Assisted Reproductive Technology/In-Vitro Fertilization Services for Veterans

Key Points

- Assisted Reproductive Technology (ART) services, including in-vitro fertilization (IVF), can be authorized to network providers by the Department of Veterans Affairs (VA) through the Community Care Network (CCN).
- Veterans must meet VA eligibility requirements.
- Once a provider agreement is established, VA will coordinate an authorization for care that includes all routine labs, medications and radiology that are required to deliver ART/IVF services.
- Medical records and documentation are required for every date of service.

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CCN Assisted Reproductive Technology/In-Vitro Fertilization Services

CCN enhances access to health care, such as Assisted Reproductive Technology/in-vitro fertilization (ART/IVF), by allowing Department of Veterans Affairs (VA) Medical Centers (VAMC) to refer Veterans to a qualified network provider closer to a Veteran's home.

ART/IVF services are available for Veterans and their legal spouses (consistent with applicable law and VA clinical guidelines) for whom VA determines have a service-connected (SC) condition that results in their inability to procreate without the use of fertility treatment.

Fertility services may include the following:

- Stimulation of ovulation
- Monitoring of ovulation stimulation
- Oocyte retrieval
- Laboratory studies
- Embryo assessment and transfer
- Luteal phase support
- Cryopreservation of sperm, oocytes, and embryos

VA determines which Veterans are eligible for ART/IVF services – only a limited and specific group of Veterans are approved for this benefit through VA.

For more information on criteria, please refer to the VHA Publications website or review the Federal Register Summary for details on ART/IVF.

For eligible Veterans and spouses, their supervising VAMC will send an authorization for care to the network provider after VA has determined eligibility for ART/IVF services through CCN.

The VAMC can assist Veterans who are interested in services but are unsure if they are eligible and/or authorized. CCN rules apply to ART/IVF services.

Covered Veterans and their spouses may utilize donor gametes and donor embryos obtained at their own expense when receiving IVF counseling and services. The Veteran pays for the procedures or associated fees for the extraction, storage, or transportation of donor gametes. VA does cover the creation, storage or use of resulting embryos.

The Referral and Authorization Process

VA will issue two authorizations for ART/IVF referrals.

- One authorization covers the portion of care for the Veteran.
- The second authorization covers the care for the spouse.

If there is a service needed, but the CPT code is not included in the ART/IVF Profile, a Request for Services (RFS) can be submitted to the couple's VAMC. Once VA issues a decision on the request, you will receive an updated authorization from the VAMC to include those services, or a letter explaining the decision to deny.

Additional visits can be requested by submitting an RFS to the VAMC. When submitting the RFS, please include any supporting documentation.

What is Covered through ART/IVF?

VA allows for a lifetime maximum of three cycles of ART/IVF treatment. The authorization covers a maximum of six attempts (egg retrieval) to achieve three complete IVF cycles (transfers) in a lifetime of the eligible SC Veterans. Egg retrievals need to be completed prior to the last embryo transfers.

- The authorization includes all routine labs, medication, and radiology that are required to deliver ART/ IVF services.

Prescriptions for medications that are taken or administered at home must be faxed to VA. The VAMC's Pharmacy information will be included in the consult documentation you receive from VA.

- Based on the Veteran's preference, VA will then mail or have the medication available for pick-up at the VA pharmacy.
- Most Veterans receive their prescription by mail within four days. Any pharmacy questions need to be directed to the couple's VAMC contact.

Services to confirm there is a successful pregnancy are included in the ART/IVF authorization.

Long-term cryopreservation and storage for gametes and embryos are a covered benefit but are not billed to TriWest – these services will be covered by VA directly; please bill the referring VAMC.

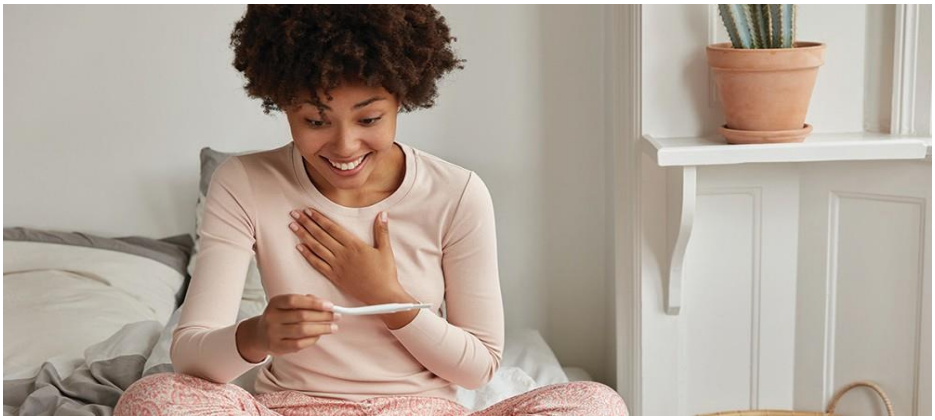
Short-term cryopreservation of gametes or embryos for use during the three cycles is included in the benefit and paid through TriWest.

The spouse of an eligible Veteran is eligible for fertility counseling and treatment under the program.

Services considered experimental by VA for IVF (to include PICSI, intralipid infusion and Zymot) will not be covered by VA or TriWest.

What Steps Occur Following a Successful Pregnancy?

VA will cover up to 10 weeks of services after the positive pregnancy test for complication surveillance. After that, subsequent maternity care must be arranged.



- Female Veterans should contact their servicing VAMC to request a referral for maternity care.
- Non-Veteran collateral spouses will need to use non-VA means to obtain maternity care beyond the 10-week surveillance period.

How Does Payment Work?

Under CCN, ART/IVF approved care is paid according to terms in your signed CCN agreement specific to ART/IVF services.

- The provider is not responsible to collect any co-payments from Veterans or Veteran spouses.
- Since ART/IVF care is considered service-related, other health insurance (OHI) is never billed as primary.
- If you have any claims denials, please do not bill the Veteran; you may correct the claim, or request reconsideration for the denial to TriWest pursuant to the signed CCN agreement.

Please submit medical records/documentation for each date of service. Medical records and documentation are required for all provided services under CCN, and providers are required to submit medical documentation directly to the authorizing VA Medical Center (VAMC), preferably via upload to VA's HealthShare Referral Manager (HSRM).

- Submit claims to TriWest's claims processing partner, PGBA.

To be processed, claims must include the VA referral/authorization number and the specific diagnosis code(s).

- Ancillary or associated providers, such as labs or anesthesiologists, can submit claims to PGBA with the same associated referral/authorization number and diagnosis code(s). These claims will associate in our system and pay at allowed rates.
- All ancillary and associated providers are encouraged to be contracted to participate in CCN. Reproductive Endocrinologist and Infertility (REI) providers are an allowable subspecialty. REIs are medical physicians with advanced training in the science of fertility and its evaluation and treatment and should be credentialed as such.
- Please ensure you are adhering to the most current ICD coding and any Medicare billing requirements. TriWest follows Medicare reimbursement guidelines, when applicable.

Other Questions?

When in doubt, please reach out to the couple's VAMC IVF case manager. There are many nuances to the ART/IVF care and VA wants to make it as easy for you and your office staff as possible.

Does your practice need additional training and information? Visit the TriWest Payer Space on Availity at: www.availity.com/ to access a number of tools, webinars and other resources.

Referrals/Authorizations – ART/IVF

The VAMC sends a referral/authorization letter for care after scheduling an appointment for the Veteran. Generally, referrals/authorizations are inclusive of all appropriate service codes.

Referral/Authorization letters cover a "downstream" servicing provider, such as a lab, specialist provider, facility or ambulatory surgery center. For an ART/IVF episode of care, these providers must be contracted for CCN.

Servicing providers do not need to submit a claim under the same tax identification number (TIN) to be paid under a single referral/authorization letter.

For complex ART/IVF referral/authorization questions, please contact your ART/IVF specialist at the couple's VAMC.

ART/IVF Letter "Clinical Information" Language

VA has approved a standardized range of codes associated with ART/IVF care. This follows the Standardized Episode of Care (SEOC) model used by VA to simplify the administrative process for providers. Much like standing orders, SEOCs simplify appointing and reduce the need for Request for Services (RFS).

Other information found in the clinical language includes:

- Duration and Quantity –Defines the time range and units/visits covered. This timeframe starts from the date of the first appointed visit.
- Overview – Lists the type of therapies and services considered covered.

Notification of Referrals

- When covered in the referral/authorization, the "downstream" specialists, therapists, labs or facilities are approved. No additional RFS is required.
- All servicing providers can submit claims. TriWest's claims system will associate the services with the referral/authorization and process the claims. For ART/IVF, all providers must be contracted under CCN.
- Please submit a RFS:
  - If your referral/authorization letter does NOT include the care needed,
  - If the underlying diagnosis has changed, or
  - If the Veteran requires a longer date range or additional visits.

For more information, please review our section below on Request for Services (RFS).

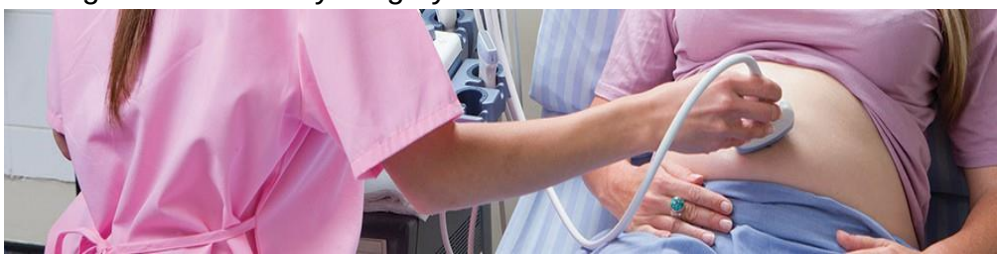
Other Important Points

- All routine lab testing and/or radiology services, when medically necessary, are included in all referrals/ authorizations, whether conducted in the provider's office or by a third-party. **If referring to a third-party for labs or other diagnostics, be sure to send the laboratory provider a copy of the referral/authorization and instruct its staff to bill TriWest.**
- A servicing provider, along with the facility or Ambulatory Surgery Center (ASC) which is used to perform the approved services, is also considered covered and should bill using the same authorization number provided to the primary physician.
- ASC services must bill with a CMS-1500 or 837 (professional) compliant electronic format. This complies with Medicare guidelines.
- VA appoints based on NPI; however, all claims, portal access and contracting is based on the TIN. If the NPI of the provider does not match the initial referral, this should not block the claim payment if the provider is fully qualified to provide care.
- Authorized HCPCS codes are limited to Level I service HCPCS. Level II HCPCS for durable medical equipment (DME), medical supplies and other equipment are not considered pre-authorized.
- VA Consult form (10-7080) has details related to each episode of care along with any care exclusion language. These are included with your authorization and should guide care decisions.
- Providers can find our Quick Reference Guides and other tools in TriWest's Payer Space on Availity (www.availity.com).

Request for Services (RFS) – ART/IVF

If Veteran needs additional or continued care, submit an RFS. If an RFS is necessary, follow the directions and the process outlined below to submit an RFS to VA.

- Carefully review the referral/authorization letter and any VA consult documentation you have received to confirm what is covered.
- Any routine laboratory, medications and radiology are considered covered. Any "downstream" service provider, such as an anesthesiologist or Ambulatory Surgery Center whose services fall under the scope of the authorization are considered covered. You do not need to submit a RFS.



Submit an RFS if:

- If you believe additional care (inpatient surgery/procedure, services outside of authorization scope) is medically necessary, please submit a RFS to VA for review and a possible new episode of care. For example, a new diagnosis of cancer requires a RFS.
- A Veteran needs continued care outside the referral/authorization's "Valid Dates" – a specified date range in which you've been authorized to provide approved services.
- A Veteran needs additional office visits beyond what was included in the referral/authorization or a second opinion outside of your practice/organization.
- If you need to provide care that is medically necessary, but not listed on the referral/authorization letter or the list of ART/IVF service codes, please submit a RFS to VA and receive VA approval before providing care.

To submit an RFS, follow these steps:

- Go to the VA Storefront. From there:
- Click "Request and Coordinate Care" on the left-hand navigation bar under "For Providers"
- Click "Request for Service (RFS) Requirements"
- The link to the RFS form will be at the bottom of the section
- Send the RFS directly to the authorizing VAMC via:
- VA's HSRM portal (preferable) or an EDI 278 transaction
- Direct messaging
- Secure email
- Secure online file exchange
- eHealth Exchange

Once approved, you will receive a referral/authorization letter from either your VAMC or TriWest. It will be at VA's discretion who the approved referral/authorization comes from. You can also check the status of your RFS through VA's HSRM (which is preferable), EDI 278 transaction, or calling the VAMC.

Laboratory Services – ART/IVF

Routine laboratory, ultrasound and X-ray services are included in the authorization sent to the provider. Providers must have an approved referral/authorization on file before rendering care, unless the Veteran needs urgent or emergent care.

When sending a Veteran to an outside laboratory, please advise the Veteran to take the referral/authorization and all other pertinent details with him or her to the appointment.

- Laboratory providers must submit claims with referral/authorization number to TriWest's claims processor, PGBA.
- Laboratory providers must submit lab work/results either:
  - Online using TriWest's Payer Space at www.availity.com; or
  - Via fax at: 866-259-0311, with a copy of the authorization letter and/or coversheet.
- Laboratory providers must follow the claims submission steps.
- All laboratory services must be completed within the time period outlined on the authorization sent to the primary provider.

NOTE: LabCorp and Quest Diagnostics are included in TriWest's network. Individual draw stations can provide services and submit claims even if not specifically listed in our directory.

Medication Process for ART/IVF

VA is responsible for supplying Veterans with all medications that are not urgent or emergent. Therefore, non-urgent medications must be filled by VA. All medications must be prescribed in accordance with the VA National Formulary.

If the Veteran needs a medication that is not on VA's National Formulary, complete a Form 10-0450 National Formulary Request for Formulary Review, which can be found on the VA Forms website at https://www.va.gov/find- forms/ and submit it to the supervising VAMC for approval or denial.

Always fax both the referral/authorization letter and prescription to the VAMC. If the Veteran prefers to take his or her prescription to the pharmacy, he or she will also need to bring a copy the authorization.

As per U.S. Drug Enforcement Administration (DEA) policies, some controlled substances will require the Veteran bring a hard copy of the prescription to the overseeing VA medical facility. Please see the DEA's drug information webpage for details.

VA has two general policies for medication: General and Urgent/Emergent. To ensure Veterans do not incur medication costs, please follow these processes.

General Prescriptions

Medications must be prescribed in accordance with the VA National Formulary. Visit VA's Pharmacy Benefits Management Services website to view or download the most current formulary and other information related to prescribing medications for Veterans.

- Formulary includes both the generic name and the dosage form information.
- If the Veteran needs a medication that's not on VA's National Formulary, you can obtain a Form 10-0450 National Formulary Request for Formulary Review, which can be found on the VA Forms website at https://www.va.gov/find-forms/. Fill out the form, return it to the Veteran's supervising VAMC and wait for approval or denial.
- Turnaround time may take 96 hours.
- If VA approves the medication, you may proceed with prescribing it and VA will cover the cost.
- TriWest recommends you do not provide samples of medications to the Veteran if it is non-formulary. Giving samples of a medication is not a justification for non-formulary continued use and may lead to a denial of your request.

Providers should always fax both the authorization letter and prescription to the appropriate VAMC's pharmacy.

If the Veteran prefers to take his or her prescription to the VAMC pharmacy directly, he or she will also need to bring a copy of the authorization letter or number.

A provider may prescribe medications to be filled at a VA Pharmacy or Consolidated Mail Outpatient Pharmacy (CMOP) as a part of an episode-of-care authorized by VA.

- Include the following information on the medication request:
    1. Prescribing provider's name
    2. Prescribing provider's address
    3. Prescribing provider's PERSONAL Drug Enforcement Administration (DEA) number (NOT a generic facility number)
    4. Prescribing provider's phone number
    5. Prescribing provider's fax number
    6. Prescribing provider's National Provider Identifier (NPI) number
    7. VA's authorization letter

NOTE: Incomplete prescriptions will not be processed and will be returned to the prescribing provider.

Urgent/Emergent Prescriptions

When there is an urgent/emergent need to start a medication and it is not possible to fill the prescription at a VA Pharmacy, the provider may write a script for a 14-day supply (without refills). The prescription may be filled at a retail CCN pharmacy for up to a 14-day supply, except for a pre-packaged drug pre-approved by VA to be dispensed in a larger supply without refills. (Opioids allow a maximum of seven days' supply, or the state limit, whichever is lesser.)

NOTE: If the diagnosis for urgent/emergent medication is not related to the ART/IVF episode of care, you should refer the Veteran to his or her primary care provider or encourage them to seek care at an urgent care or emergency room.

If the urgent/emergent medication needs to be continued beyond 14 days, the provider should write another prescription to be filled at a VA Pharmacy or VA Consolidated Mail Order Pharmacy (CMOP). Follow the process outlined above.

If the urgent/emergent medication is not on VA's Drug Formulary, the provider should write an initial 14-day prescription; however, for the second prescription, the provider must submit a Formulary Request Review Form to its local VAMC and wait for approval or denial.

Prescriptions written by an out-of-network community provider can be filled at a VA Pharmacy or paid by the Veteran out of pocket at a retail pharmacy and submitted to VA for reimbursement consideration.

Veterans who consent to participate in Human Subject Research studies and are enrolled in clinical trials **CANNOT** be authorized for those services under CCN. Veterans must be referred back to their respective Non-VA Care Office for the administration and coordination of non-VA care associated with clinical trials.

Medical Records and Documentation Requirements

Medical records and documentation are required for all provided services under CCN. Providers are required to submit medical documentation directly to the authorizing VA Medical Center (VAMC), preferably via upload to VA's HealthShare Referral Manager (HSRM).

Standard, Urgent and High-Priority timeframes may apply based on the type of care provided. However, submit urgent and emergent care documentation as soon as it is complete. Referrals to screen for cancer or to treat a suicidal Veteran are other examples of higher priority medical documentation to return quickly.

All medical documentation must be signed (written or electronic), and/or initiated by the submitting provider or practitioner.

How to Submit Medical Documentation and Claims

- Register for a secure account on TriWest's Payer Space at www.availity.com and upload medical documentation directly to the system. Documents up to 5 MB can be uploaded in PDF or TIF format.
- Claims without the VA referral/authorization number will be denied or recouped.

For more information on submitting medical documentation, refer to the Medical Records and Documentation Requirements Quick Reference Guide.

How Can We Help You?

If you have additional questions or issues, please do not hesitate to reach out to our team here at TriWest. We are here to help!

- ART/IVF Direct Network Contracting – Nicole Harrison: nharrison1@triwest.com
- CCN Participation Questions – Nicole Harrison: nharrison1@triwest.com
- If you or the Veterans in your care have issues that need to be addressed as part of a grievance, please fill out and submit a TriWest Complaint and Grievance form.
- Register with TriWest's Payer Space at www.availity.com for secure access to authorizations and claims details as well as for additional tools and easy options for updating your practice information.

The VHA Directive 1332 document details national policy and procedure for Infertility Evaluation and Treatment.

You can find more information on VA's Infertility and IVF web page.