Non-SEOC Authorization Letters
Quick Reference Guide

Key Points:

- After scheduling an appointment, TriWest Healthcare Alliance confirms the authorization in our system.
- A VA consult form is available, as a download, from TriWest’s secure portal the same day as the appointment is scheduled.
- The authorization letter, inclusive of VA consult details, will be available for download five (5) days prior to the Veteran’s appointment. TriWest can also submit the authorization, five (5) days prior to the Veteran’s appointment, via fax.
- The authorization letter will be similar for an episode-of-care through the Patient-Centered Community Care Program (PC3) or the Veterans Choice Program (VCP).
- Authorizations are now inclusive of all appropriate CMS CPT or Level I HCPCS service codes. If a code is paid for by Medicare and aligns with recognized medical practice, it is covered with rare exceptions.
- Routine lab testing and/or X-ray services, when medically necessary, are included in all authorizations, whether conducted in the provider’s office or by a third-party.
- A servicing provider, along with the facility or ambulatory surgery center which is used to perform the approved services, is also considered covered.
- For complex authorization questions: Please call 1-855-722-2838, Option 3, Option 1

As of late 2017, VA began transferring many of its referrals to a new, “Standardized Episode of Care” (SEOC) format. The format change is reflected in a new SEOC authorization letter format. This Quick Reference Guide is referring only to non-SEOCs. Please review our SEOC Quick Reference Guide for guidance on how to read and interpret your SEOC authorization.

Do You Have an SEOC Authorization?

Not all authorizations have converted to an SEOC format yet. Below is an example of an SEOC authorization versus a non-SEOC authorization. Please note that this guide is for non-SEOC authorizations only.
The Non-SEOC Authorization “Face Sheet” Information

Your authorization letter contains the information you need to provide care and is available as a fax or download from the portal. Below is an example from an SEOC mammography letter. Much like standing orders, SEOCs are a templated authorization designed to simplify appointing and reduce the need for additional or secondary authorization requests (SAR). Some SEOC authorizations do have limits on the included codes.

Information in the “Face Sheet” portion includes:

- The provider’s information including name, specialty, and national provider identifier (NPI)
- The Veteran’s name, date of birth and last four digits of the social security number (SSN)
- The authorization information including:
  - Authorization number
  - The approved date range that covers the full episode-of-care, listed under the “valid dates” section. If a provider needs to extend the authorized date range, they should submit a SAR form to TriWest.
- VA Medical Center (VAMC) that is managing the care for the Veteran.

“Face Sheet” Section

![Example Face Sheet]

The "Clinical Information" Language

The clinical section of a letter details the specific services for this episode of care. Please refer to any additional medical documents provided by VA for complete details beyond this information. Included in this section are:

- Procedure description: This is a description of authorized care. This section may include the “All Appropriate Medicare Covered Services” statement.
- Quantity and Type: If defined, this section details the number of visits or units available under this authorization. The “quantity” field indicates how many and the “type” field identifies if the authorization is approved for visits or units during the authorized time. For example, the physical therapy SEOC allows for 14 visits over 90 days.
  - If a quantity/duration is defined and provider determines additional visits/time are needed, submit a SAR.
  - If quantity is not defined, this defaults to standard practices with medical need/usage supported by provider’s medical documentation.
- Appointment information: This shows the date/time initially set with the Veteran. If this changes, please update the information via TriWest’s Provider Portal.
What Does “All Appropriate Medicare Covered Services” Mean?

TriWest and VA are using Medicare guidelines to help reduce utilization review. If an authorization references “all appropriate Medicare covered services,” TriWest is including any codes related to that specialty that are covered by Medicare, even if the exact CPT code is not listed in the authorization.

- This new approach will shift determination of additional medically appropriate services to the provider.
- Reduced routine utilization management will allow VA to focus on urgent, emergent and non-standard care requests.
- Billed codes must follow recognized practice standards and align with the condition diagnosed for each specific episode of care.

Remember...

- All routine lab testing and/or X-ray services, when medically necessary, are included in all 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 authorization, instruct its staff to bill TriWest and not to bill the Veteran.
- A servicing provider, along with the facility or ambulatory surgery center which is used to perform the approved services, is also considered covered and should bill using this authorization number. For a PC3 referral, the provider must be part of the PC3 network.
- TriWest appoints based on NPI, however all claims, portal access and contracting is based on the tax identification number (TIN).
- Authorized HCPCS codes are limited to Level I service HPCS. Level II HCPCS for durable medical equipment (DME), medical supplies and other equipment are not considered pre-authorized. Please refer to the DME Quick Reference Guide for more details.
- VA Consult forms (10-0386 and 10-7079) have details related to each episode of care along with any care exclusion language. These are included with your authorization and should guide care decisions.