



TriWest Healthcare Alliance

Department of Veterans Affairs (VA) Community Care Program Provider Handbook

Your Guide to VA Community Care Program Policies and Procedures

Introduction

We want to thank you for continuing to serve our Veterans as the Community Care programs continue to evolve. TriWest remains focused on providing the highest levels of customer service to Veterans and the community providers who serve them. Our commitment to minimizing administrative burden for provider offices and assuring timely and accurate claims payment will remain unchanged.

The Veterans Choice Program (VCP) ended on June 6, 2019, but there will be some program requirements that will continue for the foreseeable future. VCP providers are now known as “Certified Providers.” Certified Providers who want to continue treating Veterans through TriWest referrals and authorizations can continue to do so, but will need to ultimately become fully Patient-Centered Community Care (PC3) contracted and credentialed through TriWest. In addition, TriWest will be contracting under Community Care Network (CCN) for those providers operating in CCN Region 4 which includes Arizona, California, Colorado, Hawaii, Idaho, Montana, Nevada, New Mexico, Oregon, Texas, Washington, and Wyoming. The MISSION Act will provide guidance and result in modifications to the Patient-Centered Community Care (PC3) program as it serves as a bridge to full implementation of the Community Care Network (CCN).

Using This Provider Handbook

This Provider Handbook gives you and your staff basic, important information about the VA Community Care programs while emphasizing key operational aspects of the programs and their requirements. You may use this handbook to assist in coordinating care for Veterans.

This Provider Handbook is also available electronically on the TriWest Payer Space on Availity at www.availity.com. The current TriWest Provider Portal at www.triwest.com/provider is transitioning to the TriWest Payer Space on Availity. We recommend registering for an account on Availity if you haven't already.

Thank you for your service to our nation's Veterans

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Overview

The Veterans Choice Program (VCP) ended on June 6, 2019, but there will be some program requirements that will continue for the foreseeable future. VCP providers are now known as Certified providers. Certified providers who want to continue treating Veterans through PC3 referrals and authorizations can continue to do so, but will need to ultimately become a credentialed PC3 or CCN provider.

Patient-Centered Community Care (PC3)

PC3 is a program that started in 2013 to provide Veterans coordinated, timely access to high-quality care from a comprehensive network of civilian community providers. The PC3 program was designed to ensure Veterans receive coordinated, evidence-based care through civilian community providers when VA facilities are not able to provide primary care, a specialty service, or advanced imaging. Services NOT included are nursing home care, hospice, long-term acute care, homemaker and home health aide services, chronic dialysis treatments, dental care, and compensation and pension examinations.

Veterans Choice Program (VCP)

In August 2014, former President Obama signed into law the Veterans Access, Choice and Accountability Act (VACAA) of 2014, which directed the establishment of the Veterans Choice Program (VCP). It was developed to better meet the health care needs of our nation's Veterans in light of long VA wait times or when VA medical facilities were too far from a Veteran's home. The MISSION Act was passed in June of 2018 and required the end of VCP as of June 6, 2019. The MISSION Act will provide guidance and some modifications to the PC3 program as it serves as a bridge to full implementation of the Community Care Network (CCN).

To join TriWest's provider network, please visit: www.triwest.com/joinournetwork.

Policy Resources

The statutes governing the VA Community Care programs can be found in the United States Code, Title 38. VA directs TriWest on how to administer these programs. This direction comes through modifications to the Code of Federal Regulations (CFR), Title 38. TriWest's contract with VA is subsequently modified to be in compliance with these statutes and regulations.

Regions

In the United States, the VA PC3 Community Care programs are divided into six separate regions.

- **PC3 Region One** – Connecticut, Maine, Massachusetts, New Hampshire, New Jersey, New York, Pennsylvania, Rhode Island, Vermont, and West Virginia.
- **PC3 Region Two** – Alabama, Delaware, District of Columbia, Florida, Georgia, Maryland, North Carolina, South Carolina, and Virginia.
- **PC3 Region Three** – Alabama (southern portion) Arkansas, Florida (western panhandle portion), Illinois (southern portion), Indiana (southern portion), Kansas, Kentucky, Louisiana, Missouri, Mississippi, Oklahoma, Tennessee, Texas, Virginia (western portion), and West Virginia (western portion).
- **PC3 Region Four** – Colorado, Indiana, Illinois, Iowa, Michigan, Minnesota, Montana, Nebraska, North Dakota, Ohio, South Dakota, Utah, Wisconsin and Wyoming.
- **PC3 Region Five** – Arizona, California, Colorado (southern portion), Hawaii, Idaho, Nevada, New Mexico, Oregon, Texas, Washington and the territories of American Samoa, Guam, and the Northern Mariana Islands.
- **PC3 Region Six** – Alaska.

Resources: Availity and Provider Portal

For the past several years, the TriWest Provider Portal at www.triwest.com/provider has been available as your one-stop shop for information on filing claims and navigating VA Community Care programs. However, TriWest is transitioning its current Provider Portal to a new TriWest Payer Space on Availity at www.availity.com/triwest.

Availity is an online, multi-payer site where you can use a single user ID and password to work with TriWest and other health plans you accept. It is becoming TriWest's new method to access the TriWest Provider Portal and complete other secure tasks online.

To learn more about this transition, and to register for an Availity account, please visit www.availity.com/triwest.

During this transition, we encourage providers to maintain an active account on the current Provider Portal (www.triwest.com/provider), and register for an account on the new TriWest Payer Space on Availity. Until the transition is complete, both platforms offer:

- **Quick reference guides** on topics like authorizations, secondary authorization requests, claims, and medical documentation requirements;
- **Live, interactive webinars and eSeminars** to help providers learn the health care management process for PC3, including the appointing and authorization process and billing procedures;
- **Frequently asked questions** on everything from medical documentation to determining a Veteran's eligibility

Registering for a Secure Account

TriWest strongly recommends providers register for a secure account on both the current TriWest Provider Portal and on Availity. With a secure account, they can access authorization information and view claims status.

For technical assistance with the current TriWest Provider Portal: email VAPortalAssistance@triwest.com or call the Provider Portal Assistance Line at 1-855-722-2838, x3, x2.

For technical help with Availity: please call Availity at 1-800-282-4548.

TriWest's Interactive Voice Response (IVR) System

TriWest offers an IVR system at 1-855-722-2838 to assist providers with routine questions. Follow the greeting and select the applicable touch-tone prompts to get quick information and accurate answers on many topics.

Program Governance

VA Community Care program providers are obligated to abide by the rules, procedures, policies and program requirements specified in this Provider Handbook, which is a summary of the regulations and requirements related to the VA Community Care programs. Providers must read and understand the contents of this handbook outlining the governing statutes and regulations that provide final guidance for the VA Community Care programs. This handbook is **NOT** a substitute for legal advice from qualified counsel, as appropriate. VA regulations are available on the VA website at www.va.gov or www.ecfr.gov.

PC3 Network Providers

TriWest network providers under PC3 are those physicians, specialists, primary care, group practices, hospitals, facilities, and ancillary providers who have signed contracts to become part of the TriWest network. Through the contract, providers agree to provide health care services to Veterans authorized by VA and TriWest.

PC3 Local Network Representatives

For providers who have signed network contracts with TriWest under the PC3 program, TriWest has subcontracted local network representatives to help them navigate the program.

PC3 network providers should contact their local network representative for assistance with:

- Provider demographic updates (e.g., change in tax identification number, physical location, contact information, and email addresses for staff working with PC3)
- Questions about their PC3 contract

Certified Providers

TriWest Certified Providers include physicians, specialists, primary care, group practices, hospitals, facilities, and ancillary providers who agree to provide care to Veterans for each authorization sent by TriWest, and adhere to the terms and conditions for each authorization (see https://joinournetwork.triwest.com/documents/TriWest_VCP_Terms_and_Conditions.pdf). Certified Providers who want to continue treating Veterans through PC3 referrals and authorizations can continue to do so, but will need to become a credentialed PC3 or CCN provider.



Provider Credentialing Process

All services, facilities, and providers shall comply with all applicable federal and state regulatory requirements in their state or jurisdiction. Any provider on the Centers for Medicare and Medicaid Services (CMS) exclusionary list shall be prohibited from network participation.

TriWest will ensure that medical services are performed by providers with demonstrated current competence, either through current, unrestricted privileges to provide the care as required by Medicare Conditions of Participation (CoP) and Conditions for Coverage (CfC), or other measures of demonstrated competency. Go to www.cms.gov/Regulations-and-Guidance/Legislation/CFCsAndCoPs/index.html to review the current Medicare CoPs and CfCs.

Providers who have signed a contract to become a participant of the PC3 network will be credentialed by either TriWest or the local network representative. The credentialing process involves obtaining primary-source verification (PSV) of the provider's education, board certification, license(s), professional background, malpractice history and other pertinent data. Credentialing and contracting packets may be obtained from the local network representative who assists in completing the paperwork and executing the contract. If you participate in the Council for Affordable Quality Healthcare (CAQH) simply provide your CAQH ID on the form in lieu of the full credentialing application. A credentialed provider who has signed a contract is considered a network provider once they are informed of the final notification of contract execution by TriWest or the local network representative.

For additional credentialing requirements based on VA-specialty specific requirements, please reference the [Provider Credentialing Quick Reference Guide](#).

Note: It is imperative that PC3 providers wait for final notification of contract execution from TriWest or their local network representative before providing care to Veterans as network providers.

Provider Responsibilities

The agreements for providers participating in the VA Community Care programs outline the provider responsibilities under these programs. The following are certain provider responsibilities and requirements for VA Community Care programs:

- If Provider enters into any subcontracts with any subcontractors whereby such subcontractor assumes any of Provider's duties, responsibilities, or other obligations under this Agreement, Provider assumes full responsibility for credentialing, licensure, and professional liability insurance of said subcontractor and shall ensure that any such subcontracts require subcontractors to comply with the terms and conditions of their Agreement.
- Provider agrees to comply with all policies and procedures set forth in this Provider Handbook, including, without limitation, credentialing, peer review, utilization review/management, medical documentation sharing, quality-assurance programs and procedures established by TriWest or VA, including concurrent reviews, retrospective reviews, and discharge planning for inpatient admissions.
- Provider agrees to accept the PC3-contracted reimbursement rates or rates defined in the Terms and Conditions for a Certified Provider as the only payment expected from TriWest or VA for Veterans covered under the Community Care program for authorized services.
- Veterans have no co-pays or cost-shares in this program. As such, a Veteran will not be billed directly for any services or supplies furnished under this contract.
- VA regulations prohibit PC3 or Certified Providers from charging Veterans for missed appointment fees.
- Provider understands and agrees that all covered services provided to Veterans, except emergency services, must be pre-authorized by VA and TriWest. Urgent care services are not pre-authorized but will be covered for eligible Veterans effective June 6, 2019, assuming the Veterans eligibility for this benefit was confirmed.
- Provider agrees to meet office and appointment access standards (Veteran should be seen within 30 minutes of a scheduled appointment and a Veteran appointment should be scheduled within 18 days for primary care and behavioral health services and 26 days for other specialty care, as noted below in the Office and Appointment and Access Standards section.
- Provider will include his or her National Provider Identifier (NPI) and the authorization number for the episode of care when submitting claims for health care services.
- Provider agrees to submit all claims for covered services on behalf of Veterans. All claims should be submitted electronically. Providers who do not have the ability to submit claims electronically can find additional information on claims submission in the [Provider Claims Quick Reference Guide](#).

- Requests for Services (RFS) have replaced Secondary authorization requests (SAR). The RFS should be submitted by fax to TriWest at 1-866-259-0311 if TriWest did the initial appointing or, should be submitted directly to the authorizing VAMC if the VAMC is the initial appointing. The determining factor in where to submit a RFS is driven by which entity is making the Veteran appointment and performing care coordination. The majority of this work will be transitioning to VAMCs over time.
- Provider agrees to submit medical documentation for an authorized episode of care to the authorizing VAMC within the timelines outlined in the [Medical Documentation Quick Reference Guide](#). Providers agree that when providing covered services to Veterans under Community Care programs, they will not discriminate against any Veteran on the basis of his or her race, color, national origin, or any other basis recognized in applicable laws or regulations.
- Provider will give Veterans a copy of their medical records at no charge, including a narrative summary and other documentation of care, within ten (10) business days of the request.
- The Provider shall notify TriWest within twenty four (24) hours of discovery of all Veteran safety events that are sentinel events, adverse events (including adverse drug events), or intentionally unsafe acts. Adverse events involving administration of drugs shall be reported to TriWest using the Food and Drug Administration (FDA) Form 3500. A copy of the completed form shall be submitted to the FDA online and shall also be submitted to VA. The FDA reporting form can be found at: www.fda.gov/Safety/MedWatch/HowToReport/default.htm.
- Provider agrees to submit at least one email address to TriWest for purposes of communicating important Community Care program updates.
- Facilities that perform cardiac catheterizations and/or percutaneous coronary interventions and implanting cardioverter defibrillators (ICDs) are required to participate in the National Cardiovascular Data Registry (NCDR) CathPCI and NCDR ICD, respectively.
- Provider agrees to comply with all final HIPAA ASC X12N Transactions and Code Sets standards as promulgated by the secretary of HHS.
- Provider or designee should receive initial and periodic web-based training to obtain and enhance understanding of Community Care program requirements.
- Provider agrees to notify his or her local network representative (for PC3 network providers) or TriWest (for Certified providers) of any changes of tax identification number (TIN), physical and/or mailing address, phone or fax number, whether the Provider is accepting new patients, or changes in specialty services rendered within ten (10) business days of the change.

Updating Provider Demographic Information

Providers can update their own data – such as changes in mailing address, phone, fax, or email address – by logging into Availity at www.availity.com and using the Provider Data Management tool. It is important for providers to update or report any outdated or incorrect demographic information as soon as possible. This enables TriWest to provide accurate information to Veterans, ensures claims are paid appropriately, and guarantees payments are mailed to the correct address. If Availity is not an option for you, you should update your information via the following means:

- **For PC3 network providers:** contact your local network representative.
- **For Certified providers:** call TriWest at 1-866-284-3743



Appointing and Authorization Process

Appointing may happen in one of two ways:

1. Either TriWest calls to schedule an appointment for the Veteran at the provider's office; or
2. The VAMC calls to schedule an appointment for the Veteran at the provider's office.

Regardless of who makes the appointment, TriWest's systems receive the confirmation and generate an authorization number and letter. TriWest then mails or faxes the authorization letter to the provider via the number and/or address in our system. This authorization information is also available on the secure Provider Portal. The VA clinical consult information may be included with the authorization letter and is available on the secure Provider Portal at www.triwest.com, or available on VA's HSRM online tool.

The provider must have an authorization on file BEFORE rendering care, to ensure payment for services with the exception of Urgent Care services provided in network urgent care/retail location clinics.

Please refer to the [Appointment Scheduling Process Quick Reference Guide](#) for more information.



Note: No payment will be made for services not authorized by VA and TriWest with the exception of the Urgent Care benefit.

Access to Care Standards

The Veterans Health Administration (VHA), consistent with requirements included in the Mission Act, has established access to care standards for the VA Community Care programs. These standards address appointment availability, and scheduling wait time once the Veteran arrives at the office, and drive time standards. The drive time is based on the distance from the Veteran's residence address to the provider service location. These standards are monitored and reported to VA on a regular basis. PC3 local network representatives will work to contract providers to comply with these standards and assist providers with compliance.

Appointments for VA Beneficiaries will be made in accordance with the timelines and access standards applicable under Section 104 of the VA Maintaining Internal Systems and Strengthening Integrated Outside Networks (MISSION) Act of 2018, Public Law No: 115-182, and implementing regulations.

Appointment Coordinated:

- Within five (5) calendar days of TriWest receiving the referral from VA (note: this is a performance expectation that VA has for TriWest, and TriWest therefore appreciates providers assisting with making this possible)

Veteran Scheduled To Be Seen By Provider:

- Primary Care and Behavioral Health – within eighteen (18) calendar days of TriWest receiving the referral from VA
- Specialty Care – within twenty six (26) calendar days of TriWest receiving the referral from VA

Office Wait Time:

- 30 minutes from scheduled appointment

Basic Drive Time Standards:

- Primary Care and Behavioral Health – within 30 minutes' commute time
- Specialty Care – within 60 minutes' commute time

Authorization Letters

All referrals for care must come from VA with the exception of the Urgent Care benefit. If a Veteran requests care from a provider, and the provider does not have a prior VA or TriWest authorization on file, the provider should send the Veteran back to his/her VAMC, unless the provider is a network urgent care/retail location facility. Either the VAMC or TriWest will schedule an appointment on behalf of the Veteran. Urgent care/retail Location facilities should follow the separate urgent care process on page 11.

After the initial appointment is scheduled, TriWest's systems receive the confirmation and then generate a detailed authorization letter and number. The letter is mailed or faxed to the number designated in our system. The letter also is available for download from TriWest's secure Provider Portal.

The authorization letter will identify whether the care is approved and if it's following a Standardized Episode of Care (SEOC) model.

All services require prior authorization in order for the provider to receive payment with the exception of the Urgent Care benefit.

Request for Services (RFS)

A provider who believes additional or continued care beyond what was initially authorized is required should download and fill out VA's Request for Services (RFS) form on its VA Storefront webpage at www.va.gov/COMMUNITYCARE/providers/index.asp. The RFS was previously called a secondary authorization request (SAR).

To access the RFS form from VA's website listed above, first click the "Request and Coordinate Care" menu item on the left-hand navigation bar. Then click "Request for Services (RFS) Requirements," and navigate to the bottom of the section. The RFS form will be hyperlinked there.

Providers usually need to send an RFS when:

- A Veteran needs a second opinion;
- A Veteran needs continued care outside of the authorized date range (available on the authorization letter); or
- A Veteran needs additional services not included on the original authorization letter.

Be sure to include supporting medical documentation with your RFS and submit everything to the entity that appointed to your clinic.

- If TriWest appointed, submit the RFS to TriWest.
- If VA appointed, submit the RFS to the authorizing VAMC.

The appointing entity should be on your authorization letter.

Routine, Urgent, Emergent – Determining Your RFS Level

VA assesses RFS based on clinical need and priority; this allows Veterans who urgently need care to have their review process expedited. There are three clinical priority levels for an RFS – Routine, Urgent and Emergent.

ROUTINE: Any care that is not urgent or emergent is considered routine. NEVER mark your RFS for routine care as urgent or emergent. Please see below to determine if your RFS may be considered urgent or emergent.

URGENT: Only mark a RFS as urgent if at least one of the following is true:

- Processing time that lasts more than two days could jeopardize the life or health of the Veteran, or his/her ability to regain maximum function.
- Processing time that lasts more than two days will subject the Veteran to severe pain that cannot be managed without the treatment being requested.

Do NOT mark urgent for administrative urgency.

EMERGENCY: Indicate "emergent" only when a new issue/ diagnosis has developed for a Veteran who was already authorized to see you, or a Veteran self-presents for emergency reasons without a prior-authorization (for emergency room visits, please see our [Quick Reference Guide on Emergency Care](#)).

- VA determination of emergent care includes loss of limb, loss of life, loss of eyesight and other urgency at this level.
- If the care is emergent, please proceed with the care and submit the RFS immediately, indicating that the care is being rendered emergently.
- Emergent RFSs can come in after care is rendered; providers will still get paid. This is an exception to the pre-authorization requirement.

Inpatient Care Coordination and Transfer Process

TriWest will coordinate and communicate admissions and discharges with an inpatient facility whenever inpatient health care is ordered and approved by the authorizing VAMC. Care coordination will be performed by VA or TriWest in coordination with network facilities.

For discharges, the provider will coordinate with TriWest to arrange for necessary supplies, home health services and equipment. The provider needs to complete the [RFS form](#) and submit it to either TriWest or VA to obtain approval from VA. All transitions of care need to be approved by the authorizing VAMC. TriWest will coordinate with the authorizing VAMC to facilitate the transfer of the Veteran back to a VA facility or another facility. TriWest will also coordinate discharge planning to the Veteran's home if other services are required. The authorizing VAMC will approve the number of services, treatments and/or procedures.

Emergency Health Care Process

Emergency care should be provided to any Veteran who self-presents to an emergency room (ER) seeking emergency care.

All ER care is coordinated directly through VA, not TriWest. If a Veteran self-presents to an ER, the ER must call the authorizing VAMC **within 72 hours**.

VA will need to know:

- Veteran's full name
- Last four digits of the Veteran's Social Security number
- The condition for which the Veteran is being seen
- The mode of transportation by which the Veteran arrived. If arriving by ambulance, a copy of the trip report should be provided, if possible

VA health care staff will determine the Veteran's eligibility and, if appropriate, retroactively authorize care. If VAMC determines care can be covered under PC3 or CCN, TriWest will be notified, generate an authorization for provider, and process the ER claim.

If the Veteran is being seen for authorized care and, during treatment, it is determined the Veteran is experiencing an emergency, the treating provider/facility must render emergency treatment immediately and notify VA. Additionally, the local ER that receives the Veteran must follow the steps above.

If a Veteran is receiving authorized services and the treating facility determines the Veteran needs a higher level of care than its facility is capable of providing, it must obtain authorization from VA prior to transferring the Veteran to another facility.

Providers should notify VA **within 72 hours** of an emergency admission. This also applies to weekend notifications.

In the event that care is not authorized by VA, the provider must submit claims within 90 days of the encounter directly to VA for reconsideration. No separate

payment will be made for ER facility charges for inpatient services authorized under this contract that are subject to reimbursement under the [VA Inpatient Acute Care Prospective Payment System](#).

Urgent Care Process

Under the urgent care benefit, TriWest network urgent care/retail location providers may treat Veterans who self-present without a prior authorization. However, the urgent care/retail location staff will need to confirm the Veteran's eligibility before providing care.

Providers must ensure they are part of the TriWest urgent care/retail walk-in network before treating the Veteran through this benefit. Providers may request to join the TriWest network at www.triwest.com/joinournetwork.

Providers do not collect any co-pays, cost-shares, or deductibles from Veterans under the urgent care process.

Below are the steps to follow for the urgent care process:

1. The Veteran will self-present to the TriWest network urgent care/retail location clinic.
2. The urgent care/retail location clinic will ask the Veteran for his or her:
 - Date of birth
 - Last four numbers of the Social Security number
 - Overseeing VAMC
 - Home address
3. The urgent care/retail location staff will then call TriWest at 1-833-4VETNOW (1-833-483-8669) to confirm the Veteran's eligibility. Staff will input the Veteran's date of birth and last four numbers of the Veteran's Social Security number into the phone system.
 - This eligibility check is imperative because it's directly linked to approval for urgent medications the Veteran may need. Without the eligibility check, the system may deny the Veteran medication that the urgent care clinic prescribed.
4. If eligibility is confirmed, the urgent care/retail location clinic may treat the Veteran for his or her medical condition.
5. The urgent care/retail location provider may write a medically necessary prescription for up to a 14-day supply. The medicine must be listed on VA's Urgent Care Formulary, available here: www.triwest.com/urgent-formulary.
 - If the medicine is needed urgently and is not listed on the Urgent Care Formulary, the provider may look to the VA National Formulary, available here: <https://www.pbm.va.gov/PBM/nationalformulary.asp>.
 - The Veteran may fulfill the prescription at any in-network pharmacy with ExpressScripts, available at this link: <https://www.va.gov/find-locations>.

6. After the Veteran leaves, the urgent care/retail location clinic will submit medical documentation from the visit to the Veteran's VAMC within 30 days of the date of service. The provider can look up the Veteran's VAMC using his/her home address at this VA lookup tool: <https://www.va.gov/directory/guide/home.asp>.
 - The provider can also look up the medical documentation fax number for the VAMC here: www.triwest.com/vamc-contacts.
7. The urgent care/retail location clinic will then submit its claim to WPS Military and Veterans Health (WPS MVH), TriWest's claims processor. TriWest will be responsible for paying claims.

If the Veteran needs additional or follow-up care, the urgent care/retail location provider should refer the Veteran back to his/her overseeing VAMC.

Covered and Excluded Urgent Care Codes

VA defines urgent care as the treatment of non-emergent symptoms needing immediate attention, such as flu-like symptoms, strep throat, minor burns, pink-eye, or ear and skin infections. The urgent care/retail location benefit is not intended to cover routine primary care or preventive screening services.

To help providers better understand what's excluded, VA has provided a list of excluded codes, available here: www.triwest.com/UC-excluded-codes.

Critical Findings Notification Process

VA defines Critical Findings as a test result value or interpretation that, if left untreated, could be life threatening or place the Veteran at serious health risk. Critical values/results are those results from laboratory, cardiology, radiology departments and other diagnostic areas that, upon analysis, are determined to be "critical," regardless of the ordering priority.

VA requires that for any Critical Finding test result, the provider shall notify the VA point of contact (POC) by phone within 24 hours of the test/evaluation/treatment.

It should also be noted in the medical documentation who the provider spoke to at the VAMC, and when the POC was notified.

- A new diagnosis of cancer is considered a Critical Finding and notification to the VA POC shall be made **within 48 hours of diagnosis**.
- A newly identified suicide risk in a Veteran *not referred* for inpatient mental health should be considered a Critical Finding and the provider shall contact VA by phone **within 24 hours**.

Immediate notification (within 24 hours) to a VA POC

is required if the provider determines that the Veteran requires the following:

- Urgent follow-up after completion of authorized episode of care
- Urgent additional care beyond what was authorized in the SEOC

Refer to the Critical Findings section of the [Medical Documentation Quick Reference Guide](#) for more information.

Medication and Durable Medical Equipment (DME) Process

Pharmacy is included in all authorization letters. However, VA is primarily responsible for supplying Veterans with non-urgent/non-emergent medications, medical/surgical supplies (DME) and nutritional products. Prescribing must be in accordance with the [VA National Formulary Handbook](#), which includes provisions for requesting non-formulary drugs.

Always fax both the authorization and prescription to the appropriate VAMC. If the Veteran prefers to take his or her script to the VA Pharmacy, he or she will also need to bring a copy of the authorization.

When there is an immediate need to start a medication and it is not possible to obtain the medication from a VA Pharmacy, the provider may write a prescription for up to a 14-day supply (without refills). The Veteran should be informed by the provider that an emergency prescription may be obtained from a non-contracted source, and VA will reimburse the Veteran directly.

If the immediate medication is filled at a non-VA pharmacy and is expected to be continued beyond 14 days, a second prescription should be submitted to a VA Pharmacy for processing. Follow the guidelines above.

If the medication is not on VA's drug formulary, the provider must contact the authorizing VAMC and request a Formulary Review Request form. The provider should fill out the form and return it to the authorizing VAMC for approval or denial. This process can take up to 96 hours for review.

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

For more information on the pharmacy process, please visit the Pharmacy page on the TriWest Provider Portal at www.triwest.com/provider-pharmacy.

DME

VA is the primary resource for all routine durable medical equipment (DME) for Veterans. For urgent or emergent care, providers may directly supply Veterans with DME and TriWest will reimburse providers. Examples of urgent or emergent DME include: splints, crutches, canes, slings, or soft collars.

To order non-urgent or non-emergent DME for Veterans referred to you by VA:

- Download VA's RFS form and fill out the DME section.
- The RFS form is available on the VA Storefront webpage at www.va.gov/COMMUNITYCARE/providers/index.asp.
- First click the "Request and Coordinate Care" menu item on the left-hand navigation bar.
- Then click "Request for Services (RFS) Requirements," and navigate to the bottom of the section for the hyperlinked form.
- Send the RFS form with the completed DME section directly to your local, authorizing VAMC.
- The authorizing VAMC will then coordinate the routine DME directly with you and the Veteran.
- **Do NOT dispense non-urgent or non-emergent DME out of your office unless you receive VA approval.**
- Requests for exceptions to this requirement may be considered under special circumstances.
- Exceptions to this requirement will be coordinated with the authorizing VAMC and will be approved and documented in advance.

To order urgent or emergent DME:

- DME must be provided to a Veteran by a treating physician, facility, or DME supplier **at the time of treatment and before the Veteran leaves the provider's care site.**
- The provider should bill TriWest for the urgent or emergent DME, and TriWest will reimburse the provider according to its contract or agreement.
- Failure to plan or coordinate DME needs in advance of a scheduled procedure does not constitute an urgent or emergent need.

Mental Health Care Services

This section will assist you with specific mental health care aspects of VA Community Care programs. You may also refer to the [Mental Health Services Quick Reference Guide](#) for additional information and important website links.

For both inpatient and outpatient mental health care, providers should follow the Department of Veterans Affairs/Department of Defense (VA/DoD) Clinical Practice Guidelines (CPG) for the diagnosed mental health problem found at www.healthquality.va.gov. These are baseline criteria and should not replace clinical judgment.

VA covers services delivered by qualified, authorized mental health care providers practicing within the scope of their licenses to diagnose and/or treat mental health components of a medical or psychological condition.

PLEASE NOTE: all psychotherapy notes **shall be kept separate** from the Veteran's medical record, per Health Insurance Portability and Accountability Act (HIPAA) regulations.

However, medication prescription and monitoring (as appropriate); counseling session start and stop times; modalities and frequencies of treatment; results of clinical tests; and any summary of diagnosis, functional status, treatment plans, symptoms, prognosis or progress shall be provided in the medical record and do not require Veteran authorization for disclosure.

Veterans with a history of Military Sexual Trauma (MST) being treated for a mental health problem related to MST will receive care from a provider of the gender of their choice.

If suicide risk is a clinical issue, the Veteran shall be provided a written copy of the Veteran's personal Suicide Prevention Safety Plan (reference www.mentalhealth.va.gov/docs/VA_Safety_planning_manual.pdf). The plan will include the Veterans Crisis Line telephone number: 1-800-273-8255.

Any newly identified suicide risk in a Veteran not referred for inpatient mental health treatment shall be considered a Critical Finding, and therefore must be called into VA within 24 hours.

Labor, Delivery, and OB/GYN Prenatal Care

For labor, delivery and OB/GYN prenatal care, providers should follow the VA/DoD CPGs for pregnancy management at www.healthquality.va.gov. These are baseline criteria only and should not replace clinical judgement.

Patient Safety

TriWest VA Community Care providers are responsible to abide by patient safety programs that support VA requirements. TriWest is responsible for the oversight of clinical care provided to our Veterans and will review adverse events, sentinel events, close calls and intentionally unsafe acts. Providers must agree to make their medical records available for review upon request for quality purposes. www.jointcommission.org/Sentinel_Event_Policy_and_Procedures

Submitting Claims

TriWest, on behalf of VA, is the primary and only payer for all claims filed under PC3 and TriWest Certified Provider agreements.

Claims for all regions should be sent to WPS Military and Veterans Health (WPS MVH), TriWest's claims processor.

All services require prior authorization from TriWest to prevent claims denials. Additionally, claims should be submitted within 30 days after services have been rendered. No payment will be made for claims submitted after 120 days. Providers also collect no copays, cost-shares or deductibles from Veterans.

To properly submit claims, follow these steps:

- 1. Submit medical documentation to authorizing VAMC**
- 2. Submit claims to WPS MVH**
 - Send claims electronically through your clearinghouse once you have enrolled for electronic transactions with WPS Health Solutions, the parent company for WPS MVH
 - Call WPS at 1-800-782-2680 (Option #1) or visit <https://edi.wpsic.com/edir/home> to start enrollment
 - Send claims via mail to the address:
WPS MVH – VAPC3
PO Box 7926
Madison, WI 53707-7926

You may check the status of your claims anytime through the TriWest Secure Provider Portal at www.triwest.com/provider. For more information on filing claims, read the [Provider Claims Quick Reference Guide](#).

Medical Documentation Requirements

VA requires that providers submit medical documentation for **all services** directly to their authorizing VAMCs to ensure coordination of care for Veterans. Medical documentation needs to include the initial appointment evaluation and end-of-episode-of-care summary records. Timelines for submitting medical documents are included on [page 19](#).

- Outpatient care: 30 calendar days
- Inpatient care: 30 calendar days

VA has additional timeframe requirements for critical findings and certain specialties. This information is detailed in the [Medical Documentation Quick Reference Guide](#) and on [page 19](#) of this document. On a case-by-case basis authorization letter language or the VAMC may request medical documentation be returned sooner than the timelines above, based on clinical need. A phone call may be required when results or clinical findings necessitate an urgent response.

VA requires providers submit medical documentation to ensure coordination of care for Veterans.

Specialty Provider Guidelines and Additional Documentation

VA has additional documentation guidelines for two types of specialty providers. Those specialties are:

- [Radiation Oncology](#)
- [Gastroenterology](#)

Please click on the respective specialty to read the full details in its corresponding quick reference guide. Both guides can be found under the "Quick Reference Guides" section of the Provider Portal at www.triwest.com/provider.

Reimbursement Methodologies

Reimbursement rates and methodologies are subject to change per VA guidelines. The provider agrees to accept as payment for the services provided the amounts agreed to under the terms set forth in his or her PC3 contract with TriWest or Certified Provider agreement. Furthermore, the provider understands that no payment may be made for services that were not authorized by VA and TriWest.

VA prohibits providers from balance billing Veterans.

The provider acknowledges and agrees that PC3 and Medicare program reimbursement methodologies and amounts may be adjusted periodically and, when effective, will supersede the reimbursement amounts and methodologies set forth in his or her PC3 contract with TriWest, or Certified Provider agreement.

When a given medical procedure is not payable under Medicare rules, or is payable under Medicare rules but does not have established pricing at the national or local level, the provider will be reimbursed using verifiable usual and customary charges.

Health Insurance Portability and Accountability Act (HIPAA) of 1996

VA generally adheres to the U.S. Department of Health and Human Services (HHS) rules implementing administrative simplification, including privacy and security. VA also complies with the 1974 Privacy Act. For more information on VA privacy procedures, please go to www.dtic.mil/whs/directives/corres/pub1.html and www.privacy.va.gov/index.asp.

Complaint Process

If a provider or a Veteran has concerns about the level or quality of services or care received through Community Care programs, he or she has a right to file a complaint with TriWest. TriWest will work with VA to resolve complaints. You may contact TriWest at 1-855-722-2838.

Additional Provider Resources

Below is a list of resources that may be helpful when providing services to Veterans.

TriWest Provider Portal:

www.triwest.com/provider

TriWest Payer Space on Availity:

www.availity.com

VA/DoD Clinical Practice Guidelines:

www.healthquality.va.gov

VA National Formulary:

www.pbm.va.gov/PBM/nationalformulary.asp

WPS Health Solutions:

<https://edi.wpsic.com/edir/home>

Provider Contract Provisions

The following provisions are applicable to services rendered pursuant to authorizations for care under the VA Community Care programs and is incorporated by reference into the Provider's Network Agreement as if fully set forth therein.

Definitions

All defined terms herein have the same meaning as they have in the Provider Network Agreement or Program Terms & Conditions unless otherwise defined below.

1. **Party** – Any individual or entity that is a party or a third-party beneficiary to the Provider Network Agreement.
2. **DME** – Durable Medical Equipment to include any equipment that can withstand repeated use, is primarily and customarily used to serve a medical purpose, generally is not useful to a person in the absence of an illness or injury, and is appropriate for use in the home.
3. **Beneficiary** – Any individual enrolled and authorized to receive care through the TriWest Provider network by any Program incorporated into the Provider Agreement.
4. **Provider** – Any individual or entity providing healthcare services pursuant to an authorization for care issued by TriWest, or who is otherwise subject to the terms and conditions of a Program or this Handbook.

Termination

1. In the event of termination of this Agreement by TriWest or Network Subcontractor pursuant to this section, there shall be no due process procedures available to provider except for those required by State or Federal law, or by the credentialing policies of TriWest or its Network Subcontractor. TriWest and its Network Subcontractor shall have the right to immediately terminate Provider Agreements upon written notice to Provider upon the occurrence of any of the events listed below: Provider's state or federal license or authorization to do business is reduced, restricted, suspended, placed on probation or terminated (either voluntarily or involuntarily), or Provider's other applicable license or accreditation necessary to perform any services contemplated by the Provider's Agreement is reduced, restricted, suspended, placed on probation or terminated (either voluntarily or involuntarily); or
2. Provider's professional liability coverage as required under Provider's Agreement is reduced below required amounts or is no longer in effect; or
3. Provider fails to meet TriWest's or Network Subcontractor's credentialing, re-credentialing, quality management or utilization management criteria, or fails to comply with quality management or utilization management processes; or
4. Provider fails to provide material information or provides erroneous information on Provider's credentialing application or re-credentialing application; or
5. Provider is no longer Medicare-eligible, Medicaid-eligible, or is not eligible to participate in another government program; or
6. Provider or any one of its officers is arrested or indicted on felony charges that directly or indirectly relate to provisions of services under Provider's Agreement, and TriWest and Network Subcontractor makes a reasonable and good faith determination that the nature of the charges are such that termination or necessary to avoid unnecessary risk or harm to Beneficiaries that could occur during the pendency of the criminal proceedings.

Notification

- A. All notices and other communications to a Party must be in writing, hand delivered, delivered by prepaid commercial courier services with tracking capabilities, faxed, or delivered by the U.S. mail to the address listed on the signature page of the Provider's Agreement. The Parties may change the address of record by notifying the other Party of the new address. Notice shall be complete upon the earlier of actual receipt or five (5) days after being deposited into the U.S. mail. Notices and other communications in writing need not be mailed either by registered or certified mail, although a signed return receipt received through the U.S. Post Office shall be conclusive proof between the Parties of delivery of any notice or communication and of the date of such delivery.
- B. Provider shall notify TriWest or Network Subcontractor in writing immediately upon learning of any action, policies, determinations or internal or external developments that may have a direct impact on Provider's ability to perform its obligations under the Provider's Agreement. Such matters shall include, but are not limited to:
 1. Any change in ownership, specialty services provided, Medicare designation (including but not limited to sole community, critical access, etc.) or location of facility(ies);
 2. Action against or lapse of Provider's license, certification, accreditation or certificate of authority;
 3. Loss of hospital privileges;
 4. Arrest or indictment;
 5. Reduction in insurance coverage below the required limits set forth for the applicable Program, or termination of insurance coverage;
 6. Any activity that compromises the confidentiality and security of the medical records of Beneficiaries;
 7. Exclusion or any other penalty from Medicare, Medicaid, or any other federal health care program.

Provider Directory

TriWest may periodically include Provider's name, gender, work address, work fax number, work telephone number, whether the Provider is accepting new patients, specialty and sub-specialty and willingness to accept Beneficiaries in a directory of Network Providers. Provider is responsible for notifying TriWest or Network Subcontractor of any changes of address, phone or fax number, or specialty services rendered within ten (10) business days.

Electronic Communications

Provider shall provide TriWest with a valid email address and receive communication from TriWest via email. To the extent practicable, Provider shall use electronic methods (e.g. email, secure website, etc.) in performing transactions for the VA programs.

Compliance

Provider shall comply with all applicable state and federal laws as well as regulations and all rules, policies and procedures of the applicable program including without limitation to credentialing, peer review, referrals, utilization review/management, clinical practice guidelines, case management and quality assurance programs and procedures established by TriWest or the applicable health care program including submission of information concerning Provider and compliance with Preauthorization requirements, care approvals, pharmacy, dental and DME utilization requirements, care approvals, concurrent reviews, retrospective reviews, discharge planning for inpatient admissions, critical event notifications, quality of care audits, return of medical records and Prior Authorization of referrals.

VA-Specific Requirements for Certain Services and Professionals – Applicable to the PC3 Program

- A. Office-based Diagnostic and Therapeutic Tests and Procedures – tests and procedures must be performed in a safe manner by qualified physicians within their scope of practice; which includes ensuring that physicians are appropriately trained and proficient in performing the procedures.
- B. Vision Rehab and Education Professionals – providers of blind or low vision rehabilitation must be certified by the Academy for Certification of Vision Rehabilitation & Education Professionals (ACVREP).
- C. Radiology Practice (all types) Radiology Technologists
 - i. Certified by the American Registry of Radiologic Technologists (AART)
 - ii. Mammography technologists must have advanced AART certification in Mammography.
- D. Sedation – ensures that processes using sedation during a procedure conform to the requirements in Medicare Conditions of Participation for medical centers or ambulatory surgical centers.
- E. Evidence-based Psychotherapies (EBP) – providers of EBP shall have received specialized training and experience in the EBP.
- F. Facilities performing cardiac surgery shall report to the Society for Thoracic Surgery (STS) National Adult Cardiac

- Surgery Database and annually submit the Executive Summary in .PDF format to TriWest.
- G. Facilities performing cardiac catheterizations and/or percutaneous coronary interventions shall participate in the National Cardiovascular Data Registry (NCDR) Cath PCI Registry and annually submit the Executive Summary in .PDF format to TriWest.
- H. Facilities implanting cardioverter defibrillators (ICDs) shall participate in the NCDR ICD Registry and annually submit the Executive Summary to TriWest.
- I. Primary care includes, but is not limited to, medical diagnosis and medically necessary treatment provided, predicated on evidence-based principles of care (Reference: VA/DoD Clinical Practice Guidelines & US Preventative Services Taskforce <http://www.healthquality.va.gov/index.asp>). Primary care is directed toward health promotion and disease prevention, including the management of acute and chronic medical conditions. Primary care providers must coordinate, through TriWest, for any additional care needed using established points of contact (POC) and processes. Ancillary services such as labs, radiology, pathology that are not included in the primary care authorization and cannot be performed within the providers' office setting also must be coordinated with TriWest to ensure the use of TriWest network providers, or VA facilities. Diagnostic and treatment services that were not previously authorized such as MRI, CT, or any procedure that requires conscious sedation, must be preauthorized by TriWest.
- J. A primary care visit shall consist of an appropriate face-to-face office visit and should include history of present illness, system review, and a physical exam appropriate for the patient's complaint(s), clinical assessment, diagnosis, and treatment. Provider shall provide access to routine diagnostic tests include Complete Blood Count, Urinalysis, routine chemistry tests, Partial Thromboplastin Time, Prothrombin Time/International Normalized Ratio, standard 12-lead electrocardiogram, and Fecal Occult Blood Test. Routine diagnostic radiology includes chest x-ray (Antero Posterior/Lateral) and extremity, abdomen, spine, bones and joints. These and other diagnostic tests shall be conducted when determined medically appropriate for patient care, such as when requested to support VA's clinical quality performance measure guidelines. The Provider shall provide preventive services to include gender appropriate adult health screenings and counseling as recommended by the U.S. Preventative Services Task Force and other VA quality performance standards (VA/DoD Clinical Practice Guidelines–<http://www.healthquality.va.gov/index.asp>). This includes smoking cessation counseling, routine vaccinations (e.g. pneumococcal and influenza vaccinations), screening mammography, cervical cancer screening, colon cancer screening, screening for mood disorders, substance abuse, etc. as clinically appropriate. Screening mammography shall only be provided to participants by the Provider if authorized by VA. Additionally, offering continual education to patients about diseases, medications, and healthy lifestyles is required. The Provider shall ensure Veterans appointments are conducted by an appropriately certified Medical Doctor (MD), Nurse Practitioner (NP), Doctor of Osteopathy (DO), or Physician Assistant (PA) licensed and working within the scope of their practice and licensed within the state where the services are rendered. TriWest will ensure that Providers have effective on-call coverage.
- K. Provider is responsible for performing the required services and documenting that performance. The Provider shall submit documentation for the initial episode and after the final visit that summarizes the episode of care. Interim progress notes may be requested for specific specialties or when additional care is being requested for authorization by VA. These progress notes shall include scheduled encounter date and time, time patient was seen, current problem list, medication reconciliation, and recommended follow on treatments, if any.
- The medical documentation content should be commensurate with elements of medical practice documentation standards and accurately/completely reflect the care rendered. Timing and frequency of all patient care shall be based on patient needs.

Insurance Requirements

Provider shall provide and maintain policies of general and professional liability (malpractice) coverage to insure Provider and each employee or agent of Provider against any claim for damages arising by reason of personal injury or death resulting directly or indirectly from the performance under the Program. Such coverage shall be subject to the approval of TriWest or Network Subcontractor (where applicable) and be in an amount not less than either (1) the amount required by the law of the state where Provider practices, (2) the amount required by the Provider's participation in a state liability pool/fund, or (3) in the absence of applicable state law or state pool/fund, the community standard for such coverage; but in no case shall such coverage be less than One Hundred Thousand Dollars (\$100,000) per occurrence and Three Hundred Thousand Dollars (\$300,000) aggregate. Provider shall provide TriWest or its Network Subcontractor (where applicable) with a certificate of such coverage upon execution of this Agreement and shall provide TriWest or its Network Subcontractor thirty (30) days' prior notice of any change in coverage or termination of expiration of coverage. If coverage is on a claims-made basis, Provider shall ensure employed physicians have proof of tail insurance satisfactory to TriWest or Network Subcontractor upon any termination of coverage and containing an extended reporting endorsement for a period of not less than three (3) years after the termination of this Agreement.

Pharmacy/Prescribing Guidelines – Applicable to the VA Community Care Programs

VA prohibits Providers from dispensing pharmaceutical samples to Veterans. Prescribing Providers must be registered with their own state's prescription monitoring program, and must check with the state prescription monitoring program for any controlled substance utilization prior to writing any controlled substance prescription for a Veteran, and avoid any inappropriate opioid/controlled substance use. All routine or maintenance prescriptions must be fulfilled by the VA, and Provider shall transmit such prescriptions to VA for fulfillment.

Medical Documentation Guidelines – Applicable to the VA Community Care Programs

General medical documentation, including outpatient and inpatient care, recording the delivery of authorized Covered Services shall be submitted to the authorizing VA Medical Center (VAMC) within the 30-day timeframes required by the programs.

Medical Documentation Content Requirements

VA requires general medical documentation include the initial appointment and end-of-episode-of-care records. Some specialties may have additional documentation requirements.

Minimum requirements for content of medical documentation or records, as applicable to the care, may include:

- An executive summary of the encounter to include any procedures performed and recommendations for further testing or follow-up (i.e. discharge summary for inpatient);
- Results of community testing or imaging such as MRI, CT scan;
- Actual results of any ancillary studies/procedures which would impact recommended follow-up such as biopsy results (i.e. positive biopsy results from EoC GI provider who recommends a follow up such as surgery); and
- Any recommended prescriptions and treatment plans.

Providers must submit all records to the authorizing VAMC. To be compliant, records should include the following four identifiers at a minimum:

- Veteran's name
- Gender
- Date of birth
- Last four digits of Social Security number



Specific Medical Documentation Submission Timelines and Deadlines

Service	VA Submission Requirements
Inpatient (includes surgery)	<ul style="list-style-type: none"> • 30 calendar days after discharge • Discharge summary related to the episode of care • For surgery, also complete and submit the VA Purchased Surgical Care Patient Outcome Form to TriWest
Inpatient Rehabilitation	<ul style="list-style-type: none"> • Within 30 calendar days after discharge • Include functional status and status change from onset of treatment through discharge • Use the Centers for Medicare and Medicaid Services' (CMS) Inpatient Rehabilitation Facility Patient Assessment Instrument (IRF-PAI)
Outpatient Specialty Services (includes surgery)	<ul style="list-style-type: none"> • 30 calendar days after the initial appointment • If additional appointments are authorized, submit to authorizing VAMC within 30 days upon completion of episode of care • For surgery, also complete and submit the VA Purchased Surgical Care Patient Outcome Form to authorizing VAMC • If additional visits or procedures are required, please use the Secondary Authorization Request/Request for Services (SAR/RFS) Form
Critical Findings Category	<ul style="list-style-type: none"> • Definition: a test result or interpretation that, if left untreated, could be life threatening or place the Veteran at serious health risk; includes results from laboratory, cardiology, radiology and other diagnostic areas are determined to be "critical," regardless of ordering priority • Within 24 hours of identification, reach point of contact (POC) at authorizing VAMC by phone • Indicate the VAMC staff name POC and date/time of contact in your discharge summary • Submit medical documentation to authorizing VAMC as soon as possible, but no later than 30 days. Providers must comply with VA request for earlier upload in order to expedite care.
Suicide Risk <i>*Critical Finding</i>	<ul style="list-style-type: none"> • Within 24 hours by phone to authorizing VAMC POC • A newly identified suicide risk in a Veteran not referred for inpatient mental health should be considered a Critical Finding
Cancer Diagnosis <i>*Critical Finding</i>	<ul style="list-style-type: none"> • Within 48 hours by phone to authorizing VAMC POC • A new diagnosis of cancer should be considered a Critical Finding
Urgent Follow-Up/Additional Care	<ul style="list-style-type: none"> • Within 24 hours by phone to authorizing VAMC POC • If provider determines urgent follow-up is needed after completion of care, OR urgent additional care needed during episode of care.
Pathology	<ul style="list-style-type: none"> • Within 5 business days of request for slides • These are made available to VA for review/assessment
Gastroenterology Procedures	<p>Gastroenterology procedures must include the following (as appropriate):</p> <ul style="list-style-type: none"> • Type of procedure performed (e.g., colonoscopy with biopsy) • Procedural indication • Sedation medications and doses • Description of the quality of the bowel preparation (for colonoscopy or sigmoidoscopy) • Depth of insertion of the endoscope/completeness of the procedure <ul style="list-style-type: none"> • If the procedure is incomplete, an explanation must be provided • Description of all relevant findings, e.g., number and size of polyps, colitis, stricture, etc. • Full description of all interventions • If polypectomy is performed, indicate whether or not the lesion was completely removed • Description of any unanticipated events or adverse events • If specimens were removed for pathologic assessment, include a copy of pathology results • Summary assessment and recommended follow-up with final recommendations taking pathology results into account

Service	VA Submission Requirements
Medical/ Radiation Oncology Services	<ul style="list-style-type: none"> Weekly treatment management progress notes to be included in the final submission/end of treatment documentation. This includes a synopsis of findings observed during weekly treatment management visits. Side effects of treatment and care recommendations related to side effects Medical management required during treatment Description of any required breaks in therapy Height, weight and performance status using either Eastern Cooperative Oncology Group (ECOG) or Karnofsky rating scales Specific oncologic diagnosis and stage Documentation of: <ul style="list-style-type: none"> Therapy details – including: begin and end dates of treatment, treatment modality/ energy, dose per fraction and number of fractions, immobilization required for treatment, combined chemotherapy, chemotherapy schedule Names of all administered drugs, specific date(s) administered, dose (both regimen and total) and route (including any ancillary drugs, such as anti-emetics or drugs to suppress other adverse events) Any dose adjustments or delays, including the reason Tumor response to any anti-cancer treatment using standard response assessment scale as well as the results of any exam, image or test used to assess response Adverse events Any discussions of patient at a tumor board along with a summary of board recommendations
Skilled Home Health Care	<ul style="list-style-type: none"> Within 3 business days of start of care: submit initial assessment (OASIS) Within 5 business days of completion of episode of care: submit final discharge summary to TriWest Please review the Home Health Quick Reference Guide for additional details
Inpatient Rehabilitation	<ul style="list-style-type: none"> Within 30 calendar days after discharge Include functional status and status change from onset of treatment through discharge Use the Centers for Medicare and Medicaid Services' (CMS) Inpatient Rehabilitation Facility Patient Assessment Instrument (IRF-PAI)
Inpatient Mental Health	<ul style="list-style-type: none"> 30 calendar days after discharge If suicide risk is a clinical issue, the Veteran shall be provided a written copy of their personal Suicide Prevention Safety Plan Please reference VA's planning manual: http://www.mentalhealth.va.gov/docs/VA_Safety_planning_manual.pdf The plan must include the Veterans Crisis Line telephone number, 1-800-273-8255
Outpatient Mental and Behavioral Health	<ul style="list-style-type: none"> Behavioral Health Forms to speed submission are available online for both VCP and PC3 referrals As soon as possible, but no less than 30 days from the session, an Initial Assessment and a Completion of Episode of Care should be submitted If an extension or addition to authorized care/therapy is required, fax a Behavioral Health SAR/RFS as soon as possible With additional authorized care, VA may require ongoing Progress Summaries Providers should never submit psychotherapy process notes with contents of a private session Providers should submit Clinical Progress notes. These are considered part of the Veterans medical record For additional documentation requirements, please read the Mental Health Quick Reference Guide
Home Infusion Therapy (HIT)	<ul style="list-style-type: none"> An initial plan of care (CMS 485) should be submitted within three business days An end EOC record should be submitted within five business days Infusion therapy requires nursing notes and delivery tickets that support all services and medications billed Please refer to the Home Health Quick Reference Guide for additional information

Claims Submission Rules and Procedures – Applicable to VA Community Care Programs

The following guidelines are necessary in order to submit claims electronically to TriWest via WPS Military and Veterans Health (WPS MVH):

1. In transmitting EDI, Provider will transmit such claims edited and formatted according to the specifications indicated within the most current Provider User Guide or the ANSI X12 837 Implementation Guide and EDI Companion Guide supplied by WPS Health Solutions, the parent company for WPS MVH. Provider understands the WPS Health Solutions Provider User and EDI Companion Guide are proprietary and are authorized for use only by Provider and its employees working on behalf to transmit such EDI and that any other use or distribution of the WPS Health Solutions Provider User Guide or EDI Companion Guide is strictly prohibited without the express written consent of WPS Health Solutions. WPS Health Solutions shall be the final authority in resolving any disputes about how electronic data shall be submitted.
2. Provider agrees that all claims submitted via EDI, for all legal and other purpose, will be considered signed by the Provider or Provider's authorized representative.
3. Provider agrees to maintain a patient signature file. Provider understands WPS MVH may validate through file audits, those claims submitted via EDI which are included in any quality control or sampling method required by WPS MVH. Provider understands if no signed authorization is on file, an authorization must be obtained by the Provider from the patient prior to EDI submission to WPS MVH.
4. Provider acknowledges that WPS MVH and Network Subcontractor shall have no obligation with respect to the content of the information in claims either to verify, check or otherwise inspect the information supplied by the health care provider, except to reformat the claim data to the specification required by TriWest. Provider further acknowledges that TriWest will determine whether Provider has submitted enough information in the EDI claims in order to determine the completeness, accuracy and validity of the information and claims and that source documents for claims data the responsibility of the Provider.



Acronyms

CCN – Community Care Network

CoP – Medicare Conditions of Participation

CPGs – Clinical Practice Guidelines

CPT – Current Procedural Terminology

CQM – Clinical Quality Management

DME – Durable Medical Equipment

DMEPOS – Durable Medical Equipment, Prosthetics, Orthotics, and Supplies

DoD – Department of Defense

DRG – Diagnosis-Related Group

EDI – Electronic Data Interchange

EFT – Electronic Funds Transfer

EOB – Explanation of Benefits

ER – Emergency Room

ERA – Electronic Remittance Advice

FL – Form Locator

HCPCS – Healthcare Common Procedure Coding System

HHA – Home Health Agency

HHS – U.S. Department of Health and Human Services

ICD – Implantable Cardioverter Defibrillators

ID – Identification

IDME – Indirect Medical Education

IVR – Interactive Voice Response

MD – Medical Doctor

MRI – Magnetic Resonance Imaging

NDC – National Drug Code

NCDR – National Cardiovascular Data Registry

NP – Nurse Practitioner

NPI – National Provider Identifier

OPPS – Outpatient Prospective Payment System

PA – Physician Assistant

PCS – Primary Care Services

PC3 or PCCC – Patient-Centered Community Care Program

PDTS – Pharmacy Data Transaction Service

PPS – Prospective Payment System

SSN – Social Security Number

TIN – Tax Identification Number

UAC – Usual and Customary

VA – Department of Veterans Affairs

VACAA – Veterans Access, Choice and Accountability Act of 2014

VAMC – Veterans Affairs Medical Center

VCP – Veterans Choice Program

VHA – Veterans Health Administration

VANF – VA National Formulary

WPS MVH – WPS Military and Veterans Health

If you have any questions regarding this information, please contact TriWest using the Provider Customer Service contact listed below.

**Department of Veterans Affairs (VA)
Community Care Programs**

1-855-PCCCVET (1-855-722-2838)



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