OPTUM

United Healthcare

VA Community Care Network

Claims Processing Guidelines

Key Points

- VA CCN providers must submit claims to Optum within 180 days from the date of service for outpatient care or date of discharge for inpatient care.
- Use the Veteran's Social Security number (SSN) or Integration Control number (ICN), listed on the approved referral, as insured ID on claim.
- Medical documentation must be sent directly to VA and not submitted to Optum with the claim.

VA CCN Claim Submission Guidelines

VA CCN providers must submit a claim on one of the following nationally recognized claim forms:

- CMS 1500
  - Veteran’s SSN or ICN in box 1a
  - Referral number or Urgent Care Eligibility Record Number (UCERN) in box 23
- UB-04 or CMS1450
  - Veteran’s SSN or ICN in box 60
  - Referral number or UCERN in box 63A
- American Dental Association (ADA) claim form (dental codes only)
  - Veteran’s SSN or ICN in box 15
  - Referral number in box 2

NOTE: Medical providers who are billing dental procedures must submit a dental claim to Logistics Health Inc. on an ADA claim form with the appropriate CDT code(s).

Claims Processing and Filing Requirements for VA CCN

Optum is committed to processing 98% of all clean claims within 30 days of receipt of the clean claim. Clean claims are claims received with all the required data elements necessary for a successful EDI transaction, as well as all required fields for VA CCN.

Veterans are to be held harmless and may not be billed for any reason including, but not limited to, when claims for services are denied for any of the reasons identified below. Claims submitted that are missing one or more of the following elements will be denied:

- The Veteran's SSN or ICN
- An approved referral number
- A valid National Provider Identifier (NPI) number

Additional reasons that a claim may be denied include, but are not limited to, the following examples:

- Claims for care that are not within the scope of the approved referral
- Duplicate claims
- Claims for services that are not part of the Veteran's medical benefits package
- Claims submitted on unapproved claim forms (Resubmitted claims on approved claim forms must be submitted within the timely filing deadline of 180 days from date of service or date of discharge.)
- Emergency claims submitted by an in-network emergency department when an approved referral does not exist due to the in-network emergency department not contacting VA within 72 hours of the Veteran self-presenting to the emergency department to request and receive a retroactive referral
- Claims that are not submitted within 180 days from the date of service or date of discharge (i.e., claims that are submitted past the timely filing deadline)
- Administrative charges related to completing and submitting the applicable claim form
- The provider fails to submit a claim, according to the claim adjudication rules
- The provider delivers health care services outside of the validity period specified in the approved referral

When a claim is submitted to VA or other Community Care third-party administrator (TPA) in error, the provider is required to submit the claim to Optum within 180 days from the denial and must include proof of initial timely filing. Proof should include an Explanation of Payment (EOP) from VA or a provider remittance advice (PRA) from VA or other Community Care TPA. If the claim was submitted to any other payer, the claim must be submitted to Optum within 180 days of the date of service or discharge.

Out-of-network providers providing emergency services at a CCN emergency department who has obtained an approved referral must submit claim to Optum with the approved referral number listed on the claim.

Out-of-network emergency departments providing emergency services to a Veteran need to submit health care claims directly to VA and follow VA claims submission procedures.

Claims for ancillary services will be processed in accordance with CMS NCCI, MUE and related edits.

Providers may not charge Veterans for missed appointments.

For more details, refer to the VA CCN Provider Manual available in the Optum VA Community Care Network portal at provider.vacommunitycare.com > Training & Guides.

Tips to Receive Prompt Payments: Identifying Optum as the Third-Party Administrator

As VA CCN is implemented in your area, registration and billing staff must be aware of the third-party administrator to bill appropriately and be paid quickly. Please share these details with your staff.

On the ***VA CCN referral***, look for the following ***Affiliations*** and ***Networks*** specific to the VA CCN Region indicating Optum is the third-party administrator:

Affiliations:

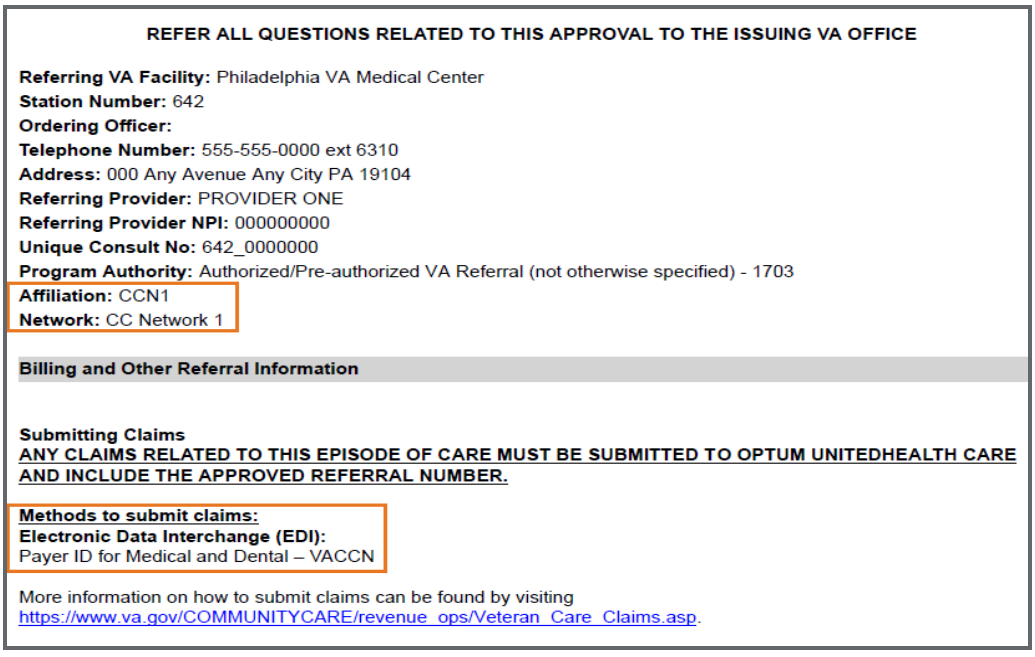
- CCN1
- CCN2
- CCN3

Network:

- CC Network 1
- CC Network 2
- CC Network 3

When you see the above ***Affiliations*** and ***Networks*** on an approved referral, the Veteran should be registered in your practice management system as VA CCN, and the claim should be submitted to Optum (or LHI for dental claims) using EDI, secure fax, mail or the provider portal.

Sample Referral Form:



REFER ALL QUESTIONS RELATED TO THIS APPROVAL TO THE ISSUING VA OFFICE

Referring VA Facility: Philadelphia VA Medical Center
Station Number: 642
Ordering Officer:
Telephone Number: 555-555-0000 ext 6310
Address: 000 Any Avenue Any City PA 19104
Referring Provider: PROVIDER ONE
Referring Provider NPI: 000000000
Unique Consult No: 642_0000000
Program Authority: Authorized/Pre-authorized VA Referral (not otherwise specified) - 1703
Affiliation: CCN1
Network: CC Network 1

Billing and Other Referral Information

Submitting Claims
ANY CLAIMS RELATED TO THIS EPISODE OF CARE MUST BE SUBMITTED TO OPTUM UNITEDHEALTH CARE AND INCLUDE THE APPROVED REFERRAL NUMBER.

Methods to submit claims:
Electronic Data Interchange (EDI):
Payer ID for Medical and Dental – VACCN

More information on how to submit claims can be found by visiting
https://www.va.gov/COMMUNITYCARE/revenue_ops/Veteran_Care_Claims.asp.

Filing a Claim

Electronic submissions are preferred.

- Payer ID: VACCN

Note: VA CCN electronic claims should be routed to Optum 360 directly or through a clearinghouse or vendor and include the approved referral number.

- Community care providers may also submit online:
  - Medical: Go to provider.vacommunitycare.com > Medical/Behavioral Provider.
  - Dental: Go to provider.vacommunitycare.com > Dental Provider.

Follow the XpressClaim Guide to submit claims directly on the Medical/Behavioral Provider portal.

If electronic capability isn't available, VA CCN providers can submit claims by secure fax or mail.

- **Medical**
  - Mailing Address:
    VA CCN Optum
    P.O. Box 202117
    Florence, SC 29502
  - Secure Fax: 833-376-3047
- **Dental**
  - Mailing Address:
    Logistics Health Inc. Attn: VA CCN Claims
    328 Front St. S.
    La Crosse, WI 54601
  - Secure Fax: 608-793-2143
    Please specify VA CCN on the fax

Electronic Payments and Statements

To enroll in Optum Pay services, administered through Optum Bank, access myservices.optumhealthpaymentservices.com.

Claim Reconsiderations

- Under VA CCN, a reconsideration is a formal process by which a VA CCN provider may request that Optum reviews a claim denied partially or in whole. When a claim is denied partially or in whole, a reconsideration request must be filed within 90 calendar days from the date of denial.

Reconsideration requests must be in writing and include the claim number, date of service, Veteran name and reason for the request, along with an explanation/justification for reconsideration.

Providers can request reconsiderations of multiple claims in a single letter or use the Grievance form available at provider.vacommunitycare.com > Documents & Links.

Please send reconsideration requests to the address or fax number listed on the remittance advice. If unable to locate the address, please submit reconsideration request by mail, secure fax or secure email:

- **Mail**:
  VA Community Care Network
  Appeals and Grievance
  Team MS-21
  3237 Airport Road
  La Crosse, WI 56403
- **Secure Fax:**
  877-666-6597
- **Secure Email:**
  - Region 1: faxAG1@optumserve.com
  - Region 2: faxAG2@optumserve.com
  - Region 3: faxAG3@optumserve.com

All other claim inquiries, including where a provider believes the claim was incorrectly paid must be submitted by mail or fax within 12 months after the claim was initially processed. Please submit the request by mail or secure fax:

- **Mail:**
  VA Community Care Network
  Claims
  P.O. Box 202118
  Florence, SC 29502
- **Secure Fax:**
  833-376-3047

Optum's target goal is to respond to reconsideration requests within 30 days of receipt of said request. However, based on volume those target goals may be slightly delayed. Please do not resubmit your requests until you have received a response from Optum.

More Information and Training

Providers participating in the VA CCN can find more information at provider.vacommunitycare.com > Training & Guides. This is where VA CCN providers will find the Provider Manual and other resources, including:

- Claims reference guides
- Medical documentation reference guide to submit documentation to VA
- Referral reference guide

Understanding Claim Numbers

The information below will help CCN providers understand how to read a claim number and what each character in the number means. All claim numbers have 13 characters. The chart below shows the five segments of a claim number and what each means.

Character	Meaning
1	Letter representing the year received. 2019 is “F,” 2020 is “G,” 2021 will be “H”
2 – 4	Three characters representing the number of days since the beginning of the year (Julian day, from 001 to 365, or 366 for leap years)
5	“X” for electronic claims (837 and portal claims), “W” for paper claims, “4” for reprocessed claims, “S” for split claims
6 – 9	Your claim’s unique number/letter combination
10 – 13	Adjustment, if any: original claim submission 0000, first adjustment 0001, second adjustment 0002

Adjustments

An adjustment is a change made to a previously processed claim that resulted in a payment.

An original claim number without an adjustment will end in 0000. Each time an adjustment is performed on a claim, the last digit of the claim number will increase by 1, e.g., 0001, 0002 and 0003.

Example: A VA CCN provider submits a corrected claim with corrected Days, Units, Times or Services (DUTS). The original claim number is F001X1234-**00-00** and the adjusted claim number will be F001X12134-**00-01**.

Reprocess

A reprocessed claim is a change that is being made to a previously processed claim that was rejected or denied.

An original claim number will end in 00-00. When a claim is reprocessed the fifth character of the claim number will be a 4.

Example: A corrected claim is received with corrected diagnosis codes for the claim that was originally denied with no payment made to the community care provider. Original claim number is F001**X**1234-00-00 and the reprocessed claim number is F001**4**1234-00-00.