Using This Provider Handbook

This Provider Handbook provides you and your staff with basic, important information about the PC3 and VCP 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.
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Patient-Centered Community Care (PC3)

PC3 is a program that was 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). The VCP was developed to better meet the health care needs of our nation’s Veterans in light of VA wait times that were too long or situations where VA medical facilities were too far from a Veteran’s home. The VCP works to address those issues. VCP is not an addition to PC3. It provides eligible Veterans with access to primary care, inpatient and outpatient specialty services, and behavioral health care.

With the VCP, Veterans can seek care from private-sector providers if:

- They face wait times longer than 30 days for care from VA;
- The closest VA medical facility with a primary care provider is greater than 40 miles from their home; or
- The closest VA Medical Center is not easily accessible from their home, due to geographic barriers (mountains, large body of water, etc.)
- The VA Medical Center does not offer the needed service

Veterans enrolled for care with VA may be eligible to receive a Veterans Choice Card. **However, Veterans must still call the number on the back of their Choice Card to confirm eligibility with VA in order to use the VCP benefits.** The VCP was developed to be a choice for Veterans; it allows an eligible Veteran to choose to receive care from a provider outside of TriWest’s PC3 network. TriWest must still verify the provider is willing to accept the terms and conditions of the VCP and meets the licensing requirements before authorizing care.

To join TriWest’s provider network, please visit: [https://joinournetwork.triwest.com](https://joinournetwork.triwest.com).

Sample VCP Choice Card

**Front of Card**

**Name:** JOHN SAMPLE  
**Member ID:** 1234567890  
**Date of Issuance:** November 2014

Call 1-866-606-8198 for information or to make an appointment

*This card does not provide pre-approval. Veterans may be liable for the cost of care that is not pre-approved.*

**Back of Card**

**Veterans Choice Program Information**

(For Veterans and Providers):


This card is for qualifying medical care outside the Department of Veterans Affairs. Please call 1-866-606-8198 to ensure that treatment has been authorized.

**Providers submit Claims to:**

WPS - VAPC3  
PO Box 7926  
Madison, WI 53707-7926

**Policy Resources**

The statutes governing the PC3 and VCP 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.
Regions
In the United States, the PC3 and VCP are divided into six separate regions.

- **Region Two** – Alabama, Delaware, District of Columbia, Florida, Georgia, Maryland, North Carolina, South Carolina, and Virginia.
- **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).
- **Region Four** – Colorado, Indiana, Illinois, Iowa, Michigan, Minnesota, Montana, Nebraska, North Dakota, Ohio, South Dakota, Utah, Wisconsin and Wyoming.
- **Region Six** – Alaska.

Your Contractor
TriWest Healthcare Alliance (TriWest) is responsible for administering the PC3 and VCP in all regions across the country.

Resources: Availity and Provider Portal
For the past several years, the TriWest Provider Portal at [www.triwest.com/provider](http://www.triwest.com/provider) has been available as your one-stop shop for information on filing claims and navigating PC3 and VCP. However, TriWest recently began transitioning its current Provider Portal to a new TriWest Payer Space on Availity at [www.availity.com](http://www.availity.com).

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, submit medical documentation, and, in the coming months, complete other secure tasks online.

To learn more about this transition, and to register for an Availity account, please visit [www.availity.com/triwest](http://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** to help providers learn the health care management process for the PC3 and VCP, 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, upload medical documentation 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 (1-855-722-2838, option 3) to assist providers with routine questions. Follow the greeting and select the applicable touch-tone prompts outlined below to get quick information and accurate answers on many topics:

- Press “1” with authorization questions
- Press “2” for assistance with the current TriWest Provider Portal
- Press “3” for claims questions
- Press “4” for provider contracting

### Program Governance

PC3 and VCP 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 PC3 and VCP programs. Providers must read and understand the contents of this handbook outlining the governing statutes and regulations that provide final guidance for the PC3 and VCP 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.
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 or VCP 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, 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.

Provider Responsibilities

The agreements for providers participating in PC3 or VCP outline the provider responsibilities under these programs. The following are certain provider responsibilities and requirements for both PC3 and VCP:

• 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 the VCP reimbursement rates as the only payment expected from TriWest for Veterans covered under either 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 VCP providers from charging missed appointment fees.
• Provider understands and agrees that all covered services provided to Veterans, except emergency services, must be authorized by VA and TriWest.
• Provider agrees to meet office and appointment access standards (Veteran should be seen within 20 minutes of a scheduled appointment and a Veteran appointment should be scheduled within 30 days of TriWest requesting an appointment with the provider), 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 in the Provider Claims Quick Reference Guide.
• Secondary authorization requests and continued care requests should be submitted by fax to: 1-866-259-0311.
• Provider agrees to submit medical documentation for an authorized episode of care to TriWest within the timelines outlined in the Medical Documentation Quick Reference Guide. Providers agree that when providing covered services to Veterans under PC3 or VCP, 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 10 business days of the request.

• The Provider shall notify TriWest within 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](http://www.fda.gov/Safety/MedWatch/HowToReport/default.htm).

• Provider agrees to submit at least one email address to TriWest for purposes of communicating important PC3 or VCP 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 PC3 and/or VCP requirements.

• Provider agrees to notify his or her local network representative (for PC3 network providers) or TriWest (for VCP 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 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](http://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 VCP providers:** call TriWest at 1-866-284-3743
Appointing and Authorization Process – Regions 3, 5, and 6

If you’re located in Regions 3, 5, or 6, the appointing and authorization process may vary depending on whether the Veteran is participating in the VCP or VA refers the Veteran directly to TriWest via PC3. Either way, TriWest makes the appointment for the Veteran and then faxes an authorization to the provider. The provider must have an authorization on file BEFORE rendering care to ensure payment for services.

TriWest’s goal is to improve clinical coordination by utilizing TriWest’s Patient Service Representatives (PSR) to ensure timely appointments for Veterans.

*Please note that the appointing process is different in Alaska. Visit www.triwest.com/provider-alaska for more information.

If the Veteran is using the VCP as distance eligible (Choice 40 miles): It is the VETERAN’S responsibility to call the number on the back of the Choice Card and confirm eligibility—not the provider’s. Once eligibility is verified, TriWest will schedule an appointment for the Veteran with the provider and send the provider a detailed authorization letter. This should all happen BEFORE the Veteran presents to the provider’s office.

If the Veteran is using the VCP as distance eligible (Choice 40 miles):

- Veteran calls TriWest to confirm VCP eligibility - Choice 40 mile
- OR
- VA sends referral to TriWest (PC3, Choice First, or Choice 30 day)
- PSR locates VCP/PC3 provider
- PSR makes appointment on behalf of Veteran
- TriWest sends authorization to provider via fax
- TriWest sends authorization to provider via fax

To reiterate, authorizations are required for all services and procedures under PC3 and VCP. If providers render care without an authorization, they risk losing reimbursement and may NOT bill the Veteran. Additionally, VA requires medical documentation for all services to ensure coordination of care for Veterans.

Please refer to the Appointment Scheduling Process Quick Reference Guide for more information.
**Appointing and Authorization Process – Regions 1, 2, and 4 (Expansion Area)**

If you are located in Regions 1, 2, or 4, you are part of the TriWest national expansion area. These regions were formerly managed by Health Net Federal Services (HNFS), but are transitioning to TriWest starting in December 2018.

The appointing and authorization process differs in Regions 1, 2, and 4, with two possible appointing pathways.

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**TriWest Pathway**

TriWest contacts you to schedule an appointment

**VAMC Pathway**

Your local VA Medical Center (VAMC) contacts you to schedule an appointment

Regardless of which pathway the appointment comes through, TriWest will always send you an authorization. **The provider must have an authorization on file BEFORE rendering care to ensure payment for services.**

The VA clinical consult information may be included with the faxed authorization letter, available on the secure Provider Portal at [www.triwest.com](http://www.triwest.com), or available on VA’s HSRM online tool.

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**Note: No payment will be made for services not authorized by VA and TriWest.**

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**Access to Care Standards**

The Veterans Health Administration (VHA) has established access to care standards for the PC3 and VCP programs. These standards address appointment availability, 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.

Drive time standards are based on the geographic area and defined as:

- **Urban** – Census Bureau-defined urbanized area, which is any block or block group having a population density of at least 1,000 people per square mile
- **Rural** – Any non-urban or non-highly rural area
- **Highly Rural** – an area having less than 7 civilians per square mile

Appointment Coordinated:

- Within five (5) calendar days of TriWest receiving the referral from VA, or the Veteran calling the number on the back of his or her Choice Card

Office wait time:

- 20 minutes from scheduled appointment

Basic drive time standards:

- **Urban** – within 45 minutes’ commute time
- **Rural** – within 100 minutes’ commute time
- **Highly Rural** – within 180 minutes’ commute time
For Veterans whose condition requires a higher level of care, the following drive-time standards apply:
- **Urban** – within 90 minutes’ commute time
- **Rural** – within 180 minutes’ commute time
- **Highly Rural** – within the community standard commute time

For Primary Care Network Access, the time distance standards are as follows:
- **Urban** – within 30 minutes’ commute time
- **Rural** – within 45 minutes’ commute time
- **Highly Rural** – within 60 minutes’ commute time

For Women’s Health, the standards are as follows:
- **Mammograms** and **Maternity Care** must be accessible within 50 mile distance or 60-minute maximum commute time (whichever is the lesser commute)

**Authorization Letters**
To initiate the appointing and authorization process, VA may send a referral directly to TriWest for a Veteran (PC3/VCP-Choice 30 day wait list or Choice First (services not available at a VA Medical Center (VAMC)), or a Veteran (distance eligible-Choice 40 miles) may call the number on the back of their Choice Card and request to be seen under the VCP.

In both instances, a TriWest PSR will schedule an appointment for the Veteran and then generate a detailed authorization letter to the provider via fax.

The authorization letter will identity whether the approved care is for PC3 or VCP (also called Choice), 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.*

**Secondary Authorization Requests (SAR)**
A provider who believes additional or continued care beyond what was initially authorized is required should visit the Secondary Authorization Request (SAR) Decision Tool on the TriWest Provider Portal at www.triwest.com/provider-SAR. Use the tool to determine whether a SAR is necessary. If so, complete the SAR form (the tool will link to it) and include notes, discharge plans and justification for the request for additional services. Fax all materials, including the completed SAR form, to TriWest at 1-866-259-0311.

**Routine, Urgent, Emergent – Determining Your SAR’s Level**
VA assesses SARs based on clinical need and priority; this allows Veterans who urgently need care to have their review process escalated. There are three clinical priority levels for a SAR – Routine, Urgent and Emergent.

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

**URGENT:** Only mark a SAR 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.

**EMERGENT:** 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 SAR immediately, indicating that the care is being rendered emergently.
- Emergent SARs 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 VA Medical Center. 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 SAR form and submit it to TriWest to obtain approval from VA. All transitions of care need to be approved by the authorizing VA Medical Center. TriWest will coordinate with the authorizing VA Medical Center 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 VA Medical Center 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 VA Medical Center 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 by ambulance, a copy of the trip report should be provided, if possible

VA health care staff will determine the Veteran’s eligibility and retroactively authorize care.

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
Urgent care is defined as care considered essential to evaluate and stabilize conditions that may result in loss of life, limb or vision; or care that, if not provided, will likely result in unacceptable morbidity/pain when there is significant delay in evaluation or treatment.

Authorizations containing the notation of “urgent” require TriWest to schedule the Veteran for care to a provider within 48 hours. If a Veteran needs urgent care and wants to use the VCP, he or she must call the number on the back of the Choice Card to make an appointment.

Regarding medical documentation, providers will be informed if VA specifies the need for an oral report in addition to the written report. All contacts to VA should be notated within the returned medical documentation.

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 VA Medical Center 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 during the authorized episode of care

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 VA Medical Center. 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 urgent/emergent 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 urgent/emergent 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 VA Medical Center and request a Formulary Review Request Form. The provider should fill out the form and return it to the authorizing VA Medical Center 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 PC3 or VCP programs. Veterans must be referred back to their respective Non-VA Care Office for the administration and coordination of non-VA care authorizations for care concomitant 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:
  • Write your prescription/order prescription for the required, routine DME.
  • Send your routine DME prescription 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 PC3 and VCP. 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 PC3 and VCP 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 and Medical Documentation**
TriWest, on behalf of VA, is the primary and only payer for all claims filed under PC3 and TriWest Choice provider agreements. VA also requires that providers submit medical documentation to TriWest for all services to ensure coordination of care for Veterans.

Medical documentation should be sent to:
- TriWest for Regions 3, 5, and 6
- The provider’s authorizing VAMC for Regions 1, 2, and 4 (expansion area)

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 180 days. Providers also collect no copays, cost-shares or deductibles from Veterans.

To properly submit claims, follow these steps:

1. **Upload medical documentation to TriWest Provider Portal at** [www.triwest.com/provider](http://www.triwest.com/provider), **or submit to the VAMC, depending on your region**
   - If submitting to TriWest and unable to access the Provider Portal, fax the medical documentation to TriWest at 1-866-259-0311

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](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](http://www.triwest.com/provider). For more information on filing claims, read the **Provider Claims Quick Reference Guide**.

**Medical Documentation Requirements**
As stated before, medical documentation is required for **all services** provided to a Veteran to ensure coordination of care. VA requires medical documentation 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
- Urgent care: 2 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 18 of this document. On a case-by-case basis an authorization or VA 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 all medical documentation to ensure coordination of care for Veterans.

For more details on medical documentation requirements in non-expansion areas (Regions 3, 5, and 6), such as the type of information to include, read the Medical Documentation Quick Reference Guide.

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 VCP agreement. Furthermore, the provider understands that no payment may be made for services that were not authorized by VA and TriWest.

The provider acknowledges and agrees that PC3, VCP 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 VCP 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.

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 network 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 PC3 or VCP, 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


WPS Health Solutions: https://edi.wpsic.com/edir/home

VA prohibits providers from balance billing Veterans.
Provider Contract Provisions

The following provisions are applicable to services rendered pursuant to authorizations for care under the VA PC3 and VCP 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.

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. 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.

G. 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.

H. 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 – Applicable to the PC3 Program**

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.

**Medical Documentation Guidelines – Applicable to the VCP and PC3 Program**

General medical documentation, including outpatient and inpatient care, recording the delivery of authorized Covered Services shall be submitted to TriWest within the 30-day timeframes required by the programs. 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.

**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 TriWest for upload to the authorizing VA Medical Center (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
Provider Portal “Types” of Medical Document Definitions

Providers submitting medical documents through the TriWest Provider Portal for a VCP authorization must select the “type” of document they are submitting from a drop-down menu. Below, you will find a chart of the “types” of medical documentation you can choose from, and how to determine what constitutes each “type” of document. Again, this is for VCP authorizations only:

<table>
<thead>
<tr>
<th>Document Type</th>
<th>Setting</th>
<th>When the document is</th>
</tr>
</thead>
<tbody>
<tr>
<td>Initial Outpatient</td>
<td>Outpatient/Office</td>
<td>Chart notes or a report from the very first visit of the authorization date range.</td>
</tr>
<tr>
<td>Final Outpatient</td>
<td>Outpatient/Office</td>
<td>Chart notes or a report from the very last visit of the authorization date range.</td>
</tr>
<tr>
<td>Initial and Final (Outpatient)</td>
<td>Outpatient/Office</td>
<td>Chart notes or report for care that will be only one date of service. “One and done”</td>
</tr>
<tr>
<td>Inpatient Discharge Summary</td>
<td>Inpatient Only</td>
<td>The discharge summary from an inpatient hospital stay; including associated lab, imaging and pathology reports.</td>
</tr>
<tr>
<td>Lab Reports</td>
<td>All</td>
<td>Lab reports for studies performed during an inpatient hospital stay or as part of an outpatient service. This is for stand-alone lab documents only. If the report is embedded in another type of medical document, please do not use this selection.</td>
</tr>
<tr>
<td>Imaging Reports</td>
<td>All</td>
<td>Radiology reports from imaging studies performed during an inpatient hospital stay or as part of an outpatient service. This is for stand-alone report documents only. If the report is embedded in another type of medical document, please do not use this selection.</td>
</tr>
<tr>
<td>Pathology Reports</td>
<td>All</td>
<td>Pathology reports performed in relation to an inpatient hospital stay or as part of an outpatient service. This is for stand-alone pathology documents only. If the report is embedded in another type of medical document, please do not use this selection.</td>
</tr>
</tbody>
</table>

Specific Medical Documentation Submission Timelines and Deadlines

<table>
<thead>
<tr>
<th>Service</th>
<th>VCP and PC3 Submission Requirements</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inpatient (includes surgery)</td>
<td>• <strong>30 calendar days</strong> after discharge</td>
</tr>
<tr>
<td></td>
<td>• Discharge summary related to the episode of care</td>
</tr>
<tr>
<td></td>
<td>• Provider will coordinate with TriWest to arrange necessary supplies, home health services and equipment.</td>
</tr>
<tr>
<td></td>
<td>• For <strong>surgery</strong>, also complete and submit the <a href="#">VA Purchased Surgical Care Patient Outcome Form</a> to TriWest</td>
</tr>
<tr>
<td></td>
<td>• Complete the <a href="#">Secondary Authorization Request (SAR) Form</a> and submit to TriWest to obtain approval from VA if needed. For more information on submission of SARs, please review the <a href="#">Quick Reference Guide on the SAR process</a>.</td>
</tr>
<tr>
<td>Inpatient Rehabilitation</td>
<td>• <strong>Within 30 calendar days</strong> after discharge</td>
</tr>
<tr>
<td></td>
<td>• Include functional status and status change from onset of treatment through discharge</td>
</tr>
<tr>
<td></td>
<td>• Use the Centers for Medicare and Medicaid Services’ (CMS) <a href="#">Inpatient Rehabilitation Facility Patient Assessment Instrument (IRF-PAI)</a></td>
</tr>
<tr>
<td>Outpatient Specialty Services (includes surgery)</td>
<td>• <strong>30 calendar days</strong> after the initial appointment</td>
</tr>
<tr>
<td></td>
<td>• If additional appointments are authorized, submit to TriWest within <strong>30 days upon completion of episode of care</strong></td>
</tr>
<tr>
<td></td>
<td>• For <strong>surgery</strong>, also complete and submit the <a href="#">VA Purchased Surgical Care Patient Outcome Form</a> to TriWest</td>
</tr>
<tr>
<td></td>
<td>• If additional visits or procedures are required, please use the <a href="#">Secondary Authorization Request (SAR) Form</a></td>
</tr>
<tr>
<td>Service</td>
<td>VCP and PC3 Submission Requirements</td>
</tr>
<tr>
<td>-----------------------------</td>
<td>-------------------------------------</td>
</tr>
<tr>
<td>Critical Findings Category</td>
<td><strong>Definition:</strong> 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</td>
</tr>
<tr>
<td></td>
<td><strong>Within 24 hours</strong> of identification, reach point of contact (POC) at authorizing VAMC by phone</td>
</tr>
<tr>
<td></td>
<td>Indicate the VAMC staff name POC and date/time of contact in your discharge summary</td>
</tr>
<tr>
<td></td>
<td>After notifying VA, submit medical documentation to TriWest as soon as possible, but no later than 30 days. Providers must comply with VA request for earlier upload in order to expedite care.</td>
</tr>
<tr>
<td>Suicide Risk</td>
<td><strong>Within 24 hours</strong> by phone to authorizing VAMC POC</td>
</tr>
<tr>
<td><em>Critical Finding</em></td>
<td>A newly identified suicide risk in a Veteran not referred for inpatient mental health should be considered a Critical Finding</td>
</tr>
<tr>
<td>Cancer Diagnosis</td>
<td><strong>Within 48 hours</strong> by phone to authorizing VAMC POC</td>
</tr>
<tr>
<td><em>Critical Finding</em></td>
<td>A new diagnosis of cancer should be considered a Critical Finding</td>
</tr>
<tr>
<td>Urgent Follow-Up/Additional Care</td>
<td><strong>Within 24 hours</strong> by phone to authorizing VAMC POC</td>
</tr>
<tr>
<td></td>
<td>If provider determines urgent follow-up is needed after completion of care, OR urgent additional care needed during episode of care.</td>
</tr>
<tr>
<td>Pathology</td>
<td><strong>Within 5 business days</strong> of request for slides</td>
</tr>
<tr>
<td></td>
<td>These are made available to VA for review/assessment</td>
</tr>
<tr>
<td>Gastroenterology Procedures</td>
<td>Gastroenterology procedures must include the following (as appropriate):</td>
</tr>
<tr>
<td></td>
<td>Type of procedure performed (e.g. colonoscopy with biopsy)</td>
</tr>
<tr>
<td></td>
<td>Procedural indication</td>
</tr>
<tr>
<td></td>
<td>Sedation medications and doses</td>
</tr>
<tr>
<td></td>
<td>Description of the quality of the bowel preparation (for colonoscopy or sigmoidoscopy)</td>
</tr>
<tr>
<td></td>
<td>Depth of insertion of the endoscope/completeness of the procedure</td>
</tr>
<tr>
<td></td>
<td>If the procedure is incomplete, an explanation must be provided</td>
</tr>
<tr>
<td></td>
<td>Description of all relevant findings, e.g.: Number and size of polyps, colitis, stricture, etc.</td>
</tr>
<tr>
<td></td>
<td>Full description of all interventions</td>
</tr>
<tr>
<td></td>
<td>If polypectomy is performed, indicate whether or not the lesion was completely removed</td>
</tr>
<tr>
<td></td>
<td>Description of any unanticipated events or adverse events</td>
</tr>
<tr>
<td></td>
<td>If specimens were removed for pathologic assessment, include a copy of pathology results</td>
</tr>
<tr>
<td></td>
<td>Summary assessment and recommended follow-up with final recommendations taking pathology results into account</td>
</tr>
<tr>
<td>Medical/ Radiation Oncology Services</td>
<td>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.</td>
</tr>
<tr>
<td></td>
<td>Side effects of treatment and care recommendations related to side effects</td>
</tr>
<tr>
<td></td>
<td>Medical management required during treatment</td>
</tr>
<tr>
<td></td>
<td>Description of any required breaks in therapy</td>
</tr>
<tr>
<td></td>
<td>Height, weight and performance status using either Eastern Cooperative Oncology Group (ECOG) or Karnofsky rating scales</td>
</tr>
<tr>
<td></td>
<td>Specific oncologic diagnosis and stage</td>
</tr>
<tr>
<td></td>
<td>Documentation of:</td>
</tr>
<tr>
<td></td>
<td>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</td>
</tr>
<tr>
<td></td>
<td>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)</td>
</tr>
<tr>
<td></td>
<td>Any dose adjustments or delays, including the reason Tumor response to any anticancer treatment using standard response assessment scale as well as the results of any exam, image or test used to assess response</td>
</tr>
<tr>
<td></td>
<td>Adverse events</td>
</tr>
<tr>
<td></td>
<td>Any discussions of patient at a tumor board along with a summary of board recommendations</td>
</tr>
<tr>
<td>Service</td>
<td>VCP and PC3 Submission Requirements</td>
</tr>
<tr>
<td>-------------------------------</td>
<td>------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Skilled Home Health Care</td>
<td>• <em>Within 3 business days</em> of start of care: submit initial assessment (OASIS)</td>
</tr>
<tr>
<td></td>
<td>• <em>Within 5 business days</em> of completion of episode of care: submit final discharge summary to TriWest</td>
</tr>
<tr>
<td></td>
<td>• Please review the <a href="#">Home Health Quick Reference Guide</a> for additional details</td>
</tr>
<tr>
<td>Inpatient Rehabilitation</td>
<td>• <em>Within 30 calendar days</em> after discharge</td>
</tr>
<tr>
<td></td>
<td>• Include functional status and status change from onset of treatment through discharge</td>
</tr>
<tr>
<td></td>
<td>• Use the Centers for Medicare and Medicaid Services’ (CMS) <a href="#">Inpatient Rehabilitation Facility Patient Assessment Instrument (IRF-PAI)</a></td>
</tr>
<tr>
<td>Inpatient Mental Health</td>
<td>• 30 calendar days after discharge</td>
</tr>
<tr>
<td></td>
<td>• If suicide risk is a clinical issue, the Veteran shall be provided a written copy of their personal <a href="#">Suicide Prevention Safety Plan</a></td>
</tr>
<tr>
<td></td>
<td>• Please reference VA's planning manual: <a href="#">http://www.mentalhealth.va.gov/docs/VA_Safety_planning_manual.pdf</a></td>
</tr>
<tr>
<td></td>
<td>• The plan must include the Veterans Crisis Line telephone number, 1-800-273-8255</td>
</tr>
<tr>
<td>Outpatient Mental and Behavioral Health</td>
<td>• <a href="#">Behavioral Health Forms</a> to speed submission are available online for both VCP and PC3 referrals</td>
</tr>
<tr>
<td></td>
<td>• As soon as possible, but <strong>no less than 30 days from the session</strong>, an Initial Assessment and a Completion of Episode of Care should be submitted</td>
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<td></td>
<td>• If an extension or addition to authorized care/therapy is required, fax a Behavioral Health SAR as soon as possible</td>
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<td></td>
<td>• With additional authorized care, VA may require ongoing Progress Summaries</td>
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<td></td>
<td>• Providers <strong>should never</strong> submit psychotherapy process notes with contents of a private session</td>
</tr>
<tr>
<td></td>
<td>• Providers <strong>should</strong> submit Clinical Progress notes. These are considered part of the Veterans medical record</td>
</tr>
<tr>
<td></td>
<td>• For additional documentation requirements, please read the <a href="#">Mental Health Quick Reference Guide</a></td>
</tr>
<tr>
<td>Home Infusion Therapy (HIT)</td>
<td>• An initial plan of care (CMS 485) should be submitted <strong>within three business days</strong></td>
</tr>
<tr>
<td></td>
<td>• An end EOC record should be submitted <strong>within five business days</strong></td>
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<td></td>
<td>• Infusion therapy requires nursing notes and delivery tickets that support all services and medications billed</td>
</tr>
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<td></td>
<td>• Please refer to the <a href="#">Home Health Quick Reference Guide</a> for additional information</td>
</tr>
</tbody>
</table>

**Claims Submission Rules and Procedures – Applicable to the VCP and PC3 Program**

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.
<table>
<thead>
<tr>
<th>Acronyms</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>CoP</td>
<td>Medicare Conditions of Participation</td>
</tr>
<tr>
<td>CPGs</td>
<td>Clinical Practice Guidelines</td>
</tr>
<tr>
<td>CPT</td>
<td>Current Procedural Terminology</td>
</tr>
<tr>
<td>CQM</td>
<td>Clinical Quality Management</td>
</tr>
<tr>
<td>DME</td>
<td>Durable Medical Equipment</td>
</tr>
<tr>
<td>DMEPOS</td>
<td>Durable Medical Equipment, Prosthetics, Orthotics, and Supplies</td>
</tr>
<tr>
<td>DoD</td>
<td>Department of Defense</td>
</tr>
<tr>
<td>DRG</td>
<td>Diagnosis-Related Group</td>
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<tr>
<td>EDI</td>
<td>Electronic Data Interchange</td>
</tr>
<tr>
<td>EFT</td>
<td>Electronic Funds Transfer</td>
</tr>
<tr>
<td>EOB</td>
<td>Explanation of Benefits</td>
</tr>
<tr>
<td>ER</td>
<td>Emergency Room</td>
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<tr>
<td>ERA</td>
<td>Electronic Remittance Advice</td>
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<tr>
<td>FL</td>
<td>Form Locator</td>
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<tr>
<td>HCPCS</td>
<td>Healthcare Common Procedure Coding System</td>
</tr>
<tr>
<td>HHA</td>
<td>Home Health Agency</td>
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<tr>
<td>HHS</td>
<td>U.S. Department of Health and Human Services</td>
</tr>
<tr>
<td>ICD</td>
<td>Implantable Cardioverter Defibrillators</td>
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<tr>
<td>ID</td>
<td>Identification</td>
</tr>
<tr>
<td>IDME</td>
<td>Indirect Medical Education</td>
</tr>
<tr>
<td>IVR</td>
<td>Interactive Voice Response</td>
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<tr>
<td>MD</td>
<td>Medical Doctor</td>
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<tr>
<td>MRI</td>
<td>Magnetic Resonance Imaging</td>
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<tr>
<td>NDC</td>
<td>National Drug Code</td>
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<tr>
<td>NCDR</td>
<td>National Cardiovascular Data Registry</td>
</tr>
<tr>
<td>NP</td>
<td>Nurse Practitioner</td>
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<tr>
<td>NPI</td>
<td>National Provider Identifier</td>
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<tr>
<td>OPPS</td>
<td>Outpatient Prospective Payment System</td>
</tr>
<tr>
<td>PA</td>
<td>Physician Assistant</td>
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<tr>
<td>PCS</td>
<td>Primary Care Services</td>
</tr>
<tr>
<td>PC3 or PCCC</td>
<td>Patient-Centered Community Care Program</td>
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<tr>
<td>PDTS</td>
<td>Pharmacy Data Transaction Service</td>
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<tr>
<td>PPS</td>
<td>Prospective Payment System</td>
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<td>Social Security Number</td>
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<td>TIN</td>
<td>Tax Identification Number</td>
</tr>
<tr>
<td>UAC</td>
<td>Usual and Customary</td>
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<tr>
<td>VA</td>
<td>Department of Veterans Affairs</td>
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<tr>
<td>VACAA</td>
<td>Veterans Access, Choice and Accountability Act of 2014</td>
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<tr>
<td>VAMC</td>
<td>Veterans Affairs Medical Center</td>
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<td>VCP</td>
<td>Veterans Choice Program</td>
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<tr>
<td>VHA</td>
<td>Veterans Health Administration</td>
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<td>VANF</td>
<td>VA National Formulary</td>
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<tr>
<td>WPS MVH</td>
<td>WPS Military and Veterans Health</td>
</tr>
</tbody>
</table>
If you have any questions regarding this information, please contact TriWest using the Provider Customer Service contact listed below for the appropriate program.

Department of Veterans Affairs (VA)
Patient-Centered Community Care (PC3)
1-855-PCCCVET (1-855-722-2838)

Veterans Access, Choice and Accountability Act of 2014 (VACAA)
Veterans Choice Program (VCP)
1-866-606-8198

www.triwest.com