CCN Home Health Care

Quick Reference Guide

Key Points:

- Under the Department of Veterans Affairs (VA) Community Care Network (CCN), skilled home health care includes: skilled bundled, skilled unbundled and skilled expanded.
- These services are authorized in either 30-, 90-, 180-, or 365-day periods as determined by VA.
- Homemaker, Home Health Aide or In-home Respite care is available through CCN with separate authorizations.
- VA is improving access for Veterans who need home infusion services.

  CCN has a 180-day timely filing limit for submitting claims. Providers should ensure claims are submitted within this timeframe. TriWest recommends submitting claims within 30 days of service date.

  Providers should ensure they are billing the appropriate Veteran ID without dashes or spaces and VA referral number on all claims.

  Providers should only bill Current Procedural Terminology (CPT) codes approved in their Standardized Episode of Care (SEOC).

- Reimbursement for services rendered cannot exceed the number of units authorized by the approved SEOC. If a provider requires additional units, they must request a new SEOC from VA.

Skilled Home Health Care

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

- **Skilled bundled:** This type of care will be reimbursed via the Medicare Patient-Driven Groupings Model (PDGM), episodic method, clearly stated in the Standard Episode of Care (SEOC) **approved referral/authorization** letter. It should be billed appropriately on a UB-04.
- **Skilled unbundled:** This type of care will be reimbursed on a fee-for-service basis and the

VA issue orders regarding services and visits. The coding allowed is to accommodate billing per hour or per 15-minute increments. It should be billed appropriately on a CMS 1500.

- **Skilled expanded:** This is skilled private duty nursing for highly dependent Veterans. It will be reimbursed on a fee-for-service basis and the Department of Veterans Affairs (VA) will issue orders regarding services and visits/hours. The coding allowed is to accommodate billing per hour or per 15-minute increment. It should be billed appropriately on a CMS 1500.

Note: Most services will reimburse on a fee-for-service basis. The coding allowed is to accommodate billing per hour or per 15-minute increment, but it may vary depending on the service. Contact the local VA Medical Center (VAMC) for specific details.

Homemaker/Home Health Aide and In-home Respite Care

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

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

Quick Billing Information:

- This care is billed on a HCFA 1500 and can be billed in 15-minute or one-hour increments.
- Medicare does not currently cover these services, but many codes have VA fee schedule rates associated with them.

Improved Access for Infusion Therapy Services

VA has improved access for Veterans in need of infusion services. SEOC paperwork now accompanies consult orders for infusion services to allow care in an Ambulatory Infusion Suite (AIS) setting. This applies to CCN approved referrals/authorizations.

Additional Information:

- The consult order by the VA provider will designate the care setting as an outpatient infusion center, AIS, or home.

- Home infusion therapy providers should use the SS modifier to identify the care setting as AIS when billing for approved AIS services.

For more information, please refer to the CCN Provider Handbook.

TriWest-Authorized Care Versus Directly Authorized VA Care

If VA transfers Veterans from directly authorized home health care to the CCN, Home Health Agencies (HHA) should be aware that TriWest Healthcare Alliance (TriWest) – ***not the VAMC*** – is the administrator and payer, and care should be provided according to the guidelines defined in this Reference Guide.

How to Initiate Home Health Care:

- A VA clinician can determine that services are needed and forward an approved referral/authorization to that VAMC's Community Care department. The appointment will be scheduled by the VAMC Community Care staff. The VAMC will also be responsible for sending all letters.
    - TriWest cannot generate an approved referral/authorization for non-credentialed HHAs for skilled home health services.
- If a community provider believes that a Veteran needs skilled home health care (not hospice), providers should submit a Request for Services (RFS) to get care authorized. VA typically has up to 14 days to review and approve this request.
- For Veterans being discharged from inpatient care, the ordering physician or the facility must submit an URGENT RFS to the VAMC prior to discharge.
    - HHAs should verify a facility has taken this step. All care *must be pre-authorized*.

Bundled Home Health Billing and Documentation

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

With transition to CCN:

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

physician that needs to sign, and by promptly submitting the plan of care to VA, the physician signature is expedited.

- Within five business days of completing care, submit an end of the EOC record (a.k.a., discharge summary) to the VAMC.

- TriWest is required by contract to follow Medicare as it pertains to billing practices only.
  - Veterans admitted to home health services under a TriWest referral/authorization are not required to meet Medicare's skilled nursing criteria. This exception is also applicable under Medicare's PDGM
  - There is no requirement for homebound status, face-to-face documentation, skilled need certification, or the Medicare Provider and Supplier enrollment (this is the Provider, Enrollment, Chain and Ownership System, a.k.a. PECOS, enrollment) by the ordering physician.
- If the agency needs more information from the VA physician to complete the assessment and case mix, the agency must contact the VA physician or someone in the local VAMC's Office of Community care.
- OASIS assessment details reveal a HIPPS code required for billing. If the HIPPS code is not included on the claim, the claim will be denied.
- At the end of the episode of care, submit final claim on a UB-04 or electronic equivalent according to Medicare PDGM guidelines using the Type of Bill Code 329.
- If a home health claim needs to be cancelled, you must submit a claim with a Type of Bill Code 328.
- In compliance with Medicare policy, claims must contain the code for the county of service. Submit value code "85" with the state and county code of the place of residence where the home health service was delivered in the amount field.
- CCN has a 180-day claims timely filing limit. Please ensure your claims are submitted within this timeframe. TriWest recommends submitting claims within 30 days of service.
- Send claims to TriWest's claims processor:
  PGBA
  PO Box 108851
  Florence, SC 29502-8851

  or submit via EDI payer ID TWVACCN (note: Payer ID may vary depending on the clearinghouse.)

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