Key Points:

- TriWest Healthcare Alliance will send providers an authorization letter for care after scheduling an appointment for the Veteran.
- The authorization letter will be the same for an episode-of-care through the Patient-Centered Community Care Program (PC3) or the Veterans Choice Program (VCP).
- Authorizations are now inclusive of all appropriate CMS CPT or Level I HCPCS service codes. If a code is paid for by Medicare and aligns with recognized medical practice, it is covered with rare exceptions.
- Routine lab testing and/or X-ray services, when medically necessary, are included in all authorizations, whether conducted in the provider’s office or by a third-party.
- A servicing provider, along with the facility or ambulatory surgery center which is used to perform the approved services, is also considered covered.
- For complex authorization questions: Please call 1-855-722-2838, Option 3, Option 1

The Authorization “Face Sheet” Information

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

Information in the “Face Sheet” portion includes:

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

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

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

**Example of Mammography SEOC clinical section**

<table>
<thead>
<tr>
<th>PROCEDURE</th>
<th>CODE RANGE</th>
<th>QTY</th>
<th>TYPE</th>
<th>APPOINTMENT INFO</th>
</tr>
</thead>
<tbody>
<tr>
<td>All appropriate Medicare covered services for MAMMO in the office or outpatient setting.</td>
<td></td>
<td></td>
<td></td>
<td>08/02/2017 10:45 am</td>
</tr>
<tr>
<td>All appropriate Medicare covered services for MRIs of the face, brain, abdomen, breast, chest, face, pelvis, lower &amp; upper extremities.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Routine diagnostic radiology: XR, extremity, abdomen, spine, joints and bones</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Routine diagnostic labs: CBC, UA, Chemistry, PT, PTT</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Covered services include the following procedure codes: 10021, 19000-19001, 19081-19086, 19100, 76641-76642, 77058-77063, 77065-77067, 80053, 88305, 88347, 3014F, G0202-G0206, G0279

**What Does “All Appropriate Medicare Covered Services” Mean?**

TriWest and VA are using Medicare guidelines to help reduce utilization review. To simplify the authorization process, TriWest will no longer include a range of pre-approved CMS codes in authorization letters unless these are defined as part of a SEOC.

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

**Remember...**

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