION

- How do you review a patient encounter?
  - Registration
  - Notification (ER) or Prior Authorization (Planned)
  - Transfer (VA Facility) or Episode of Care Occurs
  - Discharge
  - Claim Submission
  - Follow Up
  - Review
  - Appeal

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. The responsibility of TriWest / Optum Serve (CCN claim), and
  5. Coding (hybrid of Medicare coding).
     - https://www.va.gov/COMMUNITYCARE/providers/SEOC-Code-User-Agreement.asp

VA PAIN POINTS – AUTHORIZATION DENIALS

- When working a Veteran claim
  - Authorizations
    - If the patient presents for ER services, they must be authorized (exception to EMTALA). The timeline is 72 hours from start of treatment and the call is whether a bed or bay is available.
    - You have two options with this denial.
      - **OPTION #1 (Authorization on file)**
        - Under TriWest → If there is an authorization on file, see if a Secondary Authorization Request ("SAR")or Request For Service ("RFS") is appropriate.
        - Under VA → If there is an authorization on file, did you attempt a Request for Service extension?
      - **OPTION #2 (Appeal)**
        - Utilizing the Standard of Care as noted in the VA statute, if the patient feels their life is in danger and a **reasonable person** would conclude that services are needed, the VA will not deny the claim.

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.

❖ 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

AIR REPORT – KENTUCKY & RELATED MARKETS

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

Market	2019 Pop	2029 Pop	Change
Hunting Market WV (VISN 5)	31,748	26,890	-15.3%
Central Market KY (VISN 9)	135,626	151,494	+11.7%
Eastern Market KY (VISN 9)	67,069	65,861	-1.8%
Northern Market KY (VISN 9)	100,143	99,842	-0.3%
Northern Market KY (VISN 15)	149,470	138,409	-7.4%
TOTAL	**484,056**	**482,496**	**-0.03%**

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

- **Demand Change next 10 years**
  - Demand for Inpt Medical / Surgical Services will increase 4.0%
  - Demand for Inpt Mental Health Services will increase 1.6%
  - Demand for Long Term Care will increase 28.2%
  - Demand for Outpatient Medical Services reported to increase all markets.

AIR REPORT – KENTUCKY AND RELATED MARKETS

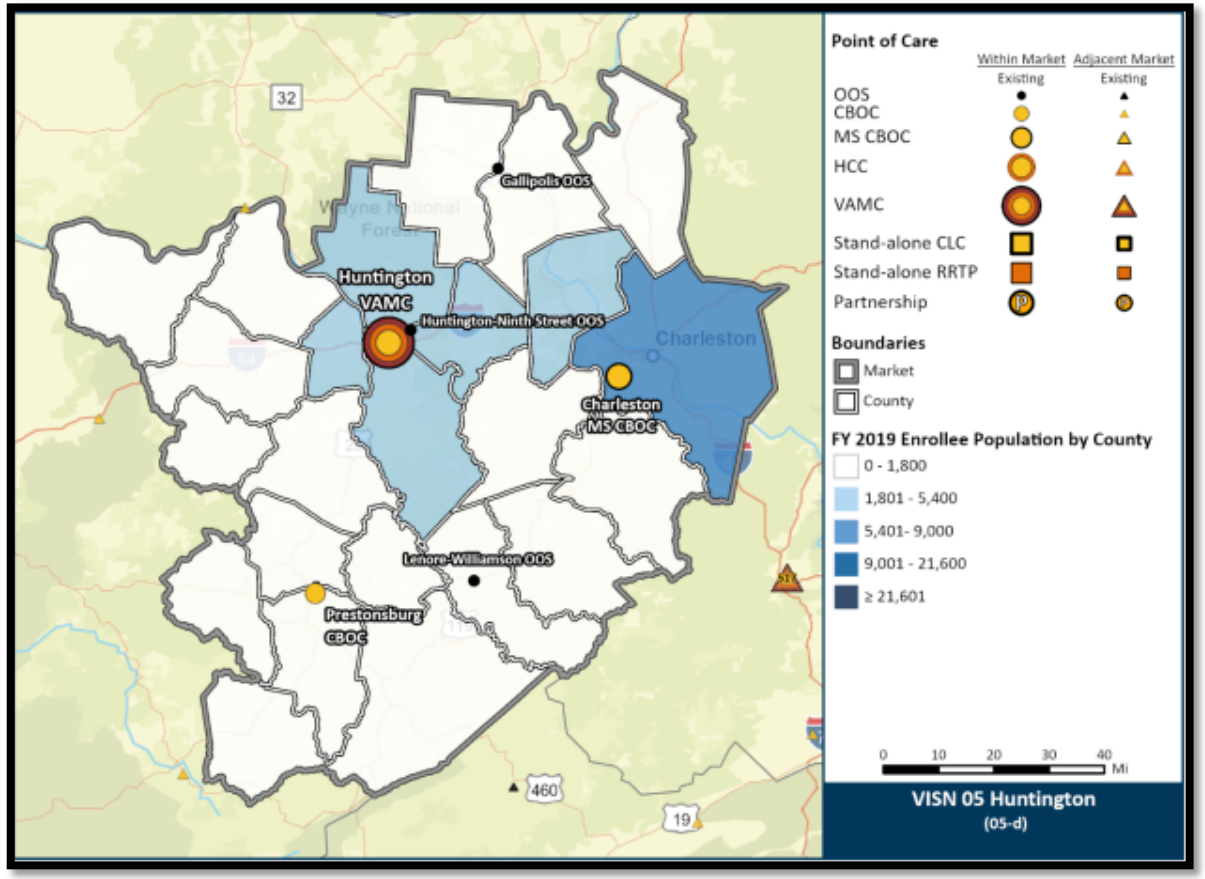
- **<u>Per AIR Report</u> – Price Tag to implement ≈ $5.28 Billion**

- **Huntington Market (NW KY)**
  1. Modernize and realign the Huntington VAMC (Collaboration for inpatient, convert ER, and build a CLC)
  2. Build a new Residential Rehabilitation Treatment Program near Charleston, WV
  3. Relocate 2 new facilities
- **Central Market (Central / Southern KY)**
  1. Modernize the Nashville VAMC (rebuild the ER, Inpatient, and Surgical spaces)
  2. Establish a collaboration around Clarksville, TN to provide inpatient services
  3. Build 3 new facilities and relocate 12 facilities
- **Eastern Market (Eastern KY)**
  1. Modernize and realign the Mountain Home VAMC (update CLC and RRTP)
  2. Construct a new stand-alone Community Living Center near Knoxville, TN
  3. Build 4 new facility and relocate 8 facilities
- **Northern Market (Northern KY)**
  1. Closing the existing Louisville VAMC upon completion of the replacement medical center
  2. Construct a new stand-alone Community Living Center near Louisville, KY
  3. Build 3 new facilities and relocate 3 facilities
- **Northern Market (Southwestern KY)**
  1. Modernize and realign the St. Louis-Jefferson Barracks VAMC (SCI/D & Inpatient Mental)
  2. Modernize and realign Poplar Bluff VAMC (relocate inpatient medicine to CCN)
  3. Build 1 new facility and relocate 9 facilities

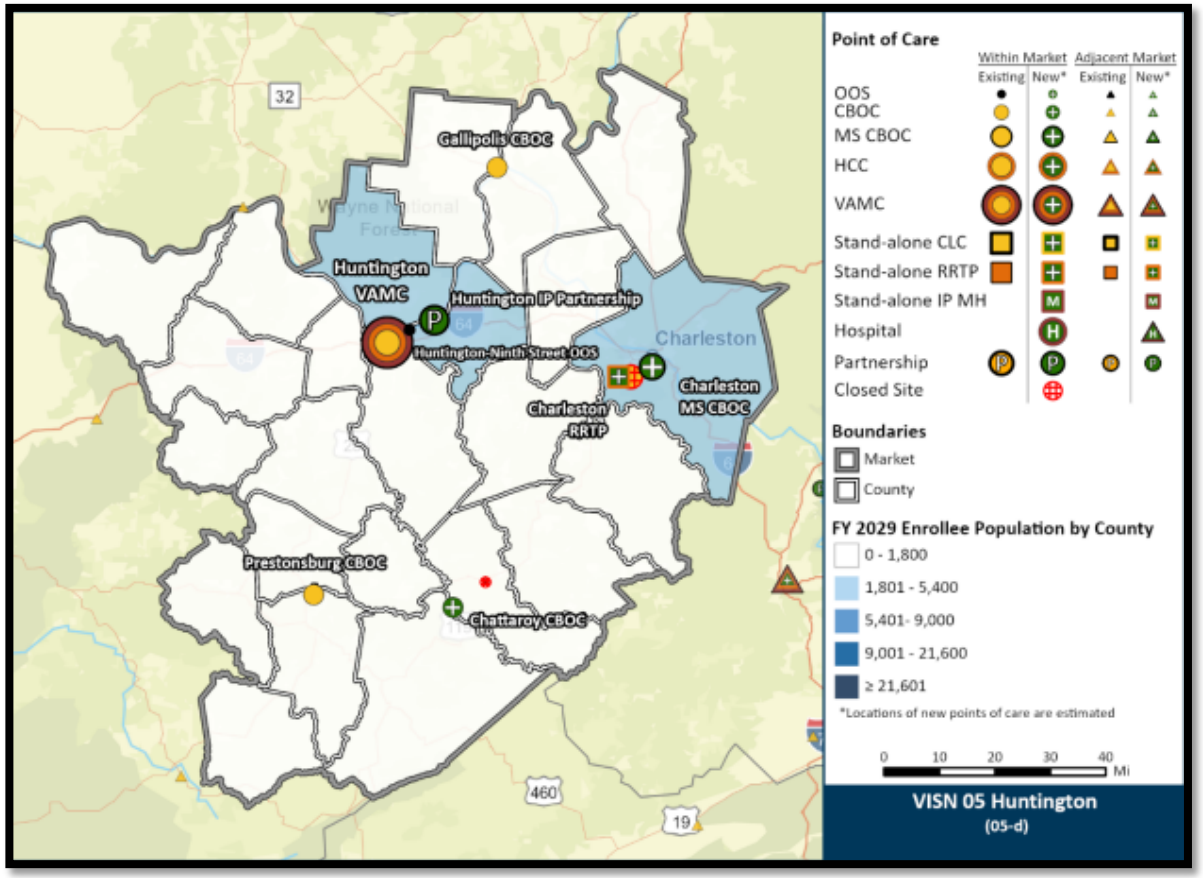
These are recommendations from the AIR Committee, Congress has yet to adopt them.

VISN 5 – HUNTING MARKET (PRESTONSBURG, KY)

Current



Optimized

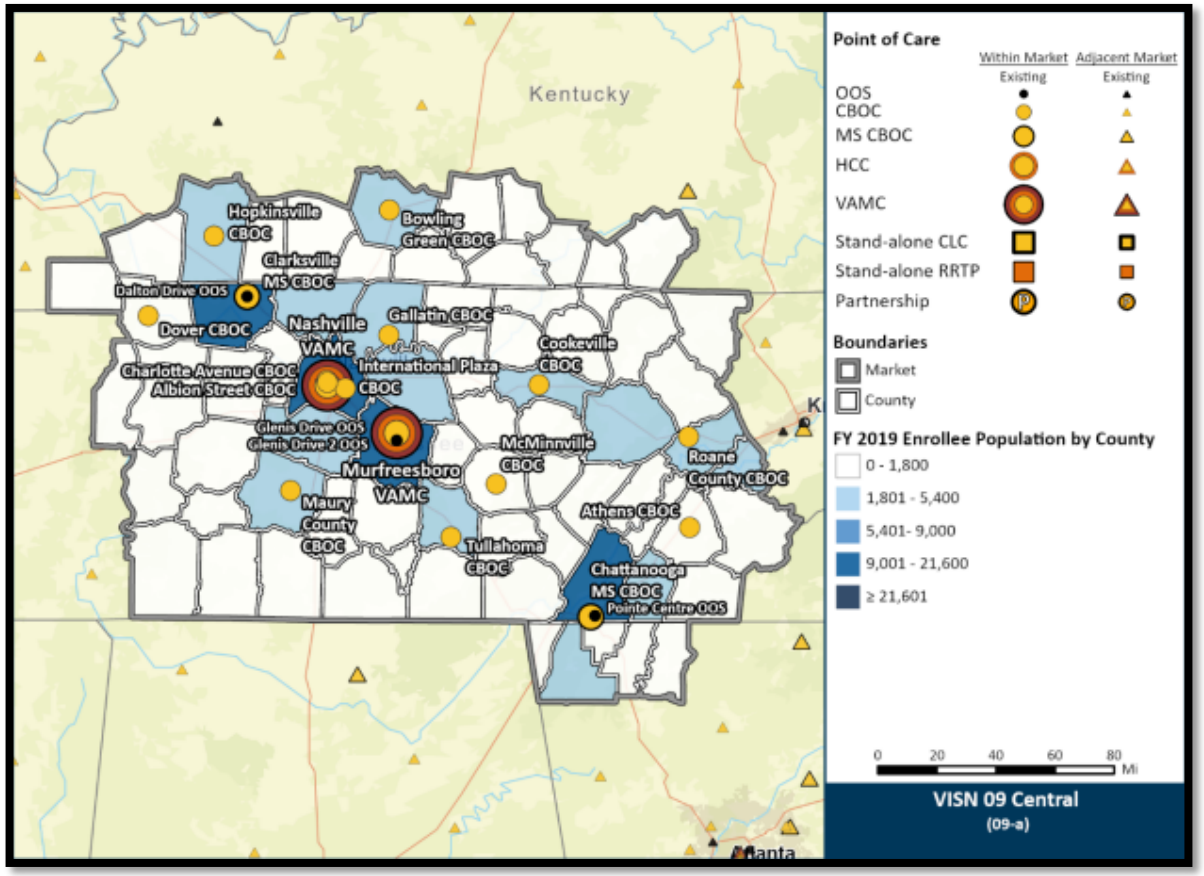


Changes in Population and Demand will lead VA to reallocate resources. Community Providers needed to assist with changes.

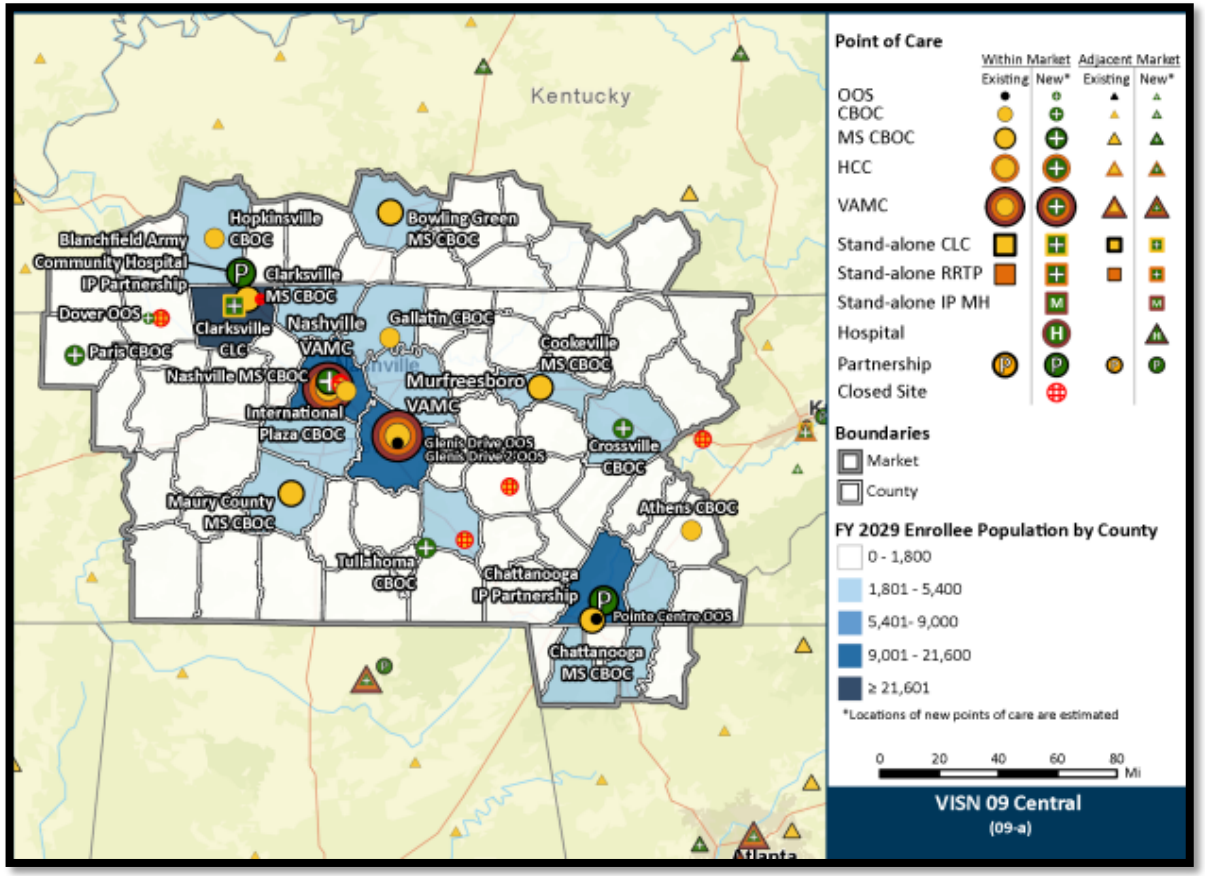
enablecomp
complex claims revenue solutions

VISN 9 – CENTRAL MARKET (SOUTH KY)

Current



Optimized

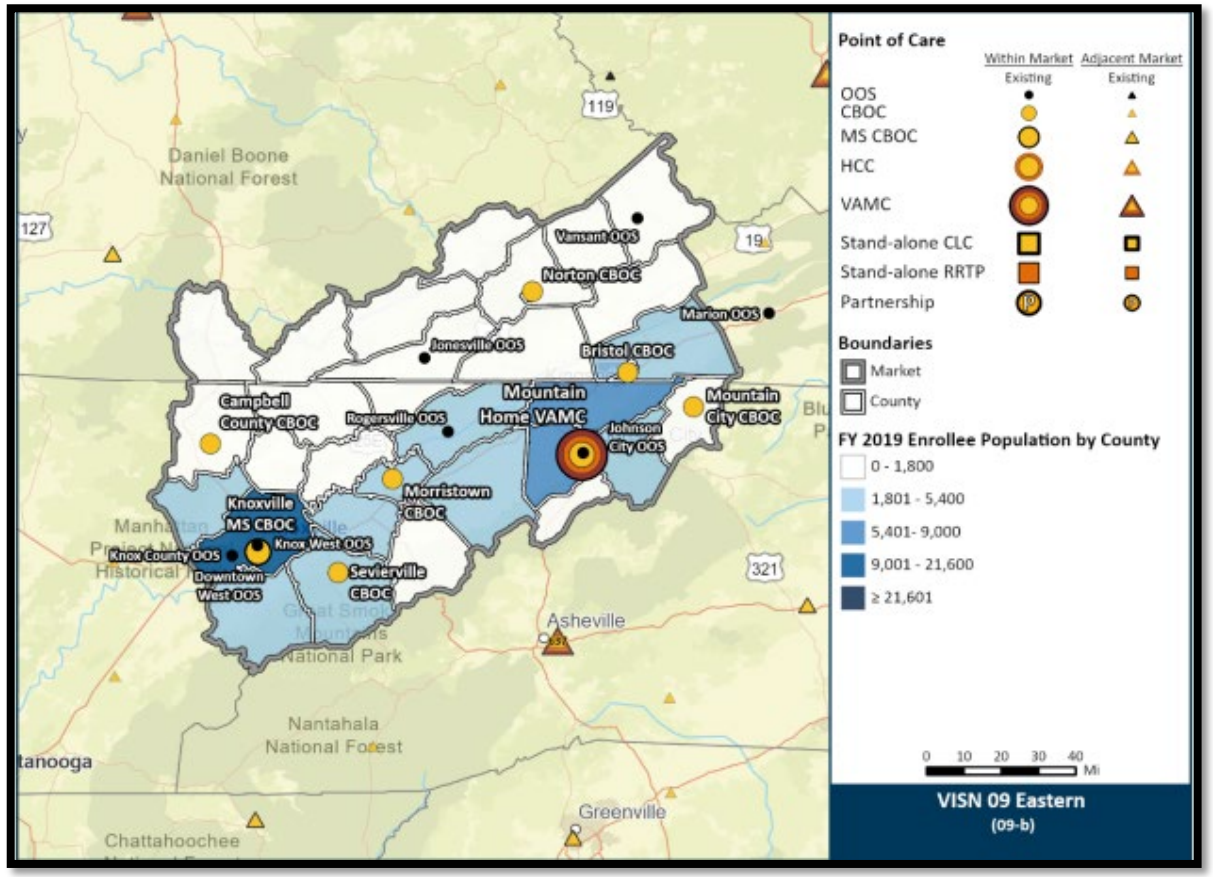


Significant population increase drives VA need to improve service options. Community Providers will still need to assist

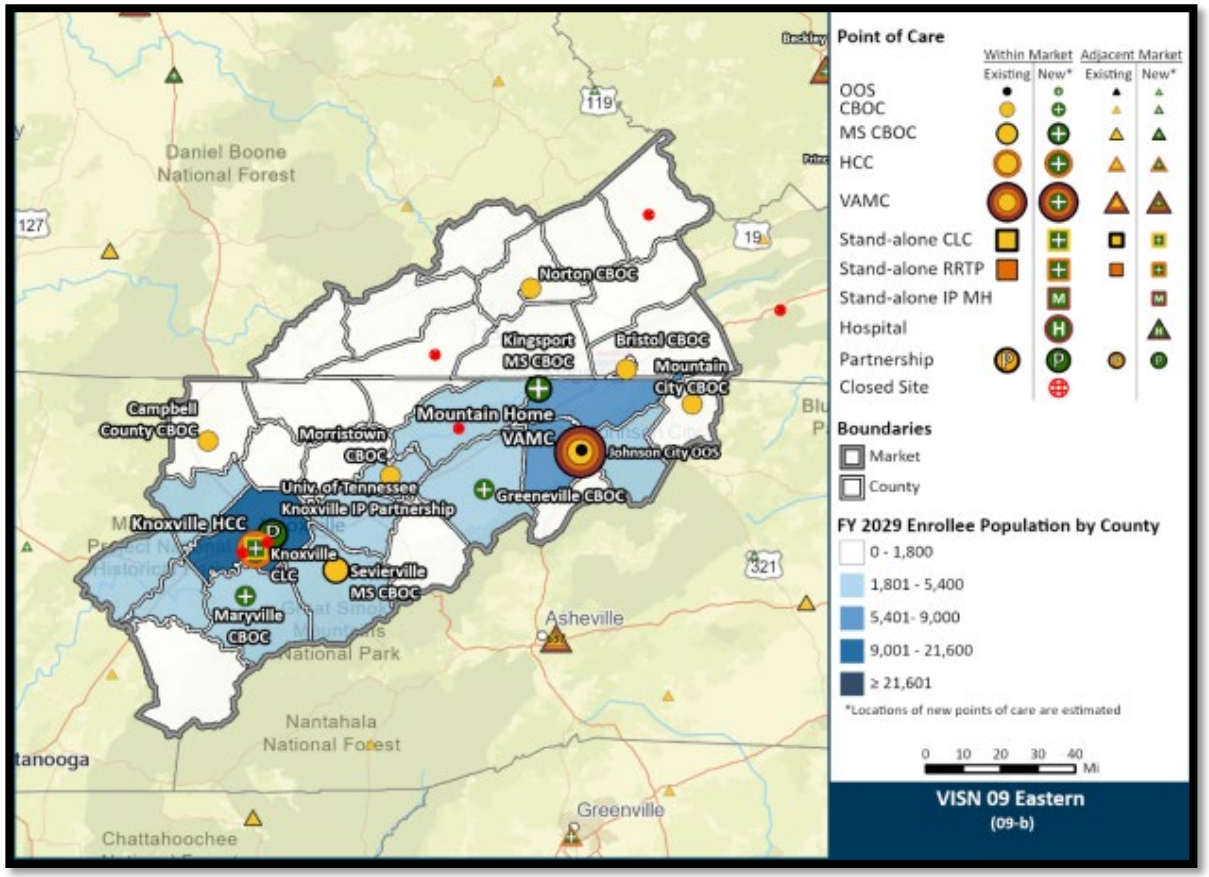
enablecomp
complex claims revenue solutions

VISN 9 – EAST MARKET (SOUTHEASTERN KY)

Current



Optimized

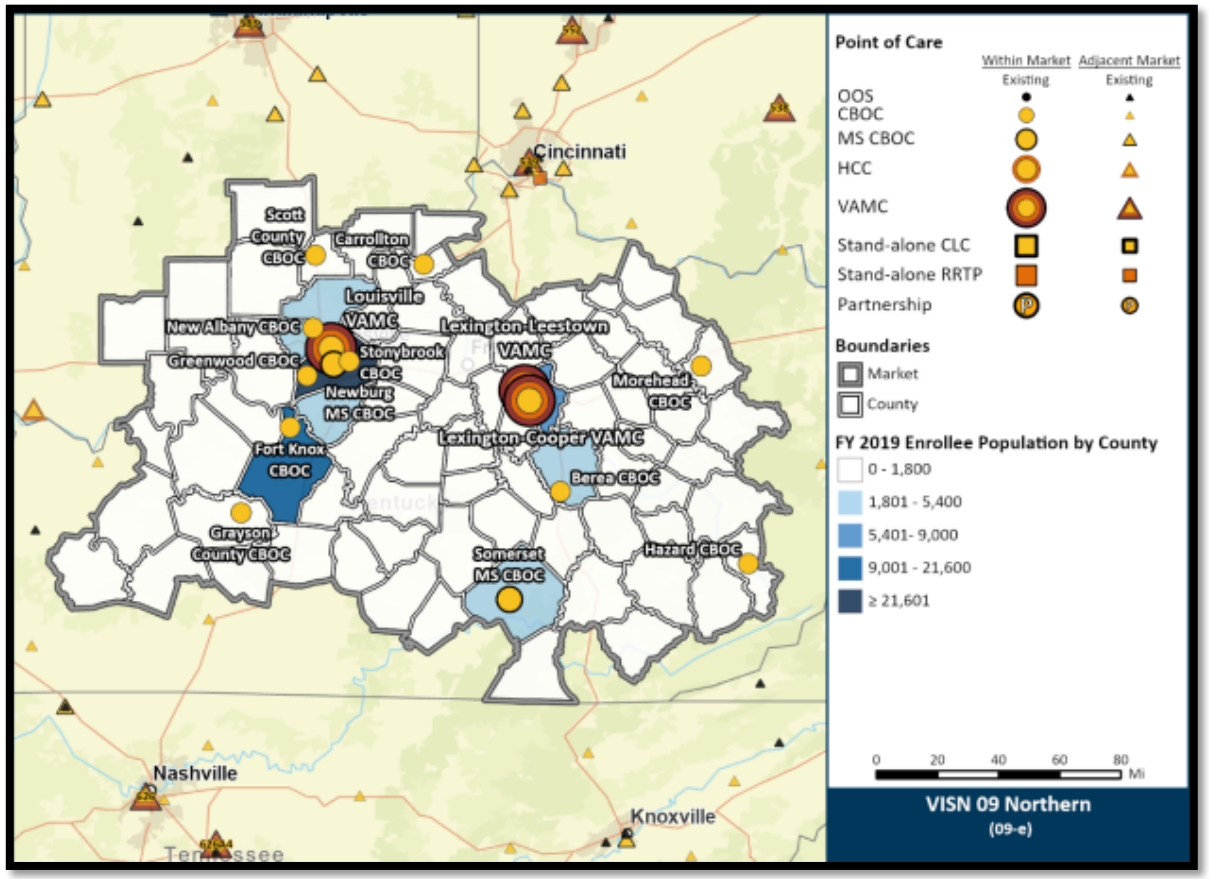


Changes in demand require the VA adapt to more nimble delivery methods. Community Providers still play a major role.

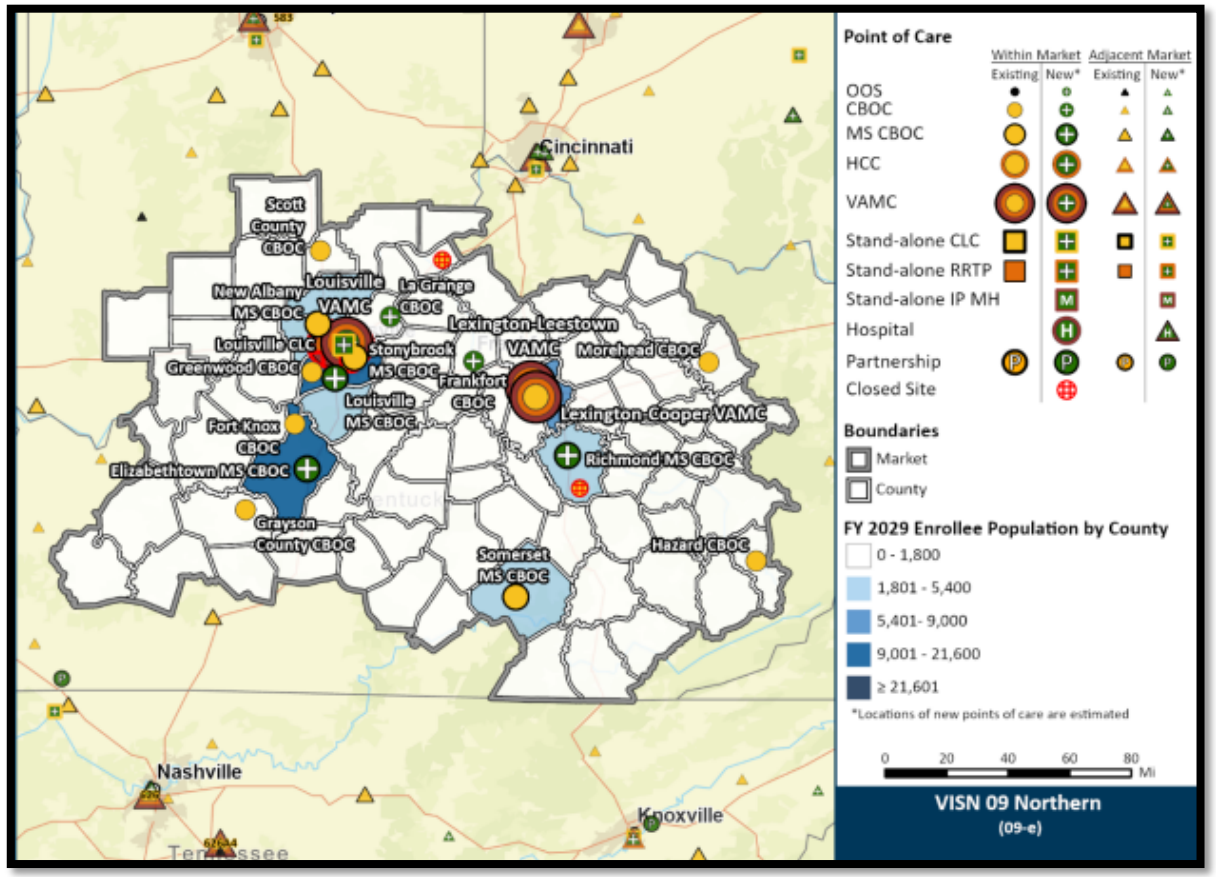
enablecomp
complex claims revenue solutions

VISN 9 – NORTH MARKET (CENTRAL AND EASTERN KY)

Current



Optimized

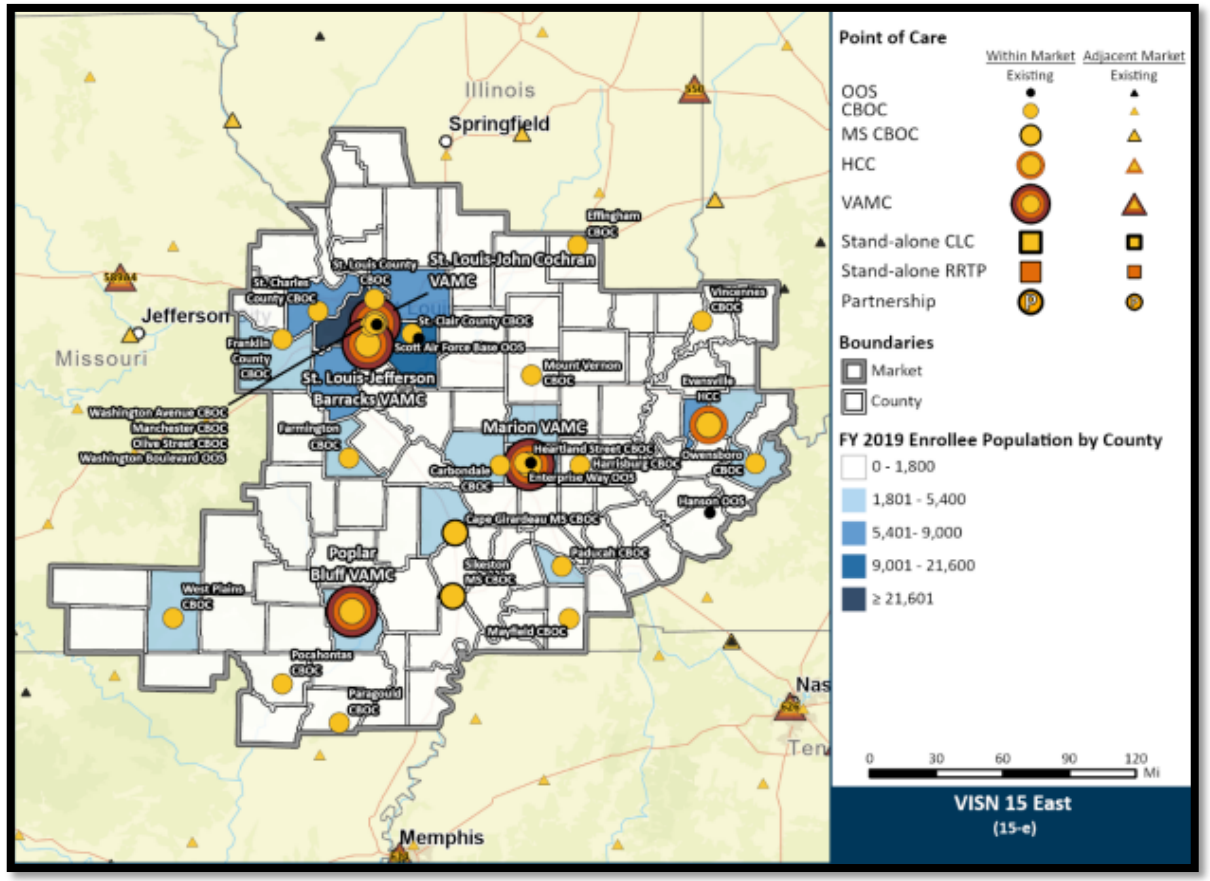


Significant improvements in care delivery will lead to excessive wait times. Community Providers still a viable option.

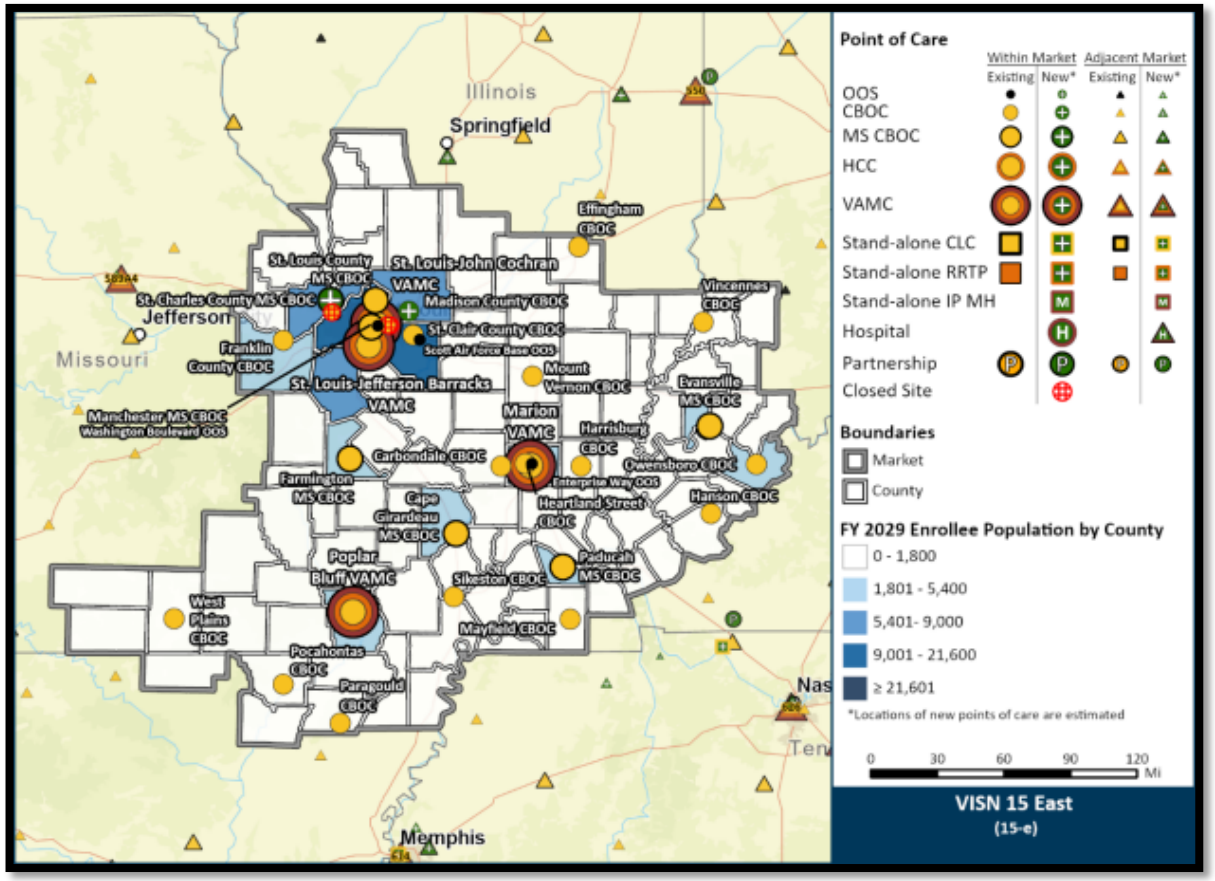
enablecomp
complex claims revenue solutions

VISN 15 – EAST MARKET (SOUTHWESTERN KY)

Current



Optimized



Improvement in care options will take time. Community Providers remain at the forefront of care delivery.

enablecomp
complex claims revenue solutions

enablecomp™
complex claims revenue solutions

QUESTIONS?

CONTACT

Ray Martin
VP, Client Services

(440) 477-8077

rmartin@enablecomp.com

4057 Rural Plains Circle, Suite 400
Franklin, TN 37064

enablecomp
complex claims revenue solutions

enablecomp™
complex claims revenue solutions

THANK YOU!