The State of VA and Work Comp:

Strategies to Maximize Your Revenue Right Now

March 12, 2025

enablecomp™
complex claims revenue solutions

Meet the Speaker

Zach Schultz, CSMC, CRCR
Sr. Director, Product Policy & Solutions

(615) 479-3328

zschultz@enablecomp.com

4057 Rural Plains Circle, Suite 400
Franklin, TN 37064

enablecomp
complex claims revenue solutions

About EnableComp

Our Services

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

enablecomp
complex claims revenue solutions

Agenda

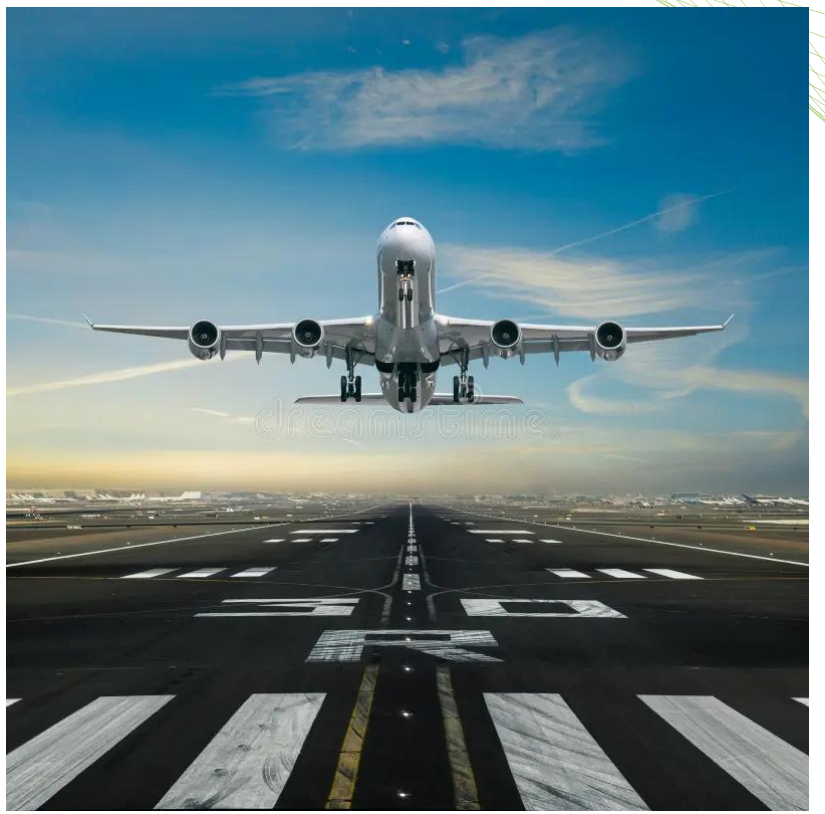
Veterans Administration and Military Claims

- VA History, Market, Legislative (MISSION/PACT/COMPACT) and Population Changes
- Different Military Payers/Claim Types
- VA Coordination of Benefits
- VA Authorizations
- VA Reimbursement
- VA Denials and Appeals
- VA in 2025 and Beyond

Workers' Compensation

- History of Work Comp
- Validating and Work Comp Billing Complexities
- Timely Filing
- Work Comp Fee Schedules
- Work Comp Appeals and Contracting

Questions & Answers



enablecomp
complex claims revenue solutions

History of the Veterans Administration

- The Veterans Administration can be traced back to the Civil War era
- In 1865, the National Asylum for Disabled Volunteer Soldiers was established by Abraham Lincoln
- During WW1, Congress created new benefits for veterans including life insurance, disability, prosthetics, rehab and hospitalization
- In 1921, the Veterans Bureau was created to consolidate the administration and functions of various agencies responsible for veteran's benefits
- In 1930, the Veterans Bureau became the Veterans Administration - a cabinet level position in 1989
- In 2018, the MISSION Act was passed expanding eligibility and creating the Community Care Network

Legislative Changes – MISSION, COMPACT, AND PACT

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

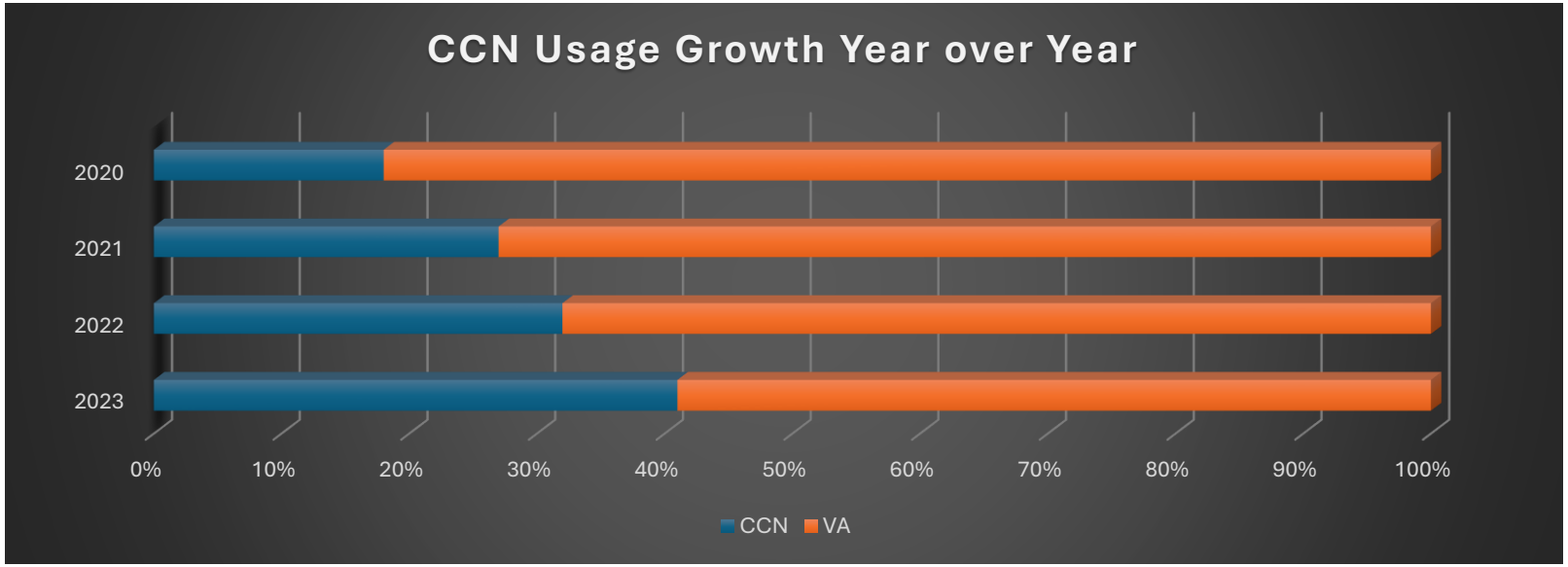
1) **"MISSION" Act** - Maintaining Internal Systems & Strengthening Integrated Outside Networks
   - Passed on June 6, 2018
   - Eligibility Expansion and Creation of the Community Care Network (CCN)

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 – 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

enablecomp
complex claims revenue solutions

Military Claim Types/Payers

- **CCN (Community Care Network)**
  - Allows veterans to receive care from community providers when VA services are unavailable.
  - Managed by third-party administrators (Optum & TriWest).
  - Requires VA authorization for non-emergency care.

- **VA Fee Basis (Non-VA Care or VA Purchased Care)**
  - Previously used for veterans needing care outside the VA due to distance, lack of services, or medical need.
    - Most commonly for emergency services
  - Replaced by CCN in most cases but still exists for special circumstances.

- **Millennium Bills (Emergency Care Reimbursement)**
  - Covers emergency medical care for veterans in non-VA facilities.
  - Available if VA care wasn't feasible and the condition is service-connected or VA-rated.
  - Requires filing within **90 days** of treatment.

- **TRICARE**
  - Health care program for active-duty service members, retirees, and their families.
  - Covers medical, dental, and pharmacy benefits.
  - Types:
    - **TRICARE Prime:** Managed care with assigned providers.
    - **TRICARE Select:** Fee-for-service with more provider choice.
    - **TRICARE for Life:** Secondary coverage for Medicare-eligible beneficiaries.
    - **TRICARE Reserve Select:** For reserve members and their families.
    - **TRICARE Retired Reserve:** For retired reservists under age 60.

- **CHAMPVA (Civilian Health and Medical Program of the Department of Veterans Affairs)**
  - For spouses, widows, and dependents of veterans with permanent service-connected disabilities.
  - Covers services similar to TRICARE but administered by the VA.

enablecomp
complex claims revenue solutions

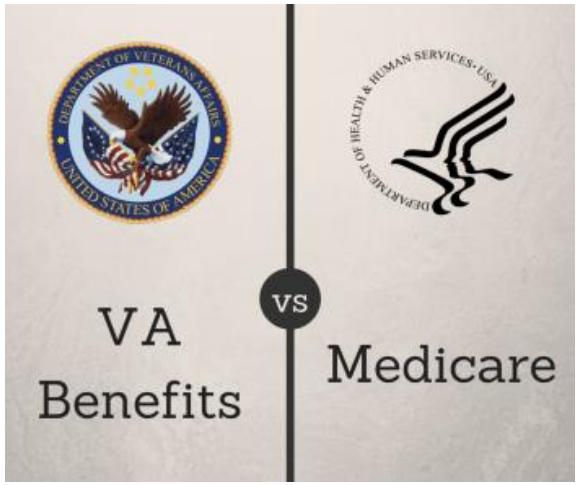
How Do Vets Get Community Care? Referral and auth process

- Request a referral
  - A referral can be requested by a veteran online at va.gov/health-care
  - Other events that can trigger a request for community care are new veteran clinical appointments, a notification from a hospital, and IP admission or Er visit
- Eligibility review
  - The VA community care team will determine the appropriate level of care using a Screening Triage Tool combined with clinical judgement
  - VA team will develop a care coordination plan
- Confirmation and referral determination
  - The veteran will contact the veteran and issue a referral within 14 days
- Schedule appointment
  - Once a referral is receiving the appointment can be scheduled
  - Vet should notify VA of this appointment within 14 days
- Authorization letter
  - An auth will be issued approving community care it will include the below information
    - Auth number
    - Info about approved community provider
    - Care description
    - Length of time before needing another referral
- Attend and track appointments

enablecomp
complex claims revenue solutions

VA Pain Points – Coordination of Benefits

- 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.



enablecomp
complex claims revenue solutions

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.

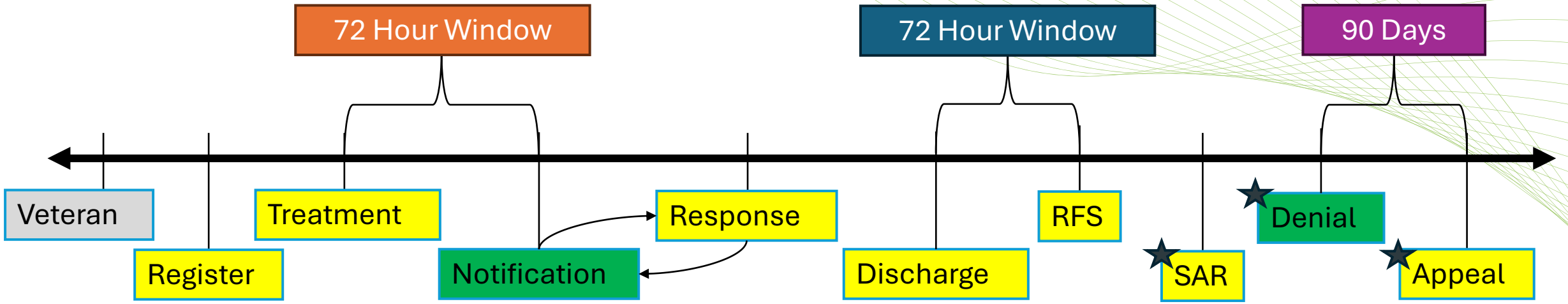
enablecomp
complex claims revenue solutions

VA Pain Points – Top 5 Denials

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

enablecomp
complex claims revenue solutions

VA Pain Points – Authorization Denials

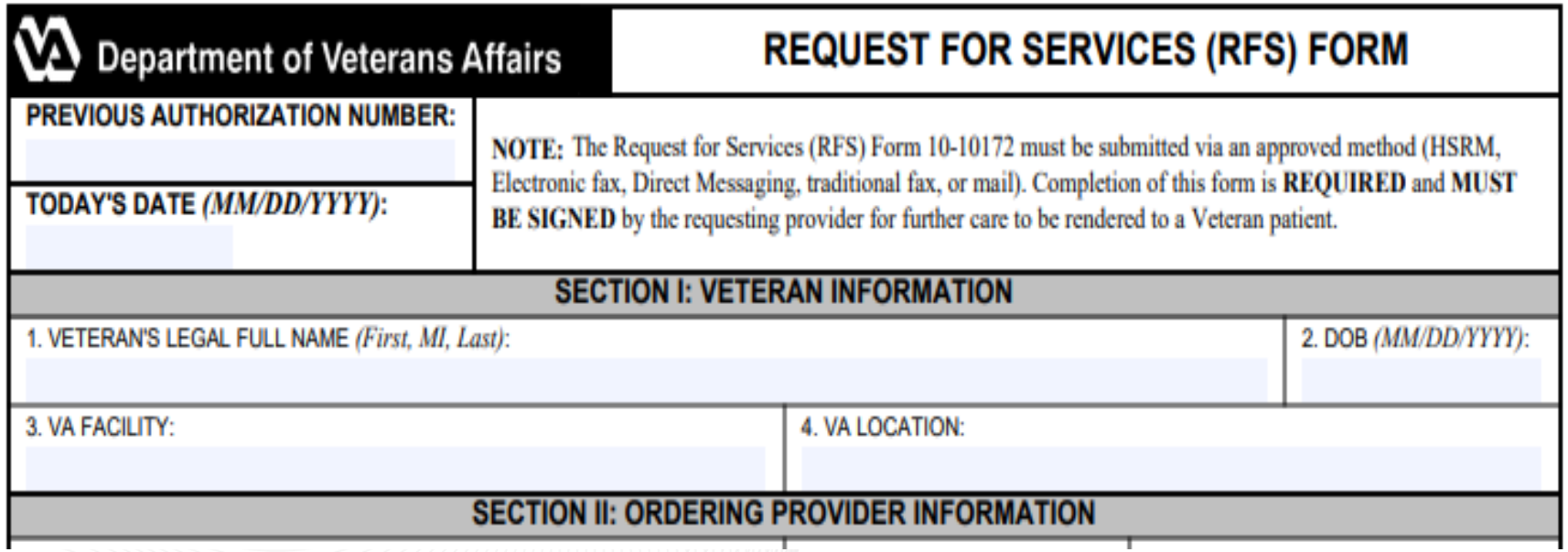


- When working a Veteran Authorization Denial, you have two options available.
  - **OPTION #1 (Authorization on file)**
    - Under CCN → If there is an authorization on file, see if you can use Secondary Authorization Request ("SAR").
    - Under VA → If there is an authorization on file, did you attempt a Request for Service extension?
  - **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.
    - You must show why an authorization was not obtained, examples include; patient unconscious at the time at presentation, mental confusion, other insurance was provided…

enablecomp
complex claims revenue solutions

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

enablecomp
complex claims revenue solutions

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

enablecomp
complex claims revenue solutions

Workers' Compensation

enablecomp
complex claims revenue solutions

History of Work Comp

- Started in the late 19th century
- Heavily influenced by Europe's worker accident insurance system created by Otto Von Bismark in Germany in 1884
- Before work comp laws, workers had to rely on litigation often facing the unholy trilogy of defenses (contributory negligence, assumption of risk, and fellow servant rules) making it difficult to win lawsuits.
- New York was the first state to enact statewide work comp laws in 1898 followed by Maryland, Massachusetts and Montana. However, these law were deemed unconstitutional.
- Wisconsin passed the first constitutionally recognized work comp laws in 1911 and by 1949 every state had enacted work comp programs.

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

WC Paint Point - Validation and Registration

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!

enablecomp
complex claims revenue solutions

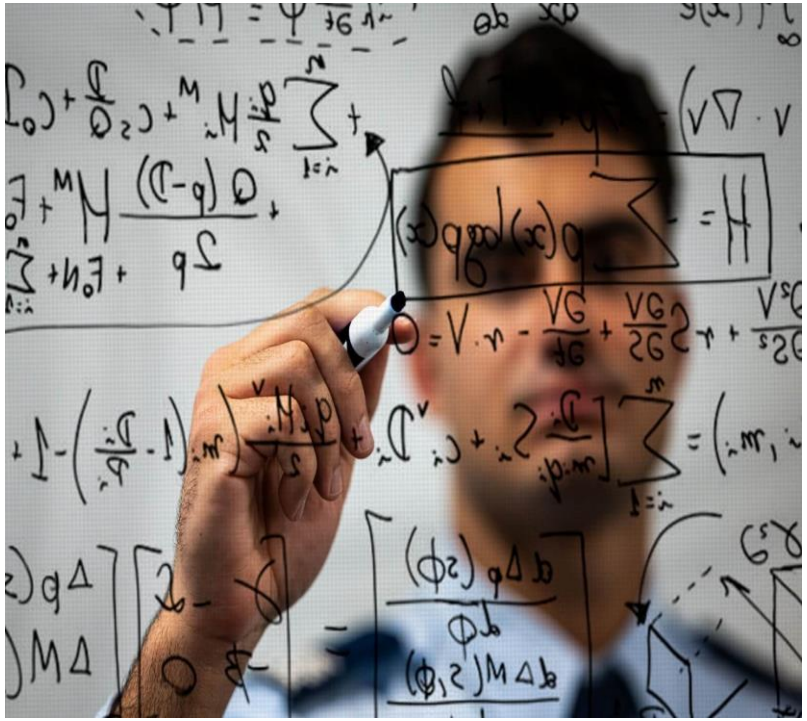
Employer Inventory Example

- 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

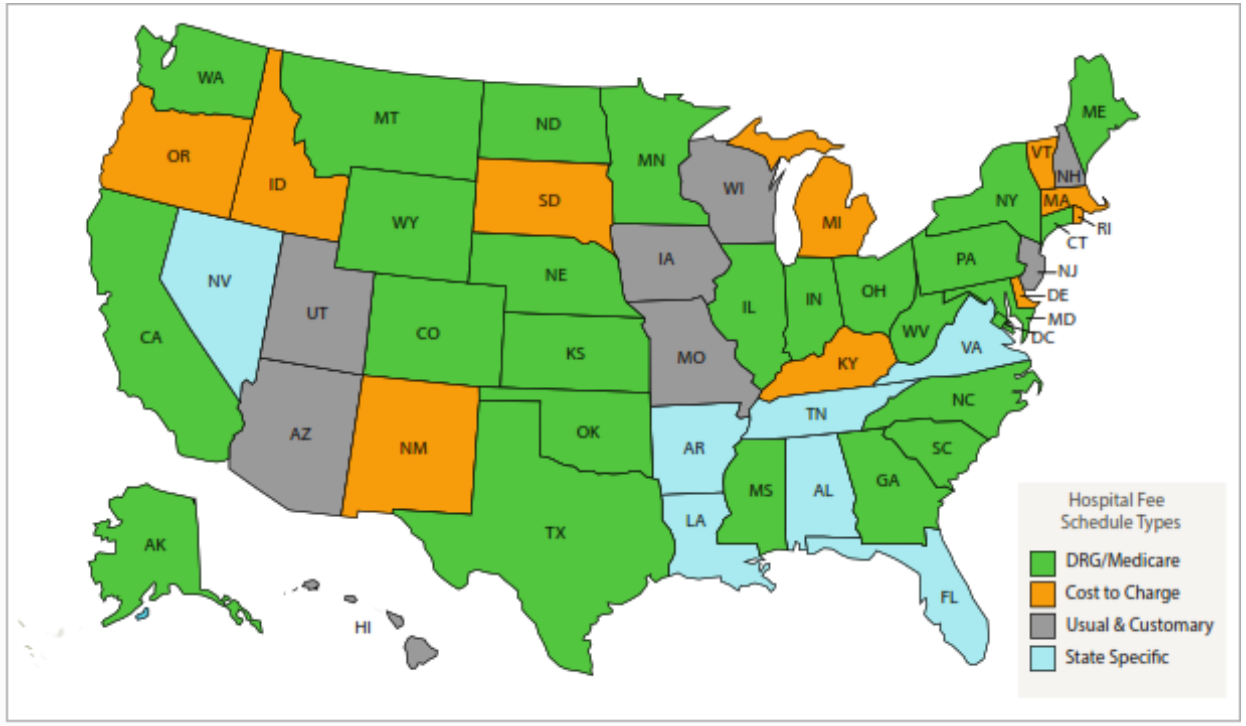
- Math problems are rarely simple and require information from multiple sources (i.e. DRG weights/Hospital cost to charge information/locality/etc.)
- Not only do state have different Fee Schedules but they have different methodologies (examples on next slide)
- A lot of hospital systems are not able 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



enablecomp
complex claims revenue solutions

Work Comp FS Types

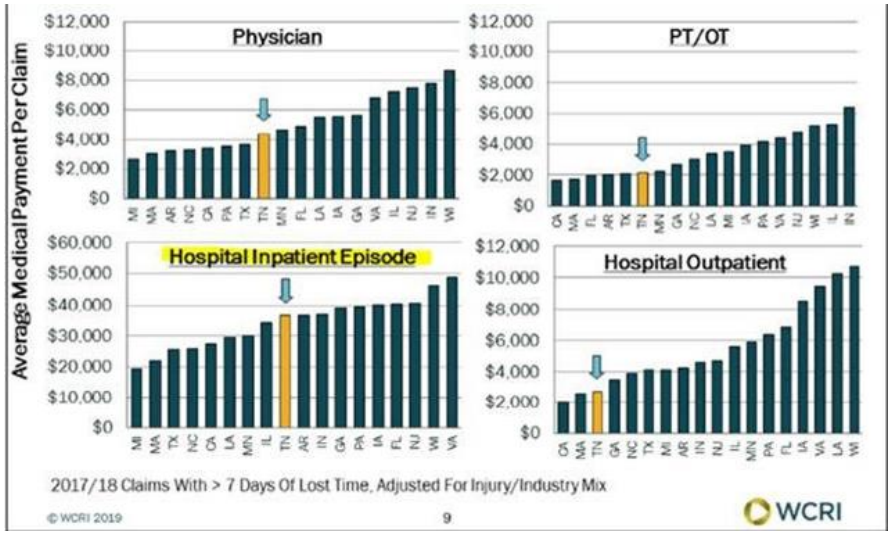
- Medicare (or Medicaid) based
  - Most common
  - Lower margins. Lower average reimbursement
  - PA has Medicare based FS
- State Specific
  - Usually more streamlined easier to navigate
  - Higher reimbursement averages
- Usual and Customary
  - No formal work comp rules/Fee Schedule in place
  - Claims 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

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



enablecomp
complex claims revenue solutions

Pennsylvania Work Comp Fee Schedule

- Inpatient Hospital Services
  - Reimbursement follows 1994 PA WC Version-12 DRG formula (Fee Schedule Tables A & B).
  - Reimbursement Formula: PA Table 5 DRG Weight × PA Impact Table Base Rate × PA Uplift (113%)
- Trauma & Burn Facility Reimbursement
  - 100% Usual & Customary Charges (Exempt from medical fee caps).
- Qualifying Facilities:
  - Level I or II Trauma Centers (Accredited by PA Trauma Systems Foundation).
  - Burn Facilities meeting American Burn Association standards.
- Qualifying Conditions
  - Life-threatening or urgent injuries requiring acute care.
  - Basic & advanced life support services for transport are also 100% reimbursable.
  - Presumptive eligibility for trauma transport if determined urgent by EMS.

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%**

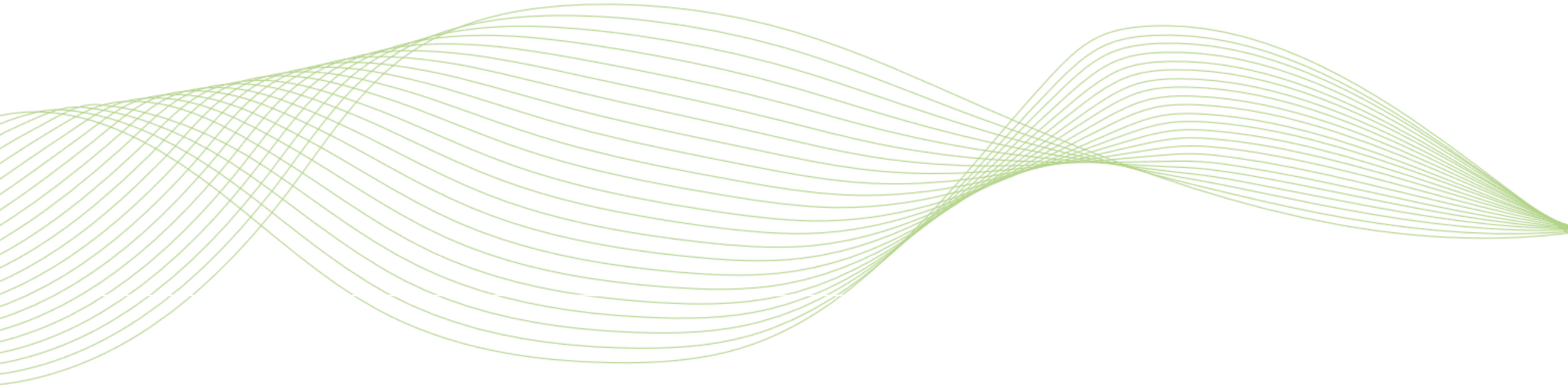
PPO	Claims	Charges	Total Payment	Percent Below Fee Schedule	PCR	Percent of Total Revenue
Emergency	123	$615,192	$295,357	-8%	48%	19%
Imaging	45	$156,970	$81,968	-12%	52%	5%
Inpatient	24	$1,070,064	$473,971	-10%	44%	30%
Lab	8	$49,821	$29,996	-36%	60%	2%
OP Surgey	48	$1,458,929	$542,939	-6%	37%	35%
Other 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%**

*PCR- Percent of Charge Ratio

enablecomp
complex claims revenue solutions

enablecomp™
complex claims revenue solutions

Questions?



Contact

Michael Galloway
RVP, Client Services

(202) 904-6073

mgalloway@enablecomp.com

4057 Rural Plains Circle, Suite 400
Franklin, TN 37064

enablecomp
complex claims revenue solutions

Thank You!

enablecomp
complex claims revenue solutions