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OVERVIEW

Welcome to the U.S. Department of Veterans Affairs (VA) Community Care Network (CCN) Provider Manual. Here, we have collected important information about the VA CCN that will help you deliver care to Veterans in your community.

This VA Community Care Network 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 the U.S. Department of Veterans Affairs (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 the VA CCN (collectively “Provider”) participating in one of the Optum VA CCN partner networks or in a leased network that is being 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 that term is 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 and its UnitedHealth Group affiliates such as UnitedHealthcare and partner networks listed under Network Resources.

This Manual is a binding part of your contract with Optum or Network Partner (the “Provider Agreement”), and includes requirements that you must comply with for 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:

- Helpful resources
- Covered services
- Credentialing
- Provider responsibilities
- Eligibility and enrollment
- Referrals
- Pharmacy and Durable Medical Equipment (DME)
- Health care management
- Medical documentation
- Claims and reimbursement
- Contract provisions

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 info.vacommunitycare.com. Please check back for updated versions, as we expect to add more information to the Manual as we get closer to the Start of Health Care Delivery (“SHCD”) for VA CCN. This guide was updated May 21, 2019, for physicians, health care professionals, facilities and ancillary providers currently...
participating in VA CCN. This guide is subject to change. We will update content in our effort to support our health care provider networks.

What is the VA CCN?

VA created the VA Community Care Network (VA CCN) to assist Veterans who can’t get necessary health care services from a VA Medical Center (VAMC) and when VA determines the Veteran is eligible based on time or distance criteria.

VA CCN gives Veterans the opportunity to receive care from a network of community health care professionals, facilities, pharmacies and suppliers.

Our Veterans have sacrificed to serve our country and this is our opportunity to show our appreciation. Participating providers can help serve Veterans in their community. VA CCN only covers Veterans, not families or dependents. VA determines a Veteran’s eligibility to get care from VA CCN providers. Providers may have the opportunity to serve:

- Veterans with VA-rated service-connected disabilities
- Veterans determined by VA to be unemployable due to service connected conditions
- Veterans who are Former Prisoners of War (POWs)
- Veterans awarded the Purple Heart Medal
- Veterans whose discharge was for a disability that was incurred or aggravated in the line of duty
- Veterans awarded the Medal of Honor
- Veterans who are receiving aid and attendance or housebound benefits from VA
- Veterans who have been determined by VA to be catastrophically disabled

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, durable medical equipment (DME), hospice care, dialysis and diagnostic radiology
United Behavioral Health

United Behavioral Health (UBH) provides a network of behavioral health and substance use disorder providers, facilities, and services for the 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

UBH includes providers who perform some of the CCN Complementary and Integrative Healthcare Services (CIHS), such as biofeedback, hypnotherapy, relaxation techniques, and Native American Healing.

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

OptumHealth Care Solutions, LLC

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

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

The OHCS network also includes providers for some of the 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 Incorporated

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

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 CCN providers as well as VA providers.
UnitedHealthcare Vision

UnitedHealthcare Vision is a network of eye care professionals covering all geographic regions. This network provides routine eye examinations to all eligible Veterans as determined by VA.

PROVIDER RESOURCES

Online

VA Community Care Provider Portal

VA will have Community Care Provider resources available at www.va.gov/communitycare/providers.

When it's available, you’ll be able to securely sign in to view a Veteran’s electronic health record (EHR) as well as track referrals and exchange data/documentation with VA.

Optum’s VA Community Care Network Portal

Optum’s provider portal vacommunitycare.com will be available closer to the start of VA CCN health care delivery. Until that site is available, the latest information is available at info.vacommunitycare.com.

Optum’s portal will provide:

- Information on claim, Referral Request status
- VA’s covered benefits
- Medical review requirements for specific codes
- Link to the VA CCN provider directory
- Links to verify Veteran eligibility
- Links to real-time pharmacy dispensing information to help prevent medication errors
- Provider resources and education

Support by Phone

When the VA CCN launches and health care delivery starts, you can call CCN Provider Services at 888-901-7407 (8 a.m. – 6 p.m., local time, Monday – Friday, excluding holidays) to:

- Check status of referrals (except urgent/emergent referrals that should route directly to the VA Community Care Contact Center)
- Check claims status
- Resolve claims issues
- Confirm Veteran eligibility
- Resolve pharmacy issues
- Resolve issues with DME, Medical Devices, orthotic items, and prosthetic items
- Verify provider enrollment status
- Resolve complaints
- Resolve benefits issues

Tip: You can go online to get much of this information and submit transactions. To learn more, please go to info.vacommunitycare.com.
COVERED SERVICES

Health Care Services

VA medical facilities provide a wide range of services, but sometimes those services may not be available at the VA medical facility or available in a timely manner.

VA determines a Veteran's eligibility to get care from a VA CCN provider, and which types of care the Veteran can receive. VA will issue an Approved Referral to authorize a specific Standardized Episode of Care (SEOC), which will include a specified number of visits and/or services. An SEOC is a set of related health care services for a specific unique illness or medical condition to be provided for a given period of time, not to exceed one year.

For a current list of VA-covered services, see va.gov/communitycare. These services may include:

- Acupuncture
- Ancillary services
- Behavioral health (to include professional counseling)
- 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

The VA SEOC Billing Code List provides the preapproved billing codes associated to the services within each SEOC. A link to the VA SEOC Billing Code List will be available at vacommunitycare.com > Documents and Links.

Durable Medical Equipment (DME), Medical Devices, Orthotic and Prosthetic Items

Providers can only provide DME and Medical Devices to eligible Veterans for an urgent or emergent condition. VA provides all non-urgent or non-emergent DME items when providers submit prescriptions for the Veteran.
Urgent/Emergent Prescriptions for DME and Medical Devices
Providers must provide DME and Medical Devices to eligible Veterans at the time of health care service delivery, or soon thereafter, when there is an urgent or emergent condition requiring DME or Medical Devices as determined by the CCN provider. This condition is defined by VA as a medical condition of acute onset or exacerbation manifesting itself by severity of symptoms including pain, soft tissues symptoms, bone injuries, etc. Urgent or emergent DME or Medical Devices may include, but are not limited to:

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

Scheduled Procedures or Discharge
For a scheduled procedure or patient discharge, if you don’t coordinate with VA to help ensure the DME or Medical Device is ready for the Veteran, that does not make it an urgent or emergent situation.

Purchase or Rental
Prescribing providers must ensure the most cost effective option for urgent/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.

Routine Prescriptions for DME and Medical Devices
You need to submit all prescriptions for routine DME and Medical Devices to VA. VA will provide the DME or Medical Device to the Veteran. The prescriptions must include the following:

- Date of request
- Patient’s full name
- Patient’s date of birth
- Patient’s last 4 digits of Social Security Number
- Patient’s Electronic Data Interchange Patient Identifier (EDIPI)
- Prescribing provider’s full name
- Prescribing provider’s address
- Prescribing provider’s phone number
- Prescribing provider’s fax number
- Diagnosis and International Classification of Diseases ICD-10 code(s)
- Description and Healthcare Common Procedure Coding System (HCPCS) code for each prescribed 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

VA reserves the right to issue comparable, functionally equivalent DME to what you prescribe.

Providers are required to submit the VA-provided form or template to VA within 24 hours, or the next business day, after completing the health care services for which the prescription was generated.
VA forms and templates for DME and Medical Devices will be available online at vacommunitycare.com and updates will be made to this Manual as soon as they are available from VA.

Hearing Aids
All prescriptions for hearing aids are to be submitted to VA for review and fulfillment. Hearing aids cannot be purchased or provided by VA CCN providers. VA will provide information for the hearing aid manufacturers that have current contracts with VA. Providers must submit all prescriptions for hearing aids to VA for review and fulfillment. Providers must provide initial testing results related to potential hearing aid needs to VA within two business days of completion of the initial testing.

Home Oxygen
You must submit all requests for home oxygen to VA for review and fulfillment. Home oxygen equipment or supplies cannot be purchased or provided by VA CCN providers. You must provide definitive testing results within 24 hours of completion of testing. 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 Equipment
Oral Appliance Therapy (OAT) for obstructive sleep apnea will be provided through Optum’s VA CCN dental network. OAT is classified as medical treatment for a medical disorder, obstructive sleep apnea, which is provided by a licensed dentist.

Follow Up Care
You are responsible for all necessary follow-up care, including patient education, training, fitting, and adjustment for the prescribed item. VA will procure and send the prescribed item to your location, unless specified otherwise, for you to provide follow-up care, training, and fitting to the Veteran.

Transplant Candidates/Chronic Dialysis
Providers must refer Veterans identified as transplant candidates back to the referring VA facility. The medical documentation must contain the recommendation and identification of the Veteran as a transplant candidate.

VA CCN Complementary and Integrative Health Services (CIHS)
VA’s medical benefits package includes CIHS, such as biofeedback, hypnotherapy, massage therapy, Native American healing, relaxation techniques (for example, mediation or guided imagery), and tai chi, based on VA’s determination that they promote, preserve, and restore health, and are in accord with generally accepted standards of medical practice. When VA determines a Veteran would benefit from CIHS in the community, they will issue an Approved Referral with a SEOC to include CIHS.

Submitting CIHS Claims
CIHS providers should submit claims using the appropriate CPT® or HCPCS code for the CIHS services listed below.

<table>
<thead>
<tr>
<th>VA National Clinic List</th>
<th>Service</th>
<th>CPT/HCPCS Code</th>
</tr>
</thead>
</table>

### Codes and Services

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Services</th>
</tr>
</thead>
<tbody>
<tr>
<td>BIOF</td>
<td>Biofeedback</td>
<td>90901, 90875, 90876, 90911</td>
</tr>
<tr>
<td>HYPN</td>
<td>Hypnotherapy</td>
<td>90880</td>
</tr>
<tr>
<td>MSGT</td>
<td>Massage therapy</td>
<td>97124</td>
</tr>
<tr>
<td>NAHL</td>
<td>Native American healing</td>
<td>98960: self-management education (1 pt)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>98961: self-management education (2-4 pt)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>98962: self-management education (5-8 pt)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>S9454: stress management class-non-physician</td>
</tr>
<tr>
<td>RLXT</td>
<td>Relaxation technique</td>
<td>98960: self-management education (1 pt)</td>
</tr>
<tr>
<td></td>
<td>(e.g., meditation, guided</td>
<td>98961: self-management education (2-4 pt)</td>
</tr>
<tr>
<td></td>
<td>imagery)</td>
<td>98962: self-management education (5-8 pt)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>S9454: stress management class-non-physician</td>
</tr>
<tr>
<td>TAIC</td>
<td>Tai chi</td>
<td>97150: group therapeutic activities</td>
</tr>
<tr>
<td></td>
<td></td>
<td>S9451: exercise classes- non-md</td>
</tr>
<tr>
<td></td>
<td></td>
<td>S9454: stress management classes</td>
</tr>
</tbody>
</table>

You can read more about the VA CCN claim submission process in [Claims Submission](#).

### CCN Health Care Service Exceptions

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

- Ambulance services (ambulance services must always be referred directly to VA for payment consideration)
- Home deliveries and deliveries by direct entry midwives also known as lay midwives or certified professional midwives
- 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

You are responsible for ensuring they work from the latest approved version. This document was valid as of: 6/10/2019
Excluded CCN Health Care Services

The following services are excluded from the 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

CREDENTIALING

Optum or UnitedHealthcare or its designee must credential providers and facilities according to requirements from nationally recognized accrediting organizations – unless the accrediting organization’s standards don’t apply to such services, facilities and providers. However, providers who are currently credentialed and participating with Optum or UnitedHealthcare, as applicable, aren’t required to complete a separate credentialing application for VA CCN.

Professional Credentialing, Licensing and Accreditation

All providers and practitioners in our VA CCN Healthcare Services Network 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 VA CCN providers who are not currently credentialed and participating with one of our UnitedHealth Group affiliates will have to complete a standardized, applicable, nationally accredited credentialing process.

If a CCN provider’s type is not credentialed under an accredited credentialing process, the provider must 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 Agency (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
  - Operate within the scope of their license
If you’re a VA CCN 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 exclusions list you won’t be eligible to participate in the network. See oig.hhs.gov/exclusions for more information about the exclusion 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 the 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

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 accreditation, including:
- Joint Commission accreditation, or
- American Osteopathic Association – AOA, or
- 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 is 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 VA CCN Provider Directory and will help to 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>
<thead>
<tr>
<th>Network</th>
<th>Provider Type</th>
<th>Submit Updates</th>
</tr>
</thead>
<tbody>
<tr>
<td>UnitedHealthcare</td>
<td>Medical professionals</td>
<td><a href="https://UHCprovider.com">UHCprovider.com &gt; mypracticeprofile</a></td>
</tr>
<tr>
<td></td>
<td>facility ancillary providers</td>
<td></td>
</tr>
<tr>
<td>UnitedHealthcare Providers</td>
<td>National laboratory ancillary</td>
<td>Email updates to <a href="mailto:naspi@uhc.com">naspi@uhc.com</a></td>
</tr>
<tr>
<td></td>
<td>providers</td>
<td></td>
</tr>
<tr>
<td>UnitedHealthcare Vision</td>
<td>Vision providers</td>
<td><a href="https://spectera.com">spectera.com</a></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Sign in with user ID and password</td>
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<tr>
<td></td>
<td></td>
<td>Click on Entity Management Tab</td>
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<tr>
<td></td>
<td></td>
<td>Complete changes and submit;</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Provider can also submit changes through Attestation process</td>
</tr>
<tr>
<td>United Behavioral Health</td>
<td>Mental health</td>
<td><a href="https://providerexpress.com">providerexpress.com</a></td>
</tr>
<tr>
<td></td>
<td>Substance abuse</td>
<td></td>
</tr>
<tr>
<td>LHI Dental</td>
<td>Dental providers</td>
<td><a href="https://logisticshealth.com">logisticshealth.com &gt; provider-network</a></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Log in to the Provider Portal Using your User name and password</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Hover Over ‘My Profile’ and select ‘Update Profile’</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Email updates to <a href="mailto:PNMProvNetRelations@Logisticshealth.com">PNMProvNetRelations@Logisticshealth.com</a></td>
</tr>
</tbody>
</table>
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 providers cancel a Veteran 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 care
- Within 48 hours for urgent care
- Within 30 days for routine care
Providers must not charge Veterans for missing a scheduled appointment.

Provider Satisfaction Surveys
CCN providers will receive provider satisfaction surveys each quarter in which they submit a claim. Providers are encouraged to respond to provider satisfaction surveys.

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. The dental provider manual is located at info.communitycare.com, select “Provider Manual”, click on VA CCN Provider Manual - Dental.

Out-of-Network Providers
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.
Fraud, Waste and Abuse Reporting

Fraud is recognized as the intentional deception or misrepresentation made by someone with the intent to receive some unauthorized benefit. It includes any act that constitutes fraud under applicable state law.

Waste or abuse is defined as provider practices that are inconsistent with sound medical practices, business practices, and fiscal practices, and which may result in unnecessary costs to VA.

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 CCN 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:

Phone:
Optum Fraud, Waste, and Abuse Hotline 844-883-3461

Mail:
Optum Fraud, Waste and Abuse
3237 Airport Road
VA Community Care Network MS-51
LaCrosse, WI 54603

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 VA CCN.

ELIGIBILITY AND ENROLLMENT

Verifying Eligibility

The VA CCN assists Veterans who can’t get necessary services from a VA provider either because the services aren’t available timely or the VA provider is too far away. VA makes the determination based on the Veterans current situation and the type of care they need.

A Veteran’s eligibility to get care from a community provider may change based on the type of care requested. Prior to providing services a providers should ensure they have an Approved Referral with a SEOC to cover the care to be provided.

You are responsible for verifying the Veteran’s identification (e.g., state driver’s license) and VA-issued identification card before delivering care. A valid Approved Referral or the Veteran’s Referral Letter are proof of eligibility. If needed, providers can confirm a Veteran’s enrollment status online at the VA’s Community Care Provider Portal or by calling 888-901-7407.

Time-Eligible Veterans

The Veterans Health Administration (VHA) has wait-time goals for scheduling appointments for hospital care, medical services, and dental services provided by VA. If Veterans are unable to schedule an appointment within those wait-time goals or within the clinically necessary times (whichever is shorter), Veteran are classified as Time-Eligible for community care.
This eligibility includes situations where the needed care or services are not provided within a VAMC that is accessible to the Veteran. This also includes situations where there is a compelling reason that the Veteran needs to receive the care or service outside of a VAMC.

Distance-Eligible Veterans
Distance-Eligible Veterans are Veterans who meet specific requirements as determined by VA to be eligible for community care because of geographic reasons including an excessive burden or any other special circumstance VA determines to be valid for providing care in the community.

Primary Care Provider (PCP) Designation
VA will assign all Veterans a PCP. The PCP may be VA provider or a VA CCN provider. VA may communicate a Veteran’s PCP assignment information on an Approved Referral.

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 Approved Referral will state when it is issued and how long it is valid, at most, for one year.

When Approved Referrals result in the need for urgent/emergent pharmacy prescriptions or urgent/emergent prescriptions for DME, those supplies and services are also authorized as part of the SEOC.

VA will issue Approved Referrals to Providers in accordance with VA referral process. VA will send Approved Referral information, including the referral number and any attachments to the provider via VA’s Community Care Provider Portal, Direct Messaging, secure email, secure fax, or eHealth Exchange.

Referrals for urgent or emergent services will follow a different process. See the section below on referral for Urgent, Emergent Services for more information about requesting an approved retroactive referral in those cases.

Additional details on how to verify the status of a VA referral request will be available closer to the SHCD.

Referral numbers must be forwarded to any ancillary providers by the referred VA CCN provider.

Any additional services or extension of a treatment period will require making an additional referral request to VA.

It is the responsibility of Providers to ensure that they have an Approved Referral before providing care or services to a Veteran. This means that the provider may need to request a new referral from VA if the Veteran’s scheduled appointment falls outside of 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.

If a service is denied for failure to obtain a referral, exceeding the referral scope, or failure to submit a timely clean claim, the provider must hold the Veteran harmless for those services and may not invoice Veterans for any services denied for failure of a Provider to obtain an Approved Referral.

If the services rendered are not authorized by VA, the provider may request a reconsideration. Requests for reconsideration must be submitted within 90 days from the date of denial.
Referral for Urgent and Emergent Medical Services

Veterans are allowed to seek emergent or urgent medical care without a referral. The VA CCN provider must notify VA on the same day but no later than 72 hours to request a retroactive referral. VA will release their contact information closer to the SHCD.

Claims and Reimbursement

It's important that providers contact VA within 72 hours of the Veteran receiving services at an in-network urgent care clinic or emergency department. The notification can be via phone call, secure email or secure fax. VA will determine if the Veteran is eligible for the care and may issue an Approved Referral to the Provider.

When VA determines the Veteran is eligible and VA CCN services are covered, they will issue an Approved Referral to the medical provider. After receiving an Approved Referral, the provider should follow the claim submission process. The claim must be submitted within the VA CCN timely filing guidelines of 180 days.

When a Veteran receives services for urgent or emergent care from an out-of-network provider or the referral request is not approved, the claim needs to be submitted within 90 days of the encounter in order for the claim to be considered under the Veterans Millennial Health Care Act (Mill Bill). The Mill Bill is a congressional authorization that allows VA to pay for emergency care in non-VA facilities for Veterans enrolled in the VA health care system.

Not following these guidelines may cause the claim to be denied.

If you are providing services to a Veteran under an Approved Referral and determine that the Veteran is experiencing an urgent or emergent symptom or condition, seek emergency treatment and notify VA immediately.

If a Veteran is receiving authorized services and the treating facility determines the Veteran needs a higher level of care than the facility is capable of providing, you must submit a referral request and notify the VA. In the request, be sure to include:

- Facility name and location
- Admitting provider’s NPI
- Admitting diagnosis
- Date of admission
- Any services already delivered (if available)
- Appropriate attachments.

Training on how to submit a referral will be located at info.communitycare.com, select Training.

Requesting a Referral for VA-Provided Care or Care from Another VA CCN Provider

If you determine during treatment that a Veteran should receive services from another provider and the services are not included in the SEOC, you must request a new referral from VA. Process as follows:

- Referring provider must submit a Referral Request to VA
- Provide the requested information and any supporting medical documentation
- VA will decide if the additional services are approved
- VA sends the determination and a referral number, if approved, to the referring provider using the same method used to make the request
The provider(s) receives the determination from VA and a referral number, if services are approved.

To help make sure the Veteran gets care in a timely manner, please submit Referral Requests on the same day that you determine that additional services are needed.

**Pharmacy**

**Prescriber Requirements**

VA requires that:

- All VA CCN providers must be registered with their own states’ prescription monitoring programs.
- Providers are prohibited from giving pharmaceutical samples to Veterans.
- Veterans can fill urgent/emergent prescriptions for a maximum of 14 days at VA CCN retail pharmacies. All other prescriptions have to be filled at a VA pharmacy.

**Prescribing Controlled Substances**

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

**Urgent and Emergent Prescriptions**

You can write an urgent/emergent prescription for up to a 14-day supply without refills. The prescription must be associated with an Approved Referral. No prescriptions for topical compounded products are considered urgent/emergent.

VA CCN providers must use the VA Urgent/Emergent Formulary when writing urgent/emergent prescriptions. If the provider can’t find an acceptable medication on the VA Urgent/Emergent Formulary, an alternative from the VA National Formulary must be used. See the [Formulary Requirements](#) section.

**Using Retail Pharmacies**

Optum’s VA Community Care Network supports e-prescribing for retail network prescriptions. VA CCN retail pharmacies 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.

Retail pharmacy network prescriptions that are not dispensed must always be reversed seven days after the date they were filled.

**Additional Urgent/Emergent Prescriptions**

Sometimes, an urgent/emergent prescription is clinically needed for continued treatment beyond the initial 14-day supply. When this happens, CCN providers must generate a second urgent/emergent prescription and transmit to the authorizing VA facility’s pharmacy.

Incomplete prescriptions will be returned to the prescribing provider and will have to be resubmitted to the authorizing VA facility’s pharmacy.
Prescribing Without a Referral

Urgent/emergent prescriptions that result from urgent or emergent services without an approved existing or retroactive referral will require the Veteran to pay for the prescription out of pocket. The prescribing provider must inform the Veteran to contact VA facility Community Care office for reimbursement of out of pocket expenses.

Routine and Maintenance Prescriptions

Providers with an Approved Referral should submit all routine/maintenance prescriptions for Veterans to the authorizing VA facility’s pharmacy for processing and fulfillment. Veterans will get their routine and maintenance medications from a VA pharmacy. VA will release information about submitting routine/maintenance prescriptions closer to the SHCD.

Prescribing providers need to include the following information when forwarding the Veteran’s prescription to the VA facility’s pharmacy:

- Prescribing provider’s full name
- Prescribing provider’s NPI number
- Prescribing provider’s TIN
- Prescribing provider’s own DEA number and expiration date (not a generic facility number
- Prescribing provider’s 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.)

Formulary Requirements

Links to the formularies will be available at vacommunitycare.com. These lists will be updated at least quarterly. Write prescriptions in accordance with VA’s National Formulary, which includes provisions for requesting non-formulary drugs (see va.gov for more information).

In addition to the online formulary, use the online formulary search tool. This provides formulary alternatives to non-formulary drugs in the same VA drug class. Utilize this application in order to prescribe appropriate formulary medications.

Seasonal Influenza Vaccine

Seasonal flu vaccine may be administered by a VA CCN retail pharmacy without an Approved Referral when the pharmacy follows recommendations from VA at publichealth.va.gov > Health & Wellness > Vaccines & Immunizations and the Centers for Disease Control and Prevention at cdc.gov/vaccines.

Pharmacy providers must verify the Veteran’s eligibility before delivering a flu vaccination by checking the Veteran’s valid identification (e.g. state driver’s license) and a VA issued identification card.

Other Vaccinations

All other vaccinations require an Approved Referral from VA.
HEALTH CARE MANAGEMENT

Critical Findings

Critical findings are 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.

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 timeframe required to provide any necessary follow-up treatment to the Veteran, whichever is quicker.

Clinical Quality Management

Optum’s Clinical Quality Management (CQM) program helps ensure high quality safe health care and 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 member medical information
- Resolve identified quality issues

CQM also receives and reviews quality-of-service concerns.

High Performing Providers and Centers of Excellence

Measures

Provider performance will be analyzed and monitored against specific measures. Based on data available, providers may be designated as high performing, and institutions designated as centers of excellence. Performance will reviewed and monitored against the following quality and performance measures which may change based on agreement with the VA:

Individual Providers

- Healthcare Effectiveness Data and Information Set (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
<table>
<thead>
<tr>
<th>Measure</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Colorectal Cancer Screening</td>
<td>Percentage of individuals ages 50-75, who had appropriate colorectal cancer screening, per current HEDIS Technical Specifications. Screening intervals vary according to the method of screening. Eligible enrollees must have evidence 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)</td>
</tr>
<tr>
<td>Annual Flu Vaccine</td>
<td>Percentage of individuals who received an influenza vaccinations during the most recent flu season.</td>
</tr>
<tr>
<td>Adult BMI Assessment</td>
<td>Percentage of individual ages 18-74 who had an outpatient visit and whose body mass index (BMI) was documented, per current HEDIS Technical Specifications.</td>
</tr>
<tr>
<td>Diabetes Care - Eye Exam</td>
<td>Percentage of individuals ages 18-75 with diabetes who had an eye exam (retinal) performed, per current HEDIS Technical Specifications.</td>
</tr>
<tr>
<td>Diabetes Care - Kidney Disease Monitoring</td>
<td>Percentage of individuals ages 18-75 with diabetes who had medical attention for nephropathy, per current HEDIS Technical Specifications.</td>
</tr>
<tr>
<td>Diabetes - Blood Sugar Controlled</td>
<td>Percentage of individuals ages 18-75 with diabetes who had HbA1c control (&lt;8.0%), per current HEDIS Technical Specifications.</td>
</tr>
<tr>
<td>Controlling Blood Pressure</td>
<td>Percentage of individuals ages 18-85 who had a diagnosis of hypertension and whose blood pressure was adequately controlled (&lt;140/90), per current HEDIS Technical Specifications.</td>
</tr>
<tr>
<td>Reducing the Risk of Falling</td>
<td>Percentage of patients age 65 or older who have been screened for fall risk by a primary provider.</td>
</tr>
<tr>
<td>Pharmacotherapy Management of COPD Exacerbation (PCE)</td>
<td>Percentage of individuals 40 years of age and older with an inpatient discharge or an ED visit for a COPD exacerbation: 1) the percentage who were dispensed a systemic corticosteroid within 14 days of the event and 2) the percentage who were dispensed a bronchodilator within 30 days of the event, per the current HEDIS Technical Specifications.</td>
</tr>
</tbody>
</table>

- **Premium Designation Rating**
  Providers may receive a notification and template requesting specific data related to the above measures. Providers are required to complete and return the template document within 30 days.

**Group Practice Providers**

Individual provider performance will be aggregated to determine Group Practice Provider performance.

**Hospital Measures**

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

<table>
<thead>
<tr>
<th>Measure</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patients who reported that YES, they were given information about what to do during their recovery at home</td>
<td></td>
</tr>
<tr>
<td>Patients who reported that NO, they were not given information about what to do during their recovery at home</td>
<td></td>
</tr>
<tr>
<td>Patients who “Strongly Agree” they understood their care when they left the hospital</td>
<td></td>
</tr>
<tr>
<td>Patients who “Agree” they understood their care when they left the hospital</td>
<td></td>
</tr>
<tr>
<td>Patients who “Disagree” or “Strongly Disagree” they understood their care when they left the hospital</td>
<td></td>
</tr>
<tr>
<td>Patients who gave their hospital a rating of 9 or 10 on a scale from 0 (lowest) to 10 (highest)</td>
<td></td>
</tr>
<tr>
<td>Patients who gave their hospital a rating of 7 or 8 on a scale from 0 (lowest) to 10 (highest)</td>
<td></td>
</tr>
<tr>
<td>Patients who gave their hospital a rating of 6 or lower on a scale from 0 (lowest) to 10 (highest)</td>
<td></td>
</tr>
<tr>
<td>Patients who reported YES, they would definitely recommend the hospital</td>
<td></td>
</tr>
<tr>
<td>Patients who reported YES, they would probably recommend the hospital</td>
<td></td>
</tr>
<tr>
<td>Patients who reported NO, they would not recommend the hospital</td>
<td></td>
</tr>
</tbody>
</table>

### Acute Myocardial Infarction (AMI) Measures

<table>
<thead>
<tr>
<th>Measure</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Average number of minutes before outpatients with chest pain or possible heart attack who needed specialized care were transferred to another hospital</td>
<td></td>
</tr>
<tr>
<td>Average number of minutes before outpatients with chest pain or possible heart attack got an ECG</td>
<td></td>
</tr>
<tr>
<td>Median Time to Fibrinolysis</td>
<td></td>
</tr>
<tr>
<td>Outpatients with chest pain or possible heart attack who got drugs to break up blood clots within 30 minutes of arrival</td>
<td></td>
</tr>
<tr>
<td>Outpatients with chest pain or possible heart attack who received aspirin within 24 hours of arrival or before transferring from the emergency department</td>
<td></td>
</tr>
</tbody>
</table>

### Patient Safety Indicators (PSI) Measures

- 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
- Blood stream infection after surgery
- A wound that splits open after surgery on the abdomen or pelvis
- Accidental cuts and tears from medical treatment

**Hospital Acquire Infection (HAI) Measures**

- 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*

**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
- 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 a reasonable time and providing complete medical records upon request
  - Routine requests: provider will return medical records within 30 days from request date
  - Expedited requests: provider will return medical records within 21 days from request date
  - Participating in audits regarding performance assessments of provider practices
  - Responding to peer review communications and directed corrective actions within specified time frames

Failure to submit medical records and/or data impact provider network status. Also failure to submit timely information will impede the patient safety investigation process.
Potential Quality Issue Review
For VA CCN, Optum assesses medical records, claims, continuing care for potential quality issues.

Potential patient safety or quality-of-care concerns are categorized using the following categories:

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

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

If you become aware of a potential quality issue (PQI) while providing care to a Veteran, please complete and submit the PQI Referral Form which will be available at vacommunitycare.com.

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 fix a performance area of concern.

CQM Confidentiality
Providers are responsible for ensuring 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, including:

- 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
VA CCN 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 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
Monitoring the Quality of Medical Care Through Review of Medical Records

A well-documented medical record reflects the quality of care delivered to Veterans. VA and Optum will review medical records as part of oversight activities. Providers should maintain medical records in a manner that is current, detailed and organized. This allows for effective and confidential patient care and quality reviews.

Documentation Guidelines

Although VA may request additional medical documentation, at a minimum the following applicable data elements for medical documentation must be included:

- Encounter notes must include any procedures performed and recommendations for further testing or follow-up.
- In lieu of encounter notes, a clinical summary may be provided for ancillary services when appropriate (e.g., physical therapy, occupational therapy, speech and language pathology, and nutrition services).
- Results of community testing or imaging such as MRI or CT scan (images must always be provided to VA upon request).
- Actual results of any ancillary studies/procedures that would impact recommended follow up such as biopsy results (e.g., biopsy results from the provider who recommends a follow up, such as surgery).
- Any recommended prescriptions, Medical Devices, supplies or equipment, and treatment plans.
- Other medical documentation based on clinical need.

Medical records must also include:

- Provider authentication (including a written signature, written initials or electronic signature and provider phone number)
- Veteran unique identifier
  - Internal Control Number (ICN) – primary beneficiary ID; and
  - Social Security Number – secondary beneficiary ID; or
  - Electronic Data Interchange Patient Identifier (EDIPI); or
  - Patient Control Number (PCN); and
- Veteran’s full name (including suffix)
- Veteran’s date of birth
- Referral number

For example documentation, see Appendix A - VA Example of Documentation Inclusions in this Manual.

Submitting Medical Documentation

VA CCN providers submit medical documentation directly to VA and referring provider. VA will release more information about how to submit medical documentation closer to the SHCD.

Submission Timeframes

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

- Outpatient care
  - Within 30 days after initial appointment for documentation associated with the first appointment of an SEOC
• Within 30 days after completion of the SEOC for medical documentation that covers the entire SEOC
• Inpatient care
  • Within 30 days of inpatient care; documentation must at least include a discharge summary

In the event VA requests medical documentation for urgent follow up that was not submitted upon request, providers must submit the requested medical documentation upon request.

Failure to Comply
If a CCN provider does not comply with submission requirements, VA will notify Optum. A representative from Optum will notify the provider of an improper submission and the provider will have 30 days to respond to VA with corrected medical documentation.

VA CCN Medical Documentation Training and Assistance
Training material will be located on info.vacommunitycare.com 60 days before the SHCD.
Optum will offer training and assistance to providers for submission of timely medical documentation to VA.

Clinical Quality Medical Documentation Requirements
Providers will be required to
• Submit medical records to Optum directly or through its designee, immediately upon 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
We know that you want timely payment. We work hard to process your claims timely and accurately. We prefer to receive claims submissions electronically, but we will also accept paper forms.

Providers must submit claims on nationally recognized claims forms including:
• CMS-1500
• CMS 1450, UB-04
• ADA claim form

Providers must always include the provider’s National Provider Identifier (NPI) number, except in those cases when providers are not eligible to receive an NPI number. Providers who are not eligible to receive an NPI must always file claims that include the provider’s tax ID number (TIN) or other provider ID.

Out-of-network providers must submit claims directly to VA following VA claims submission procedures, which will be released closer to the SHCD.

Reimbursement
Providers will be reimbursed in accordance with the payment provisions in the Provider Agreement and any applicable payment appendices.

The VA Fee Schedule is available at info.vacommunitycare.com.
Claims Processing and Filing

Applicable claims processing and filing requirements for VA CCN include the following:

- Administrative charges submitted by the provider related to completing and submitting the applicable claim form or any other related information will be denied.
- Providers may not charge Veterans for missed appointments.
- Duplicate claims will be denied.
- Claims that are submitted for services that are not part of the Veteran’s medical benefits package as well as claims submitted for care that is not within the scope of the Approved Referral will be denied.
- Claims submitted on unapproved claim forms will be rejected. Resubmitted claims on approved claim forms need to be submitted within the timely filing deadline of 180 days.
- Claims for urgent or emergency services will be given a pending status until VA determines whether to issue a retroactive referral. In the event VA issues one, the provider will be reimbursed for that claim. In the event VA issues a denial, the claim will be denied.
- Out-of-network emergency providers need to submit health care claims directly to VA following VA claims submission procedures.
- Claims submitted that do not have an Approved Referral number will be denied.
- Claims that do not include a valid NPI number (or TIN number for providers who are not eligible for an NPI) will be denied.
- Claims for care that is not emergent or urgent and that do not contain a valid referral number will be denied.
- Claims that are not submitted within 180 days from the date of service or date of discharge will be denied for passing the timely filing deadline.

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.

VA CCN randomly reviews claims to confirm that signature-on-file requirements are being followed. At the SHCD, requirements can be found on vacommunitycare.com.

Provider’s Signature on File

Optum and its Network Partners verify the signature of providers on all claim submissions for services provided as part of their normal business operations.

In lieu of a provider’s actual signature on a VA CCN claim, 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 for use of a facsimile signature or a notarized authorization or power of attorney for another person to sign on their 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. 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 Power of Attorney (POA), or similar indication of the type of authorization granted by the provider.

In the absence of any indication to the contrary Optum and its Network Partners assume the proper authorization is on file, validating through file checks, those claims containing facsimile and representatives’ signatures which are included in their quality control audit, and program integrity Network
Partner may return a claim with a request for the signature authorization when it is found that there is no authorization on file or it is out-of-date. Failure to comply will result in a claim denial.

**Claims Submission**

**Electronic:**
VA CCN claims require an Approved Referral. You must include the referral number on your claim submission. Electronic submissions are preferred for sending claims to Optum using an Electronic Data Interchange (EDI) software program from a vendor, clearinghouse, or billing service. You may also go to Optum's VA Community Care Network Portal (vacomunitycare.com) and select the medical or dental claims portal and follow that portal’s directions to submit claims directly on the portal.

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

- **Medical**
  - Payor ID: VACCN
  - Mailing Address:
    - VA CCN Optum
    - PO Box 202117
    - Florence, SC 29502
  - Secure Fax: (833) 376-3047

- **Dental**
  - Payor ID: VACCN
  - Mailing Address:
    - Logistics Health Inc.
    - Attn: VA CCN Claims
    - 328 Front St S
    - La Crosse, WI 54601
  - SecureFax: (608) 793-2143, please specify VA CCN on the fax

**Timely Filing**
Claims must be submitted within 180 days from the date of service or date of discharge.

**Claims Processing Timelines**
Optum is committed to processing 98 percent of all clean claims within 30 days. Clean claims are claims received with all the required data elements necessary for adjudication without needing supplemental information. Claims that aren’t clean will be returned with a clear explanation of deficiencies within 30 days of being received.

You may use the secure area of Optum’s VA Community Care Network Portal 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. Duplicate claims (any claim that was previously submitted for the same service provided to a particular individual on a specified date of service) will be denied.
Claim Denials

Veterans are to be held harmless and may not be billed when claims for services are denied for following reasons:

- If the provider doesn’t have an Approved Referral from VA
- If the provider doesn’t meet the prior authorization requirements of the Veteran’s other health insurance (OHI)
- If you fail to submit a claim according to the Claims Adjudication Rules (these will be available at vacommunitycare.com)
- If you deliver health care services outside of the validity period or outside the scope of the Approved Referral
- If you provide services that are not part of the Veteran’s medical benefits package or for services that are not in the scope of the Approved Referral

Remittance Advice

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

Claim Reconsiderations

Reconsideration is a formal process requesting Optum review a claim denied partially or in whole, or the payment was incorrect. A reconsideration request must be filed within 90 calendar days from the date of denial of the initial payment decision by mailing the request to the below address or faxing the request using the below fax number:

VA Community Care Network
Appeals and Grievance
Team MS-21
3237 Airport Road
La Crosse, WI 54603

Fax: Secure: (877) 666-6597

Subrogation

Provider must ensure that Optum is notified in all circumstances of any 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 CCN health care services. Optum will work with the VA and notify Provider if any recoupment processes will be initiated.

Mill Bill

Mill Bill is a congressional authorization that allows VA to pay for emergency care in non-VA facilities for Veterans enrolled in the VA health care system, under certain circumstances and guidelines.

A claim without an Approved Referral for emergency care provided by a Network Provider must always be submitted directly to VA for VA to review and determine whether the services are covered under the Mill Bill.
Veteran Appeals
In the event Optum denies a claim and the Veteran has a financial liability for that denied claim (such as denied emergency service claims), we 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 always be available to the Veteran through vacommunitycare.com.

Claims Audits
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 us regarding Veterans who have scheduled appointments, but there is no associated claims activity. This may occur if a Veteran missed an appointment, cancels an appointment and does not reschedule.

PROVIDER TRAINING
Closer to the SHCD, Optum will be providing training and learning material for you and your staff. This includes video modules designed for self-paced learning on specific topics. Training material will be located on info.vacommunitycare.com 60 days before the SHCD.

At SHCD, the training materials will be located at vacommunitycare.com.

Training
Provider training will include, but is not limited to:

- VA CCN Provider Manual
- VA CCN Quick Reference Guide (QRG)
- VA CCN Frequently Asked Questions (FAQ)
- VA CCN Awareness Training
- Why Join VA CCN?
- General Medical Benefits
- Behavioral Health Pharmacy Benefits
- Vision Benefits
- DME Benefits
- Understanding VA CCN for Providers
- Customer Service Process – Points of Contact
- Provider Contracting-Credentialing
- Timeframes
- Fraud, Waste and Abuse
- High Performing Providers
- Referrals
- SEOC
- Medical Documentation
- Navigate the Provider Portal
- How to Register For an Optum ID
- How to Access eLearningAcronyms
<table>
<thead>
<tr>
<th>Acronym</th>
<th>Meaning</th>
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</thead>
<tbody>
<tr>
<td>BH</td>
<td>Behavioral Health</td>
</tr>
<tr>
<td>CARF</td>
<td>Commission on Accreditation of Rehabilitation Facilities</td>
</tr>
<tr>
<td>CCN</td>
<td>Community Care Network</td>
</tr>
<tr>
<td>CIHS</td>
<td>Complementary and Integrative Healthcare Services</td>
</tr>
<tr>
<td>CMS</td>
<td>The Centers for Medicare and Medicaid Services</td>
</tr>
<tr>
<td>CoE</td>
<td>Centers of Excellence</td>
</tr>
<tr>
<td>CPT</td>
<td>Current Procedural Terminology</td>
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<tr>
<td>CQMP</td>
<td>Clinical Quality Management Program</td>
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<tr>
<td>CVS</td>
<td>CVS Caremark</td>
</tr>
<tr>
<td>DME</td>
<td>Durable Medical Equipment</td>
</tr>
<tr>
<td>DOS</td>
<td>Dates of Service</td>
</tr>
<tr>
<td>EDI</td>
<td>Electronic Data Interchange</td>
</tr>
<tr>
<td>EDIPI</td>
<td>Electronic Data Interchange Patient Identifier, found on enrollment card.</td>
</tr>
<tr>
<td>EHR</td>
<td>Electronic Health Record</td>
</tr>
<tr>
<td>EOB</td>
<td>Explanation of Benefits</td>
</tr>
<tr>
<td>ES</td>
<td>Enrollment System</td>
</tr>
<tr>
<td>FDA</td>
<td>Food and Drug Administration</td>
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<tr>
<td>FQHC</td>
<td>Federally Qualified Health Center</td>
</tr>
<tr>
<td>HCAHPS</td>
<td>Hospital Consumer Assessment of Healthcare Providers and Systems Survey</td>
</tr>
<tr>
<td>HCPCS</td>
<td>Healthcare Common Procedure Coding System</td>
</tr>
<tr>
<td>HEDIS</td>
<td>Healthcare Effectiveness Data and Information Set</td>
</tr>
<tr>
<td>HHS</td>
<td>U.S. Department of Health and Human Services</td>
</tr>
<tr>
<td>ICD</td>
<td>International Classification of Diseases</td>
</tr>
<tr>
<td>LHI</td>
<td>Logistics Health Incorporated</td>
</tr>
<tr>
<td>MRI</td>
<td>Magnetic Resonance Imaging</td>
</tr>
<tr>
<td>NPI</td>
<td>National Provider Identifier</td>
</tr>
<tr>
<td>Acronym</td>
<td>Meaning</td>
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<tr>
<td>OHI</td>
<td>Other Health Insurance</td>
</tr>
<tr>
<td>OIG</td>
<td>Office of Inspector General</td>
</tr>
<tr>
<td>PAL</td>
<td>Prior Authorization List</td>
</tr>
<tr>
<td>PBM</td>
<td>Pharmacy Benefits Management</td>
</tr>
<tr>
<td>PCP</td>
<td>Primary Care Provider</td>
</tr>
<tr>
<td>POC</td>
<td>Point of Contact</td>
</tr>
<tr>
<td>PQI</td>
<td>Potential Quality Issue</td>
</tr>
<tr>
<td>RA</td>
<td>Remittance Advice</td>
</tr>
<tr>
<td>RHC</td>
<td>Rural Health Clinic</td>
</tr>
<tr>
<td>SC</td>
<td>Service-Connected condition</td>
</tr>
<tr>
<td>SHCD</td>
<td>Start of Health Care Delivery</td>
</tr>
<tr>
<td>SEOC</td>
<td>Standardized Episode of Care</td>
</tr>
<tr>
<td>SNF</td>
<td>Skilled Nursing Facility</td>
</tr>
<tr>
<td>SSN</td>
<td>Social Security Number</td>
</tr>
<tr>
<td>UBH</td>
<td>United Behavioral Health</td>
</tr>
<tr>
<td>VA</td>
<td>U.S. Department of Veterans Affairs</td>
</tr>
<tr>
<td>VA CCN</td>
<td>VA Community Care Network</td>
</tr>
<tr>
<td>VAMC</td>
<td>VA Medical Center</td>
</tr>
<tr>
<td>VBA</td>
<td>Veterans Benefits Administration</td>
</tr>
<tr>
<td>VHA</td>
<td>Veterans Health Administration</td>
</tr>
</tbody>
</table>
### Glossary

<table>
<thead>
<tr>
<th>Term</th>
<th>Meaning</th>
</tr>
</thead>
<tbody>
<tr>
<td>Approved Referral</td>
<td>Approved referrals 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.</td>
</tr>
<tr>
<td>Claim</td>
<td>An invoice for health care, dental or pharmacy services</td>
</tr>
<tr>
<td>Clean Claim</td>
<td>A claim that contains all the required data elements necessary for adjudication without requesting supplemental information from the submitter</td>
</tr>
<tr>
<td>Complementary and Integrative Healthcare Services (CIHS)</td>
<td>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.</td>
</tr>
<tr>
<td>Covered Services</td>
<td>Health care services and supplies that are covered under the VA CCN as described in 38 CFR 17.38 and for which Provider has received an Approved Referral</td>
</tr>
<tr>
<td>Critical Finding</td>
<td>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.</td>
</tr>
<tr>
<td>Distance-Eligible</td>
<td>Distance-Eligible and Special-Circumstances Veterans (referred to as “Distance-Eligible” Veterans) are Veterans who meet specific VA requirements to be eligible for community care because of geographic reasons.</td>
</tr>
<tr>
<td>Durable Medical Equipment (DME)</td>
<td>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.</td>
</tr>
<tr>
<td>EDI 278 request</td>
<td>Requests for referrals for additional visits, DME, emergent services or services outside of initial referral.</td>
</tr>
<tr>
<td>EDI 835 Remittance Advice (RA)</td>
<td>An electronic explanation of payments and other decision-making information.</td>
</tr>
<tr>
<td>Electronic Data Interchange (EDI)</td>
<td>The electronic exchange of information between two or more organizations.</td>
</tr>
<tr>
<td>Eligible Veteran</td>
<td>Any Veteran who is eligible to receive care in the community due to either time-eligibility or distance-eligibility.</td>
</tr>
<tr>
<td>Emergent Care</td>
<td>Medical care required within twenty-four 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.</td>
</tr>
<tr>
<td>Term</td>
<td>Meaning</td>
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</tr>
<tr>
<td>Emergent Health Care Need</td>
<td>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.</td>
</tr>
<tr>
<td>Enrolled Veteran</td>
<td>Any Veteran who is enrolled in VA’s patient enrollment system and is eligible to receive health care benefits.</td>
</tr>
<tr>
<td>Expired Approved Referral</td>
<td>An Approved Referral that has passed the end date.</td>
</tr>
<tr>
<td>General Care</td>
<td>All other care and services offered under VA Health Benefit Package other than primary care and Complementary and Integrative Health Services (CIHS).</td>
</tr>
<tr>
<td>Medical Device</td>
<td>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.</td>
</tr>
<tr>
<td>Non-service Connected Care</td>
<td>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.</td>
</tr>
<tr>
<td>Primary Care</td>
<td>Health care at a basic, rather than specialized, level.</td>
</tr>
<tr>
<td>Referral Request</td>
<td>A request and approval process that authorizes the Veteran to obtain specified care within a specified timeframe from additional resources in the community. Upon approval, a referral number is generated. The referral number must always be included on claims submitted by CCN providers for payment.</td>
</tr>
<tr>
<td>Remittance Advice</td>
<td>An explanation of payments and other decision-making information.</td>
</tr>
<tr>
<td>Service Connected Care</td>
<td>Medical care and services provided for a Veteran for a service-connected (SC) 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.</td>
</tr>
<tr>
<td>Standardized Episode of Care</td>
<td>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 one year.</td>
</tr>
<tr>
<td>Time-Eligible</td>
<td>Veterans who are unable to schedule an appointment for hospital care, medical services, or dental services with VA within the wait time goals of the Veterans Health Administration (VHA) for such care or services or the period determined by a VA provider to be clinically necessary for such care or services, whichever is shorter. This includes when such care or services are not provided within a VA medical facility that is accessible to the Veteran. This also includes when there is a compelling reason, determined by VA, that the Veteran needs to receive the care or service outside of a VA medical facility.</td>
</tr>
<tr>
<td>Term</td>
<td>Meaning</td>
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</tr>
<tr>
<td>Urgent Health Care Need</td>
<td>Non-life threatening conditions that require care in a timely manner (such as within 24 hours) to avoid having them worsen.</td>
</tr>
<tr>
<td>Urgent Care</td>
<td>Provision of immediate medical service offering outpatient care for the treatment of acute and chronic illness or injury.</td>
</tr>
<tr>
<td>VA Community Care Network</td>
<td>A network of community-based providers and services designed to coordinate with VA in providing timely, accessible and high-quality health care to Veterans.</td>
</tr>
<tr>
<td>VA Facility</td>
<td>A VA facility is a VA hospital or VA medical center.</td>
</tr>
<tr>
<td>VA Hospital</td>
<td>A VA hospital is any VA-owned, staffed, and operated facility providing acute inpatient and/or rehabilitation services.</td>
</tr>
<tr>
<td>VA Medical Center</td>
<td>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).</td>
</tr>
</tbody>
</table>
APPENDIX A – VA EXAMPLE OF DOCUMENTATION INCLUSIONS

VA’s Example Medical Documentation for VA CCN Providers

According to the VHA Handbook 1907.01, Health Information Management and Health Records, health record documentation is required to record pertinent facts, findings, and observations about an individual’s health history, including past and present illnesses, examinations, tests, treatments, and outcomes. A separate, unique health record is created and maintained for every individual assessed or treated by VA, as well as those receiving community or ancillary care at VA expense. The health record documents the care of the patient and is an important element contributing to high quality care.

All community care provider documentation scanned or imported into the Veteran electronic health record (EHR) must be complete, including the provider signature authenticating the originating VA community provider of care documentation prior to inclusion into the VHA electronic health record. Authentication may include a written signature, written initials, or electronic signatures. If unsigned documents are received, three attempts must be made to work with the VA Community Care provider to obtain authenticated documents.

Note: Not all of the documents listed below are necessary to be included in the received documentation. For example, a primary care visit may include only the progress note as no ancillary services were performed.

Primary Care

- Initial evaluation note
- Progress notes
- Summary note of care when patient requires no further treatment (i.e., the episode of care)
- Ancillary services, if performed (Results)
  - Imaging
  - Laboratory
  - Other testing (e.g., electrocardiogram, pulmonary function testing, etc.)
- Medications, administered and/or prescribed

Inpatient Care – Medical - (i.e. Acute Inpatient)

Note: Facilities may prioritize the order of clinical documents within the inpatient stay so that pertinent clinical documents, such as Discharge Summary, H&P, and Operative Reports, are sequenced first and readily available to clinical staff. Prioritization of the documents must be stated in the facility’s local policy.

- Discharge summary
- History and physical
- Consultations
- Diagnostic and therapeutic procedure report, if performed (Results)
- Informed consent
- Ancillary services, if performed (Results)
  - Imaging
  - Laboratory
  - Other testing (e.g., electrocardiogram, pulmonary function testing, etc.)
- Transfer note/summary
- Against Medical Advice (AMA) note (if patient left AMA)
- Discharge note or discharge instructions
- Discharge medications
- Legal documents, (e.g., advance directive, living will, power of attorney, conservatorship)
- State authorized portable orders
- Do Not Resuscitate (DNR) or Do Not Attempt Resuscitation (DNAR)
• Autopsy
• Death certificate

**Inpatient Care – Surgical**
• Discharge summary
• History and physical
• Consultations
• Informed consent
• Operative report
• Post-operative note
• Anesthesia evaluation
• Anesthesia plan
• Post-anesthesia note
• Diagnostic and therapeutic procedure report
• Surgical pathology and cytopathology reports
  ○ Should be received within 48 hours
• Ancillary services, if performed (Results)
  ○ Imaging
  ○ Laboratory
  ○ Other testing (e.g., electrocardiogram, pulmonary function testing, etc.)
• Transfer note/summary
• Against Medical Advice (AMA) note (if patient left AMA)
• Discharge note or discharge instructions
• Discharge medications
• Legal documents (e.g., advance directive, living will, power of attorney, conservatorship)
• Do Not Resuscitate (DNR) or Do Not Attempt Resuscitation (DNAR) Note
• Autopsy
• Death certificate

**Inpatient Mental Health**
• Discharge summary
• History and physical
• Consultations (if performed)
• Ancillary services performed (Results, if performed)
  ○ Imaging
  ○ Laboratory
  ○ Other testing (e.g., electrocardiogram, pulmonary function testing, etc.)
• Transfer note/summary
• Against Medical Advice (AMA) note (if patient left AMA)
• Discharge note or discharge instructions
• Discharge medications
• Legal documents (e.g., advance directive, living will, power of attorney, conservatorship)

**Ambulatory Surgery**
• History and physical
• Operative note
• Operative report
• Anesthesia evaluation
• Anesthesia plan
• Post-anesthesia note
• Informed consent
• Surgical pathology and cytopathology reports
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Emergency Room (ER) Care

Note: ER documentation received must be authenticated before it’s included in the VA health record.

- ER provider note
- Treatment plan
- Transfer note/summary (point of stability for transfer)
- Condition at discharge
- Discharge instruction
- Ancillary services, if performed (results)
  - Imaging
  - Laboratory
  - Other testing (e.g., electrocardiogram, pulmonary function testing, etc.)
- Ambulance/Transportation note, if transported
- Discharge medications, administered and/or prescribed

Veteran Death at ER

- Discharge summary
- Death certificate

Specialty/Outpatient Care

- Consultation note
- Progress note
- Treatment plan
- Summary note of care when patient requires no further treatment.
- Ancillary services performed (results)
  - Imaging (e.g., mammography report, including BI-RAD)
  - Laboratory
  - Other testing (e.g., electrocardiogram, pulmonary function testing, etc.)
- Medications, administered and/or prescribed

Observation (Short Stay Admission)

- Initial progress note
- History and physical
- Progress notes
- Discharge note or discharge instructions, including discharge diagnoses
- Discharge medications

Outpatient Mental Health

- Initial evaluation note
- Progress notes
- Summary note of care when patient requires no further treatment.
- Treatment plan
- Medications, administered and/or prescribed
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