

CCN Home Health Care

Quick Reference Guide

Key Points

- Under the Department of Veterans Affairs (VA) Community Care Network (CCN), skilled home health care includes: skilled bundled, skilled unbundled, and skilled expanded.
- Providers should only bill Current Procedural Terminology (CPT) codes approved in their Standardized Episode of Care (SEOC).
- Reimbursement for services rendered cannot exceed the number of units authorized by the approved SEOC. If a provider requires additional units, they must request a new referral from VA.
- Claims for bundled services must have a bundled VA referral. Bundled services submitted with an unbundled services VA referral number will be rejected.
- Claims for bundled services must be submitted on a CMS UB04, using Type of Bill (TOB) 32X.
- Unbundled services must be submitted on a CMS UB04, using TOB 34X or CMS-1500 using place of service 12.

Skilled Home Health Care

CCN includes skilled bundled, skilled unbundled, and skilled expanded home health care.

- **Skilled bundled:** This type of care will be reimbursed via the Medicare Patient-Driven Groupings Model (PDGM), episodic method, as stated in the SEOC **approved referral/authorization letter**. Skilled bundled services follow a plan of treatment and should be billed appropriately on CMS UB04, using TOB 32X. Skilled bundled home health services can be billed in 30 day episodes of care. RAP claims are no longer required to be billed as of 2022 dates of service. Only bundled services should be submitted with a VA referral for bundled care.
- **Skilled unbundled:** This type of care will be reimbursed on a fee-for-service basis as VA issues orders regarding services and visits. Unbundled services are not under a plan of treatment and are not paid using CMS PDGM methodology. Providers can bill per hour or per 15-minute increments, using the appropriate procedure codes. Unbundled services can be billed on a CMS 1500 form, with Place of Service 12, or on a CMS UB04 form. Unbundled services claims billed on a UB04, must be billed with TOB 34X.
- **Skilled expanded:** This is skilled private duty nursing for highly dependent Veterans. Services do not follow a plan of treatment and will be reimbursed on a fee-for-service basis as VA issues orders regarding services and visits/hours. Providers can bill per hour or per 15-minute increments, using the appropriate procedure codes. Services can be billed on a CMS 1500 form or UB-04 form, using TOB 34X.



Homemaker/Home Health Aide and In-home Respite Care

This care is included in the CCN Healthcare Benefit which includes help with daily activities such as bathing, grooming, meal preparation and household tasks. These services enable independence and safety for Veterans in their home setting.

- This care can only be authorized by VA. The appropriate SEOC will be selected by VA based upon the Veteran's needs. Each SEOC will indicate the number of hours authorized each week, and duration in which care may be rendered.
- The specific type and quantity of services that have been requested by the VA physician is identified in the VA documentation, which the providing agency should use as guidance when rendering care.
 - For example, the SEOC may approve up to 20 hours per week, but the VA physician only ordered 10 hours per week. In this case, the agency should only provide the number of 10 hours of care, per week that were ordered, even though the SEOC approves more.

Quick Billing Information:

- This care is billed on a CMS 1500 and can be billed in 15-minute or one-hour increments.
- Medicare does not currently cover these services, but many codes have VA fee schedule rates associated with them.
 - If multiple services are provided on the same day, the provider must follow the guidelines below:
 - All charges for the same date must be billed on the same claim.
 - Provider must also include Time of Day modifiers below or modifier 76 to distinguish services.
 - UF – Services performed in the morning
 - UG – Services performed in the afternoon
 - UH – Services performed in the evening
 - UJ – Services provided in the night
 - Please see below if billing modifier 76 for 3 or more services on same date of service:
 - Correct Claim example:
 - 1/1/23 to 1/1/23, G0156, 3 units
 - Incorrect Claim example:
 - 1/1/23 to 1/1/23, G0156, 1 unit
 - 1/1/23 to 1/1/23, G0156, modifier 76, 1 unit
 - 1/1/23 to 1/1/23, G0156, modifier 76, 1 unit

Bundled Home Health Billing and Documentation

Once an HHA has been contacted (via phone or written approved referral/authorization letter), VA has initiated transfer of the Veteran's care to TriWest's administration under CCN.

With transition to CCN:

- Begin following CMS' PDGM reimbursement model immediately (skilled bundled only). TriWest is required to mirror the (PDGM) reimbursement model established by CMS.
- Create a plan of care from the OASIS assessment and submit it to the authorizing VAMC.
 - Within three business days from the start of care, submit the initial plan of care on a CMS 485 form which should be signed by the clinician that performed the initial evaluation (e.g., a registered nurse, physical therapist, occupational therapist, physician's assistant, or a physician).
 - It is not necessary to wait until the ordering clinician signs the plan. Promptly submitting the plan of care to VA will ensure that the VA physician's signature is expedited.



- Within five business days of completing care, submit an end of the EOC record (a.k.a., discharge summary) to the VAMC.
- TriWest follows Medicare's reimbursement methodology.
 - Veterans admitted to home health services under a TriWest referral/authorization are not required to meet Medicare's skilled nursing criteria. This exception is also applicable under Medicare's PDGM.
 - There is no requirement for homebound status, face-to-face documentation, skilled need certification, or the Medicare Provider and Supplier enrollment (this is the Provider, Enrollment, Chain and Ownership System, a.k.a. PECOS, enrollment) by the ordering physician.
 - Medicare does not pay for services or equipment after the beneficiary's death. Coverage under a VA CCN SEOC is for the Veteran, once they pass the care/auth ends.
- If the agency needs more information from the VA physician to complete the assessment and case mix, the agency must contact the VA physician or someone in the local VAMC's Office of Community care.
- OASIS assessment details reveal a HIPPS code required for billing. If the HIPPS code is not included on the claim, the claim will be denied.
- At the end of the episode of care, submit final claim on a UB-04 or electronic equivalent according to Medicare PDGM guidelines using the Type of Bill Code 329.
- If a home health claim needs to be cancelled, you must submit a claim with a Type of Bill Code 328.
- In compliance with Medicare policy, claims must contain the code for the county of service. Submit value code "85" with the state and county code of the place of residence where the home health service was delivered in the amount field.
- CCN has a 180-day claims timely filing limit. Please ensure your claims are submitted within this timeframe. TriWest recommends submitting claims within 30 days of service.
- Submit claims via EDI to PGBA using Payer ID: TWVACCN (note: Payer ID may vary depending on the clearinghouse.)
- The appropriate Veteran ID and VA referral numbers must be submitted on all claims. Do not use special characters, dashes, or spaces in these fields.