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UnitedHealthcare

VA Community Care Network

VA CCN Provider Manual

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OVERVIEW

Welcome to the Department of Veterans Affairs (VA) Community Care Network (CCN) Provider Manual. We've collected important information about the VA CCN that will help you deliver care to Veterans in your community.

This VA CCN Provider Manual (this "Manual") applies to Covered Services you provide to Veterans as part of the VA CCN. Veteran eligibility and coverage are determined by VA.

This Manual is for any facility, ancillary provider, physician, physician organization, other health care professional, supplier or other entity engaged in the delivery of health care services under VA CCN (collectively "provider") participating in one of the Optum VA CCN partner networks or in a leased network managed by a vendor that has subcontracted with Optum or one of its affiliates for VA CCN (see the "Network Resources" section below for more information on Optum VA CCN partner networks).

As used in this Manual, "you," "your" or "provider" refers to any provider as defined above. Except where expressly indicated, the information included in this Manual is applicable to all types of providers subject to the Manual.

As used in this Manual, "us," "we" or "our" refers to Optum or UnitedHealthcare (collectively "Optum") or one of the other VA CCN-affiliated Network Partners (collectively "Network Partner(s)") with which you have contracted for VA CCN.

This Manual is a binding part of your contract with Optum or Network Partner (the "Participation Agreement") and includes requirements that you must comply with for the VA CCN, including the following categories of information, which will help you better understand VA CCN requirements, as well as how to collaborate with VA and deliver and coordinate care for the Veterans you will be serving:

- Provider resources
- Covered services
- Credentialing
- Provider responsibilities
- Eligibility and enrollment
- Referrals
- Pharmacy and durable medical equipment (DME)
- Health care management
- Medical documentation
- Reimbursement and claims process
- Provider training and resources

The table of contents contains hyperlinks to specific sections. This enables providers and staff to access needed information quickly and efficiently.

Terms and acronyms in this Manual are defined the first time they appear. They are also spelled out in the Glossary and Acronyms sections at the end of this Manual.

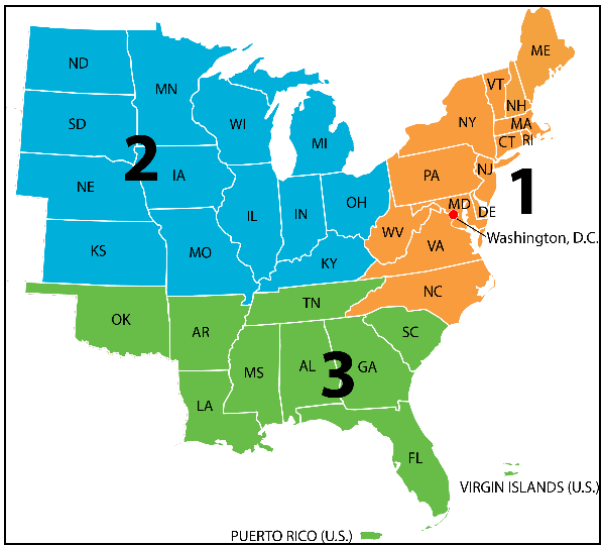
Important Note about This Manual

The Manual will be updated, as needed, and we'll post the latest version to Optum VA Community Care Network provider portal, provider.vacommunitycare.com > Training & Guides. Please check back for updated versions. This guide was updated Oct. 23, 2020, for physicians, health care professionals, facilities and ancillary providers currently participating in the VA CCN.

What Is VA CCN?

VA recognizes that while the health care landscape is constantly changing, VA's unique population and broad geographic demands will continue to require community-based care for Veterans. VA is committed to providing eligible Veterans with the care they need when and where they need it. A significant component of having one method for Veterans to receive care from community providers is the ability for VA to purchase community services through the CCN contracts awarded to Third-Party Administrators (TPAs). Optum was awarded Region 1, Region 2 and Region 3.

Region 1	Region 2	Region 3
Connecticut	Illinois	Alabama
Delaware	Indiana	Arkansas
District of Columbia	Iowa	Florida
Maine	Kansas	Georgia
Maryland	Kentucky	Louisiana
Massachusetts	Michigan	Mississippi
New Hampshire	Minnesota	Oklahoma
New Jersey	Missouri	Puerto Rico
New York	Nebraska	South Carolina
North Carolina	North Dakota	Tennessee
Pennsylvania	Ohio	U.S. Virgin Islands
Rhode Island	South Dakota	
Vermont	Wisconsin	
Virginia		
West Virginia		



Regions are based on provider locations. The provider may receive referrals for Veterans residing in a different state than the provider's location. Each Region's VA CCN Health Care Delivery Schedule is located on provider.vacommunitycare.com > Training & Guides. The schedules show when VA Medical Centers (VAMC) began issuing new approved referrals to Community Care Network providers.

CCN is fully deployed in Regions 1, 2 and 3. VA CCN gives Veterans the opportunity to receive care from a network of community health care professionals, facilities, pharmacies and suppliers.

Veterans have sacrificed to serve our country, and this is an opportunity to provide them with the timely, accessible and high-quality care they deserve. Providers can help Veterans access a network of community health care through their contract with Optum or another Network Partner. VA CCN only covers Veterans, not families or dependents. VA determines a Veteran's eligibility to get care from community providers.

NETWORK RESOURCES

Optum's complete and comprehensive health care provider network includes:

UnitedHealthcare

UnitedHealthcare provides the network for traditional medical services for the VA CCN. The UnitedHealthcare network includes:

- Primary care providers
- Specialty and sub-specialty providers
- Acute care hospitals
- Laboratories
- Specialty pharmacies
- Ambulatory surgery centers
- Long-term acute care facilities
- Federally Qualified Health Centers (FQHCs)
- Rural Health Clinics (RHCs)
- Urgent care facilities
- Ancillary services including home health, DME, hospice care, dialysis and diagnostic radiology

United Behavioral Health

United Behavioral Health (UBH) provides a network of behavioral health and substance use disorder facilities and providers who perform Complementary and Integrative Healthcare Services (CIHS) for VA CCN. The UBH network includes:

- Psychiatric hospitals
- Inpatient and outpatient mental health and substance use disorder programs
- Psychiatrists
- Psychologists
- Social workers
- Marriage and family therapists
- Counselors

VA CCN CIHS includes biofeedback, hypnotherapy, relaxation techniques and Native American healing.

UBH serves all areas, except Puerto Rico and the U.S. Virgin Islands. Those areas are covered by a leased network.

OptumHealth Care Solutions, LLC

OptumHealth Care Solutions, LLC, (OHCS) provides a network of freestanding physical health providers and services for VA CCN, which includes:

- Physical therapy
- Occupational therapy
- Speech therapy
- Chiropractic services
- Acupuncture

The OHCS network also includes providers who provide some CIHS, including:

- Massage therapy
- Tai chi

OHCS provides tai chi in all areas. All other specialties listed above are provided by OHCS in all areas except Puerto Rico and the U.S. Virgin Islands. Those areas are covered by a leased network.

Logistics Health, Inc.

Logistics Health, Inc. (LHI) provides a network of general and specialized dental providers covering all geographic areas. This network provides outpatient dental care to all eligible Veterans.

CVS Caremark Pharmacy

CVS Caremark Pharmacy serves as a pharmacy benefits manager (PBM) and a retail pharmacy network covering all geographic areas for the VA CCN. The retail pharmacies provide prescription fulfillment services for urgent or emergent prescriptions from VA CCN and VA providers.

UnitedHealthcare Vision

UnitedHealthcare Vision provides a network of eye care professionals covering all geographic areas. This network provides routine eye examinations.

PROVIDER RESOURCES

Online

VA Community Care Provider Portal and Website

VA has VA CCN provider resources available at va.gov/COMMUNITYCARE/providers.

VA Community Care Provider portal, also known as HealthShare Referral Manager (HSRM), will enhance efficiency with electronic file sharing between VA and providers by allowing VA CCN providers to sign in to view approved referrals, submit medical documentation and Request for Service (RFS) form.

Optum VA Community Care Network Provider Portal

Optum VA Community Care Network provider portal is available at provider.vacommunitycare.com. The provider portal contains Training & Guides, News & Announcements and Documents & Links. A new COVID-19 section has been added where providers can view the latest VA Community Care Network information related to COVID-19. Additional functionality is available from the Medical/Behavioral Provider icon after you sign in.

Optum's portal provides:

- Claim status and submission
- Provider resources and education
- Real-time pharmacy dispensing information to help prevent medication errors
- Referral status

- Veteran eligibility

Online assistance is available through online chat from 8 a.m. – 6 p.m. provider's local time, Monday – Friday, excluding federal holidays, at provider.vacommunitycare.com > Medical/Behavioral Provider.

Support by Phone

A dedicated Provider Services support team is available to answer inquiries from 8 a.m. – 6 p.m. provider's local time, Monday – Friday, excluding federal holidays.

- CCN Provider Services Region 1: 888-901-7407
- CCN Provider Services Region 2: 844-839-6108
- CCN Provider Services Region 3: 888-901-6613

To determine the appropriate phone number for the provider's region, click here.

CCN Provider Services assists with:

- Benefits issue resolution
- Claims status and issue resolution
- Pharmacy issue resolution
- Provider enrollment
- Referrals status
- Veteran eligibility

Tip: Providers can obtain much of this information and submit transactions on Optum VA Community Care Network provider portal. To learn more, please go to provider.vacommunitycare.com.

COVERED SERVICES

Health Care Services

Eligibility for community care is determined by VA before a Veteran can be referred to a community provider. VA will issue an approved referral to authorize a specific standardized episode of care (SEOC). SEOCs will indicate a set of services and procedures that relate to a specific category of care and will include a specified number of visits, services and duration, not to exceed one year.

The VA health benefits may include, but are not limited to:

- Acupuncture
- Adult day health care
- Ancillary services
- Assisted Reproductive Therapy (ART) and In Vitro Fertilization (IVF)
- Behavioral health (to include professional counseling and substance abuse)
- Chronic dialysis treatment
- Comprehensive rehabilitative services
- Dental care
- Emergent care
- Geriatrics (non-institutional extended care services, including, but not limited to non-institutional geriatric evaluation, non-institutional adult day health care and non-institutional respite care)
- Home health care (skilled and unskilled)
- Hospice, palliative and respite care

- Hospital services
- Immunizations
- Implants – when provided as part of an authorized surgical or medical procedure
- Inpatient diagnostic and treatment services
- Long-term acute care
- Maternity* and women's health
- Outpatient diagnostic and treatment services (including laboratory services)
- Pharmacy
- Preventive care
- Reconstructive surgery
- Rehabilitative services and therapies
- Residential care
- Skilled nursing facility care – limitation of rehabilitation services is no more than 100 days per calendar year
- Transplant services
- Urgent care**

* Newborns are covered under the Veteran's maternity and newborn approved referral for the first seven days. Claims for newborns must be submitted with the Veteran's Social Security number (SSN) or Integration Control number (ICN) and include the Veteran's approved referral number. If newborn services are performed by an out-of-network provider and there is not a maternity and newborn approved referral for the Veteran, the claims will be denied, and the out-of-network provider will need to submit claims directly to VA.

** Optum began administering the urgent care benefit for Region 1 on March 18, 2020, and Regions 2 and 3 on Sept. 1, 2020.

COVID-19 viral testing of eligible Veterans is eligible for reimbursement at one of the following locations:

- CCN in-network urgent care/retail locations in conjunction with a clinical visit for care
- CCN provider office when an approved referral exists
- CCN in-network emergency departments**,** if the visit otherwise meets criteria for VA coverage of emergency care services and the emergency department receives a retroactive approved referral within 72 hours.

Request for Services

Providers must submit a Request for Service (RFS) form 10-10172 to VA, when a need is identified for additional care that falls outside the original referral and SEOC or if there is a need to extend the duration of the referral. VA will process all requests within three business days and the provider will be notified of the decision or outcome through their preferred method of communication. The notification will also indicate if the care will be provided within VA or in the community. This form is also used for DME, medical devices, orthotics, prosthetics, eyeglasses and oxygen requests.

The provider is required to send the completed form to VA the same day the provider determines care is needed.

This form can be uploaded into HSRM or sent to VA through secure email or secure fax and must include the provider signature. The signature is necessary since the RFS serves as physician orders. This form is available at provider.vacommunitycare.com > Documents & Links. A separate form is required for each service requested.

All requests must contain the following information:

- Date of request
- Veteran's full name
- Veteran's date of birth
- Veteran's last four digits of SSN
- Prescribing provider's full name
- Prescribing provider's address
- Prescribing provider's phone number
- Prescribing provider's fax number
- Prescribing provider's specialty type
- Prescribing provider's signature
- Diagnosis and International Classification of Diseases ICD-10 code(s)
- Description and Healthcare Common Procedure Coding System (HCPCS) code for each item
- Detailed information (brand, make, model, part number, etc.) and medical justification for each prescribed item (if a specific brand/model/product is prescribed)
- Item delivery location/address and expected delivery date
- Check the applicable box indicating if education and/or fitting has been completed

VA will decide if the additional services are approved. If services are approved, VA will either issue an approved referral or VA will provide the services.

If the services requested are not authorized by VA, the provider may request referral reconsideration from VA. Requests for referral reconsideration must be submitted to VA within 90 days from the date of denial.

Durable Medical Equipment, Medical Devices, Orthotic and Prosthetic Items

Providers may only provide DME, medical devices, orthotics and prosthetics to eligible Veterans for an urgent or emergent condition for the first 30 days. CCN will not pay for DME rentals beyond the initial 30 days. Provider must submit RFS to VA if rental required beyond 30 days. VA provides all non-urgent or non-emergent DME items. To locate more information on VA's expansive list of DME, medical devices, orthotics and prosthetics, access prosthetics.va.gov/psas.

Urgent or Emergent DME, Medical Devices, Orthotics and Prosthetics

If a provider determines that DME, medical devices, orthotics and prosthetics are needed emergently or urgently to stabilize or decrease the risk of further injury, it is covered under the visit and can be provided by the community provider. Urgent or emergent DME, medical devices, orthotics and prosthetics may include, but are not limited to:

- Canes
- Crutches
- Manual wheelchairs
- Slings
- Soft collars
- Splints
- Walkers

Scheduled Procedures or Discharge

Providers must coordinate with VA in advance of a scheduled procedure or patient discharge to help ensure the DME, medical device, orthotics and prosthetics are approved and available to the Veteran when needed.

Purchase or Rental

Providers must help ensure the most cost-effective option for urgent or emergent DME or medical devices when considering renting or purchasing. The rental period may not be more than 30 days. Providers should submit requests for long-term DME needs to VA for fulfillment, using the RFS form. The RFS form must include the following:

- Detailed information (brand, make, model, part number, etc.) and medical justification for each prescribed item (if a specific brand/model/product is prescribed)
- Item delivery location/address and expected delivery date
- Patient education was completed or mailed to provider to finalize education
- Medical provider's signature

Routine DME, Medical Devices, Orthotics and Prosthetics

Providers must submit all requests for routine DME, medical devices, orthotics and prosthetics to VA using an RFS form. VA will provide the DME, medical devices, orthotics and prosthetics to the Veteran. VA reserves the right to issue comparable, functionally equivalent DME, medical devices, orthotics and prosthetics.

Hearing Aids

The provider treating the Veteran must be an audiologist licensed in the state where services are being provided.

Hearing aids cannot be purchased or provided by providers. Providers must provide the initial testing results related to the potential hearing aid needs to VA for review by completing the appropriate hearing aid order form based on the recommended make and model. The specific audiogram requirements are outlined in the Veterans Health Administration (VHA) Audiology Toolkit provided by VA with the approved referral. If the hearing aid request is approved, VA will place an order for the Veteran's hearing aid. VA will send the hearing aid to the requesting provider who will be responsible for the Veteran's follow-up care and hearing aid fitting.

Home Oxygen

Providers must submit all requests for home oxygen to VA for review and fulfillment using an RFS form including the definitive testing results and a detailed home oxygen prescription. Home oxygen equipment or supplies cannot be purchased or provided by providers. The need for home oxygen must always be planned sufficiently in advance of the procedure or patient discharge to avoid delay in fulfilling the prescription.

Sleep Apnea

Oral Appliance Therapy (OAT) is classified as medical treatment for a medical disorder, obstructive sleep apnea, which is provided by a licensed dentist. OAT for obstructive sleep apnea will be provided through Optum's VA CCN dental network.

Follow-Up Care

Providers are responsible for all necessary follow-up care, including Veteran's education, training, fitting and adjustment. VA will procure and send the requested item to the provider's location, unless the provider indicates on the RFS form that training and education has already been completed, in which case the item may be sent to the Veteran directly.

Assisted Reproductive Technologies (ART) In Vitro Fertilization (IVF)

When clinically appropriate, VA Medical Centers (VAMC) may issue approved referrals for ART/IVF services for an eligible Veteran and the Veteran's spouse. VA determines the Veteran's eligibility based on the Veteran having a service-connected (SC) condition that results in the inability to procreate without the use of fertility treatment. The Veteran's spouse, defined as a legally married, opposite sex spouse, does not have to be a Veteran to receive ART/IVF services.

There are four SEOCs for ART/IVF services which outline the care VA may authorize:

- Infertility Female
- Infertility Male
- IVF ART Female
- IVF ART Male

Covered services may include:

- Stimulation of ovulation
- Monitoring of ovulation stimulation
- Oocyte retrieval
- Laboratory studies
- Embryo assessment and transfer
- Luteal phase support
- Cryopreservation of sperm, oocytes and embryos

See the below table for maximum IVF attempts and completed cycles.

IVF Attempt	IVF Cycle
Embryo transfer does not occur	Embryo is transferred to the uterus
It counts as an attempt if: 1. An egg retrieval occurs, and no eggs are retrieved or, 2. Eggs are retrieved but embryos are not transferred due to: a. No embryos are available for transfer b. Embryos are cryopreserved but not yet transferred 3. A cryopreserved embryo is thawed/rewarmed and is not viable for transfer and thus is not transferred	**It counts as a completed cycle if:** 1. There is a fresh embryo transfer (regardless of the number of embryos transferred) 2. There is a cryopreserved and thawed/rewarmed embryo transfer (regardless of the number of embryos transferred 3. Each transfer counts as a completed cycle, regardless of whether or not a pregnancy and/or live birth results
VA will cover up to six attempts to achieve three completed cycles over the lifetime of the Veteran	VA will cover three completed cycles over the lifetime of the Veteran

IVF and infertility prescriptions are not considered urgent or emergent. VA pharmacies will provide prescription fulfillment services for eligible Veterans and their spouses for all IVF and infertility related medications.

- VA pharmacies do not stock IVF and fertility prescriptions as standard shelf medications. The provider must coordinate with VA pharmacies on IVF and infertility medication/prescription needs to ensure a Veteran and/or spouse receive prescriptions in a timely manner.

Urgent/emergent prescriptions written for a Veteran or spouse by a CCN in-network provider can be filled at a CCN pharmacy using the urgent/emergent formulary. Urgent/emergent prescriptions written for a Veteran or spouse by a provider who is not contracted for CCN, must be filled at a VA pharmacy or paid by the Veteran out of pocket at a retail pharmacy. Veteran may submit to VA for reimbursement consideration.

Transplants

When clinically appropriate, VA Medical Centers (VAMC) may issue approved referrals for transplant services. Approved referrals will be issued to a Medicare-approved Certified Transplant Center (CTC) for transplant services.

To ensure the Veteran receives timely care, VA requires the CTC to either accept or reject a comprehensive evaluation approved referral within the specific time frames listed below. VA will determine whether a referral is classified as stable or emergency for purposes of the below time frames.

- Stable Referrals: Initial review and acceptance or rejection of referral must be completed by the CTC within 10 business days of receipt of referral.
- Emergency Referrals: The CTC will ensure availability of an appropriate in-network transplant physician for discussion within six hours by phone.

The CTC must complete the initial face-to-face comprehensive transplant evaluation by the multidisciplinary transplant team and submit the evaluation results to the referring VAMC no later than 60 days after the approved referral was received. If the CTC determines the Veteran to be a transplant candidate, the CTC must submit an RFS form to VA requesting transplant services. The comprehensive transplant evaluation results and course of treatment shall be reviewed and agreed to between the CTC and the referring VAMC.

When VA issues a waitlist management and transplantation referral to CTC, it includes all medically necessary services included in SEOC. Ventricular assist device (VADs) is not part of a transplantation referral. If a Veteran needs a VAD the CTC must submit an RFS form. VA will review request and if approved will provide the service or issue an approved referral to a CCN Provider to implant device.

The CTC responsible for the transplant shall list the Veteran on the Organ Procurement and Transplantation Network (OPTN) organ waiting list and communicate the listing of the Veteran to the referring VAMC facility within 5 business days of that event.

Following a transplant, the CTC may receive a post-transplant follow up approved referral and SEOC. The CTC is responsible for all medically necessary post-transplant care included in the post-transplant SEOC.

Urgent Care

Optum began administering the urgent care benefit for Region 1 on March 18, 2020, and Regions 2 and 3 on Sept. 1, 2020. To determine the states included in each region, click here.

- Urgent care providers must be participating in the VA CCN and post Optum-provided signage that clearly identifies them as a VA urgent care benefit participating location.
- Eligible Veterans may receive urgent care without an approved referral.

Providers Required to Verify Veteran Eligibility

VA CCN urgent care providers are required to call the Urgent Care Eligibility Call Center to verify eligibility at 888-901-6609 prior to providing care to a Veteran. The automated Interactive Voice Response (IVR) is available 24 hours a day, seven days a week. If eligibility is not verified, it will cause a delay in the Veteran filling a prescription and may lead to your claim being denied if the Veteran is not eligible.

To verify eligibility, have the following information available:

Veteran information:

- Last four digits of the Veteran's SSN
- Date of birth (MMDDYYYY)

Urgent care facility information:

- National Provider Identifier (NPI) number
- ZIP code of the urgent care location

Upon verifying Veteran eligibility, the IVR will provide an Urgent Care Eligibility Record Number (UCERN), which will be required on the claim.

If the Veteran is not eligible for the urgent care benefit, the Veteran will be required to pay out-of-pocket if they choose to be seen. The Veteran may contact VA to discuss urgent care eligibility status and possible reimbursement of out-of-pocket expenses.

Veterans may also verify eligibility for urgent care by calling 844-698-2311 or by checking the Veteran portal at vacommunitycare.com > I am a Veteran.

Covered Services

The urgent care benefit is considered open access. Eligible Veterans may go to an in-network urgent care facility, walk-in retail health clinic or on-campus outpatient hospital for care without a referral from VA. The urgent care benefit covers injuries and illnesses that require immediate attention, but are not life-threatening, such as:

- Cold and flu
- Ear infection
- Minor injury
- Pink eye
- Skin infection
- Strep throat
- Flu shot

If you have urgent care benefit questions, please call the Urgent Care Eligibility Call Center at 888-901-6609, 7 a.m. – midnight, provider's local time, seven days a week.

Preventive and dental services are excluded.

Medical Documentation Requirements for Urgent Care

VA CCN urgent care providers must fax or securely email all medical documentation to the Veteran's assigned VAMC, if known, or the closest VAMC to the Veteran's residential ZIP code within 30 days of the date of service. To locate the appropriate VA facility to submit your medical documentation, use the Find VA Locations locator tool at va.gov/find-locations.

For more information on the urgent care benefit, visit va.gov/communitycare > Urgent Care or provider.vacommunitycare.com > Training & Guides > Benefits > Urgent Care Benefits.

Pharmacy

Prescriber Requirements:

- Providers are prohibited from giving pharmaceutical samples to Veterans.
- VA may use VA-approved alternate prescribing practices when issuing medication.
- Incomplete prescriptions will be returned to the prescribing provider and will have to be resubmitted to the authorizing VA facility's pharmacy.
- VA does not consider topical compounds urgent or emergent.

Prescribing Controlled Substances

Before prescribing controlled substances for a Veteran, VA requires providers to check their state's prescription-monitoring program to see if the Veteran has been prescribed other controlled substances. This can help providers and Veterans help ensure appropriate use of controlled substances.

Urgent and Emergent Prescriptions

Providers can write an urgent or emergent prescription to be filled at a VA CCN retail pharmacy for up to a 14-day supply without refills. Opioids may be filled up to a seven-day supply or to state limits, whichever is less. When it is determined to be medically appropriate, a second prescription for opioids may be filled at a VA CCN retail pharmacy for up to a seven-day supply or state limits, whichever is less (up to a 14 days' total supply). Buprenorphine may be filled for an initial 14-day supply and will allow for a second fill of up to a 14-day supply within 30 days (up to a 28-day total supply). With the exception of Urgent Care, the prescription must be associated with an approved referral.

When urgent or emergent prescriptions are clinically needed for continued or maintenance treatment beyond the initial urgent/emergent 14-day supply, providers must generate a second prescription for the additional days' supply. Providers should submit the second prescription to the referring VA facility's pharmacy by electronic prescribing or fax. To obtain the pharmacy fax number, contact the community care representative at the referring VA medical facility.

Urgent or emergent prescriptions for the same drug and strength within 30 days of the original 14-day prescription will not be eligible at a VA CCN retail pharmacy with the exception of a one-time continuation of pain or antibiotic therapy. Following the dispensing of the second 14-day supply by VA CCN retail pharmacy, subsequent prescriptions for the same therapy will be required to be filled at the local VA pharmacy.

When a medication requires prior authorization, providers must submit supporting medical documentation for the urgent or emergent prescription to the VA CCN retail pharmacy. The retail pharmacy, through the PBM, will review and determine if the prior authorization drug request (PADR) is approved. If it is approved, the retail pharmacy will dispense the medication as appropriate. Providers can submit a PADR using electronic prescribing or by fax to CVS Caremark at 888-836-0730. Providers can call CVS Caremark at 855-297-2026 with questions on the PADR submission process or status.

Using VA CCN Retail Pharmacies

VA CCN retail pharmacies support electronic prescribing and follow established clinical protocol for registration of new patients to determine a Veteran's allergy and previous drug history. The pharmacy must dispense prescriptions in accordance with the VA pharmacy mandatory generic substitution policy.

Prescribing Without a Referral

If there is not an approved referral for emergency care, the Veteran will be required to pay out-of-pocket for the prescription. The prescribing provider must inform the Veteran of their option to contact the nearest VA to request reimbursement for any out-of-pocket expenses.

Routine and Maintenance Prescriptions

Providers with an approved referral must submit a prescription for routine and maintenance medication to the authorizing VA facility's pharmacy to fulfill by fax or electronic prescribing. Prescribing providers need to include the following information when forwarding the Veteran's prescription to the VA facility's pharmacy:

- Veteran's full name
- Veteran's date of birth
- Veteran's ICN or SSN
- Prescribing provider's full name
- Prescribing provider's National Provider Identifier (NPI) number
- Prescribing provider's tax identification number (TIN)
- Prescribing provider's own Drug Enforcement Administration (DEA) number and expiration date (not a generic facility number)
- Prescribing provider's office address
- Prescribing provider's office phone number
- Prescribing provider's fax number (if applicable)
- Prescribing provider's discipline (e.g., physician, physician assistant, nurse practitioner, etc.)

When a prior authorization is required, a provider must submit the medical documentation with the prescription to VA pharmacy for review. The referring VA pharmacy will determine if the PADR is approved and dispense the medication as appropriate. Providers can submit a PADR using electronic prescribing or by faxing to VA pharmacy.

Formularies: Finding VA's Preferred Medications

- VA has an Urgent/Emergent Formulary and a National Formulary located at pbm.va.gov > VA National Formulary > Formulary Documents.
- The Urgent/Emergent Formulary is also available at provider.vacommunitycare.com > Formulary and Pharmacy Search.
- When prescribing for an urgent or emergent need, providers must use the Urgent/Emergent Formulary.
- For all routine maintenance prescriptions, please reference the VA National Formulary and submit the prescription directly to the VA pharmacy for fulfillment. The National Formulary is available at pbm.va.gov > VA National Formulary > Formulary Documents.
- The VA Formulary Search tool provides formulary alternatives to non-formulary drugs in the same VA drug class. The tool is available at pbm.va.gov/apps/VANationalFormulary.
- Additional information about VA's formularies and requesting non-formulary medications, including VA National Formulary Frequently Asked Questions, is available at pbm.va.gov > VA National Formulary > Formulary Documents.

Seasonal Influenza (Flu) Vaccine

Flu vaccinations do not require a referral or copayment at a VA CCN retail pharmacy that offers flu vaccinations, in accordance with VA vaccination recommendations, at publichealth.va.gov > Health and Wellness > Vaccines and Immunizations and the Centers for Disease Control and Prevention (CDC) immunization protocols at cdc.gov/vaccines.

- A VA CCN retail pharmacy administering the flu vaccine must verify the Veteran's eligibility before delivering a flu vaccination. Veterans are required to present a valid identification with full name and a photograph to verify eligibility and identity. The identification may be in the form of a Veteran Health Identification Card (VHIC), federal-issued identification (e.g., passport) or state-issued identification (e.g., driver's license).
- Veterans who have a scheduled office visit with a provider may request a flu vaccination at no charge during the referred visit.
- Urgent Care eligible Veterans may receive a flu vaccination at a CCN urgent care facility. Claim must be billed with an UCERN.
- Providers will follow the Claim Submission guidelines when requesting reimbursement for the flu vaccination.

Other Vaccinations

All other vaccinations require an approved referral from VA.

VA CCN Complementary and Integrative Healthcare Services (CIHS)

VA's medical benefits package includes CIHS based on VA's determination that they promote, preserve and restore health, and are in accordance with generally accepted standards of medical practice. Where applicable, VA will issue an approved referral with a SEOC to include CIHS. More information on SEOCs can be found in the Referral Section of this manual.

CIHS providers should submit claims using the appropriate CPT® code or Healthcare Common Procedure Coding System (HCPCS) code for the CIHS services listed below:

- Biofeedback
- Hypnotherapy
- Massage therapy
- Native American healing
- Relaxation techniques (for example, meditation or guided imagery)
- Tai chi

VA CCN Health Care Service Exceptions

The following services may be provided to Veterans directly by VA, but are not payable under your VA CCN Participation Agreement:

- Ambulance services (ambulance services must be referred directly to VA for payment consideration)
- Home deliveries and non-approved maternity care services to include deliveries by direct entry midwives (also known as lay midwives or certified professional midwives) and medical procedures not consistent with the standard of care for maternity care services
- Medical and rehabilitative evaluation for artificial limbs and specialized devices, such as adaptive sports and recreational equipment

- Nursing home care, including state Veterans' home per diem
- Veteran travel
- Yoga
- CIHS: acupressure, Alexander technique, animal-assisted therapy (falls under recreation therapy), aroma therapy, biofield therapies (healing touch, reiki and therapeutic touch), emotional freedom technique, rolfing, reflexology, somatic experiencing and zero balancing

Excluded VA CCN Health Care Services

The following services are excluded from the VA CCN health benefit package:

- Abortion or abortion counseling
- Drugs, biologicals and medical devices not approved by the Food and Drug Administration (FDA) unless they are used under approved clinical research trials
- Gender alterations, however, medically indicated diagnostic testing or treatments related to gender alterations are covered benefits
- Hospital and outpatient care for a Veteran who is either a patient or inmate in an institution of another government agency, if that agency has a duty to give the care or services
- Membership in spas or health clubs
- Out-of-network services, other than certain limited services provided pursuant to a VA CCN approved referral

CREDENTIALING

Optum, UnitedHealthcare or its designee must credential providers and facilities according to requirements from nationally recognized accrediting organizations. Credentialing is generally not required for health care professionals who are permitted to furnish services only under the direct supervision of another licensed independent practitioner or for hospital- or facility-based health care professionals who provide services to covered persons incidental to hospital or facility services. Providers who are currently credentialed and participating with Optum or UnitedHealthcare, as applicable, aren't required to complete a separate credentialing application for the VA CCN.

Professional Credentialing, Licensing and Accreditation

All providers and practitioners in the VA CCN must be credentialed by the appropriate accrediting organization.

The credentialing process involves obtaining primary-source verification of the provider's education, board certification, license, professional background, malpractice history and other pertinent data.

New providers, who are not currently credentialed and participating with one of our Network Partners, will have to complete a standardized, applicable, nationally accredited credentialing process to participate in the VA CCN.

If a provider specialty is not credentialed under an accredited credentialing process, the provider must operate within the scope of the provider's professional license and maintain and provide, upon request, the following documentation:

- Proof of identity with a government-issued photo and I-9 documentation
- An active, unrestricted license from the state where the service is provided, if applicable (unskilled home health excluded)
- Criminal background disclosure

- Current National Provider Identifier (NPI) number, if applicable (unskilled home health excluded)
- Drug Enforcement Administration (DEA) number if controlled substances are prescribed
- Education and training, if applicable (unskilled home health excluded)
  - Professional references
  - Proof of professional liability insurance in an amount in accordance with the laws of the state in which the care is provided
  - Tax ID number (TIN)
  - Work history

If you're a provider licensed, registered or certified in more than one state, you must certify that:

- None of the licenses, registrations or certifications in those states has been terminated for cause
- You haven't involuntarily relinquished such license, registration or certification in any of those states after being notified in writing by that state of a potential termination for cause

The provider must notify the appropriate Network Partner within five days of the occurrence of action, lapse or limit impacting the provider license, registration or certification as applicable. If any state in which a provider is licensed, registered or certified terminates such license, registration or certification, the provider will be removed from the VA CCN.

All services, facilities and providers must adhere to all applicable federal and state regulatory requirements. Optum will monitor the U.S. Department of Health and Human Services (HHS) Office of Inspector General (OIG) exclusionary list. If you're on the exclusionary list, you won't be eligible to participate in the network. See oig.hhs.gov/exclusions for more information about the exclusionary list. If you don't maintain your credentialing status, your Provider Agreement could also be terminated.

In accordance with requirements outlined in the OIG's Compliance Guidance, all services, facilities and providers, as applicable, must have a compliance program in place that includes:

- Conducting internal monitoring and auditing
- Implementing compliance and practice standards
- Designating a Compliance Officer or contact
- Conducting appropriate training and education
- Responding appropriately to detected offenses and developing corrective action
- Developing open lines of communication
- Enforcing disciplinary standards through well-publicized guidelines

Professional Liability Insurance Requirement

Providers must maintain, during the term of their Provider Agreement, professional liability insurance issued by a responsible insurance carrier of not less than (per specialty per occurrence):

- $1,000,000 per occurrence
- $3,000,000 aggregate

In lieu of purchasing the required insurance coverage, a provider may self-insure its medical malpractice and/or professional liability, as well as its commercial general liability coverage.

Unskilled or non-clinical providers (e.g., tai chi instructors, massage therapists, etc.) are only required to maintain insurance coverage consistent with the types and limits commonly necessary for their scope of practice, as determined by Optum and VA.

Providers must notify Optum of any change in professional liability insurance carrier. New professional liability policies must meet the coverage limits and other coverage requirements.

Facility Accreditation

All inpatient facilities must maintain one of the following accreditations:

- Joint Commission accreditation
- American Osteopathic Association – AOA
- Commission on Accreditation of Rehabilitation Facilities – CARF

Rehabilitation facilities that maintain a Joint Commission accreditation are not required to maintain an additional CARF accreditation.

Facilities are required to immediately notify the appropriate Network Partner of any changes in facility accreditation.

CIHS Credentialing

When a CIHS provider's practice area provides for certification or licensure, the provider must have and maintain that certification or licensure.

Like all providers, CIHS providers must comply with all applicable federal and state laws, statutes and regulatory requirements.

PROVIDER RESPONSIBILITIES

Updating Demographic Information

It's important for providers to report any outdated or incorrect demographic information as soon as possible. This allows us to provide accurate information to Veterans and referring providers through the VA CCN Provider Directory and will help ensure that claims are appropriately paid, and payments are made correctly.

Providers are encouraged to view the online VA CCN Provider Directory and verify their information. Any corrections should be immediately reported to the Network Partner maintaining your record.

Table 1: Provider Demographic Updates

Network	Provider Type	Submit Updates
UnitedHealthcare	Medical professionals Facilities Ancillary providers	UHCprovider.com/mypracticeprofile
UnitedHealthcare Providers	National laboratory National ancillary providers	Email updates to naspi@uhc.com

Network	Provider Type	Submit Updates
UnitedHealthcare Vision	Vision providers	spectera.com Sign in with user ID and password. Click on the Entity Management tab. Complete changes and submit. Provider can also submit changes through Attestation process.
United Behavioral Health	Mental health Substance abuse	providerexpress.com
Logistics Health Incorporated (LHI)	Dental providers	All updates must be submitted by email to LHI_ProviderNetworkCommunications@logisticshealth.com
Optum Complex Care Management (Optum CCM)	Skilled nursing facilities	For skilled nursing facilities (SNFs), follow the process defined by your Optum Regional Contract team.
OptumHealth Care Solutions, LLC (OHCS)	Acupuncture Chiropractic Massage therapy Occupational therapy Physical therapy Speech pathology Tai chi	myoptumhealthphysicalhealth.com Fax updates to 888-626-1701 Mail updates to: Optum Provider Data Mgmt. MN103-0700 P.O. Box 1459 Minneapolis, MN 55440-1459

Non-Discrimination

Providers must provide all services for any person determined eligible by VA, regardless of the race, color, religion, sex or national origin of the person for whom such services are ordered.

Veteran Appointments

Providers must honor all appointments with Veterans for covered services with an approved referral.

If a provider cancels a Veteran's appointment, the appointment must be rescheduled in a timely manner based on the medical necessity of the Veteran and the required VA CCN appointment availability standards, from the time of initial appointment request:

- Within 24 hours for emergent health care need
- Within 48 hours for urgent health care need
- Within 30 days for routine care need

Providers must not charge Veterans for missing a scheduled appointment.

Provider Satisfaction Surveys

Participating in the Provider Satisfaction Survey is important because the results allow both VA and Optum to understand areas where the network experience can be enhanced for all stakeholders.

The survey was developed by VA and is required to be made available to providers with one or more claims submitted within a quarter.

Individual responses are confidential to VA.

To complete the survey, go to provider.vacommunitycare.com > News & Announcements. Select the Provider Satisfaction Survey hyperlink and follow the prompts to complete each question. Once finished, select Submit.

Questions related to the survey can be directed to CCN Provider Services for your region.

Dental Provider Requirements

VA CCN dental providers must comply with the most current version of the Code on Dental Procedures and Nomenclature published in the American Dental Association's (ADA) Current Dental Terminology (CDT) manual. There is a separate provider manual for dental providers located at provider.vacommunitycare.com > Training & Guides > VA CCN Provider Manual for Dental Providers. Dental functionality is available from provider.vacommunitycare.com > Dental Provider.

Out-of-Network Providers

Typically, out-of-network providers must submit health care claims directly to VA and follow the VA claim submission process. Supporting medical documentation must be submitted with the claim. You can find information on VA's process at va.gov/communitycare. The only applicable out-of-network providers who may be eligible for reimbursement by Optum are (1) ancillary providers when their services are provided as an adjunct to medical or surgical services provided by in-network providers and (2) Out-of-network facility providers, at which the services provided are performed by an in-network physician performing scheduled, non-emergent care. For these limited instances where out-of-network providers are eligible for reimbursement by Optum for VA-approved care as defined in the SEOC, the reimbursement amounts paid by Optum to out-of-network providers may be less than the reimbursement amounts paid to in-network providers. All care provided to a Veteran must be included on a CCN-approved referral. To ensure timely claims processing, in-network providers should forward the approved referral, including referral number, to the out-of-network provider when the in-network provider or facility refers to another provider for approved services on the referral. To ensure timely claims processing, the out-of-network provider should include the referral number on the claim.

Fraud, Waste and Abuse Reporting

Fraud is the intentional misrepresentation of information to gain undeserved payment for a claim. Fraud is generally defined as knowingly and willfully executing, or attempting to execute, a scheme or artifice to defraud any health care benefit program or to obtain (by means of false or fraudulent pretenses, representations or promises) any of the money or property owned by, or under the custody or control of, any health care benefit.

One example could be when a provider or staff member knowingly bills for services not provided or bills more costly services than provided, including billing for brand name drugs when generics are dispensed.

Waste is the spending of federal health care dollars on services that are unnecessary. Abuse is a questionable practice that is inconsistent with accepted medical or business practices. Instances of waste or abuse may be unintentional, resulting from a variety of causes, including limited knowledge about best practices or delays in implementing new processes that would improve efficiencies.

As a provider, if you identify potential fraud, waste or abuse, report it to Optum immediately so we can investigate and respond.

To report suspected fraud or abuse, please contact Optum using one of the following methods:

Complete the Fraud, Waste and Abuse Reporting form available at provider.vacommunitycare.com > Document & Links.

Phone:
Optum Fraud, Waste, and Abuse Hotline:

- Region 1: 844-883-3461
- Region 2: 844-883-3669
- Region 3: 844-883-3684

To determine the provider's region, click here.

In cases of fraud, waste or abuse, Optum will make every reasonable attempt to recover improper payments for services delivered to Veterans or to anyone not eligible to receive a benefit as part of the VA CCN.

ELIGIBILITY AND ENROLLMENT

Confirming Eligibility

VA determines Veteran eligibility for community care. A Veteran must be eligible for community care to be referred to a provider participating in VA CCN. Veterans are required to present a valid identification with full name and a photograph to verify identity before receiving care. The identification may be in the form of a Veteran Health Identification Card (VHIC), U.S. government-issued passport or a state driver's license. Veterans will not have a VA CCN health insurance identification card. An approved referral sent to the provider or the referral letter VA has sent the Veteran is proof of eligibility. Providers can confirm a Veteran's enrollment status online at provider.vacommunitycare.com > Medical/Behavioral Provider or by calling CCN Provider Services for your region.

Primary Care Provider (PCP) Designation

Each Veteran will have a PCP. If the Veteran's PCP is a VA CCN provider, VA will issue an approved referral to the PCP indicating the length of time it is valid, either six months or one year. VA may communicate a Veteran's PCP assignment information on an approved referral. This helps ensure that providers can share pertinent medical documentation with the assigned PCP.

REFERRALS

All services require an approved referral from VA before claims can be processed. Approved referrals from VA will authorize a specific SEOC that will include a specified number of visits and/or services related to a plan of care. The referral packet will include the referral with a SEOC, consult/order with chief complaint, patient history and clinical findings related to the chief complaint. The consult/order states what the VA provider is requesting from the community provider. Because VA does not want to delay treatment of a

Veteran, in addition to the consult/order, the provider is approved for all medically necessary services for the quantities listed on the SEOC. Services the provider feels are medically necessary, that are included within the SEOC, may be completed without an additional approved referral. The VA SEOC billing code list of preapproved billing codes associated to the services within each SEOC are located at va.gov/COMMUNITYCARE/providers/PRCT_requirements.asp#list or provider.vacommunitycare.com > Documents & Links > Fee Schedules and VA SEOC Billing Codes > VA SEOC Billing Code List.

The approved referral will state the issue and expiration date. The expiration date may change based on the date of first appointment to allow for the complete time frame from first appointment to the expiration date. When recalculated, a new referral is not issued. However, the provider will be able to see the update in HSRM or provider.vacommunitycare.com > Medical/Behavioral Provider.

During the COVID-19 public health emergency, VA will allow providers to care for CCN patients through telehealth and telephonic consults, when clinically appropriate and with an approved referral from a VAMC. For additional details, please see the Treating Veterans during the COVID-10 Public Health Emergency reference document at provider.vacommunitycare.com.

When approved referrals result in the need for urgent or emergent pharmacy prescriptions, or urgent or emergent prescriptions for DME, medical devices, orthotics and prosthetics, these supplies and services are also authorized as part of the SEOC.

VA will send approved referral information, including the referral number and any attachments, to the provider through HSRM, direct messaging, secure email or secure fax.

When VA is referring to a CCN laboratory with a lab and pathology SEOC, the standing lab order will be part of the referral packet.

When VA authorizes a specific number of services per week, Optum calculates approved visits based on a Sunday through Saturday week.

Referrals for emergent services will follow a different process. See the section below on referrals for emergent medical services for more information about requesting an approved retroactive referral in those cases.

To verify the status of a referral, access HSRM, provider.vacommunitycare.com > Medical/Behavioral Provider or call CCN Provider Services for your region.

When it is necessary for a CCN provider to refer care to another provider for services on the approved referral and SEOC, the referring provider must call CCN Provider Services for your region to verify participation status and confirm they are referring to an in-network CCN provider. To ensure timely claims processing, the referring provider should forward the approved referral, including the referral number, to the referred provider.

In limited circumstances when the Veteran has an approved referral, out of network claims may be considered for reimbursement by Optum. For these limited instances where out-of-network providers are eligible for reimbursement by Optum for VA-approved care, as defined in the SEOC, the reimbursement amounts paid by Optum to out-of-network providers may be less than the reimbursement amounts paid to in-network providers. Refer to the Out-of-Network Providers section for more information.

All providers are not permitted to balance bill Veterans for services listed on the approved referral and SEOC.

Any additional services not listed on the SEOC or extension of a treatment period will require making a referral request to VA using the RFS form, with the exception of laboratory or radiology services. Laboratory

and radiology services are covered as long as there is an approved referral on file for the date of service(s) and condition.

It is the responsibility of providers to ensure there is an approved referral before providing care or services to a Veteran, including when a Veteran self-schedules the appointment. This means the provider may need to request a new referral from VA if the Veteran's scheduled appointment falls outside the approved referral's dates of service. This applies to all visits, whether it is the Veteran's initial visit or a follow-up appointment.

With an approved referral, VA is always primary, and claims should be submitted to Optum. If a Veteran has other health insurance please see va.gov/COMMUNITYCARE/providers/PRCT_requirements.asp for additional information.

For an example of a referral packet, see Appendix A – Sample VA Referral Packet in this Manual.

Referral for Emergent Medical Services

Veterans are allowed to seek emergent medical care in a VA CCN emergency department without a referral. The provider must notify the Emergency Care Centralized Notification Center by e-mail or phone within 72 hours of the Veteran presenting to the emergency department:

- VHAEmergencyNotification@va.gov
- 844-72HRVHA (844-724-7842)

The person notifying VA should be prepared to supply the case-specific information detailed in the Non-VA Hospital Emergency Notification, VA Form 10-10143g, when calling or emailing notification.

VA will determine if the Veteran is eligible to receive community care and, if eligible, issue a retroactive approved referral to the provider.

After receiving an approved referral, the provider should follow the Claim Submission Process. The claim must be submitted to Optum within the VA CCN timely filing guidelines of 180 days from the date of service for outpatient care or date of discharge for inpatient care. Claims submitted outside of those timely filing requirements will be denied.

When a Veteran receives services for emergency care from an out-of-network provider, the claim needs to be submitted to VA with medical documentation as soon as possible. Additional information on emergency care and the Non-VA Hospital Emergency Notification form is on VA's community care website at va.gov/COMMUNITYCARE/providers/info_EmergencyCare.asp.

Emergency claims submitted by a provider without an approved referral will be denied. The referral number is required on the claim. To determine the correct location for the referral number on the claim, access the Claims Submission section. Emergency claims denied without a referral would need to be submitted to VA for payment consideration.

If you're providing services to a Veteran under an approved referral and determine that the Veteran is experiencing an emergent symptom or condition, provide emergency treatment to the Veteran or assist the Veteran in seeking emergency treatment and notify the nearest VA immediately.

If a Veteran is receiving approved services and the treating facility determines the Veteran needs a higher level of care than the facility is capable of providing, the facility must notify VA through direct messaging, secure email, secure fax, telephone or EDI (when available). The request should include:

- Facility name and location
- Admitting provider's NPI number

- Admitting diagnosis
- Date of admission
- Any services already delivered (if available)
- Appropriate attachments

Training on how to submit a request for referral is available at provider.vacommunitycare.com > Training & Guides.

HEALTH CARE MANAGEMENT

Critical Findings

Critical findings are findings or results that require immediate evaluation by a provider, such that failure to take immediate appropriate action might result in significant morbidity to, serious adverse consequences to or death of the Veteran.

When a provider makes a critical finding, the provider must communicate the finding, verbally or in writing, to the Veteran, referring provider and VA within either two business days of the discovery or the time frame required to provide any necessary follow-up treatment to the Veteran, whichever is sooner.

Clinical Quality Management

Optum's Clinical Quality Management (CQM) program helps ensure high-quality, safe health care services by using established quality monitoring and improvement principles.

We use our CQM program to:

- Identify the scope of care and services given
- Monitor clinical performance against evidence-based clinical guidelines and service standards
- Monitor and assess the quality and appropriateness of services given to Veterans
- Review the medical qualifications of participating health care professionals
- Achieve continued improvement of member health care and services
- Enhance patient safety and confidentiality of Veteran medical information
- Resolve identified quality issues

CQM also receives and reviews quality-of-service concerns received from VA, a Veteran or a provider about another provider.

High-Performing Providers and Centers of Excellence

Measures

Provider performance will be analyzed and monitored against specific quality and performance measures agreed upon by Optum and VA. Providers who meet the threshold for quality and performance measures are designated as High-Performing Providers, and institutions are designated as Centers of Excellence. Performance will be reviewed and monitored against the following quality and performance measures, which may change based on agreement with VA:

Individual Providers

- Healthcare Effectiveness Data and Information Set (HEDIS®) Measures

Table 2: HEDIS® Measures

Breast Cancer Screening	Percentage of women, ages 50-74, who had a mammogram to screen for breast cancer, per current HEDIS® Technical Specifications.
Colorectal Cancer Screening	Percentage of individuals, ages 50-75, who had an appropriate colorectal cancer screening, per current HEDIS® Technical Specifications. Screening intervals vary according to the method of screening. Eligible enrollees must have evidence of one of the following: • Fecal occult blood test (last year) • FIT-DNA test (last three years) • Flexible sigmoidoscopy (last five years) • CT colonography (five years) • Colonoscopy (last 10 years)
Annual Flu Vaccine	Percentage of individuals who received an influenza vaccination during the most recent flu season.
Adult BMI Assessment	Percentage of individuals, ages 18-74, who had an outpatient visit and whose body mass index (BMI) was documented during the measurement year or the year prior to the measurement year, per current HEDIS® Technical Specifications.
Diabetes Care – Eye Exam	Percentage of individuals, ages 18-75, with diabetes, who had an eye exam (retinal) performed, per current HEDIS® Technical Specifications.
Diabetes Care – Kidney Disease Monitoring	Percentage of individuals, ages 18-75, with diabetes, who had medical attention for nephropathy, per current HEDIS® Technical Specifications.
Diabetes – Blood Sugar Controlled	Percentage of individuals, ages 18-75, with diabetes, who had HbA1c control (<8.0%), per current HEDIS® Technical Specifications.
Controlling Blood Pressure	Percentage of individuals, ages 18-85, who had a diagnosis of hypertension and whose blood pressure was adequately controlled (<140/90), per current HEDIS® Technical Specifications.
Reducing the Risk of Falling	Percentage of individuals, ages 65 or older, who have been screened for fall risk by a primary provider.
Pharmacotherapy Management of COPD Exacerbation (PCE)	Percentage of COPD exacerbations with an inpatient discharge or ED visit, for individuals, ages 40 and older, who were dispensed appropriate medications (two measures): 1) A systemic corticosteroid within 14 days of the event 2) A bronchodilator within 30 days of the event

- Premium Designation

  Other internal data included in High-Performing Provider designation is the Premium Designation data, which provides a designation for providers based on their ability to demonstrate consistent quality and cost-efficient outcomes. These designations help Veterans make informed decisions about their choices in health care providers. The Premium Designation program evaluates doctors in 16 premium specialty areas representing 47 credentialed specialties. All quality measures for the program are based on nationally recognized and established evidence-based performance measurements from organizations such as the National Quality Forum (NQF), the AQA Alliance, NCQA and specialty societies such as the American Medical Association (AMA) Physician Consortium for Performance Improvement (PCPI).

Group Practice Providers

Individual provider performance will be aggregated to determine group practice provider performance. A High-Performing Provider designation will be assigned at the group practice provider level.

Institutional Providers

Hospital Compare Measures

Hospital Consumer Assessment of Healthcare Providers and Systems Survey (HCAHPS) Measures

- Patients who reported that YES, they were given information about what to do during their recovery at home
- Patients who reported that NO, they were not given information about what to do during their recovery at home
- Patients who "Strongly Agree" they understood their care when they left the hospital
- Patients who "Agree" they understood their care when they left the hospital
- Patients who "Disagree" or "Strongly Disagree" they understood their care when they left the hospital
- Patients who gave their hospital a rating of 9 or 10 on a scale from 0 (lowest) to 10 (highest)
- Patients who gave their hospital a rating of 7 or 8 on a scale from 0 (lowest) to 10 (highest)
- Patients who gave their hospital a rating of 6 or lower on a scale from 0 (lowest) to 10 (highest)
- Patients who reported YES, they would definitely recommend the hospital
- Patients who reported YES, they would probably recommend the hospital
- Patients who reported NO, they would not recommend the hospital

Acute Myocardial Infarction (AMI) Measures

- Average number of minutes before outpatients with chest pain or possible heart attack who needed specialized care were transferred to another hospital
- Average number of minutes before outpatients with chest pain or possible heart attack got an ECG
- Median time to fibrinolysis
- Outpatients with chest pain or possible heart attack who received drugs to break up blood clots within 30 minutes of arrival
- Outpatients with chest pain or possible heart attack who received aspirin within 24 hours of arrival or before transferring from the emergency department, outpatients with chest pain or possible heart attack who received aspirin within 24 hours of arrival

Patient Safety Indicators (PSI) Measures include:

- Pressure sores
- Deaths among patients with serious treatable complications after surgery
- Collapsed lung due to medical treatment
- Broken hip from a fall after surgery
- Bleeding or bruising during surgery
- Kidney and diabetic complications after surgery
- Respiratory failure after surgery
- Serious blood clots after surgery
- Bloodstream infection after surgery
- A wound that splits open after surgery on the abdomen or pelvis

- Accidental cuts and tears from medical treatment

Hospital-Acquired Infection (HAI) Measures include:

- Central line-associated bloodstream infections (CLABSI) in ICUs and select wards
- Catheter-associated urinary tract infections (CAUTI) in ICUs and select wards
- Surgical site infections (SSI) from colon surgery
- Surgical site infections (SSI) from abdominal hysterectomy
- Methicillin-resistant Staphylococcus Aureus (MRSA) blood infections
- Clostridium difficile (C.diff.) intestinal infections

An individual provider, group practice provider or institutional provider must meet or exceed the threshold to achieve the designation of a High-Performing Provider or Center of Excellence.

Potential Quality Issue Review

For VA CCN, Optum assesses medical records, claims, referrals and other relevant documentation during the potential quality issue (PQI) investigation process. All care provided under the VA CCN contract, including medical surgical, behavioral health, dental, pharmacy and all complimentary integrated health services, are within the scope for PQI investigations. PQI includes quality of service and/or quality of care concerns, including CMS and National Quality Forum (NQF)-identified "Never Events," in all or any of the following categories:

- Surgical events
- Product or device events
- Patient protection events
- Care management events
- Environmental events
- Radiologic events
- Criminal events
- Documentation events
- Dental events

Providers may be contacted about a potential quality issue by an Optum VA CCN representative.

If you become aware of a PQI while providing care to a Veteran, please complete and submit the Potential Quality Issue (PQI) Referral Form, which is available at provider.vacommunitycare.com > Documents and Links.

Provider Participation

Providers are required to participate in the CQM process in accordance with their Provider Agreement and VA requirements.

Activities that are related to the CQM process may include:

- Participating in the investigation of grievances, PQIs, trends and quality studies
- The request of medical records*, including what documents to send. Optum CQM activities that may require medical records include investigation of a PQI, grievance or identification of possible care concern, trends seen in data and clinical quality studies requiring medical record data.
  - The volume of requests depends directly on the number of grievances, PQIs and/or selection for study sample.

    - Optum must request records upon receipt of PQIs, trends, grievances and/or quality studies.
    - The number of pages will vary based on the episode(s) of care and documentation of care provided.
    - *Please note that Optum is not authorized to reimburse providers for the costs of medical records requested in connection with the CQM process for CCN.
- Complying with peer review, patient safety and clinical quality programs and procedures established by Optum or VA, including:
    - Concurrent reviews
    - Retrospective reviews
    - Allowing Optum and its designees to have access to provider records within the requested time frame and providing complete medical records upon request
    - Participating in audits regarding performance assessments of provider practices
    - Responding to peer review communications and directed corrective actions within specified time frames
- Documentation and submission of HEDIS® and/or HEDIS®-like data for Veterans referred to the provider's practice.

Failure to submit medical records and/or data may impact provider network status. Also, failure to submit timely information will impede the patient safety investigation process.

On-Site Provider Reviews

As part of the Clinical Quality Management Plan (CQMP), Optum may conduct on-site evaluations of providers who have been identified for further evaluation based on performance indicators. Optum may help the provider in developing an action plan to help remedy an area of concern.

CQM Confidentiality

Providers are responsible for helping to ensure the privacy and security protection of information in accordance with applicable federal, state and local laws and provisions applicable to sensitive and personally identifiable health care information.

All Clinical Quality information shall be treated as confidential and in accordance with applicable federal, state and local laws and regulations.

- Individual Veterans will be referred to by number only, using names only when specific reference is necessary.
- Everything related to CQM activities are considered privileged and confidential information.
- We limit PHI access to the minimum necessary.

MEDICAL DOCUMENTATION

Providers are responsible for creating, maintaining and submitting a Veteran's medical documentation to VA according to established requirements.

Access to Records

You are required to:

- Send VA copies of the Veteran's medical or administrative records related to care
- Give access to records to VA or Optum for all dates of service that occurred when you were a contracted provider

Submitting Medical Documentation

Providers must submit medical documentation directly to VA and the referring provider using one of the following:

- HealthShare Referral Manager (HSRM) at va.gov/communitycare > For Providers > Care Coordination > HealthShare Referral Manager (not available for Urgent Care)
- Veterans Health Information Exchange (VHIE) at va.gov/communitycare > For Providers > VA Exchange for Community Care Partners (not available for Urgent Care)
- Secure, encrypted email (Azure RMS) at va.gov/communitycare > For Providers > Azure Rights Management Services
- Secure fax located on the approved referral, or Veteran's l local VAMC for Urgent Care

All medical documentation must include:

- Provider authentication (including a written signature, written initials or electronic signature and provider phone number)
- The Veteran's unique identifier
  - ICN – primary beneficiary ID; or
  - SSN – secondary beneficiary ID; or
  - Electronic Data Interchange Patient Identifier (EDIPI); or
  - Patient Control number (PCN)
- Veteran's full name (including suffix)
- Veteran's date of birth
- Approved referral number

Submission Time Frames

Medical documentation must be submitted to VA and the referring provider when applicable, according to the following time frames:

- Outpatient care
  - Within 30 days of the Veteran's initial appointment
  - Within 30 days of completing care included on an approved referral
- Inpatient care
  - Within 30 days of discharge to include, at a minimum, the discharge summary
- When VA requests medical documentation, it will include the submission deadline
- For urgent requests from VA, documentation is required within 24 hours of receiving the request

Failure to Comply

If a VA CCN provider does not comply with submission requirements, VA will notify Optum.

A representative from Optum will notify the provider of failure to comply. Providers have 30 days to respond to VA with corrected medical documentation.

Clinical Quality Medical Documentation Requirements

Providers will be required to:

- Submit medical records to Optum directly or through its designee, immediately on receipt of request, no later than 21 days for expedited requests or 30 days for routine requests, for purposes of clinical quality review
- Maintain a release of medical records with the Veteran's signature on file

REIMBURSEMENT AND CLAIMS PROCESS

As VA CCN is implemented in your area, registration and billing staff must be aware of the appropriate third-party administrator to bill and be paid quickly. Please share these details with your staff.

On the VA CCN referral, look for the following ***Affiliations*** and ***Networks*** specific to the VA CCN region indicating Optum is the third-party administrator.

Affiliation:

- CCN1
- CCN2
- CCN3

Network

- CC Network 1
- CC Network 2
- CC Network 3

When you see the above ***Affiliations*** and ***Networks*** on an approved referral, the Veteran should be registered as VA CCN, and the claim should be submitted to Optum (or LHI for dental claims) using EDI, secure fax, mail or the provider portal.

For an example, see Appendix A – Sample VA Referral Packet in this Manual.

Reimbursement

Providers will be reimbursed in accordance with the payment provisions and requirements in their respective Provider Agreements and any applicable payment appendices. For Covered Services rendered by providers to Eligible Veterans, the contract rates will be the lesser of:

(1) Provider's Eligible Charges (as defined in the Provider Agreement and any applicable payment appendices), or

(2) The applicable contract rates determined in accordance with the Provider Agreement and any applicable payment appendices. All coding and billing guidelines issued by CMS will be followed by provider in submitting claims unless otherwise specified in the Provider Agreement and any applicable payment appendices.

Services reimbursed under CMS MS-DRG payment methodology, episodic payments and payment appendices where reimbursement is based on a negotiated percentage of the facility-specific Medicare rate letter, such as Critical Access Hospitals and Rural Health Clinics, are not subject to lesser of logic, unless otherwise stated by CMS, for example under CMS Fee Schedule methodologies. Services reimbursed under CMS APC methodology, where applicable or other outpatient services reimbursed under CMS Fee Schedule methodologies, may be subject to lessor of logic as determined by CMS.

Long-Term Care Hospitals (LTCH) (also known as Long-Term Acute Care facilities) will not be subject to the LTCH Prospective Payment System (PPS) rules that, under Medicare, could result in reimbursement reductions. For all services that LTCHs provide, the payment will be 100% of Medicare rates.

Medical providers contracted for VA CCN as part of a UnitedHealthcare Participation Agreement, who receive an approved medical referral identified by a medical SEOC to include dental services, must file medical CPT or HCPCS codes to Optum and dental CDT codes to LHI. Reimbursement for dental services as part of a medical referral will be in accordance with your UnitedHealthcare payment appendix.

Medical providers contracted for VA CCN, as part of a UnitedHealthcare Participation Agreement, who receive an approved dental referral signified by Category of Care: dental and a dental SEOC, must file medical CPT or HCPCS codes to Optum and dental CDT codes to LHI. Payment for dental services as part of a dental referral will be in accordance with the fixed rates for the applicable CCN region listed on the dental fee schedule available here.

Links to CMS and VA Fee Schedules are available at provider.vacommunitycare.com > Documents & Links.

VA Fee Schedule is updated annually by VA and additional updates may be implemented at VA discretion. Optum will have 30 days from the VA publish date to implement the new/updated VA Fee Schedule in our claim system. VA may classify rate revisions as retroactive. Optum will use date of service to determine applicable rate and reprocess affected claims at the new published rate.

Providers with a VA CCN general acute care hospital payment appendix or VA CCN critical access hospital payment appendix that did not permit reimbursement for a VAD or Chimeric Antigen Receptor T-Cell Therapy (CAR-T) are now eligible for reimbursement. When VA has approved a referral and SEOC that includes a VAD or CAR-T procedure for a particular Veteran, reimbursement rates will be payable in accordance with the reimbursement methodology in your payment appendix and terms of your agreement.

For applicable academic medical centers, Indirect Medical Education (IME) is eligible for reimbursement even when a hospital's current VA CCN payment appendix reflects IME as an exclusion.

T2003 is eligible for reimbursement for non-emergent medical transportation provided by the Adult Day Health Care Services Provider (ADHC) with an approved referral and Adult Day Health Care Services SEOC.

When VA authorizes a specific number of services per week, Optum calculates approved visits based on a Sunday through Saturday week.

Claims Processing and Filing

Electronic submissions are preferred for sending claims to Optum using EDI from a vendor, clearinghouse or billing service.

Providers must submit claims on nationally recognized claims forms, including:

- CMS-1500
  - Veteran's SSN or ICN in box 1a
  - Referral number or UCERN in box 23
- UB04 or CMS-1450
  - Veteran's SSN or ICN in box 60
  - Referral number or UCERN in field 63A
- American Dental Association (ADA) claim form (dental codes only)
  - Veteran's SSN or ICN in box 15
  - Referral number in field 2

  NOTE: Medical providers billing dental procedures must submit a dental claim to LHI on an ADA claim form with the appropriate CDT code(s).

Timely Filing

Claims must be submitted within 180 days from the date of service for outpatient care or the date of discharge for inpatient care.

Claims Submission

Electronic:

Payer ID: VACCN
Note: VA CCN electronic claims should be routed to Optum 360 directly or through a clearinghouse or vendor.

Use the provider portal to submit online:

- **Medical/Behavioral**: Go to provider.vacommunitycare.com > Medical/Behavioral Provider
- **Dental**: Go to provider.vacommunitycare.com > Dental Provider

Paper

If electronic capability isn't available, providers can submit claims by secure fax or mail.

- Medical
  - Mailing:
    VA CCN Optum
    P.O. Box 202117
    Florence, SC 29502
  - Secure Fax:
    833-376-3047
- Dental
  - Mailing:
    Logistics Health, Inc.
    Attn: VA CCN Claims
    328 Front St. S.
    La Crosse, WI 54601
  - Secure Fax:
    608-793-2143 (Please specify VA CCN on the fax.)

Claims Processing Timelines

Optum is committed to processing 98% of all clean claims within 30 days of receipt of the clean claim. Clean claims are claims received with all the required data elements necessary for adjudication without needing supplemental information. Claims that do not meet the definition of a clean claim will be returned to the provider with an explanation of deficiencies within 30 days of being received.

You may use the provider portal at provider.vacommunitycare.com > Medical/Behavioral Provider to verify claims status. All claims submitted will be acknowledged either with a payment, a provider remittance advice or returned with a specific request for additional information.

Claim Denials

- Veterans are to be held harmless and may not be billed for any reason including, but not limited to, when claims for services are denied for any of the reasons identified below. Claims submitted that are missing one or more of the following elements will be denied:
    - The Veteran's SSN or ICN
    - An approved referral number
    - A valid NPI number

- Additional reasons that a claim may be denied include, but are not limited to, the following examples:
    - Claims for care that aren't within the scope of the approved referral
    - Duplicate claims
    - Claims for services that are not part of the Veteran's medical benefits package
    - Claims submitted on unapproved claim forms. (Resubmitted claims on approved claim forms must be submitted within the timely filing deadline of 180 days from the date of service or date of discharge)
    - Emergency claims submitted by an in-network emergency department when an approved referral does not exist due to the in-network emergency department not contacting VA within 72 hours of the Veteran self-presenting to the emergency department to request a retroactive referral
    - Claims that are not submitted within 180 days from the date of service or date of discharge (i.e., claims that are submitted past the timely filing deadline)
    - Administrative charges related to completing and submitting the applicable claim form
    - The provider fails to submit a claim according to the claims adjudication rules
    - The provider delivers health care services outside of the validity period specified in the approved referral

- Out-of-network providers providing emergency services need to submit health care claims directly to VA and follow VA claims submission procedures.
- Claims for ancillary services will be processed in accordance with CMS NCCI, MUE and related edits.
- Veterans are to be held harmless and may not be billed when claims are denied.
- Providers may not charge Veterans for missed appointments.

Veteran's Signature on File

When a Veteran has signed a release of information statement, providers should indicate "Signature on File" on the claim submission. A new signature is required every year. Claims submitted for diagnostic tests, test interpretations or other similar services do not require the Veteran's signature. When submitting these claims, you must indicate "patient not present" on the claim submission.

Optum randomly reviews claims to confirm that signature-on-file requirements are being followed.

Provider's Signature on File

Optum will follow its normal business operations to verify signature of providers on claim submissions.

In lieu of a provider's actual signature, the following are acceptable alternatives:

- A facsimile signature or signature of a representative is accepted only if Optum or the Network Partner has on file a notarized authorization from the provider to use a facsimile signature or Power of Attorney (POA) for another person to sign on the provider's behalf.
- The facsimile signature may be produced by a signature stamp or a block letter stamp, or it may be computer-generated if the claim form is computer-generated.
- If a POA is on file, the authorized representative may sign using the provider's name, followed by the representative's initials or using the representative's own signature followed by POA, or similar indication of the type of authorization granted by the provider.
- The provider is required to update their signature authorization on file annually.
- Optum may return a claim with a request for the signature authorization when there is no authorization on file, or it is out-of-date.
- Failure to comply with these requirements will result in claim denial.

Remittance Advice

VA CCN will transmit a provider remittance advice using EDI 835. For providers who don't use EDI, an 835 transaction will be created, printed and mailed.

Claim Reconsiderations

Under VA CCN, a reconsideration is a formal process by which a provider may request that Optum reviews a claim denied, partially or in whole, or where a provider believes payment was incorrect.

- Where a claim is denied partially or in whole, a reconsideration request must be filed within 90 calendar days from the date of denial.
- When a claim has not been denied partially or in whole, but the provider believes the claim has been incorrectly paid, the provider must file a reconsideration request within 12 months after the claim was initially processed.

Reconsideration requests must be in writing and must include the claim number, date of service, Veteran name and reason for the request, along with an explanation/justification for reconsideration.

Providers can request reconsiderations of multiple claims in a single letter or use the Grievance form available at provider.vacommunitycare.com > Document & Links.

Please send reconsideration requests to the address or fax number listed on the remittance advice. If unable to locate the address, please submit the reconsideration request by mail, secure fax or secure email:

VA Community Care Network

- Mailing:
  VA Community Care Network
  Appeals and Grievance
  Team MS-21
  3237 Airport Road
  La Crosse, WI 56403

- Secure Fax:
  877-666-6597

- Secure Email:
  - Region 1: faxAG1@optumserve.com
  - Region 2: faxAG2@optumserve.com
  - Region 3: faxAG3@optumserve.com

Optum's target goal is to respond to reconsideration requests within 30 days of receipt of said request; however, based on volume those target goals may be slightly delayed. Please do not resubmit your requests until you have received a response from Optum.

Subrogation

You must notify the nearest VA in all circumstances of any VA CCN health care services related to or associated with any claim involving subrogation against: (i) workers' compensation carrier, (ii) an auto liability insurance carrier, (iii) third-party tortfeasor (e.g., medical malpractice) or (iv) any other situation where a third party is responsible for the cost of VA CCN health care services. Optum will work with VA and notify you if any recoupment processes will be initiated.

Veteran Appeals

In the event Optum denies a claim and the Veteran has a financial liability for that denied claim (such as emergency care without an approved referral), Optum will provide a notice of the denial to the Veteran with a description of their right to appeal to VA.

A copy of the Veteran's explanation of benefits (EOB) will be available to the Veteran through vacommunitycare.com > I am a Veteran.

Claims Audits

Optum may recover from Provider amounts owed to Optum pursuant to VA CCN requirements, including payments that were made beyond or outside what is provided under the Provider Participation Agreement.

Provider will receive a recoupment letter with the reason for the recovery including claims detail and the amount due. The provider will be required to submit the refund within the time frame specified in the provider's agreement. If the refund is not received, future claims will be offset with the amount owed. If your reconsideration request is overturned and the offset has already completed, Optum will reimburse the amounts previously recouped.

Claims identified and substantiated as fraud or abuse will be denied or subject to recovery from the Provider by Optum. See Fraud, Waste and Abuse for more information.

Claim/Referral Audit and Compliance

As a provider, you must respond to inquiries from Optum regarding Veterans who have scheduled appointments, but there is no associated claims activity. This may occur if a Veteran missed or cancelled an appointment and does not reschedule.

PROVIDER TRAINING AND RESOURCES

VA CCN providers will find information, resources and helpful links at provider.vacommunitycare.com > Training & Guides.

Training

Provider training will include, but is not limited to:

- VA CCN Provider Manual
- Benefits reference guides
- Claims reference guides
- Medical documentation reference guide
- Referral reference guide
- Educational videos

Community Provider Toolkits

VA has additional tools and resources available for Providers working with Veterans. This includes easy-to-access information about how to screen for military experience, understanding military culture and referring to VA, as well as tools for working with a variety of behavioral health concerns. Providers have access to VA's Community Provider Toolkit available at mentalhealth.va.gov/communityproviders/about.asp. One of the tools available in the VA toolkit is the Military Health History – a pocket card for health professionals to help Veterans understand their medical condition.

Optum also offers a Provider Toolkit to assist provider offices and office staff with essential tools and guidelines. The goal of this toolkit is to collaborate and streamline critical information that will further assist your practice and office in caring for Veterans. The Behavioral Toolkit for Providers – Military and Veterans is available at providerexpress.com.

VA Recommended Training

VA has developed this highly recommended course that will help providers to understand how to care for Veterans and includes topics such as military culture, suicide awareness and prevention, military sexual trauma, post-traumatic stress disorder and traumatic brain injury. All providers are recommended to complete this one-hour training course titled Community Care Provider – A Perspective for Veteran Care **Course ID 1085488.** This course offers licensed independent providers a Continuing Medical Education (CME) credit.

VA Required Training

Providers must complete applicable VA required trainings to successfully manage Veteran care.

ACRONYMS

Table 3: Acronyms

Acronym	Meaning
ART	Assisted Reproductive Technologies
BH	Behavioral Health
CAR-T	Chimeric Antigen Receptor T-Cell Therapy

Acronym	Meaning
CARF	Commission on Accreditation of Rehabilitation Facilities
CCN	Community Care Network
CIHS	Complementary and Integrative Healthcare Services
CMS	The Centers for Medicare & Medicaid Services
CPT	Current Procedural Terminology
CQMP	Clinical Quality Management Program
CVS	CVS Caremark
DME	Durable Medical Equipment
DOS	Dates of Service
EDI	Electronic Data Interchange
EDIPI	Electronic Data Interchange Patient Identifier
EHR	Electronic Health Record
EOB	Explanation of Benefits
FDA	Food and Drug Administration
FQHC	Federally Qualified Health Center
HCAHPS	Hospital Consumer Assessment of Healthcare Providers and Systems Survey
HCPCS	Healthcare Common Procedure Coding System
HEDIS®	Healthcare Effectiveness Data and Information Set
HHS	U.S. Department of Health and Human Services
HSRM	HealthShare Referral Manager
ICD	International Classification of Diseases
ICN	Integration Control Number
IME	Indirect Medical Education
IVF	In Vitro Fertilization
LHI	Logistics Health Incorporated
MRI	Magnetic Resonance Imaging

Acronym	Meaning
MSDRG	Medicare Severity Diagnosis-Related Group
NPI	National Provider Identifier
OHI	Other Health Insurance
OIG	Office of Inspector General
OPTN	Organ Procurement and Transplantation Network
PBM	Pharmacy Benefits Manager
PCP	Primary Care Provider
PQI	Potential Quality Issue
RFS	Request for Services
RHC	Rural Health Clinic
SEOC	Standardized Episode of Care
SNF	Skilled Nursing Facility
SSN	Social Security Number
UBH	United Behavioral Health
VA	U.S. Department of Veterans Affairs
VA CCN	VA Community Care Network
VAD	Ventricular Assist Device
VAMC	VA Medical Center
VBA	Veterans Benefits Administration
VHA	Veterans Health Administration
VHIC	Veteran Health Identification Card

GLOSSARY

Table 4: Glossary

Term	Meaning
Approved referral	An approved referral from VA will support a specific plan of care as it relates to a specified number of visits and/or services related to a standardized episode of care for a specified Veteran as long as the services are provided by a provider.
Certified Transplant Center (CTC)	Medicare-approved hospital or medical facility that provides transplantation of an organ, or combination thereof: heart, lung, liver, kidney, pancreas; or bone marrow; or stem cell.
Claim	An invoice for health care, dental or pharmacy services
Clean claim	A claim that contains all the required data elements necessary for adjudication without requesting supplemental information from the submitter
Complementary and Integrative Healthcare Services (CIHS)	CIHS includes practices that promote, preserve and restore health, such as biofeedback, hypnotherapy, massage therapy, Native American healing, relaxation techniques (such as meditation and guided imagery) and tai chi. Note that acupuncture is included as basic care in VA's benefits package, so it isn't listed with CIHS.
Covered services	Health care services and supplies that are covered under the VA CCN, as described in 38 CFR 17.38 and for which the provider has received an approved referral
Critical Access Hospital	A designation given to eligible rural hospitals by the Centers for Medicare & Medicaid Services (CMS).
Critical finding	Those findings or results that require immediate evaluation by a health care provider such that failure to take immediate appropriate action might result in death, significant morbidity or serious adverse consequences to the Veteran.
Durable medical equipment (DME)	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.
EDI 278 Request	Requests for referrals for additional visits, DME, emergent services or services outside of initial referral. At this time, VA does not accept 278 transactions for VA CCN.
EDI 835 remittance advice (RA)	An electronic explanation of payments and other decision-making information.
Electronic data interchange (EDI)	The electronic exchange of information between two or more organizations.

Term	Meaning
Eligible charge	Defined in the Provider Agreement and any applicable payment appendices
Eligible Veteran	Any Veteran who VA determines is eligible to receive community care.
Emergent care	Medical care required within 24 hours or less essential to evaluate and stabilize conditions of an emergent need that, if not provided, may result in unacceptable morbidity/pain if there is significant delay in the evaluation or treatment.
Emergent health care need	Conditions of one's health that may result in the loss of life, limb, vision or result in unacceptable morbidity/pain when there is significant delay in evaluation or treatment.
Enrolled Veteran	Any Veteran who is enrolled in VA's patient enrollment system and is eligible to receive health care benefits.
Episodic Payments	A payment method that covers all the care a patient receives in the course of treatment for a specific illness, condition or medical event.
General care	All other care and services offered under VA Health Benefit Package other than primary care and Complementary and Integrative Health Services (CIHS).
Medical device	An instrument, apparatus, implement, machine, contrivance or other similar or related article, including a component part or accessory, which is intended for use in the cure, mitigation or treatment of disease or compensates for a person's loss of mobility or other bodily functional abilities and function as a direct and active component of the person's treatment and rehabilitation.
Non-service connected care	Medical care and services provided for a Veteran for an illness or injury that was not incurred in or aggravated by military service as determined by VA.
Pharmacy benefit manager	A third-party administrator for prescription drug programs.
Primary care	Health care at a basic, rather than specialized, level.
Potential quality issue	A clinical or system variance warranting further review and investigation for determination of the presence of an identified quality issue (IQI).
Provider	Physician, practitioner or ancillary facilities participating in VA CCN.
Provider Agreement	An executed agreement between Optum or Network Partner with the provider for VA CCN.
Referral request	A request and approval process that authorizes the Veteran to obtain specified care within a specified time frame from additional resources in the community. Upon approval, a referral number is generated. The referral number must always be included on claims submitted by VA CCN providers for payment.

Term	Meaning
Remittance advice	An explanation of payments and other decision-making information.
Rural Health Clinics	A clinic in a rural area that has primary care and outpatient services.
Service-connected care	Medical care and services provided for a Veteran for a service-connected condition is an illness or injury decided by the Veterans Benefits Administration (VBA) as having been incurred or aggravated in line of duty in the active military, naval or air service.
Special authority	Individuals eligible for VA benefits due to designation given by VA.
Standardized episode of care (SEOC)	A set of clinically related health care services for a specific unique illness or medical condition (diagnosis and/or procedure) provided by an authorized provider during a defined, authorized period of time not to exceed year.
Urgent health care need	Non-life-threatening conditions that require care in a timely manner (such as within 24 hours) to avoid having them worsen.
Urgent care	Provision of immediate medical service offering outpatient care for the treatment of acute and chronic illness or injury.
VA Community Care Network	A network of community-based providers and services designed to coordinate with VA in providing timely, accessible and high-quality health care to Veterans.
VA facility	A VA facility is a VA hospital or VA medical center.
VA hospital	A VA hospital is any VA-owned, staffed and operated facility providing acute inpatient and/or rehabilitation services.
VA medical center	A VA medical center is a VA point of service that provides at least two categories of care (inpatient, outpatient, residential or institutional extended care).

APPENDIX A – SAMPLE VA REFERRAL PACKET

VA | U.S. Department of Veterans Affairs

VA Form 10-7080 - Approved Referral For Medical Care

Veteran Name: PATIENT ONE
Veteran ICN: 1234567890V123456
Veteran EDIPI: 123456
Veteran Date of Birth: 1900-01-01
Veteran Address: 000 Any ST
Any City, PA 19144
Veteran Phone Number: (555)555-5555

Referral Number: VA0000000000
Priority: Routine
Referral Issue Date: 2020-04-14
Expiration Date: 2020-08-18
First Appointment Date: 2020-06-19

Referring VA Facility: Philadelphia VA Medical Center

VA Telephone Number: 215-555-1111 ext. 6310

VA Fax Number: 555-555-2222

Initial Community Care Provider/Facility: HOSPITAL OF UNIVERSITY OF PA
Initial Provider Location: HOSPITAL OF UNIVERSITY OF PA-000 ANY ST, ANY CITY, PA, 19104-282N00 000X
Provider Name (if known): Trustees of the University Pennsylvania
Community Provider NPI: 0000000000

Any claim related to this episode of care **MUST INCLUDE THE APPROVED REFERRAL NUMBER** on the EDI transaction as the Referral Number or Prior Authorization number.

Please see below for Additional VA Referring Facility Information and Billing Information

Pertinent Clinical Information

Chief Complaint: needs bilateral carotid duplex.

Patient History / Clinical Findings / Diagnosis (Comorbidities): carotid stenosis

Provisional Diagnosis: I6529 Occlusion and stenosis of unspecified carotid artery

Services Authorized

Service Requested: Ultrasound SEOC 1.2.4 PRCT

Category of Care: RADIOLOGY ULTRASOUND

Procedural Overview – Standardized Episode of Care (SEOC)

No.	Service/Procedure	No. Visits Authorized
1.	Ultrasound for referred condition indicated on consult	1

SEOC Disclaimer

- Please visit the VHA Storefront va.gov/COMMUNITYCARE/providers/index.asp for additional resources and requirements pertaining to the following *Pharmacy prescribing requirements * Durable Medical Equipment (DME), Prosthetics, and Orthotics prescribing requirements * Precertification (PRCT) process requirements * Request for Services (RFS) requirements

REFER ALL QUESTIONS RELATED TO THIS APPROVAL TO THE ISSUING VA OFFICE

Referring VA Facility: Philadelphia VA Medical Center
Station Number: 642
Ordering Officer:
Telephone Number: 555-555-0000 ext. 6310
Address: 000 Any Avenue Any City PA 19104
Referring Provider: PROVIDER ONE
Referring Provider NPI: 0000000000
Unique Consult No: 642_0000000
Program Authority: Authorized/Pre-authorized VA Referral (not otherwise specified) – 1703
Affiliation: CCN1
Network: CC Network 1

Billing and Other Referral Information

ANY CLAIMS RELATED TO THIS EPISODE OF CARE MUST BE SUBMITTED TO OPTUM, UNITEDHEALTHCARE AND INCLUDE THE APPROVED REFERRAL NUMBER.

Methods to submit claims:

Electronic data Interchange (EDI):

Payer ID for Medical and Dental – VACCN

More information on how to submit claims can be found by visiting va.gov/COMMUNITYCARE/revenue_ops/Veteran_Care_Claims.asp.

Any claim related to this episode of care **MUST INCLUDE THE APPROVED REFERRAL NUMBER** on the EDI transaction as the Referral Number or Prior Authorization number.

Precertification

The Standardized Episode of Care (SEOC) referral you have accepted does not include services that require Third-Party Payer (TPP) precertification. It is imperative that you notify the VA if you have scheduled any of these specific services for a Veteran that has Other Health Insurance (OHI), so that VA can notify the TPP. VHA is required by law to bill the TPP. VHA is required by law to bill the TPP for care that is not for a Service Connection or Special Authority eligibility.

Notification details and specific care requiring TPP precertification for this SEOC can be found at https://www.va.gov/COMMUNITYCARE/providers/PRCT_requirements.asp.

Pharmacy

CVS Caremark is the retail pharmacy network for Veterans' immediately needed or Urgent/Emergent prescriptions.

Immediate-need prescriptions:

Must follow the VA Urgent/Emergent Formulary which can be found at pbm.va.gov/PBM/nationalformulary.asp

Prescription can only go up to a 14-day supply. No refills for the immediate need medication may be authorized.

Only a seven-day supply for opioids, or up to the opioid-prescribing limit allowed by the state – whichever is less – may be authorized.

Immediate-need prescription extending past 14 days:

The provider will need to send second prescription (beyond 14 days) to the referring VA medical facility's pharmacy for prescription fulfillment services.

Routine/maintenance prescriptions:

Must be sent to the referring VA medical facility's pharmacy

If you do not have the ability to electronically submit prescriptions to pharmacies, please contact the Community Care representative at the referring VA medical facility for their pharmacy fax number. Please refer to va.gov/COMMUNITYCARE/providers/Service_Requirements.asp for additional instructions related to prescriptions.

Veterans Health Administration

VHA Medical Documentation

Document Created: 06/10/2020 11:18

The documents accompanying this transmission contain confidential health information that is legally privileged. This information is intended only for the use of the individual or entity providing care to this Veteran. The authorized recipient of this information is prohibited from disclosing this information to any other party unless required to do so by law or regulation and is required to destroy the information after its stated need has been fulfilled and in accordance with agency destruction and retention requirements. If you are not the intended recipient, you are hereby notified that any disclosure, copying or distribution is strictly prohibited as this information is protected by Federal Privacy law (e.g., HIPAA Privacy Rule). If you have received this information in error, please notify the sender immediately and arrange for the return or destruction of these documents.

PHILADELPHIA VAMC, 3900 Woodland Avenue, Philadelphia, Pennsylvania 19104-4551

VA Referrals phone: 999.999.9999 EXT 6060 **Fax: 999.999.9999**

Point of Contact (POC): Provider One

Phone: Fax:

Patient Name: PATIENT ONE
0000 Any Street
Any City, FLORIDA 00000

DOB: 01/01/1900
Phone (residential): (123)123-4567
Phone (mobile): (123)123-4567

Referral Type: Community Care Network

Next of Kin Contact Information

TWO, PATIENT

Address (Next Of Kin)
0001 Any Street
Any Town, NEW JERSEY 00000

Phone: (111)111-1111

CONSULTS

Current PC Provider: TWO, PROVIDER
Current PC Team: PHL PACT GOLD 07
Current Pat. Status: Outpatient
UCID: 123_XXXXXX
Primary Eligibility: SC LESS THAN 50% (VERIFIED)
Patient Type: SC VETERAN

OEF/OIF: NO
Service Connection/Rated Disabilities
SC Percent: 10%
Rated Disabilities: TINNITUS (10%)
TRAUMATIC BRAIN DISEASE (0%)
FACIAL SCARS (0%)
IMPAIRED HEARING (0%)
Order Information
To Service: VASCULAR SURGERY OUTPT
From Service: PHL PACT GOLD TEAM NP 7
Requesting Provider: TWO, PROVIDER

Service is to be rendered on an OUTPATIENT basis
Place: Consultant's choice
Urgency: Routine
Clinically Ind. Date: Mar 02, 2020
Orderable Item: VASCULAR SURGERY OUTPT
Consult: Consult Request
Provisional Diagnosis: Occlusion and Stenosis of unspecified Carotid artery (ICD-10-CM I65.29)
Reason For Request:
Routine Consult
Consult ordered as: Face-to-Face Clinic Visit
(Consult Will Be Denied Unless Medically Optimized)

Ordering Provider and Contact Number: 4911

Does the patient require van transportation? No

Carotid Disease
If the patient is having active carotid TIA/stroke symptoms, then send the patient to the nearest Emergency Department rather than placing a Vascular Surgery consult.
For patients to be seen in vascular surgery clinic for carotid disease they must have a carotid duplex study less than or equal to 60 days old.

Carotid Disease: Recent Negative Symptoms (No carotid symptoms):
If duplex scan >50% ICA stenosis -> consult Vascular Surgery.
Need duplex results:

Inter-facility Information
This is not an inter-facility consult request.

Status: ACTIVE
Last Action: STATUS CHANGE

Facility Activity	Date/Time/Zone	Responsible Person	Entered By
CPRS RELEASED ORDER	03/02/20 16:14	TWO, PROVIDER	TWO, PROVIDER
ADDED COMMENT	03/02/20 22:55	THREE, PROVIDER	THREE, PROVIDER

SR – Schedule/reschedule routine appointment.
ME – May discontinue if Veteran fails to respond to the mandated scheduling effort

RECEIVED	03/03/20 13:22	FOUR, PROVIDER	FOUR, PROVIDER
SCHEDULED	03/09/20 15:14	FOUR, PROVIDER	ONE, SURGEON

PHL VASCULAR SURGERY I/V MD Consult Appt. on 04/14/20 @ 09:30 #COO# PID 03/02/2020 SPOKE TO PATIENT APPT SCHEDULED.

STATUS CHANGE	04/14/20 11:30	FOUR, PROVIDER	TWO, SURGEON

PHL VASCULAR SURGERY I/V MD Appt. on 4/14/20 @9:30 was cancelled by the Clinic.
Remarks: COVID19

Note: TIME ZONE is local if not indicated

No local TIU results or Medicine results available for this consult

PROBLEM LIST

Sensitive Diagnoses

No sensitive diagnoses were provided.

Other Diagnoses

Problem	Code
<< DEFIBRILLATOR>>	R69.
CAD -Coronary artery disease	R69.
Carcinoma in situ of colon	D01.0
Hypertensive heart disease with heart failure	I11.0

APPOINTMENTS

Appointment Date and Time	Location
09/10/2020 10:00:00	PHL PACT TELE GOLD TEAM NP 7
06/19/2020 10:00:00	COM CARE-VASCULAR LAB

MEDICATIONS

100 most recent outpatient medications released by VA to Veteran in the last 6 months

Medication Name and Dose	Quantity	Refill Number	Issue and Fill Date	Status
CETIRIZINE HCL 10MG TAB	Qty:30	Fill: 3 of 11	Orig: 2020-01-29	ACTIVE
TAKE ONE TABLET BY MOUTH DAILY FOR ALLERGY SYMPTOMS			Last: 2020-05-06	
FLUTICASONE PROP 50MCG 120D NASAL INHL	Qty:1	Fill: 1 of 11	Orig: 2020-01-29	ACTIVE

NON-VA MEDICATIONS

Local Drug Name and Dose	Medication Route	Schedule
CARVEDILOL 25 MG TAB	MOUTH	TWICE A DAY
LOSARTAN 100MG TAB	MOUTH	ONCE DAILY

ALLERGIES

No documented allergies

ORDERS

VASCULAR SURGERY OUTPT Con Consultant's Choice
Activity:
03/02/2020 16:13 New Order entered by FOUR, PROVIDER (NURSE
UCID: 642_3953421 Order Text:
VASCULAR SURGERY OUTPT Cons
Consultant's Choice Nature of Order:
ELECTRONICALLY ENTERED
Signature: SERVICE CORRECTION TO SIGNED ORDER

Current Data:
Treating Specialty:
Ordering Location: PHL PACT GOLD TEAM NP 7
Start Date/Time: 03/02/2020 16:14
Stop Date/Time:
Current Status: ACTIVE
Orders that are active or have been accepted by the service for processing.
e.g., Dietetic orders are active upon being ordered, Pharmacy orders are active when the order is verified, Lab orders are active when the sample has been

collected, Radiology orders are active upon registration.
Order #56369066

Order:
Consult to Service/Specialty: VASCULAR SURGERY OUTPT
Reason for request:

Routine Consult
Consult ordered as: Face-to-Face Clinic Visit
(Consult Will Be Denied Unless Medically Optimized)
Ordering Provider Name and Contact Number: 4911
Does the patient require van transportation? No
Carotid Disease
If the patient is having active carotid TIA/stroke symptoms, then send the patient to the nearest Emergency Department rather than placing a Vascular Surgery consult. For patients to be seen in vascular surgery clinic for carotid disease they must have a carotid duplex study less than or equal to 60 days old. Carotid Disease: Recent Negative Symptoms (No carotid symptoms): if duplex scan >50% ICA stenosis > consult Vascular Surgery. Need duplex results:

Category: OUTPATIENT
Urgency: ROUTINE
Clinically Indicated Date: Mar 02, 2020
Place of Consultation: Consultant's Choice
Provisional Diagnosis: Occlusion and Stenosis of unspecified Carotid Artery (ICD-10-CM I65.29)
Consult No: 3953421

PROGRESS NOTES

LOCAL TITLE: VASCULAR SURGERY TELEPHONE NOTE
STANDARD TITLE: VASCULAR SURGERY TELEPHONE ENCOUNTER NOTE
NOTE DATE OF NOTE: APR 13, 2020@10:50
ENTRY DATE: APR 13, 2020@10:50:42
AUTHOR: FIVE, PROVIDER EXP COSIGNER:
URGENCY: STATUS: COMPLETED

87yo male h/o CAD, HTN and chronic recurrent bilateral otalgia Whom is being evaluated for bilateral moderate degree cardia stenosis. He has had a history of cerebellar stroke in the past, which was found incidentally on a CT. He has no known history of acute cerebrovascular event in recent months nor TIA or amaurosis. He is otherwise functioning well and has not smoked since 1970s.

VASCULAR HISTORY
None
Past Medical History
1. Ischemic congestive cardiomyopathy due to 05/10/16
SIX, PROVIDER

coronary artery disease
EF < 10% on 11/2015, has AICD
2. CAD - Coronary artery disease 05/10/16
SIX, PROVIDER
s/p drug eluting stent to RCA and Mid LAD, 10/2014

On examination could be performed due to telephone encounter

VASCULAR IMAGING
1/2020
Right side: Common Carotid artery – No disease. Carotid Bulb – Mild to moderate plaque. Internal Carotid artery – Moderate to severe, partly calcified plaque resulting in a 50 to 69% Internal Carotid artery stenosis based on the velocity flow measurements. External Carotid artery – Moderate plaque

Plan Discussed at length the etiology pathophysiology and prognosis of this disease. Educated him about treatment modalities, which included conservative therapy consisting of antiplatelet and hypercholesterolemic medications. He has maintained smoking cessation since 1970s and continues to be in relatively good state of health. We will see him for a face-to-face visit in 6 months with repeat carotid duplex exams.

/es/ PHYSICIAN ONE, MD

TELEPHONE NOTE – CLINIC DISRUPTION DUE TO CORONAVIRUS/COVID-19
Call placed to patient/family.
Able to reach patient/family.
Confirmed that patient is scheduled for clinic appointment on April 14, 2020
Indication: carotid stenosis
Any acute concerns at this time voiced by patient/family:
none

Informed patient/family that because of coronavirus concerns, the VA has offered a number of scheduling options to reduce risk to our patients, including:
- keeping appointment as scheduled in clinic
- cancelling currently scheduled appointment and rescheduling for a future date
- performing telephone interview on the date/time of their scheduled appointment, with the understanding this would not include physical examination - performing a video interview on the date/time of their scheduled appointment, via VA Video Connect, with the understanding this would not include physical examination (this is only an option for providers with VVC access)

Informed patient/family that due to coronavirus concerns, all persons entering the VA are being screened for infectious symptoms. Please accommodate accordingly with the understanding there may be delays in entering the building because of this.
If coming to clinic, answer the following:

1. Any fever, cough, or flu like symptoms? No
2. Any travel to COVID-affected areas in the last 14 days? No
3. Have you been in close contact with someone (including health care workers) who has been CONFIRMED to have coronavirus? No

LABS

Lab	Result	Abnormal	Specimen Date	Reference Range	Units
CO2	26		2019-01-13	22 - 31	mEq./L.
CREATININE	0.8		2019-01-13	0.6 - 1.5	mg/dl
GLUCOSE	86		2019-01-13	70 - 115	mg/dl
POTASSIUM	3.9		2019-01-13	3.30 - 5.10	mEq./L.
SODIUM	135		2019-01-13	135 - 147	mEq./L.