Medicare Claims Processing Manual
Chapter 37 - Department of Veterans Affairs (VA) Claims Adjudication Services Project

Table of Contents
(Rev. 11427, 05-20-22)

Transmittals for Chapter 37

1 - Background on the VA Claims Adjudication Services Project

1.1 - Requirements for Processing VA Institutional and Professional Claims

1.1.2 – Requirements for Processing VA Durable Medical Equipment Prosthetics Orthotics and Supplies (DMEPOS) Claims

1.2 - Department of VA Claims Adjudication: Coinsurance and Deductible

1.3 - Generating Unsolicited Responses to the VA

1.4 - Use of Legacy Provider Numbers After National Provider Identifiers (NPIs) Are Fully Implemented

1 - Background on the VA Claims Adjudication Services Project
(Rev. 1454, Issued: 02-22-08, Effective: 04-01-08, Implementation: 04-07-08)

Current law permits the VA to collect appropriate Medicare coinsurance and deductible amounts from supplemental insurers for claims for supplies and services ordinarily covered by Medicare but furnished:

- At VA facilities; and
- For veterans eligible to receive both VA health and Medicare benefits and also having Medicare supplemental insurance.

To facilitate this process, the Centers for Medicare & Medicaid Services (CMS) entered into an interagency agreement with the VA whereby CMS will help the VA work with the designated CMS MAC to adjudicate claims for these services to produce remittance advices equivalent to those ordinarily produced for Medicare claims. Medicare does not pay these claims, but the remittance advices show how much Medicare would have paid had the claims been payable by Medicare along with the applicable deductibles and coinsurance. In adjudicating a claim and generating these remittance advice notices, the CMS MAC must verify that the services provided are covered benefits, certify admission where appropriate, conduct prepayment utilization screening, and authorize payment. CMS has a single A/B MAC (A) and (B) to process these claims. The remittance advices, sent by the VA to the supplemental insurers, will help the insurers determine payment amounts they owe to the VA.

The VA funds all of the work on this project, including systems changes.

1.1 - Requirements for Processing VA Institutional and Professional Claims
(Rev. 4023, Issued: 04-20-18, Effective: 07- 20-18, Implementation: 07-20- 18)

Veterans typically see more than one physician at a VA facility on a given day. The A/B MAC (B)-defined provider number will contain a "V" in the first position and specialty codes. Including specialty codes permits the VA to have multiple provider numbers to accommodate various professional services furnished at a given facility on the same day for the same beneficiary-veteran. CWF will edit to ensure that only claims having all three of the following conditions will be processed according to the special VA claims adjudication procedures of this project:

1. A demo number of 31 is present;

2. A V is present in the first position of the A/B MAC (B) defined provider number field (HUBC Field 83 Provider Number, Positions 440-449); and

3. The VA A/B MAC (B) number is present

If only two of these conditions are present, then CWF will reject the claim. If only the demo code of 31 is present, CWF will also reject the claim.

The VA will use the ASC X12 837 professional claim format for A/B MAC (B) equivalent claims.

To process VA claims from various localities, the VA A/B MAC (A) and (B) has established a database for the Medicare physician fee schedule to include pricing information for all of the States.

The VA will use the following bill types for A/B MAC (A) equivalent claims: 11x, (Hospital Inpatient, Part A), 12x (Hospital Inpatient, Part B), 13x (Hospital Outpatient), 14x (Hospital Other, Part B), 18x (Hospital Swing Beds), 21x (SNF inpatient), and 23x (SNF outpatient). These claims are submitted using the ASC X12 837 institutional claim format.

The SNF VA provider numbering scheme is as follows:

a 2 digit numeric state code, followed by a "5", followed by a 1 digit one up number, followed by with a "V", ending with a single position alpha numeric.

1.1.2 – Requirements for Processing VA Durable Medical Equipment Prosthetics Orthotics and Supplies (DMEPOS) Claims

(Rev. 11427; Issued: 05-20-22; Effective: 01-01-23; Implementation: 01-03-23)

NOTE: *CMS seeks to reduce burden and modernize processes to ensure a reduction in improper payments and an increase in customer satisfaction. The Certificate of Medical Necessity (CMN) form and DME Information Form (DIF) were originally required to help document the medical necessity and other coverage criteria for selected Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) items. In the past, a supplier received a signed CMN from the treating physician or created and signed a DIF to submit with the claim. Due to improvements in claims processing and medical records management, the information found on CMNs or DIFs is available either on the claim or in the medical record and is redundant. Therefore, to reduce burden and increase customer satisfaction, providers and suppliers no longer need to submit these forms for services rendered after January 1, 2023.*

- ***For claims with dates of service on or after January 1, 2023*** *– providers and suppliers no longer need to submit CMNs or DIFs with claims. Due to electronic filing requirements, claims received with these forms attached will be rejected and returned to the provider or supplier.*
- ***For claims with dates of service prior to January 1, 2023*** *– processes will not change and if the CMN or DIF is required, it will still need to be submitted with the claim, or be on file with a previous claim.*

This statement applies throughout the Program Integrity Manual wherever CMNs and DIFs are mentioned.

The process of receiving VA DMEPOS claims for a no-pay Electronic Medicare Remittance Advice (e-MRA) is effective on April 1, 2018. The processing of these claims, as with the Part A and Part B claims, allows for a CMS no-pay e-MRA to be generated for all DMEPOS claims submitted to CMS by the VA. VA DMEPOS claims are processed by a single DME MAC. For VA DMEPOS claims the e-MRA displays the amount that Medicare would have paid for the claim using the same fee schedule payments as DMEPOS Medicare claims would've paid and are based on the beneficiary's state of residence. The same deductible and coinsurance rules applicable to Medicare are applied to the VA claims and are provided on the e-MRA.

The VA submits DMEPOS claims via the ANSI X12 837P electronic format. The VA claims will be processed through the Medicare DME MAC Common Electronic Data Interchange (CEDI) front end system, DMEPOS claims processing system (VMS) and the common working file (CWF). In addition to following the ANSI X12 837P standards for claims submissions the following criteria applies:

- The VA's submitter of record is the approved biller and submits all VA electronic claims to CEDI.
- The VA supplies CMS, the VA DME MAC and CEDI with the VA facility NPI list. Validation of the NPI is done at the CMS front end contractor.
- VA claims are processed as mandatory assigned claims, no beneficiary submitted claims will be processed.
- VA DMEPOS submitted claims must be for beneficiaries that reside in the US and its territories.
- The VA must submit claims for Medicare approved HCPCS provided on the DMEPOS jurisdiction list which can be found at https://www.cms.gov/Center/Provider-Type/Durable-Medical-Equipment-DME-Center.html.
- The VA DMEPOS claims are subject to the Medicare timely filing rules. Claims will be accepted for processing with dates of service one year prior to the date of receipt.
- The VA will submit paper CMNs for DMEPOS items that require a CMN per Medicare rules. The CMNs will be faxed (until the time VA has the ability to submit CMNs electronically) to the DME MAC. Claims requiring a CMN may be held for up to 2 weeks to allow for receipt of the CMN. Claims will be denied if a CMN is not received within 2 weeks.

The CWF edits to ensure the same three conditions stated above for A/B claims are applicable and must be present for adjudication on the DMEPOS claims. In addition, MSP claims are accepted from the VA and the CWF will apply MSP editing to VA DMEPOS claims.

Finalized claims will be included in the VA e-MRA and produced in the CMS flat file format. CEDI will translate the VA e-MRA flat file to the ANSI X12 835 format and make the file(s) available for the VA's submitter of record to retrieve.

Adjustments to claims submitted by the VA can be made only for redeterminations or cancels. This applies to all DMEPOS claims submitted by the VA for VA facilities and for independent suppliers.

1.2 - Department of VA Claims Adjudication: Coinsurance and Deductible

(Rev. 1454, Issued: 02-22-08, Effective: 04-01-08, Implementation: 04-07-08)

Part of this process involves the calculation of the deductible applicable to the Medicare-equivalent VA claims. The CWF calculates the deductible based on true Medicare claims, i.e., for Medicare services rendered by Medicare providers to Medicare beneficiaries, and sends this information back to the shared system maintainers for this project. The MCS and FISS further adjust the deductible information received from CWF with the deductible amounts that apply to the Medicare-equivalent VA claims. This arrangement results in a calculation of the deductible for the VA's equivalent of Part A and B claims.

In addition, effective January 1, 2005, CWF began to calculate the Part B-equivalent deductible for Medicare claims taking into consideration the VA equivalents of both Medicare outpatient and professional claims as well as true Medicare claims.

To confirm that CMS has made no payment on the VA claim, the remittance advice will include message MA118 –"Coinsurance and or deductible amounts apply to a claim for services or supplies furnished to a Medicare Eligible veteran through a facility of the Department of Veterans Affairs. No Medicare payment issued". Existing claim adjustment reason codes 1 (deductible) and/or 2 (coinsurance) will be used to report those amounts on these remittance advice transactions.

As necessary, CWF expands the VA claim auxiliary file within CWF so that the history of VA Part A-equivalent no-pay claims, adjudicated for the MRA Project, contain sufficient information about the VA claims and Medicare-equivalent Part A deductible and coinsurance amounts applied so that an unsolicited response can be generated. The auxiliary file contains sufficient information so that there can be one such unsolicited response for each VA claim affected.

The VA auxiliary file within CWF also provides a claims history for VA Part B equivalent claims. The auxiliary contains the information about VA claims necessary to show Medicare-equivalent Part B deductibles satisfied by the VA claims. National Claims History is not updated with the VA deductible information, and these changes have no effect on Medicare claims. CWF sends the Part B deductible information to the A/B MACs (A) and (B) for this project. This affects claims with dates of service of January 1, 2004, and after and will use deductible amounts for calendar years 2004 and after.

1.3 - Generating Unsolicited Responses to the VA

(Rev. 1454, Issued: 02-22-08, Effective: 04-01-08, Implementation: 04-07-08)

While the VA is entitled by law to collect the coinsurance and deductible amounts that would have been payable had the claim been a true Medicare claim, it is generally permitted to do so only to the extent that there are no true Medicare claims for coinsurance and deductible submitted to the insurer for the same beneficiary for the same year. While the VA submits these Medicare-equivalent claims in good faith, based on the current deductible information within CWF and maintained by the shared systems, situations sometimes arise where a true Medicare claim is subsequently adjudicated and for whom the insurers' payment of deductible is owed. When this occurs, and the supplemental insurer processes the true Medicare claim, it may deny the claim believing it has already paid the deductible, with the possible result of providers in turn billing the Medicare beneficiary for this amount. While the VA is willing to pay back the amounts it collected in error, it will not always know that this situation has occurred, and has asked Medicare to help it determine when this situation has transpired. The solution is an unsolicited response, sent to the VA, indicating that a change in Medicare deductible has occurred since the adjudication of the VA claim. The unsolicited response will show the amount of deductible approved for the affected VA claim and the total true Medicare deductible satisfied as of the date the Medicare claim was adjudicated. There will be one unsolicited response per affected VA claim. The unsolicited responses will be generated each time a Medicare claim affecting the deductible is adjudicated after the adjudication of a VA claim applying a deductible for the same year of service, even if the VA claim has not overapplied the deductible. Although this provision became effective January 1, 2006, it affects claims with dates of service January 1, 2004, and later.

1.4 - Use of Legacy Provider Numbers After National Provider Identifiers (NPIs) Are Fully Implemented

(Rev. 1454, Issued: 02-22-08, Effective: 04-01-08, Implementation: 04-07-08)

While equivalent to Medicare claims in overall appearance and the nature of the services rendered, VA claims contain unique elements to ensure that they are processed appropriately and apart from Medicare claims, and in particular that payment is not made. Among these characteristics are a demo code and provider numbers which are unique to this project.

CMS has determined that it is in its best interests to have the VA continue to submit the MRA project transactions with its legacy numbers instead of NPIs.

In addition, if the VA providers begin using an NPI for other purposes, Medicare-equivalent remittance advice claims must be submitted to CMS with a VA OSCAR number as the provider identifier. The demo number (31) will be assigned based on the OSCAR number submitted and by the A/B MAC (A) or (B) number.

Transmittals Issued for this Chapter

Rev #	Issue Date	Subject	Impl Date	CR#
R11427CP	05/20/2022	Claims Processing Manual Update - Pub. 100.04 for Elimination of Certificates of Medical Necessity (CMNs) and Durable Medical Equipment Forms (DIFs)	01/03/2023	12734
R11414CP	05/12/2022	Claims Processing Manual Update - Pub. 100.04 for Elimination of Certificates of Medical Necessity (CMNs) and Durable Medical Equipment Forms (DIFs) – Rescinded and replaced by Transmittal 11427	06/13/2022	12734
R4023CP	04/20/2018	Update of Internet Only Manual (IOM), Medicare Claims Processing Manual, Publication 100-04, Chapter 37 - Department of Veterans Affairs (VA) Claims Adjudication Services Project	07/20/2018	10621
R3009CP	08/01/2014	Update to Pub. 100-04, Chapter 37 to Provide Language-Only Changes for Updating ASC X12	09/02/2014	8770
R1454CP	02/22/2008	Department of Veterans Affairs (VA) Claims Adjudication Services Project - New IOM Chapter - Pub. 100-04, Chapter 37 “Department of Veterans Affairs (VA) Claims Adjudication Services Project”	04/07/2008	5938

Back to top of chapter