FSC | FINANCIAL SERVICES CENTER

IHSC Provider Information

U.S. Immigration and Customs Enforcement

VA | U.S. Department of Veterans Affairs

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IHSC Frequently Asked Questions

What is ICE Health Service Corps (IHSC)?

- IHSC serves as Immigration and Customs Enforcement's (ICE) medical authority relating to healthcare provided to those in ICE custody.
    - For more information about ICE and IHSC, please visit www.ice.gov.

Who is the VAFSC and why does VAFSC pay for immigration detainees' healthcare?

- The VA Financial Services Center (VAFSC) provides financial services to many federal customers.
- The VAFSC has an agreement with ICE to provide medical claims processing services.
- Claims are reimbursed with Department of Homeland Security (DHS) funds.

What is Electronic Claims and Adjudication Management System (eCAMS) and how does this affect claims submission/processing?

- The VA Financial Services Center (VAFSC) is transitioning its legacy claims processing systems to a new, more robust claims processing system, Electronic Claims and Adjudication Management System Healthcare Engine (eCAMS HCE™).
- The eCAMS system will improve auto-implements standard Medicare processing rules.
- You may notice an increase in auto-denials due to eCAMS's usage of Medicare-related business rules.
- If your claim has been denied, please refer to your Explanation of Payment (EOP) (previously referred to as EOB) or the electronic remittance (835) from your clearinghouse. Review your claim for billing or accuracy errors before trying to resubmit your corrected claim.
- As of 01/06/2023 all Professional, Institutional, and Dental claims are processed in eCAMS. Claims are no longer processed in PCM unless they were received before 01/06/2023 and had a date of service prior to 10/1/2022.

What are keys to understanding Reimbursement Rates?

- Medical services are reimbursed at the lesser of the Medicare allowable rate or billed charges.
- Previously, the claims adjudication system (Plexis) reimbursed professional claims at the resource-based relative value scale (RBRVS) plus geographic pricing cost index (GPCI) rate. Professional claims processed in the new adjudication system, eCAMS, will be reimbursed at the Medicare Physician Fee Schedule (MPFS) rate.
- All payments will incorporate a two percent (2%) reduction in accordance with the Budget Control Act of 2011. Note: Sequestration for dates of service from May 1, 2020 through July 1, 2022 has been updated per CMS guidance.
- Authorized health services are reimbursed in accordance with Title 18, Part III, Chapter 301, Section 4006 of the U.S. Code and shall not exceed the prescribed reimbursement rates unless explicitly authorized.
- Inpatient claims will be priced using the Inpatient Prospective Payment System (IPPS) logic.
- Outpatient claims will be priced using Outpatient Prospective Payment System (OPPS) logic.
- CPT code 80050 is not covered by the Medicare Physician Fee schedule and CPT Code 80050 will be denied for reimbursement. When billing, the component tests must be billed individually for reimbursement.
- Before reaching out to the VA FSC call center for general Medicare billing guidance please perform your due diligence to ensure you are billing per CMS (Centers for Medicare & Medicaid guidance) (cms.gov).

Will health care costs be covered by ICE if the detainee is released from ICE or U.S. Customs and Border Protection (CBP) custody?

- No, health care coverage is only provided for the dates the detainee is in ICE or CBP custody.
- If the detainee is released from ICE or CBP custody, the detainee/patient is responsible for the hospital/provider charges from the date of release from ICE/CBP custody until the date of hospital discharge.
- Please note ICE includes Homeland Security Investigation (HSI) and CBP includes U.S. Border Patrol (BP) and Office of Field Operations (OFO).

How to contact VAFSC customer service representatives?

- You may contact a representative at VAFSC to discuss claim status at vafscDIHS@va.gov or call 800-479-0523 M-F 7:30 AM – 3:30 PM CST.
    - Explanation of Payments (EOPs) will be mailed to medical providers by the Department of Treasury.
    - Customer Service representatives at VAFSC are not authorized to release EOPs due to strict privacy regulations.

ID.me & SAM.gov

What is ID.me and why do I need an account?

- ID.me is a two-step verification requirement to access the IHSC eCAMS Provider Portal (ePP) for claim and payment status and EOP statements.
- ID.me helps protect against fraud and identity theft.
- Without an ID.me account you cannot access the IHSC eCAMS Provider Portal (ePP).

Where do I sign up for ID.me?

- Instructions for new users in creating an ID.me account are located in the ID.me New User Sign Up Guide at https://www.IHSCepp.fsc.va.gov.

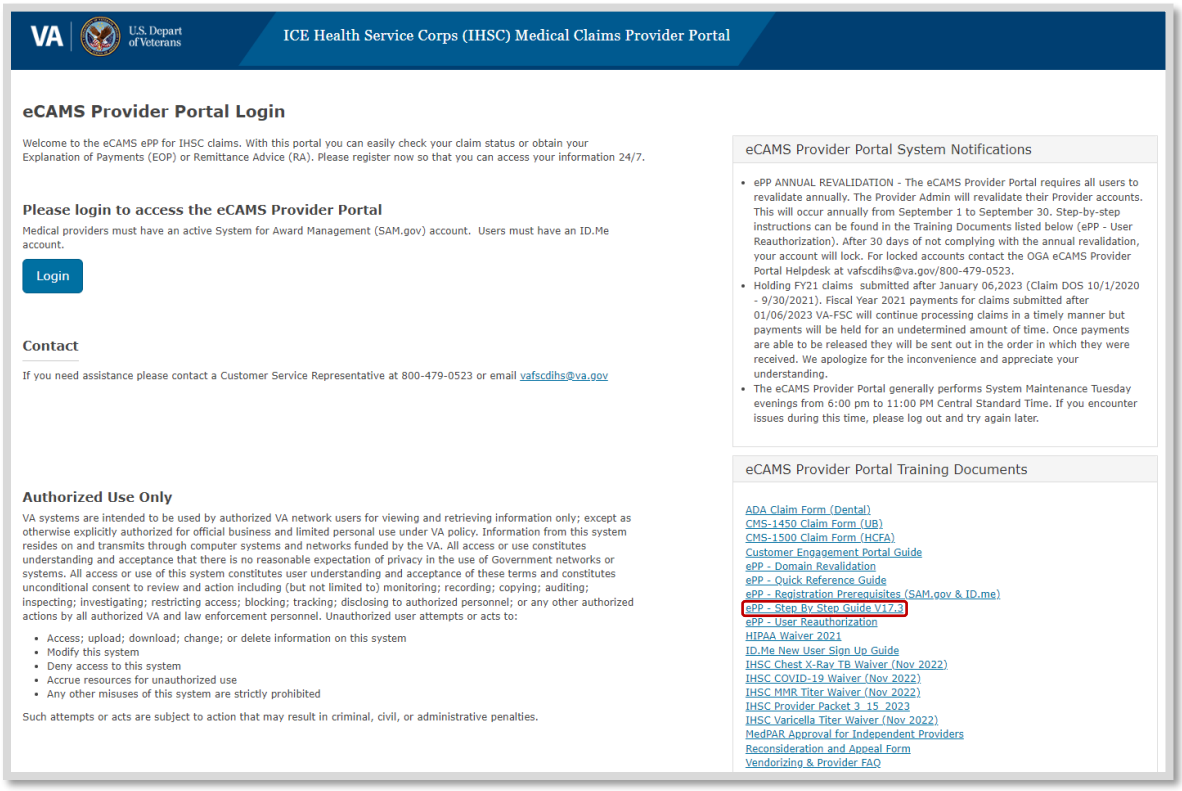
What is SAM.gov and why do I need an account?

- SAM.gov is the primary database of vendors doing business with the government and is a requirement to access the IHSC eCAMS Provider Portal (ePP).
- Prior to setting up your account in the IHSC eCAMS Provider Portal (ePP), you must be registered in SAM.gov and ID.me. If you are already registered in SAM.gov, please verify that your Accounts Receivable email address in SAM.gov is current and accurate.
- Please see SAM.gov for information and help on registration https://sam.gov/content/entity-registration.
- SAM.gov is not required for claim payment. Both a paper EOP and electronic remittance (835) will be sent for all paid and denied claims processed in eCAMS.
    - * **Important Note:** Although registering for SAM.gov is not required in order to receive a claim payment, if you do register you are required to keep your registration active and current. Payments cannot be made to an account that has an inactive SAM.gov registration. This is used as part of the FSC payment validation process. *
- If the POC of the SAM.gov account initiates an update within SAM.gov (for example, changing their email address) that update could take up to 30 days to reach the VA system.

IHSC eCAMS Provider Portal (ePP)

What is the IHSC eCAMS Provider Portal (ePP)?

- eCAMS Provider Portal (ePP) is the VAFSC provider portal that grants access to view claim status and Explanation of Payments (EOPs), previously referred to as EOB, for claims processed in the new claims adjudication system, eCAMS.
- ePP will have information for claims processed in eCAMS.
- All claims received as of Jan 6, 2023, regardless of date of service, will be available in ePP.
- Each Organization must be registered with SAM.gov before users can gain access.
- All Users must register with ID.me in order to sign up for an account with ePP.
- Your organization's Point of Contact for SAM.gov must follow the ePP Step by Step Guide to register the ePP Admin and additional provider user accounts. Refer to Image below.
- Once ePP Admin is established with your organization, then they can assign additional provider user accounts.
    - Any additional accounts the Admin would like to set up must be created with the new user's ID.me email address.
- In order to access ePP register at https://www.IHSCepp.fsc.va.gov.
    - You can only register once you have received an EOP from the new system.



Why does the VAFSC verify my ePP account annually?

- For security purposes, IHSC eCAMS Provider Portal (ePP) Tax ID domain and current users will need to be reverified annually.

- The IHSC ePP Provider Admin for the organization is required to complete the domain revalidation process so that access to IHSC ePP will not be interrupted.
- At that time, the IHSC ePP Provider Admin will need to download the ePP – Domain Revalidation guide located at https://www.ihscepp.fsc.va.gov (available prior to logging in). Those steps will need to be completed first, then they may proceed to the ePP - User Reauthorization guide to reauthorize any additional provider users that may be on this account, if applicable.
- If there are any questions, contact Department of Immigration Health Services (DIHS) Customer Support at vafscDIHS@va.gov or call (800) 479-0523.

What are the eCAMS Provider Portal (ePP) claims statuses and descriptions?

IHSC eCAMS Provider Portal (ePP) Claims Statuses	
Claim Status	**Description**
IN PROCESS	Claim has been received, please allow 30 days from received date for processing.
PAID	Claim has been paid and payment process is complete.
DENIED	Claim has been processed and has been denied.
REJECTED	Claim has not been accepted into the claims processing system. See 277CA rejection reasons below.
ADJUSTED	Claim has been adjusted/corrected, resurrected, or voided.
ADJUSTMENT COMPLETE	Claim has been adjusted/corrected, resurrected, or voided and processing is complete.
CANCELLED	Payment for claim has been cancelled.

Vendorizing & VA 10091 Form

How does a provider become a Payee?

- All providers of medical service for ICE/CBP detainees are required to submit (and keep current) a VA 10091 form to the VAFSC.
  - The form must be completed online at https://www.cep.fsc.va.gov.
  - Please submit a VA 10091 form to include the Tax Identification Number (TIN), Billing National Provider Identifier (NPI) and Doing Business As (DBA) name.
  - For support please call 877-353-9791 or email vafsccshd@va.gov.

Why do I have to submit a VA 10091 form? Is it required?

- In accordance with the Federal Acquisitions Register (FAR), 31 CFR Part 208, the electronic funds transfer (EFT) rule requires that federal payments be made electronically, no exceptions.
- **No waivers are available to vendors/providers.** As a result, any vendor/provider of the Federal government is required to receive payment by EFT. A VA 10091 form is also required to be on file with FSC for payments to be made.
- This form is for the billing provider only and a separate form must be submitted for each unique Tax ID number and **Billing NPI** combination that will be submitted on the claim.
- Please ensure the address entered is where you would like to receive the explanation of payment (EOP). This address should match the Pay-To address on the claim.

Does the business need a SAM.gov account to submit a VA 10091 form?

- No, it is not required. However, if the process has been started to obtain a SAM.gov account for the business but it is not completed in its entirety, it will affect any VA 10091 form submissions.
- If the SAM.gov account is in “ID Assigned” status, and not “Active Registration” status, the VA 10091 form will be automatically rejected by the Nationwide Vendor File team.

- If there is a SAM.gov account for the business, please ensure it is in "Active Registration" status prior to submitting the VA 10091 form.
- For assistance with completing SAM.gov registration, please contact SAM.gov customer support.

If claims were denied because my VA 10091 form was not on file, will my claims be automatically reprocessed once that information is submitted?

- No, claims will need to be resubmitted.

I submitted my VA 10091 form, why are claims still denying?

- It is possible you are not filling out the online VA 10091 form correctly or not allowing enough time for it to be processed.
- If the billing and/or banking information has changed and the claim we received has the original billing and/or banking address, your claims will be denied.
    - If the business has a SAM.gov account:
        - The billing address on the claim must match the remittance address in SAM.gov.
        - If the business has a Unique Entity Identifier (UEI), the UEI must be in an "Active Registration" status before the VA 10091 form can be initiated. It should not be in "ID Assigned" Status.
    - If the business DOES NOT have a SAM.gov account:
        - The billing address on the claim must match what was submitted on the VA 10091 form.
- A VA 10091 form must be submitted for each Billing NPI and Tax ID combination.
- If a paper VA 10091 form is submitted on or after 10/1/2023 via fax or email it will be rejected and not considered for vendorizing.
- Complete the VA 10091 form online at https://www.cep.fsc.va.gov.

Dental Claims

How do I submit my dental claims and how are they reimbursed?

- Dental EDI claims are now accepted for all dates of service. We highly recommend that you submit your dental claims as EDI to avoid processing delays and Optical Character Recognition (OCR) errors.
- Dental paper claims will also be accepted.
- Dental services are reimbursed at 90th percentile UCR or the lesser of billed charges.
- Authorization for dental codes that do not have a covered rate will need to be pre-approved prior to the procedure. Contact the IHSC Referral Coordinator, Field Medical Coordinator or CBP Program Analyst for more information.

ADA Dental Claim Form

- To avoid rejection of your claims, please ensure you are always using the latest version of the ADA Claim Form for your claim submissions.
    - Resource: https://www.ada.org/publications/cdt/ada-dental-claim-form
- Currently the latest version is the **2024 ADA Claim Form**, effective January 1, 2024.
- Any year version prior to the 2019 ADA Claim Form (such as the 2012 version) will not be accepted and will be rejected and returned to the provider.
- The 2019 ADA Claim Form will only continue to be accepted through March 31, 2024. After that date, VA-FSC will not accept any version other than the 2024 ADA Claim Form.

Dental Claims: Electronic (EDI) Claim Submission

- The clearinghouse for the VA-FSC, PNT Data, is accepting dental EDI claim submissions with the Payer ID VAICE.
- If you are connected directly to PNT Data you may contact PNT Data Support at support@pntdata.com (preferred method) or call (860) 257-2030. PNT Data Support is available 8 AM - 8 PM EST, Monday through Friday to ensure you can submit electronically.
- If you are not connected directly to PNT Data your submitter (clearinghouse) should contact PNT Data Support directly to establish an electronic connection.

Dental Claims: Common Causes of Denied/Rejected Claims

- If any handwritten information is on the claim, the claim will be rejected and returned to sender. Please ensure all information is typed and legible.
- If the submitter is utilizing any old ADA Claim Forms (i.e. 2006, 2012, 2016, 2018 versions), the claim will be rejected and returned to sender.
- Not entering a tooth number for dental radiograph CDT Codes (e.g. D0220, D0274) will result in a denial.
- Missing/Incomplete Authorization Number will result in a denial. Dental claims need to have a valid authorization number included in Box 2 of the ADA Claim Form.
    - If you do not have a valid authorization number, you will need to contact the jail or detention facility responsible for the detainee to obtain one.
- Entering the incorrect Area of the Oral Cavity or Tooth Anatomy will result in a denial.
    - For assistance, please refer to the instructions in the following ADA Guides.
    - ADA Guide to Dental Procedures Reported with Area of the Oral Cavity or Tooth Anatomy (or Both):
        - 2024: Version 7 - Effective January 1, 2024: https://www.ada.org/-/media/project/ada-organization/ada/ada-org/files/publications/cdt/appendix_3_guide_to_reporting_area_of_the_oral_cavity_and_tooth_2024jan.pdf
        - 2023: Version 6 - Effective January 1, 2023: https://www.ada.org/-/media/project/ada-organization/ada/ada-org/files/publications/cdt/appendix-3_areaoftheoralcavityandtoothanatomybycdtcode_2023jan.pdf
        - 2022: Version 5 - Effective January 1, 2022: https://www.ada.org/-/media/project/ada-organization/ada/ada-org/files/publications/cdt/areaoftheoralcavityandtoothanatomybycdtcode_2022jan.pdf
        - 2021: Version 4 - Effective January 1, 2021: https://www.ada.org/-/media/project/ada-organization/ada/ada-org/files/publications/cdt/cdtcode_areaoforalcavity_toothtable_v4_2021jan.pdf

How do I submit a multi-page ADA Dental Claim Form?

- If there are more than 10 CDT codes to be billed for the encounter, submit a multi-page dental claim.
- Instead of totaling each page and submitting them as separate claims, they should be submitted as one claim with the **consolidated total** on the **final page** only.
- For the first page, ensure “PAGE 1 OF X” is typed in Box 35 of the claim (Remarks) and leave the total billed charges in Box 32 BLANK (Total Fee).

33. Missing Teeth Information (Place an "X" on each									
1	2	3	4	5	6	7	8	9	10
32	31	30	29	28	27	26	25	24	23
35. Remarks **PAGE 1 OF 2**									

31a. Other Fee(s)	
32. Total Fee	

- For the following pages, ensure "PAGE X OF X" is typed in Box 35 of the claim (Remarks) and include the total billed charges in Box 32 on the final page (Total Fee). See example below.

33. Missing Teeth Information (Place an "X" on each									
1	2	3	4	5	6	7	8	9	10
32	31	30	29	28	27	26	25	24	23
35. Remarks **PAGE 2 OF 2**									

31a. Other Fee(s)	
32. Total Fee	**1000.00**

How do I submit a corrected ADA Dental Claim Form?

- For corrected dental claims ensure the original claim number is written in Box 35 of the claim as: CLAIM ID: XXXXXXXXXXXXXXXXXX; FREQUENCY CODE: 7; Any Other Claim Notes (If Applicable)

33. Missing Teeth Information (Place an "X" on each missing tooth.)																34. Diagnosis Code List Qualifier	
1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	34a. Diagnosis Code(s)	A
32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17	(Primary diagnosis in "A")	B
35. Remarks **CLAIM ID: 302333300000304000; FREQUENCY CODE: 7; ANY OTHER CLAIM NOTES**																	
AUTHORIZATIONS																**ANCILLARY CLAIM/**	
36. I have been informed of the treatment plan and associated fees. I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan, unless prohibited by law, or the treating dentist or dental practice has a contractual agreement with my plan prohibiting all																38. Place of Treatment (Use "Place of Servic	

- For voided dental claims ensure the original claim number is written in Box 35 of the claim as: CLAIM ID: XXXXXXXXXXXXXXXXXX; FREQUENCY CODE: 8; Any Other Claim Notes (If Applicable)

33. Missing Teeth Information (Place an "X" on each missing tooth.)																34. Diagnosis Code List Qualifier	
1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	34a. Diagnosis Code(s)	A
32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17	(Primary diagnosis in "A")	B
35. Remarks **CLAIM ID: 302333300000304000; FREQUENCY CODE: 8; ANY OTHER CLAIM NOTES**																	
AUTHORIZATIONS																**ANCILLARY CLAIM/**	
36. I have been informed of the treatment plan and associated fees. I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan, unless prohibited by law, or the treating dentist or dental practice has a contractual agreement with my plan prohibiting all																38. Place of Treatment (Use "Place of Servic	

Other Claim Types: Critical Access Hospital, DME, or Pharmacy

Are you a critical access hospital?

- Please submit the rate letter covering the claim dates of service along with the rate letter immediately preceding and following that letter. It is the hospital's obligation to submit their current rate letter to keep their claims paid in a timely manner.
    - Please submit your rate letter via fax 512-460-5538 or email it to vafscdihs@va.gov.
- Ensure you send an updated rate letter as soon as you receive it to avoid claim denial or improper payment(s).
- Please ensure you bill with the proper type of bill (85X for outpatient and 11X for inpatient).

How should I bill Durable Medical Equipment (DME) claims?

- Office Visits: If there is an office visit associated with the service then it will need to be billed separately from the DME. The office visit claim should have its own separate authorization/MedPAR obtained from the detention facility responsible for the non-citizen. The specialty should not be DME. The place of service should correspond with an office setting (for example, POS 11).
- DME: The DME should be billed on its own claim, with its own authorization/MedPAR with a specialty of DME. Please refer to the list of acceptable POS codes for DME claims below.

What place of service is acceptable for Durable Medical Equipment (DME) billing?

- When billing DME services only use POS (place of service) 01, 04, 09, 12, 13, 14, 33, 54, 55, 56, 65.

Who can I contact regarding pharmacy benefits and billing?

- Please direct all pharmacy benefits and billing questions to IHSC's account representative, Scriptcare at 800-880-9988.

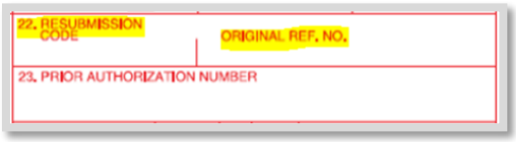
Claim Submission

How do I fill out the HCFA/UB/ADA?

- The FSC highly recommends you transition to electronic claim submission to avoid Optical Character Recognition (OCR) errors and to support auto adjudication.
- **The FSC will NOT accept any handwritten claims**; these will be returned to the sender.
- Professional (CMS 1500) and institutional (CMS-1450/UB-04) claims should be submitted on OCR Red (red background) claim forms for optimal scanning.
    - Per CMS, acceptable claim forms are those printed in OCR Red ink. Although a copy of the claim form can be downloaded, copies of the form cannot be used for submission of claims, since your copy may not accurately replicate the scale and OCR color of the form.
- For basic instructions on filling out the CMS-1500 (HCFA) please refer to NUCC at https://www.nucc.org/index.php/1500-claim-form-mainmenu-35/1500-instructions-mainmenu-42.
- For basic instructions on filling out the CMS-1450 (UB) please refer to NUBC at https://www.nubc.org/.
- For basic instructions on filling out the ADA Dental please refer to the American Dental Association T https://www.ada.org/publications/cdt/ada-dental-claim-form.

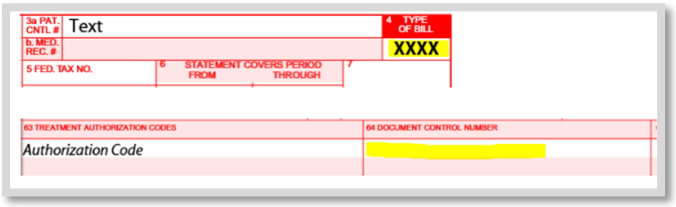
- When filling out the **CMS-1500** ensure you include the following:
    - Box 11c should contain "Immigration Health Services."
    - Box 23 should contain the MedPar/Referral/Authorization number.

- Box 6 should only have Relationship of Self selected.
- Box 26 should contain the patient account number.
- Do not include a facility as the referring provider. The referring provider can be an individual with an NPI and should be different than the billing provider.
- The rendering provider should also be an individual and must include the NPI and should be different than the billing provider.
- For corrected claims ensure box 22 “Resubmission Code” includes the frequency code “7” and box 22 “Original Ref No” must include the original claim number (found on your EOP) to avoid claim rejection.
- For voided claims ensure box 22 “Resubmission Code” includes the frequency code “8” and box 22 “Original Ref No” must include the original claim number (found on your EOP) to avoid claim rejection.



- Ambulance claims on CMS-1500 forms require the following in Box 32: Service Facility Location.
  - **From:** City, State, and Zip Code.
  - **To:** Street Address, City, State, and Zip Code.

- When filling out the **CMS-1450/UB-04** ensure you include the following:
  - Box 50 should contain “Immigration Health Services.”
  - Box 63 should contain the MedPar/Referral/Authorization number.
  - Box 59a should only include relationship of 18 (Self).
  - Box 3a should contain the patient account number.
  - Do not include a facility as the referring provider. The referring provider can be an individual with an NPI and should be different than the billing provider.
  - The rendering provider should also be an individual and must include the NPI and should be different than the billing provider.
  - For corrected claims ensure box 4 Type of Bill includes the frequency code “7” and box 64 must include the original claim number (found on your EOP) to avoid claim rejection.
  - For voided claims ensure box 4 Type of Bill includes the frequency code “8” and box 64 must include the original claim number (found on your EOP) to avoid claim rejection.



- When filling out the ADA dental claim form ensure you include the following:
  - Lines should include tooth numbers, quadrants, etc. per the ADA guidance to avoid denials due to duplicates.

How do I submit a corrected EDI claim?

- You must include the correct frequency code for the claim submission (7 for corrected claims, 8 for void).
- You must include the original claim number (this may be found in the EOP or 835) in the REF*F8.

- Any claim that has frequency code "7" or "8" and does not include REF*F8 will be rejected.

My claim is in Cancelled status, how do I resubmit it for payment?

- The claim will need to be resubmitted as a corrected claim with the preceding claim number (TCN) and frequency code 7. Please see above for specific claim type guidance.

Additional instructions for proper claim submission:

- The most efficient way to submit claims and avoid errors is to submit claims electronically.
- EDI is the fastest and preferred method for claim submission. You will receive electronic remittance (835) via the clearinghouse you use.
    - Payer ID: VAICE
    - Beginning March 21, 2023 all EDI claim submission must be completed through PNT Data Corp.
    - If any assistance is needed, please email PNT Support at support@pntdata.com (preferred method) or call (860) 257-2030. PNT Support is available 8 AM-8 PM EST, M-F.
- Paper (handwritten information on claims will not be accepted):
    - Send typed claims to:
      ICE Health Service Corps
      VA Financial Services Center
      PO Box 149345
      Austin, TX 78714-9345
- If choosing to submit paper claims via traditional mail, it is recommended that you use certified mail and obtain a tracking number for future tracking purposes. A tracking number will be the quickest and most efficient way to locate a package that was mailed in. You will also be able to track the shipment yourself and receive a signature upon arrival for confirmation of receipt.
- Examples of acceptable ID numbers are:
    - ICE Alien ID numbers:
        - 9 digits in length and begin with 0 or 2 (e.g. **0**12345678, **2**12345678)
    - Border Patrol (BP) ID Numbers:
        - MedPARs created prior to April 2023: 9-13 alphanumeric characters in length followed by an optional alpha character with "BP" prefix followed by a 3-5 letter alpha station code (e.g. **BPALP**123456789, **BPELCS**1234**ABC**56789, **BPLRDOP**123456789**C**).
        - MedPARs created since April 2023: "BP" prefix, followed by a 3 to 6 letter alpha station, followed by a numeric string (the Subject ID) starting with a number 3 and total of 9 digits in length (e.g. **BPAlP3**12345678).
    - Office of Field Operations (OFO) ID Numbers:
        - MedPARs created prior to October 2023: 9-16 alphanumeric characters in length with "OF" prefix (e.g. **OF**123456789, **OF**1234**AR**567890123).
        - MedPARs created since October 2023: "OF" prefix, followed by a numeric string (the Subject ID) starting with a number 3 and total of 9 digits in length (e.g. **OF3**12345678).
    - Homeland Security Investigations (HSI) ID Numbers:
        - MedPARs created prior to October 2023: 12-13 alphanumeric characters in length with "HSI" prefix (e.g. **HSI**123456789).
        - MedPARs created since October 2023: "HSI" prefix, followed by a numeric string starting with a number 0, 2 (the Alien ID) or 3 (the Subject ID) and total of 9 digits in length (e.g. **HSI0**12345678, **HSI3**45678901).
- Examples of acceptable authorization numbers also known as authorization codes are:
    - 13-digit numbers like YYYYMMDD##### (e.g. 2021010212345)
        - See example of a MedPAR/Referral Authorization below.

- If an authorization is not required, do not include anything in the authorization field. Claims submitted with invalid authorization formats will deny.
- Please ensure that the services rendered are covered by the authorization
  - If an authorization lists specific CPT codes to be reimbursed, those codes, and ancillary codes associated with those codes, will be the only codes reimbursed.
  - A separate authorization is required for services not outlined in the original authorization. Additional services should be requested within one week from the DOS.
  - To obtain authorizations or to have an authorization corrected, please contact the detention facility or border patrol station referring the detainee or the name and contact information on the MedPAR/Referral.
  - VAFSC will not be able to assist with obtaining or correcting authorizations.
- For EDI claim submissions, please ensure the authorization number, if required for the claim, is submitted at the Header Level of the claim and not the Line Level of the claim.
- Only professional Ambulatory Surgical Center (ASC) claims will be accepted. Institutional ASC claims will be denied.
- Outpatient institutional claims require a line level date of service.
- Type of Bill 113/114 is only accepted for Critical Access Hospitals.
- Zip code must be 9 digits. Claims with invalid zip codes will be rejected. You may use the detention facility address as the subscriber address.
  - Paper claims may continue to use a 5 digit zip code.
- Mobile X-Ray (R0070, R0075, and Q0092) billed without the Radiology Service on the same claim will be denied.

How do I submit additional claim documentation?

- If you are submitting a paper claim you may include your medical documentation along with the paper claim.
- There is no need to submit a paper claim along with medical documentation or claim attachments when an electronic claim has already been submitted. You may mail or fax the medical records separately from the electronic claim.
- The FSC cannot accept electronic attachments at this time.

MedPAR/Authorization

What is a MedPAR?

- A Medical Payment Authorization Request (MedPAR) or authorization issued by IHSC for the approval of healthcare services rendered to detainees.

Whom can I contact to retrieve an IHSC MedPAR/Referral authorization?

- Please check your records as paperwork should have accompanied the detainee from the detention facility that referred to you for healthcare services.
- If you still need to contact the detention facility for this or other information, please refer to Detention Facilities | ICE or Border Patrol Sectors | U.S. Customs and Border Protection (cbp.gov) or HSI Field Offices | ICE to assist in locating the detention facility that referred the detainee to you for healthcare services.

Do healthcare services require a MedPAR/Referral authorization number?

- All services require a MedPAR/Referral authorization number obtained in advance of any healthcare services being rendered with the **EXCEPTIONS** as follows:
  - ER Visits and Inpatient Admissions will require an authorization **AFTER** the detainee is discharged.
  - Ambulances will require an authorization **AFTER** the transport occurs.
  - Waivers for: Chest X-ray to rule out pulmonary tuberculosis (TB), Varicella, MMR titer and COVID-19.
  - Restrictions apply; please refer to the waivers for Chest X-ray r/o TB, Varicella, MMR titer and COVID in the Documents section at https://www.ihscepp.fsc.va.gov.
  - COVID testing claims will require a MedPAR for dates of service of 2/1/2024 and forward. The COVID-19 Waiver will no longer apply at that time.

Can you share an example of an authorization generated from MedPAR system with required claim entries?

Claims must be submitted within one year from date of health service.

Claims must include a 13-digit authorization Code, for example: "2017020200023".

For proper provider claim submission information, please visit: https://www.ice.gov/ihs-managed-care.

For updates regarding claims status or questions regarding an Explanation of Benefits (EOB), visit: https://www.hcps.fsc.va.gov/ or call VAFSC customer service 800-479-0523 M-F 730-330 CST.

Invasive procedures performed by off-site providers require informed consent in the preferred language of the detainee, documented prior to the procedure. Full medical records, including informed consent, must be submitted to site provider after the appointment or procedure is completed.

A separate treatment authorization request will be required for services beyond and outside the scope of the original authorization. Services rendered may not be paid without an approved authorization. All payment for services is subject to detainees' eligibility and custody. Unless otherwise specified, payment for IHSC authorized health services is made in accordance with US Code Title 18, Part 3, Chapter 301, Sec. 4006. All claims are subject to retrospective review. For further information regarding IHSC, please visit our website: https://www.ice.gov/ice-health-service-corps

Please ensure all claims include the Patient Identification Information and the Authorization code.

IMPRINT OF DETAINEE ID PLATE, COMPUTER LABEL OR COMPLETE BELOW:	
PT Name: TEST PATIENT 1	Alias:
DOB: 09/04/1985	ID #: 222111333 2
Nationality: MEXIC	Facility: HITU Detention Center

AUTHORIZED ACTION:

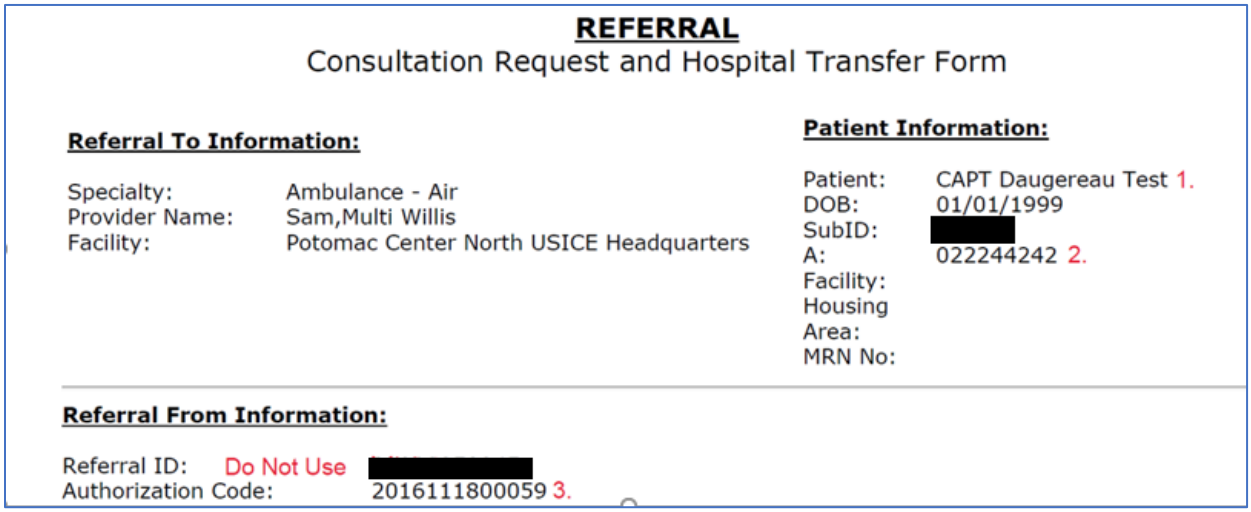
Status: Approved 4
Authorizer: Auto Approve/Harris RN
Hospital Admit Date:

Auth Code: 2022080400229 3
Appointment Date: 05/02/2022
Discharge Date:

1. Enter the name of patient as shown above in box 2 of CMS-1500, box 8b of UB-04 or box 12 of ADA claim form.

2. Enter the Alien ID # as shown above in box 1A of CMS-1500, box 60 of UB-04 or box 15 of ADA claim form.
3. Enter the "Auth Code" as shown above in box 23 of CMS-1500, box 63a of UB-04 or box 2 of ADA claim form.
4. Please take note of the authorization status to ensure it states "Approved".

Can you share an example of an authorization generated from IHSC eHR system with required claim entries?



REFERRAL
Consultation Request and Hospital Transfer Form

Referral To Information:

Specialty: Ambulance - Air
Provider Name: Sam,Multi Willis
Facility: Potomac Center North USICE Headquarters

Patient Information:

Patient: CAPT Daugereau Test 1.
DOB: 01/01/1999
SubID: [redacted]
A: 022244242 2.
Facility:
Housing Area:
MRN No:

Referral From Information:

Referral ID: Do Not Use [redacted]
Authorization Code: 2016111800059 3.

1. Enter the name of patient as shown above in field 2 of CMS-1500, field 58 of UB-04 or field 12 of ADA claim form.
2. Enter the Alien ID # as shown above in field 1A of CMS-1500, field 60 of UB-04 or field 15 of ADA claim form.
3. Enter the 'Authorization Code' as shown above in box 1A of CMS-1500, field 63a of UB-04 or field 2 of ADA claim form.
4. Please **do not use** the Referral ID as an Authorization Number on claim. The claim will be denied.

Additional IHSC Information

Why does IHSC require a Letter of Understanding (LOU)?

- This Letter of Understanding (LOU) confirms the understanding and professional relationship between your healthcare facility/practice and ICE Health Service Corps (IHSC). It documents your willingness to provide services to ICE, CBP-BP, CBP-OFO and HSI detainees. In exchange, IHSC will authorize payment for normal and customary charges at the prevailing Medicare for fee schedule. The letter describes the terms of agreement between IHSC and the healthcare facility/practice.

Why would IHSC request medical records?

- IHSC will request medical records to ensure continuity of medical care and/or auditing purposes. Your facility will be contacted by IHSC staff for medical services rendered to an IHSC detainee. IHSC will submit written requests for an IHSC detainee medical record.
- An exemption from HIPAA applies to a correctional institution or a law enforcement official (Department of Homeland Security (DHS), Immigration and Customs Enforcement (ICE) having lawful custody of an inmate, or other individual, if the correctional institute or law enforcement official determines that such protected health information.
- Please see HIPPA Waiver for more information at https://www.ihscepp.fsc.va.gov/.

Does IHSC Conduct Utilization Reviews?

- To better monitor efficacy and appropriateness of the provision of care, IHSC's Utilization Management Program employ Utilization Review Consultants (URCs) to evaluate medical necessity consistent with clinical diagnoses and appropriate level of care delivery. The URCs review provision of care information according to national, evidenced-based Milliman Care Guidelines (MCG). While MCG provides direction for utilization review decisions, final coverage determinations may involve physicians' clinical expertise, knowledge of availability of resources, supporting clinical information, and consultation with an ordering physician.
- When conducting a utilization review (UR) and completing medical payment authorization for services, IHSC requires you to comply with any requests for clinical information, documents or discussion related to reviews and discharge planning for hospitalizations. Failure to provide requested information within one business day can result in an initial denial.

Do Invasive Procedures require Informed Consent?

- Yes, Invasive procedures performed by off-site providers require informed consent in the preferred language of the detainee, documented prior to the procedure. Full medical records, including informed consent, must be submitted to site provider after the appointment or procedure is completed.

Do interpreter services need to be provided?

- Yes, it is federal law that any health care provider that accepts federal funds (ICE) are required by law to provide interpreter services. Title VI of the Civil Rights Act of 1964, which prohibits discrimination based on national origin.
- When interpreter services are utilized, documentation required in the medical record of the company, language used, and interpreter ID number. If a company is not used, at a minimum, the interpreting health care provider's name, title, language used should be documented in the medical record.
- IHSC does not reimburse for these services.

Why does IHSC credential providers and what is required?

- All practitioners involved in the healthcare for those persons detained in the custody of ICE/CBP must be credentialed according to the IHSC Clinical Staff Bylaws.

What is the timely filing limit for claims?

- The timely filing limit for claim submission is one (1) year or 365 days from the date of service.
    - No claims can be paid beyond this limit unless appealed.
    - Most denials do not require an appeal; they can be resolved by submitting a corrected claim.

- Please see appeals guidance and contact customer service at 800-479-0523 if you have questions.

Bills of Collection (BOC) & Treasury Offset Program (TOP)

What are Bills of Collection (BOC) and what is the process?

- A Bill of Collection (BOC) is a formal request to collect a debt (i.e., overpayment, erroneous payment, etc.) owed to the FSC.
- After 60 days, providers are sent their final notice of indebtedness.
  - If no payment is received in the next 31 days, the amount owed is reported to the Treasury Offset Program (TOP) for collection.
  - TOP will intercept and reduce the next Treasury payment, made to the provider by any federal agency, by the amount owed, assess a fee to the provider, then forward payment to VAFSC and any remaining funds to the provider.
  - The provider will receive notification from TOP when this occurs.
- Once TOP intervenes to collect the debt, the VAFSC is not privy to the details of the payments offset to satisfy the debt.
  - Inquiries must be made to TOP to obtain that information.
- Interest and penalties may apply to BOCs that are past due.
  - You must make payment arrangements within 30 days from the bill date to repay the debt.
  - Debts that become past due and debts being repaid by installments will be charged interest at an annual rate of 1%. A monthly administrative cost of collection fee of $1.40 (subject to change annually) may also be charged. Further, a penalty charge of 6% annually will be assessed on any account more than 90 days past due.
  - If full payment of the debt is received within 30 days, no interest or administrative cost of collection fees or penalty charges will be assessed.
- Checks with returned funds may be sent to the address below.

  VA Financial Services Center
  Payable To: Department of Veterans Affairs
  OGA eCAMS
  Agent Cashier (0474B1)
  PO Box 149975
  Austin, TX 78714-8975

How can I contact Treasury Offset Program (TOP)?

- 800-304-3107 or TDD 866-297-0517
  - You will need the debt number provided in the letter from TOP.

Appeals & Reconsiderations

What is required to file an Appeal or Reconsideration?

- Please contact a Customer Service Representative at 800-479-0523 or email to VAFSCDIHS@va.gov to discuss line item/claim denials prior to submitting an Appeal or Reconsideration, because the issue may be resolved telephonically.
- Many denials can be resolved by submitting a corrected claim or speaking with a Customer Service Representative and will not require taking the following actions.

- If a Customer Service Representative is unable to resolve the issue, please follow the process below.

ICE Health Service Corps Appeals and Reconsideration Process
Appeals: request for VAFSC to reconsider the denial of an entire claim or to review the reimbursement rate.
Reconsiderations: request for VAFSC to reconsider a line item denial on an otherwise paid claim.
Appeals and Reconsiderations must be received within six (6) months from the date of the INITIAL claim decision. For your request to be routed correctly and considered, the following are required: ▪ A completed Appeal/Reconsideration Request form. ○ An electronic version of the form can be found in Documents section at https://www.ihscepp.fsc.va.gov/. ▪ A copy of the Explanation of Payments (EOP) letter. ▪ A clean claim for processing. ▪ Documents to support your position, e.g. proof of reimbursement methodology, proof of timely filing, a copy of the MedPAR/Authorization (Medical Payment Authorization Request).
Mail documentation to: ICE Health Service Corps VA Financial Services Center Attn: Appeals Department PO Box 149345 Austin, TX 78714-9345 Or email to: VAFSCDIHSAppeals@va.gov (fastest and preferred method)

Rejection Letters & Clearinghouse

Paper Rejection Letters

- The Clearinghouse will mail rejection letters for paper claims that do not meet standard requirements.
- If you receive a rejection letter you must resubmit your claim.
- The letter will be sent to the Billing Provider on the claim or the Pay to Provider if provided.

Additional Clearinghouse Business Requirements

- The Service Facility NPI is required on Institutional Claims when the Service Facility Name is present.
- The Service Facility NPI is required on Professional Claims when the Service Facility Name is present unless the claim is for Mobile X-Ray services.
- The Referring Provider is not required on any claim. If the Referring Provider is submitted the NPI must be present.
- For EDI Claims do not include the patient loop for any claims, ensure relationship is SELF.

Denial Codes

What are IHSC/VAFSC Common Denial Codes?

IHSC/VAFSC Explanation of Benefits – Denial Codes
Effective October 1, 2022
***Subscriber = Member/Detainee**

PCM Error Code:	PCM Provider Language:	eCAMS Error Code:	eCAMS Provider Language:
DENIED1	(Incorrect Alien ID # in box 1a on HCFA 1500, box 60 on UB 04 or box 15 on the ADA/Dental form - Refer to Provider Information – Claim Requirements on ePP)	**02110**	Incorrect ICE/CBP Number.
DENIED2	(Bill patient directly for services rendered, ICE/CBP Not responsible)	**99003**	DETAINEE WAS NOT IN CUSTODY FOR DATE(S) OF SERVICE (Bill patient directly for services rendered, ICE/CBP Not responsible)
N/A	**N/A**	**22004**	DETAINEE WAS NOT IN CUSTODY FOR DATE(S) OF SERVICE (Bill patient directly for services rendered, ICE/CBP Not responsible)
DENIED3	(The authorization # does not cover the date(s) of service on claim)	**99011**	The authorization # does not cover the date(s) of service on claim.
DENIED2 or DENIED3	See description above.	**22011**	Claim reimbursed per authorized dates, which was less than the dates billed. This could have affected payment.
DENIED4	(The appointment date does not match the appointment date in notes/clinical notes)	**40002**	The appointment date does not match the appointment date in notes/clinical notes.
DENIED5	(HCPCS/CPT code(s) does not match specialty on authorization form. Contact the person who initiated the MedPAR found in the notes/clinical notes section)	**40003**	HCPCS/CPT code(s) does not match specialty on authorization form. Contact the person who initiated the MedPAR found in the notes/clinical notes section.
DENIED6	(Notes/clinical notes does not cover type of service - ex. billing for in-patient but notes/clinical notes on authorization form state ER – Contact the person who initiated the MedPAR found in the notes/clinical notes section)	**40004**	Notes/clinical notes does not cover type of service - ex. billing for in-patient but notes/clinical notes on authorization form state ER Contact the person who initiated the MedPAR found in the notes/clinical notes section.
DENIED7	(You have submitted a claim for dates of service that exceed one year and one day from the original date of service. Claim is denied for timely filing)	**22001**	You have submitted a claim for dates of service that exceed one year and one day from the original date of service. Claim is denied for timely filing.
DENIED8	AUTH # REQ ON DENTAL, UB04 BOX63, HCFA 1500 BOX23 (The claim was submitted without an authorization # in box 23 on HCFA 1500, box 63 UB 04, or box 2 on the ADA/Dental form)	**99007**	AUTH # REQ ON DENTAL BOX2, UB04 BOX63, HCFA 1500 BOX23 (The claim was submitted without an authorization # in box 23 on HCFA 1500, box 63 UB 04, or box 2 on the ADA/Dental form)
003	(A duplicate claim was found for this charge based on the member, provider, service dates, place of service, procedure code, and modifier)	**60101**	18 - Exact duplicate claim/service
003	(A duplicate claim was found for this charge based on the member, provider, service dates, place of service, procedure code, and modifier)	**60102**	18 - Exact duplicate claim/service

037	(Request that the authorization be transmitted from ICE by point of contact in notes/clinical notes)	**99002**	Authorization Number was not transmitted to VA FSC. Request that the authorization be transmitted from ICE by point of contact in notes/clinical notes.
038	(Incorrect MedPAR/Authorization #/Numerical value in box 23 on HCFA 1500, box 63 on the UB 04 or box 2 on the ADA/Dental form - Refer to Provider Information – Claim Requirements on ePP)	**99001**	Authorization/Numerical Information invalid. Incorrect MedPAR/Authorization #/Numerical value in box 23 on HCFA 1500, box 63 on the UB 04 or box 2 on the ADA/Dental form - Refer to Provider Information - Claim Requirements on ePP.
DENIED9	(Verify you are using the current procedure code(s) on your claim)	**00437**	181 - Procedure code was invalid on the date of service. N56 - Procedure code billed is not correct/valid for the services billed or the date of service billed.
DENIED10	(Authorization cancelled because the detainee was released from custody, refused service, the appt was cancelled or rescheduled - Contact the person who initiated the MedPAR found in the notes/clinical notes section)	**99005, 40011**	This authorization was cancelled and now inactive. Please contact the detention facility that is responsible for the detainee to obtain an active authorization.
DENIED11	(No funding available for year on claim)	**40005**	FISCAL YEAR CLOSED - No funding available for year on claim.
DENIED12	(Critical Access Hospital - Submit current Rate Letter to VA FSC to cover date(s) of service)	**40006**	Critical Access Hospital - Submit current Rate Letter to VA FSC to cover date(s) of service.
DENIED13	(Verify name or ID on the claim to name on the MedPAR)	**99010**	Verify name or ID on the claim to name on the MedPAR.
DENIED13	(Verify name or ID on the claim to name on the MedPAR)	**40007**	Verify name or ID on the claim to name on the MedPAR.
NC	(Code(s)/service(s) are not covered by Medicare)	**40009**	No Pricing Available for Code.
PR1	(Complete VA 10091 form online at https://www.cep.fsc.va.gov))	**60902**	We have received medical claims that are rejecting due to a Vendorizing issue. Please complete VA Form 10091 at https://www.cep.fsc.va.gov (ID.me account required). Paper submissions will not be accepted.
PR2	TREASURY ELECTRONIC DIRECT DEPOSIT DENIED	**N/A**	**N/A**
PR3	(Provider no long wants Tax ID used - Complete VA 10091 form online at https://www.cep.fsc.va.gov and attach letter for inactive Tax ID Verification)	**N/A**	**N/A**
PR4	(BILLING ADDRESS does not match BILLING ADDRESS on file with VA FSC – Complete VA 10091 form online at https://www.cep.fsc.va.gov)	**60902**	We have received medical claims that are rejecting due to a Vendorizing issue. Please complete VA Form 10091 at https://www.cep.fsc.va.gov (ID.me account required). Paper submissions will not be accepted.
PR5	(BILLING ADDRESS does not match BILLING ADDRESS on file with VA FSC – Complete VA 10091 form online at https://www.cep.fsc.va.gov)	**60902**	We have received medical claims that are rejecting due to a Vendorizing issue. Please complete VA Form 10091 at https://www.cep.fsc.va.gov (ID.me account required). Paper submissions will not be accepted.
PR6	(New Provider enrollment documents are needed – Complete VA 10091 form online at https://www.cep.fsc.va.gov)	**60902**	We have received medical claims that are rejecting due to a Vendorizing issue. Please complete VA Form 10091 at https://www.cep.fsc.va.gov (ID.me account required). Paper submissions will not be accepted.
N/A	**N/A**	**40001**	16-Claim/service lacks information or has submission/billing error(s). N54-Claim information is inconsistent with pre-certified/authorized services
N/A	**N/A**	**99009**	DOB on the claim does not match the DOB on the authorization.

N/A	**N/A**	**22009**	16 - Claim/service lacks information or has submission/billing error(s). N390 - This service/report cannot be billed separately.
N/A	**N/A**	**53001**	The provider is listed on the OIG Exclusionary List.
N/A	**N/A**	**22012**	You have submitted a claim for dates of service that exceed one year and one day from the original date of service. Claim is denied for timely filing.
N/A	**N/A**	**22013**	You have submitted a claim for dates of service that exceed one year and one day from the original date of service. Claim is denied for timely filing.
N/A	**N/A**	**22014**	You have submitted a claim for dates of service that exceed one year and one day from the original date of service. Claim is denied for timely filing.
N/A	**N/A**	**22015**	N640 - Exceeds number/frequency approved/allowed within time period.
N/A	**N/A**	**22016**	Charge exceeds the authorization allowed amount. Please contact the detention facility that is responsible for the detainee.
N/A	**N/A**	**22017**	Charge exceeds the authorization allowed amount, resulting in partial payment. Please contact the detention facility that is responsible for the detainee.
N/A	**N/A**	**99015**	The visits on the authorization does not cover the date(s) of service on claim. Please contact the detention facility that is responsible for the detainee.
N/A	**N/A**	**40012**	The claim has been adjusted based on provider payment refunded.
N/A	**N/A**	**40013**	After IHSC review a BOC was determined to be needed. This claim has been adjusted per that request.
N/A	**N/A**	**40014**	**Authorization Date Mismatch for Inpatient Structured Data:** The authorization # does not cover the date(s) of service on claim. There may be an issue with missing/invalid authorization structured data. Please contact the detention facility that is responsible for the detainee to obtain a new authorization
N/A	**N/A**	**40015**	**Authorization Date Mismatch for Structured Data:** The authorization # does not cover the date(s) of service on claim. There may be an issue with missing/invalid authorization structured data. Please contact the detention facility that is responsible for the detainee to obtain a new authorization.

Rejection Codes

What are IHSC/VAFSC 277CA Rejection Reasons and how will I receive the 277CA?

- All claims processed in eCAMS will be subject to 277CA reject business rules.
- 277CA rejections will be available for review within the IHSC eCAMS Provider Portal (ePP).
- Electronically submitted claims will additionally have the 277CA available to the submitter of the claim.
- However, for claims submitted via paper mail, the 277CA rejection information will **ONLY** be available within the IHSC eCAMS Provider Portal (ePP).

IHSC/VAFSC 277CA Rejection Reasons Effective October 1, 2022				
Status Code	**Category Code**	**Entity Code**	**eCAMS Error Code**	**eCAMS Description**
538	**A7**	**NA**	**00265**	Adjustment claim submitted does not have a valid Parent claim ID
21, 234	**A7**	**NA**	**18705**	Invalid Patient Status
188, 21, 510	**A7**	**NA**	**17910**	Future Statement/Service Dates

128, 21	**A6**	**85**	**02790**	Missing Billing Provider TIN
188, 21, 510	**A7**	**NA**	**02789**	Future Admission Date
21, 454, 508, 700	**A7**	**NA**	**02786**	Invalid Other Procedure Codes
21, 465, 508, 700	**A7**	**NA**	**02785**	Invalid Principal Procedure Code
21, 454	**A7**	**NA**	**02782**	Invalid Procedure Code
158, 21, 510	**A3**	**IL**	**02781**	Future Beneficiary Date of Birth
187, 21	**A6**	**NA**	**02780**	Dental Date of Service
484	**A3**	**85**	**02778**	Foreign Currency Not Allowed
21, 500	**A3**	**IL**	**02776**	Invalid Beneficiary Zip Code
21, 465, 507	**A7**	**NA**	**02775**	Invalid Procedure Code
21, 508, 673, 700	**A7**	**NA**	**02774**	Invalid Patient Reason for Visit
21, 738	**A7**	**NA**	**02772**	Invalid Procedure Code - Professional
21, 738	**A7**	**NA**	**02771**	Invalid Procedure Code - Institutional
21, 455	**A7**	**NA**	**00347**	Invalid Revenue Code
21, 249	**A7**	**82**	**00170**	Place of Service not valid
562	**A7**	**NA**	**02791**	Billing provider not on file
495	**A7**	**NA**	**00029**	Adjustment/Void claim received for a parent claim that is in adjusted/voided/CA Reject/denied/credit status
562	**A7**	**NA**	**00761**	Billing Provider Different From Original
33	**A7**	**NA**	**00032**	Member submitted on the adjustment/void is different from the parent
21, 276	**A7**	**NA**	**00033**	Claim Type submitted on the adjustment/void is different from the parent
21, 258	**A7**	**NA**	**02792**	Billed units greater than 1 when multiple teeth information is present
178	**A3**	**82**	**00160**	Total Charge not equal to sum of sub-charges
33	**A7**	**NA**	**02110**	The member submitted on the claim is not found in our member subsystem