Medical Documentation Requirements
Quick Reference Guide

Key Points:
- Medical documentation is required for all services provided to a Veteran under the Veterans Affairs Patient-Centered Community Care (PC3) Program and the Veterans Choice Program (VCP).
- Medical documentation should be submitted to TriWest before submitting claims to Wisconsin Physicians Service (WPS), TriWest’s claims processor.
- Medical documentation and associated forms can be uploaded directly to the TriWest Provider Portal at www.triwest.com/provider after providers register for a secure account.

How to submit medical documentation and claims:

1. **Upload Medical Documentation to TriWest Provider Portal**
   - Register for a secure account on TriWest’s Provider Portal at www.TriWest.com/provider and upload medical documentation directly to the system.
   - *Documents up to 5 MB can be uploaded in PDF or TIF format*
   - If unable to access the Provider Portal, fax medical documentation to TriWest at 1-866-259-0311.

2. **Submit Claims to WPS**
   TriWest uses WPS for all claims processing. After submitting medical documentation to TriWest, send claims either:
   - **Electronically.** Set up an EDI to submit electronic claims by calling WPS at 1-800-782-2680 and selecting Option 1.
   - **Via mail.** Mail paper claims to the following:
     WPS-VAPC3
     PO Box 7926
     Madison, WI 53707-7926

** Below are specific timelines and requirements for medical documentation and/or required forms, based on the specific service provided. **
**General Medical Documentation Content Requirements:**

VA requires medical documentation under the Veterans Choice Program include only the initial appointment and end-of-episode-of-care records. Providers submitting claims for a PC3 authorization still need to submit medical documents after every visit. The notes should include, at minimum:

- Veteran’s name
- Gender
- Date of birth
- Last four digits of social security number

**Provider Portal “Types” of Medical Document Definitions:**

As of June 30, 2017, providers submitting medical documents through the TriWest Provider Portal for a Choice authorization now need to 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 Choice authorizations only:

**Use**

To aid in determining what **Document Type** to label medical documentation being uploaded via the Provider Portal.

<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 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 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>Service</td>
<td>Choice Submission Requirements</td>
<td>PC3 Submission Requirements</td>
</tr>
<tr>
<td>-------------------------------------</td>
<td>------------------------------------------------------------------------------------------------</td>
<td>------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Inpatient (includes surgery)</td>
<td>• 30 calendar days of discharge&lt;br&gt;• Send to TriWest&lt;br&gt;• Discharge summary related to the episode of care&lt;br&gt;• (For surgery) Complete and submit the <a href="#">VA Purchased Surgical Care Patient Outcome Form</a> to TriWest</td>
<td>• 30 calendar days of discharge&lt;br&gt;• Send to TriWest&lt;br&gt;• Discharge summary related to the episode of care&lt;br&gt;• (For surgery) Complete and submit the <a href="#">VA Purchased Surgical Care Patient Outcome Form</a> to TriWest</td>
</tr>
<tr>
<td>Outpatient Specialty Services (includes surgery)</td>
<td>• 75 calendar days after the initial appointment&lt;br&gt;• Send to TriWest&lt;br&gt;• If additional appointments are authorized, submit to TriWest within 75 days upon completion of episode of care.&lt;br&gt;• (For surgery) Complete and submit the <a href="#">VA Purchased</a></td>
<td>• 14 calendar days after the initial appointment (must submit documents after every visit)&lt;br&gt;• Send to TriWest&lt;br&gt;• If additional appointments are authorized, submit to TriWest within 75 days upon completion of episode of care.&lt;br&gt;• (For surgery)</td>
</tr>
</tbody>
</table>

---

**Medical Documentation Submission Timelines and Deadlines:**

Imaging Reports: All
- 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.

Pathology Reports: All
- 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.
<table>
<thead>
<tr>
<th>Service</th>
<th>Choice Submission Requirements</th>
<th>PC3 Submission Requirements</th>
<th>Associated Forms/links</th>
</tr>
</thead>
<tbody>
<tr>
<td>Surgical Care Patient Outcome Form to TriWest</td>
<td>Complete and submit the VA Purchased Surgical Care Patient Outcome Form to TriWest</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Service</th>
<th>VCP Submission Requirements</th>
<th>PC3 Submission Requirements</th>
<th>Associated Forms/links</th>
</tr>
</thead>
<tbody>
<tr>
<td>Critical Findings</td>
<td>24 hours of identification by phone to VA point of contact <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 <strong>Indicate the VA staff name and date/time of contact in your discharge summary</strong></td>
<td>24 hours of identification by phone to VA point of contact <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 <strong>Indicate the VA staff name and date/time of contact in your discharge summary</strong></td>
<td>The provider should contact the VA POC name and number on the authorization for the Veteran and make notification of Critical Findings.</td>
</tr>
<tr>
<td>Suicide Risk <strong>Critical Finding</strong></td>
<td>24 hours by phone to VA <strong>Newly identified suicide risk in a Veteran not referred for inpatient mental health should be considered a Critical Finding</strong></td>
<td>24 hours by phone to VA <strong>Newly identified suicide risk in a Veteran not referred for inpatient mental health should be considered a Critical Finding</strong></td>
<td></td>
</tr>
<tr>
<td>Cancer Diagnosis <strong>Critical Finding</strong></td>
<td>48 hours of diagnosis <strong>Notify VA</strong> <strong>New diagnosis of cancer should be</strong></td>
<td>48 hours of diagnosis <strong>Notify VA</strong> <strong>New diagnosis of cancer should be</strong></td>
<td></td>
</tr>
<tr>
<td>Service</td>
<td>VCP Submission Requirements</td>
<td>PC3 Submission Requirements</td>
<td>Associated Forms/links</td>
</tr>
<tr>
<td>-------------------------------------</td>
<td>----------------------------------------------------------------------------------</td>
<td>-----------------------------------------------------------------------------------</td>
<td>---------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Skilled Home Health Care</td>
<td>- <strong>3 business days</strong> of start of care: submit initial plan of care to TriWest</td>
<td>- <strong>3 business days</strong> of start of care: submit initial plan of care to TriWest</td>
<td>- <strong>3 business days</strong> of start of care: submit discharge summary to TriWest</td>
</tr>
<tr>
<td></td>
<td>- <strong>5 business days</strong> of completion of episode of care: submit</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Urgent Follow-Up/Additional Care

- **24 hours** to VA point of contact
- If provider determines urgent follow-up needed after completion of care, OR urgent additional care needed during episode of care
- **24 hours** to VA point of contact
- If provider determines urgent follow-up needed after completion of care, OR urgent additional care needed during episode of care

Pathology

- **5 business days** of request for slides
- Made available to VA
- **5 business days** of request for slides
- Made available to VA

Gastroenterology Procedures

- Additional documentation for Gastroenterology procedures is required from the provider.
- Same as VCP

Medical/Radiation Oncology Services

- Additional documentation for Medical/Radiation Oncology services is required.
- Same as VCP

Required additional documentation:

### What should you include in your medical records for TriWest and VA?

Minimum requirements for content of medical documentation, **as applicable to the care**, 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.