Home Health Care
Quick Reference Guide

Key Points:
- TriWest Healthcare Alliance cannot pay fee-for-service under the Veterans Choice Program (VCP) or Patient-Centered Community Care (PC3) program, even if providers previously directly billed the Department of Veterans Affairs (VA) in this fashion.
- Home health providers who see Veterans under the VCP or PC3 need to bill TriWest according to Medicare guidelines.
- When completing the Request for Anticipated Payment (RAP) on the UB-04, providers should bill at minimum one penny, even though the Medicare requirement is zero.
- If a Veteran was previously referred directly from VA, providers must initiate a new Outcome and Assessment Information Set (OASIS) assessment once the Veteran has been referred.
- If TriWest calls a home health agency requesting care for a Veteran, or the provider receives an authorization from TriWest, VA has initiated transfer of the care from its facility to TriWest’s community care provider under VCP or PC3.

TriWest Authorized Care

As VA transfers Veterans from directly authorized home health care to the VCP or PC3 programs, providers should be aware that TriWest – not VA Medical Centers – is the administrator. Additionally, TriWest is responsible for authorizing the care in coordination with VA and paying provider claims.

Therefore, home health providers should follow the process below if:
- TriWest calls the provider requesting a Veteran be seen; OR
- TriWest sends an authorization to the home health provider for a Veteran to be seen.

Home Health Documentation:

Once TriWest has contacted the home health provider via phone or written authorization, VA has already initiated transfer of the Veteran’s care to TriWest’s community care provider under the VCP or PC3.

With transition to VCP or PC3 program:
- Begin following the Medicare model immediately.
- Discontinue fee-for-service billing to the VA medical center once the VA authorization ends and the VCP or PC3 authorization from TriWest begins.
Initiate a new episode of care (EOC), including a new OASIS assessment.
Create a plan of care from the OASIS assessment and submit it to TriWest as medical documentation.
  - **Within three business days** from the start of care – submit the initial plan of care (CMS 485 Form) to TriWest. The 485 should be signed by the clinician that performed the initial evaluation. This can be a registered nurse, physical therapist, occupational therapist, or a physician.
  - It is not necessary to wait until the ordering physician signs the plan. It is often a VA physician that needs to sign and by submitting the 485 to TriWest, physician signature is facilitated
  - **Within five business days** of completing care, submit an end EOC record (a.k.a. discharge summary)

TriWest follows Medicare as it pertains to billing practices only.
  - Veterans admitted to home health services under a TriWest authorization are not required to adhere to Medicare’s Skilling criteria.
  - There is no requirement for: homebound status, face-to-face documentation, skilled need certification, or the Medicare Provider and Supplier (PECOS) enrollment by the ordering physician.

Bill TriWest’s claims processor, WPS Military and Veterans Health (WPS MVH), on a UB-04 according to Medicare guidelines. Per contractual requirements, TriWest cannot pay fee-for-service.

**Additional Billing Guidelines**

Home health providers also need to follow these additional billing guidelines:

- After completing the OASIS assessment, submit RAP claim using **Type of Bill Code 322** to WPS MVH.
- When completing the RAP on the UB-04, providers should bill at minimum one penny, even though the Medicare requirement is zero.
- At the end of the episode-of-care, submit final billing using **Type of Bill Code 329**
- OASIS assessment details reveal a code required for billing. If the OASIS data/code is not included on the claim, then the claim will be denied.
- If a Home Health claim needs to be cancelled, you must submit a claim with a Type of Bill Code 328.
- All providers should make their best efforts to submit claims within 30 days.
- VCP and PC3 programs have a 180-day timely filing limit. Please ensure your claims are submitted within this timeframe.

To learn more about Medicare’s Prospective Payment System (PPS) for Home Health, please visit the [Centers for Medicare and Medicaid (CMS) website](https://www.cms.gov).

**When Are VA Programs Primary?**

Veterans may elect to use their Veteran benefits over Medicare, even if Medicare is listed as the primary payer. If you receive an authorization from TriWest, the Veteran has elected to use his or her VA benefits. For these authorizations, VA programs are primary. Claims should be sent to WPS MVH. Veteran benefits cannot pay secondary to Medicare.
Follow These Steps to Submit Claims to TriWest:

(1) Upload Medical Documentation to TriWest Provider Portal

- Upload all documentation including the 485 Form, nursing notes and the final discharge summary to TriWest. TriWest will then upload this documentation to the supervising VA medical center to ensure continuity of care.
- If you are unable to access or upload via the Provider Portal, fax medical documentation to TriWest at 1-866-259-0311.
- Do not upload documentation with claims via a clearinghouse or Availity. WPS MVH cannot send your documentation to VA for review.
- For additional information on general medical documentation, please refer to the Medical Documentation Quick Reference Guide.

(2) Submit Claims to WPS MVH

TriWest uses WPS MVH for all claims processing and can accept electronic claims through your clearinghouse/billing service or via Availity. Claims submission via Availity is at no additional charge for TriWest providers.

- WPS requires providers to pre-enroll with WPS in addition to enrolling with their clearinghouse for electronic transactions.
- To find clearinghouse Payer IDs, please visit: http://www.wpshealth.com/resources/provider-resources/edi/index.shtml or contact TriWest Provider Services at providerservices@triwest.com.
- Mail paper claims to WPS MVH-VAPC3, PO Box 7926, Madison, WI 53707-7926. Paper claims must be on CMS compliant forms or they will be rejected.