



TriWest Healthcare Alliance

Department of Veterans Affairs (VA) Community Care Network (CCN)
Provider Handbook

Thank you for your service to our nation's Veterans

The English version of this manual will govern for the purposes of legal interpretation in case of disagreement or ambiguity.

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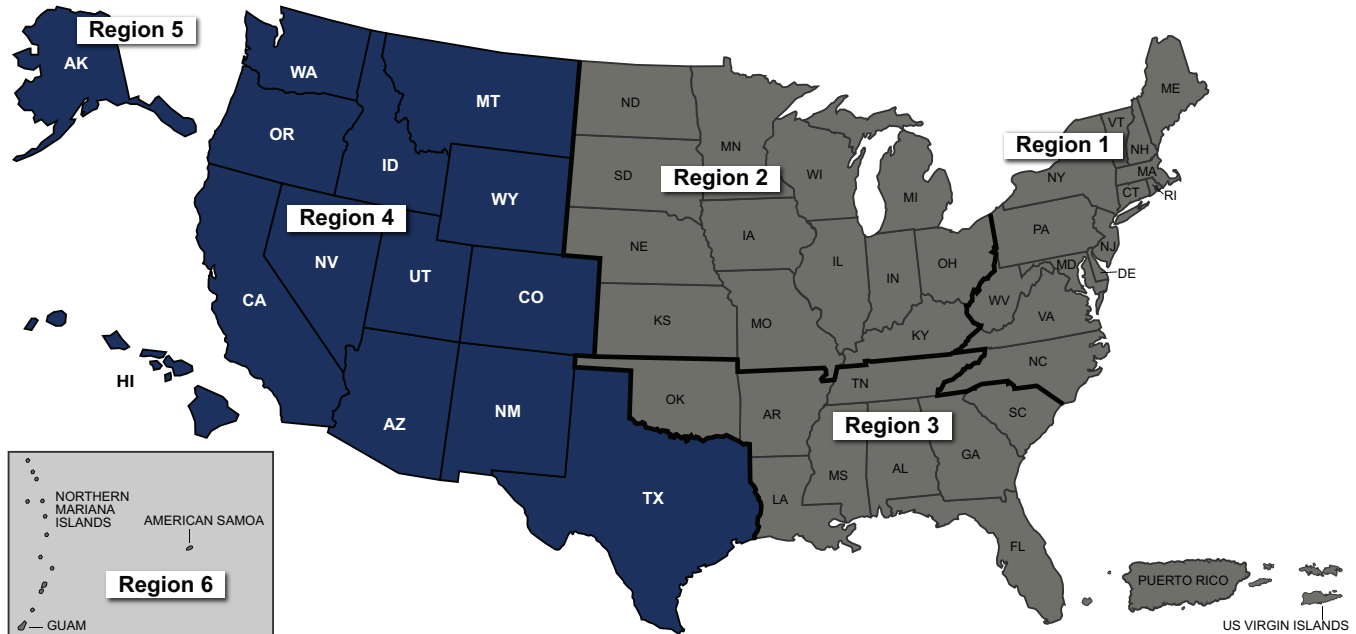
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Welcome!

The following Provider Handbook applies to the Department of Veterans Affairs (VA) Community Care Network (CCN) for TriWest network providers in Regions 4 and 5. The new CCN is a network to augment local VA Medical Center (VAMC) resources or availability. CCN is VA's modernization pathway to streamline its community care programs, providing more choices and robust care coordination for Veterans using one consolidated program instead of multiple programs.

Essentially, CCN allows Veterans to receive health care services in their communities when VA determines it is needed. CCN covers all medical and surgical services, behavioral health, primary care services, routine diagnostic tests, radiology, laboratory, and preventive services.

TriWest Healthcare Alliance (TriWest) is VA's partner and third-party administrator for CCN in Regions 4 and 5, which includes the following 14 states: Alaska, Arizona, California, Colorado, Hawaii, Idaho, Montana, Nevada, New Mexico, Oregon, Texas, Utah, Washington, and Wyoming.



Provider Training

Providers will need to know how CCN works to ensure seamless care to Veteran patients.

TriWest has a full training program via its Payer Space on Availity that walks providers through the CCN processes and procedures. The training covers such topics as appointing and approved referrals/authorizations, claims submission, requests for services, and other CCN processes and procedures.

The training methods TriWest has available include:

- **Webinars** – live, interactive virtual classes where providers can ask questions in real time.
- **MicroLearning Videos** – short, bite-sized video snippets that cover various aspects of CCN.
- **eSeminar Learning Paths** – MicroLearnings based on a variety of topics that, when viewed consecutively, form a complete eSeminar. Think of MicroLearnings as individual songs and the Learning Path as the playlist.

Register for Training Now!

To register for CCN webinar sessions, login to Availity at <https://www.availity.com>. Sign up for an account for free.

After logging into Availity:

- Navigate to the TriWest Payer Space
- Click on the TriWest Learning Center
- Register for the various CCN webinars at the times that work for you

Providers may also enroll in an on-demand eSeminar Learning Path by navigating to the TriWest Learning Center, as mentioned above.

Required VA Training!

Section 131 of the Department of Veterans Affairs (VA) MISSION Act of 2018 requires all CCN providers with a DEA number who can prescribe medications for Veterans to complete opioid safety training within 180 days of July 1, 2020. CCN providers who join the TriWest network after July 1, 2020, have 180 days to complete the opioid safety training from the date of their signed and executed contract.

The required opioid safety information is part of the VA Opioid Safety Initiative, a comprehensive strategy to reduce reliance on opioid medications and improve effectiveness and safety for Veterans. To meet the requirement, providers will register online and download a two-page fact sheet. If you do not visit <https://train2serve.com/> to register and take the VA-mandated training within the 180-day timeframe, you may cease receiving new Veteran referrals until you complete the training.

The VA's recommended military culture training – [*Community Care Provider-A Perspective for Veteran Care*](#) – emphasizes the importance of knowing the influence of military culture and experience to improve treatment outcomes for Veterans. According to VA, Veterans seen by culturally informed providers reported they were more satisfied with their visit and, therefore, more comfortable seeking and sharing information about their health care needs. Providers will receive one hour of Accreditation Council for Continuing Medical Education (ACCME) accreditation for completing the military culture training. Here is a link: <https://train.missionact.org/main/course/1085488/>.

Take the opioid training to ensure you can continue receiving referrals to care for Veterans. Please:

- Visit <https://train2serve.com/>
- Select “Register Now”
- Complete the registration process
- Download the Opioid Safety Initiative information

If you do not visit <https://train2serve.com/> to register and take the VA-mandated training within the 180-day timeframe, you may cease receiving new Veteran referrals until you complete the training.

Availity Resources

TriWest leverages [Availity](#) as its one-stop shop for all information, training, and online provider support for CCN. This multi-payer site is where providers can use a single user ID and password to work with TriWest and other participating payers online.

Providers will need to register for a free Availity account and navigate to the TriWest Payer Space to access all TriWest webinar sessions, eSeminar Learning Paths, quick reference guides (QRGs), and the Provider Handbook through a Secure Login on Availity. Providers can also check the status of their claims in real-time using Availity's claims tool.

Have questions for TriWest regarding the Availity portal capabilities? Please visit <https://www.availity.com/triwest> or call Availity for technical assistance at 800-282-4548.

VA Storefront – Home for VA's CCN Information

VA created an online hub for CCN called the [VA Storefront](#). There is a special section devoted to providers, including one to “Request and Coordinate Care” that includes:

- Care Coordination Overview
- Precertification Requirements
- Request for Service (RFS) Requirements
- Durable Medical Equipment/Pharmacy Requirements

When providers first arrive at the VA Storefront homepage, it will be titled “Community Care” and will open with a Provider Overview message. The majority of tools that providers need to reference are on the left-hand navigation menu under the “For Providers” button.

For more information on the VA Storefront, including screen shots of how to navigate it, please review the TriWest [VA Storefront Quick Reference Guide](#).

HealthShare Referral Manager (HSRM) Portal

HSRM is VA's tool to manage the entire care coordination process, including a method for providers to use to submit medical documentation and RFS forms to the VA Medical Center (VAMC). To access the HSRM portal for RFS and medical documentation upload, the provider must first be in VA's provider directory. If a provider has signed a network contract and completed credentialing with TriWest, he/she should be part of VA's provider directory.

Users should set up an account with ID.me using his/her Social Security number and phone number. This allows for a secure, 2-step verification process each time a user logs on. For practices that cannot utilize the 2-step verification process – which requires a phone or text message – contact the local VAMC and fax documentation directly.

There should be one Point of Contact (POC) for each community provider who will fill out the end-user tracker form with information about all staff who would like HSRM access. The POC will send this completed end-user tracker form to the HSRM Community Provider Help Desk at HSRMsupport@va.gov. This Help Desk is also available by phone at 844-293-2272.

To help provider staff members, VA is offering HSRM training hosted through [VHA TRAIN](#).

Who to Contact

For questions about CCN Regions 4 and 5, please email TriWest at providerservices@triwest.com, or call 877-226-8749.

For questions on Availity, here are some resources:

- For an overview of the Availity multi-payer platform – <https://www.availity.com/healthplans>
- For more information on the TriWest transition to Availity – <https://www.availity.com/triwest>
- For Availity technical support – call 800-282-4548
- You can also open a support ticket via Availity's Provider Engagement Portal Account.

CCN Health Benefit Package

CCN covers, at a minimum, a basic set of services for Veterans called the "CCN Health Benefit Package."

The CCN Health Benefit Package includes:

- Comprehensive Rehabilitative Services
- Hospital Services
- Ancillary Services
- Behavioral Health (to include professional counseling)
- Residential Care
- Home Healthcare (Skilled and Unskilled)
- Hospice/Palliative Care/Respite
- Geriatrics (Non-institutionalized extended care services, including but not limited to non-institutional geriatric evaluation, non-institutional adult day health care, and non-institutional respite care)
- Outpatient Diagnostic and Treatment Services (including laboratory services)
- Inpatient Diagnostic and Treatment Services
- Long Term Acute Care
- Acupuncture
- Maternity and Women's Health
- Telehealth
- Chronic Dialysis Treatment
- Assisted Reproductive Technology services (ART)
- Flu Shots
- Therapeutic Vaccines
- Complementary and Integrated Health Care
- Skilled Nursing
- Pharmacy
- Dental
- Emergent Care
- Urgent Care/Urgent Care Walk-In
- Durable Medical Equipment (DME) Medical Devices, Orthotic, and Prosthetic items
- Reconstructive Surgery

- Immunizations
- Implants (when provided by an authorized surgical or medical procedure)
- In Vitro Fertilization (IVF)

Note: CCN health care services includes certain rehabilitative services/therapies provided by non-licensed practitioners (e.g., blind and low-vision rehabilitation services, driver rehabilitation services, and recreational therapy).

CCN Complementary and Integrative Healthcare Services (CIHS)

The CCN Health Benefit Package also includes certain Complementary and Integrative Healthcare Services (CIHS) under certain conditions pursuant to 38 C.F.R. §17.38. Network providers who specialize in covered CIHS should submit claims using the appropriate CPT code or Healthcare Common Procedure Coding System (HCPCS) code. If a CPT or HCPCS code is unavailable, the provider should use the appropriate VA National Clinic List Code for the specified service, listed below.

For more information on how to submit claims, please review the [CCN Provider Claims Quick Reference Guide](#) located in the TriWest Payer Space on Availity, <https://www.availity.com>.

CIHS under CCN include:

- Biofeedback (VA National Clinic List Code = BIOF)
- Hypnotherapy (VA National Clinic List Code = HYPN)
- Massage Therapy (VA National Clinic List Code = MSGT)
- Native American Healing (VA National Clinic List Code = NAHL)
- Relaxation Techniques, such as meditation and guided imagery (VA National Clinic List Code = RLXT)
- Tai Chi (VA National Clinic List Code = TAIC)

Exclusions: CCN Health Benefit Package

The CCN Health Benefit Package EXCLUDES:

- Abortion or abortion counseling
- Drugs, biologicals, and MD not approved by the Food and Drug Administration (FDA) unless used under approved clinical research trials
- Gender alteration surgeries; 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 provide the care or services
- Membership in spas or health clubs
- Out-of-network services

Services Covered by CCN Health Benefit Package, but TriWest Cannot Provide

Pursuant to 38 C.F.R. § 17.38, or otherwise provided by VA, the following services are **covered under the CCN Health Benefit Package**, but **cannot be provided by TriWest under the CCN contract**:

- Beneficiary travel
- 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
- Home deliveries
- Ambulance services (ambulance services shall be referred directly to VA for payment consideration)
- Yoga and services included on CIHS Directive List 2 (Healing Touch, Acupressure, Alexander Technique, Reflexology, Reiki, Therapeutic Touch, Emotional Freedom Technique, Animal Assisted Therapy (falls under Recreation Therapy), Aroma Therapy, Biofield Therapies, Rolfing, Somatic Experiencing, and Zero Balancing)

Provider Responsibilities to Veterans

As a CCN provider, VA has designated certain responsibilities when caring for Veterans.

- First, always ensure that appointments for authorized services are honored.
- Providers must honor all appointments with Veterans for covered services with an approved referral/ authorization. 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 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
- If the provider determines the Veteran needs additional care beyond what's authorized, submit an RFS directly to VA, preferably through VA's online HSRM portal.
- A payment for authorized services under this contract is always deemed payment in full. This means providers are not allowed to balance bill Veterans or TriWest for services provided under the CCN contract.
- Providers may NEVER charge a Veteran for not keeping a scheduled appointment.
- Providers should never solicit Veterans or VAMCs for services
- Providers must always notify TriWest immediately in cases where CCN health care services are being provided that are related to, or associated with, any claim involving subrogation against:
 - Workers' compensation carrier;
 - An auto liability insurance carrier;
 - Third-Party tortfeasor (e.g., medical malpractice); or
 - Any other situation where a third party is responsible for the cost of CCN health care services.

VA requires TriWest to report these cases to VA within 30 days of identifying the event. Therefore, providers must notify TriWest immediately to comply with this VA requirement.

High Performing Provider

VA has created a High Performing Provider (HPP) designation under CCN for those providers who excel in a set of standard health care evaluation metrics. Providers are scored on a set of standard quality metrics approved by VA to determine whether they are deemed to be an HPP. The HPP designation may be used by VA or TriWest when selecting a provider to see a Veteran.

The HPP designation describes CCN providers based on standard quality metrics approved by VA.

For more information on the HPP designation, please review the [HPP Quick Reference Guide](#). Inquiries regarding the HPP process can be submitted to CQHPP@TriWest.com. A summary of specific provider metrics is available on request by completing the HPP Inquiry Form on the TriWest Payer Space on Availity (<https://www.availity.com>) under the "Resources" tab. Providers should send the completed HPP Inquiry Form to CQHPP@triwest.com.

Provider Credentialing Requirements

The following list is a compilation of credentialing requirements that providers must meet in order to be accepted into the TriWest Provider Network:

- A. Provider must meet the requirements of state and local laws and, as applicable, must have a full, current, non-probationary and unrestricted license in the state where services are delivered.
- B. Provider must remain in compliance with the seven (7) elements of the OIG's Compliance Program Guidance.
 1. Implementing written policies, procedures and standards of conduct.
 2. Designating a compliance officer and compliance committee.
 3. Conducting effective training and education.
 4. Developing effective lines of communication.
 5. Conducting internal monitoring and auditing.
 6. Enforcing standards through well-publicized disciplinary guidelines.
 7. Responding promptly to detected offenses and undertaking corrective action.
- C. As applicable, provider cannot have had any state license termed for cause or have relinquished any state license after being notified in writing by that state of potential termination for cause.

- D. As applicable, providers shall meet all Medicare Conditions of Participation (CoP) and Conditions for Coverage (CfC), where such conditions exist, subject to Centers for Medicare & Medicaid Services (CMS) modifications, as required by the U.S. Department of Health and Human Services (HHS). These conditions may be met through CMS certification or accreditation by organizations deemed by CMS to meet or exceed the CMS Medicare standards set forth in the CoP/CfC. For additional details regarding these requirements see <http://www.cms.gov>.

CCN Processes and Procedures

Approved Referrals and Authorizations

The Veteran must have an approved referral/authorization from VA **BEFORE** an appointment can be set. The approved referral/authorization is the process starting point. Providers must have an approved referral/authorization on file before rendering care, unless the Veteran needs urgent or emergent care. Providers may check the status of an approved referral/authorization using VA's secure, web-based system, HSRM, available on the VA website.

Providers should not administer non-urgent or non-emergent care to Veterans without an approved referral/authorization; otherwise, they risk not being reimbursed for their services.

The Three (3) Ways to Generate an Approved Referral/Authorization

An approved referral/authorization can be triggered in one of three ways:

- 1. The provider determines a Veteran patient needs additional care beyond what was originally authorized.**
 - Request additional or extended care by submitting an RFS form directly to VA, preferably through VA's secure, web-based system, HSRM, or via an EDI 278 compliant interface.
- 2. The Veteran contacts his or her local VAMC to confirm CCN eligibility.**
 - If the Veteran is eligible, VA may refer the Veteran to a community provider and either appoints the Veteran to a CCN provider, delegates appointing to TriWest, or allows the Veteran to self-schedule.
- 3. VA assesses the Veteran's need and makes the determination to refer the Veteran for care in the community, therefore generating an approved referral/authorization.**
 - VA will then send the authorization information to TriWest for administrative purposes.

REMEMBER! Once VA generates an approved referral/authorization, the appointing process can begin and the authorization letter will follow.

Appointing Process

The provider must have an approved referral/authorization before an appointment can be made. Except for urgent or emergent care, providers should not administer care that does not have an approved referral/authorization from either VA or TriWest; otherwise, they risk not being reimbursed.

Under CCN, there are multiple pathways for an appointment to be made: direct from a VAMC, coordinated by TriWest, or self-appointed by a Veteran.

Pathways for Appointing

- 1. VAMC Direct Appointing**
 - Veteran's VAMC approves care.
 - Veteran's VAMC contacts the provider's office, schedules an appointment on behalf of the Veteran, and sends the authorization letter to the provider.
- 2. TriWest Appointing**
 - Veteran's VAMC approves care and delegates the appointment process to TriWest.
 - TriWest contacts the CCN provider on behalf of the Veteran to schedule the appointment and then sends VA's authorization letter to the provider.
- 3. Veteran Self-Appointing**
 - Both the VAMC and TriWest offer self-appointing options for Veterans. A Veteran can self-appoint when he/she has an approved referral/authorization.
 - Veterans MUST have an approved referral/authorization in order to self-appoint; otherwise, the provider risks not being reimbursed.**
 - If the Veteran does not self-appoint within 90 days after the approved referral/authorization was generated, the approved referral/authorization will be returned to VA.
 - Either TriWest or VA sends the provider an authorization letter after receiving appointment information.

- If the provider hasn't received an approved referral/authorization letter within a week of a Veteran self-scheduling an appointment, the provider should contact the VAMC or TriWest to ensure the appointment information is available.
- A Veteran may also self-appoint through the Veteran self-service website or phone app.

Regardless of which appointing pathway is used, providers may NEVER charge a Veteran for not keeping a scheduled appointment under CCN.

Drive-Time and Appointing for Veterans

The following are VA standards for drive-time and appointing for Veterans:

Drive-Time Standards Based Upon Location

Urban	45 minutes
Rural	100 minutes
Highly Rural	180 minutes

The following services are EXCLUDED from the drive-time standards: telehealth, non-urgent neurosurgery and cardiothoracic surgery, rheumatology, and dermatology.

Maximum Appointment Availability Times

	Primary Care	Specialty Care	Emergent	Urgent
Urban	30 days	30 days	24 hours	48 hours
Rural	30 days	30 days	24 hours	48 hours
Highly Rural	30 days	30 days	24 hours	48 hours

Request for Services (RFS)

A Request for Services (RFS) is a provider-generated request for new or additional care outside the scope of the current approved referral/authorization. Providers should always submit the RFS directly to the authorizing VAMC, preferably via the HSRM portal. Providers should always submit an RFS on the same day it is determined it's needed and before delivering care, unless it is emergent care. In that case, the RFS can be submitted simultaneously.

Below are the reasons to submit an RFS to the VAMC:

- More visits are needed than included in the Standardized Episode of Care (SEOC) approved referral/authorization
- A condition needs to be addressed that wasn't indicated for treatment
- Additional needed services are not included, or specifically excluded, on the initial approved referral/authorization and are not commonly rendered
- The Veteran needs to be referred to a specialty service not included on the original approved referral/authorization
- The valid date range included on the initial approved referral/authorization needs to be extended

How to Submit an RFS

VA prefers providers submit an RFS via the HSRM portal, available on VA's website.

To access and submit an RFS online, follow these steps:

- Go to the VA Storefront at <https://www.va.gov/COMMUNITYCARE/providers/index.asp>.
 - Click "Request and Coordinate Care" on the left-hand navigation bar under "For Providers"
 - Click "Request for Service (RFS) Requirements"
 - Navigate to the link to the RFS form at the bottom of the section
- Send the RFS directly to the authorizing VAMC via:
 - VA's HSRM portal (preferable) or an EDI 278 transaction
 - Direct messaging
 - Secure email
 - Secure online file exchange
 - eHealth Exchange

Once approved, providers will receive an authorization letter from either your VAMC or TriWest. Providers can also check the status of your RFS through VA's HSRM (which is preferable), EDI 278 transaction, or by calling the VAMC.

Veteran Eligibility

Proof of a Veteran's eligibility for CCN is confirmed by the approved referral/authorization. Upon receipt of the approved referral/authorization, the provider may proceed with care covered in the approved referral/authorization letter.

Urgent care and retail walk-in clinics need to confirm a Veteran's eligibility **BEFORE** rendering care by first calling 833-4VETNOW (833-483-8669).

Emergency rooms should provide care to any Veteran who self-presents, and call the nearest VAMC within 72 hours of the beginning of providing care to a Veteran. VA will then confirm the Veteran's eligibility and coordinate further with the emergency room. VA may generate an authorization for TriWest to pay the Emergency Room claim if the provider is in network and the 72 hour notification was completed.

Telehealth Services

Telehealth services are allowed under the CCN as long as the telehealth service provider meets all applicable requirements. All telehealth services must comply with state regulations and any additional criteria established by VA or TriWest. This may include Veteran culture training, platform compatibility and compliance with billing and medical documentation submission and timeframes. The requirements for the provision of telehealth services include:

1. The provider of telehealth services must be licensed in the state in which the beneficiary is located.
2. State licensing entities with jurisdiction over the telehealth service provider and the beneficiaries' care must not prohibit telehealth for that particular service or provider type. State requirements must be followed at all times.
3. The provider of telehealth services must be appropriately licensed and credentialed according to VA and TriWest requirements.
4. The telehealth provider must leverage technology to personally and meaningfully provide the services via telehealth and not delegate this responsibility to staff that do not meet VA or TriWest requirements.
5. Videoconferencing and other technology platforms used for telehealth services must have the appropriate verification, confidentiality, and security parameters necessary to be properly utilized for the purpose and must meet the requirements of the Health Insurance Portability and Accountability Act (HIPAA) Privacy and Security Rules. Applications such as Facetime or Skype designed for general-purpose video conferencing, and not specifically for healthcare purposes may not meet such requirements.
 - a. Audio and Video transmissions must be secured using point-to-point encryption that meets healthcare industry standards
 - b. Providers shall not utilize software that allows multiple concurrent sessions to be opened by a single user
 - c. Protected Health Information (PHI) and other confidential patient data shall only be backed up or stored on secure data storage locations approved for this purpose and compliant with HIPAA rules.
 - d. Any Telehealth should be delivered through technology and connectivity with sufficient bandwidth and resolution to ensure the quality of video and/or audio receiving is sufficient to effectively deliver services to the patient.
6. The telehealth provider must comply with all applicable federal and state laws, rules and regulations governing the issuance of prescriptions for controlled substances at both the provider's site and the patient location. Prescriptions must also otherwise adhere to VA and TriWest requirements under the CCN.
7. All billing and claims requirements must be met for the provider to be reimbursed. Claims must include Place of Service "02" and list the provider that actually rendered the service.
8. Both the telehealth provider and the patient's location, including city/town, state and zip code, must be documented in the medical records for the date of service.

Please note that any waiver of any telehealth restrictions by VA pursuant to COVID-19 is temporary and does not alter or supersede the guidance or instructions by any applicable state licensing authority.

If you are interested in providing telehealth care, please email TriWest Telehealth at telehealth@TriWest.com.

Urgent Care/Retail Walk-In Process

Under the Urgent Care/Retail Walk-In benefit, TriWest network urgent care/retail location providers may treat Veterans who self-present without an approved referral/authorization. However, the urgent care/retail location staff **must** confirm the Veteran's eligibility before providing care by calling 833-4VETNOW (833-483-8669). This step also activates the prescription (Rx) benefit for the Veteran for the urgent care visit.

Are you proud to be a network provider caring for our nation's Veterans? Show your community! Download a Proudly Caring for Veterans badge for your website or office today.
www.triwest.com/proudlycaring

Providers must ensure they are part of the TriWest network before treating the Veteran through this benefit. Providers may request to join the TriWest network at <https://www.triwest.com/joinournetwork>.

Providers do not collect any co-pays, cost-shares, or deductibles from Veterans under the Urgent Care process.

The Veteran will be billed separately by VA for any applicable copayment. If a Veteran has general questions about copayments, direct them to <https://www.va.gov/health-care/copay-rates>.

Below are the steps to follow for the Urgent Care process:

1. The Veteran will self-present to the TriWest network urgent care/retail location clinic. The urgent care/retail location clinic will ask the Veteran for his or her:
 - Date of birth
 - Last four digits of the Social Security number (SSN)
 - Overseeing VAMC
 - Home address
2. The urgent care/retail location staff will then call TriWest at 833-4VETNOW (833-483-8669) to confirm the Veteran's eligibility. Staff will input the Veteran's date of birth and last four Social Security digits into the phone system.
 - This eligibility check is imperative because it's directly linked to approval for urgent medications the Veteran may need. Without the eligibility check, the system may deny the Veteran medication that the urgent care clinic prescribed.
3. If eligibility is confirmed, the urgent care/retail location clinic may treat the Veteran for his or her medical condition.
4. The urgent care/retail location provider may write a medically necessary prescription for up to a 14-day supply. The medicine must be listed on VA's Urgent Care Formulary, available here: <https://www.pbm.va.gov/nationalformulary.asp>.
 - The Veteran may fulfill the prescription at any in-network pharmacy with ExpressScripts, available at this link: <https://www.va.gov/find-locations>. No voucher is required for a Veteran when fulfilling an urgent medication prescription. However, it will not process if a check of the Veteran's eligibility was not done in advance.
5. After the Veteran leaves, the urgent care/retail clinic must submit medical documentation from the visit to the Veteran's associated VA facility based on the Veteran's residential ZIP code **within thirty (30) days** from the date of service. Providers may submit medical documentation via fax, email or Industry Standards Electronic Means to the Veteran's VAMC.
 - If the Veteran doesn't know his or her home VAMC, the clinic can look up the VAMC closest to the Veteran's home address using this VA lookup tool: <http://www.va.gov/find-locations>.
6. The urgent care/retail location clinic will then submit its claim to WPS Military and Veterans Health (WPS MVH), TriWest's claims processor. TriWest will be responsible for paying claims.

If the Veteran needs additional or follow-up care, the urgent care/retail location provider should refer the Veteran back to his/her authorizing VAMC.

Covered and Excluded Urgent Care Codes

VA defines urgent care as the treatment of non-emergent symptoms needing immediate attention, such as flu-like symptoms, strep throat, minor burns, pink-eye, or ear and skin infections. The Urgent Care/Retail Location benefit is not intended to cover routine primary care or preventive screening services.

To help providers better understand what's excluded, VA has provided a list of excluded codes, available here: <https://www.triwest.com/UC-excluded-codes>.

Flu Shots

VA allows providers to administer the flu shot to Veterans during an urgent care/walk-in visit. VA will cover flu shots as a standalone service under the CCN Urgent Care/Walk-in benefit or at any network retail pharmacy.

Urgent Care that Turns into an Emergency Situation

If a Veteran's urgent care situation escalates to a true emergency, the urgent care or retail location clinic should take whatever action is necessary to protect the health and safety of the Veteran. For example: Call 9-1-1, call the Veteran's family to transport the Veteran to the emergency room, or order an ambulance to take the Veteran to the emergency room.

Critical Findings during Urgent Care

Providers must report any Critical Findings discovered during an urgent care/retail location treatment to the Veteran's home VAMC within 24 hours by phone.

VA defines a Critical Finding as one of the following:

- A test result value or interpretation that, if left untreated, could be life-threatening or place the Veteran at serious risk
- A newly identified suicide risk in a Veteran
- A new diagnosis of cancer

Emergency Health Care Process

Community hospitals and providers treating Veterans who self-present to an emergency department are required to notify VA within **(72) hours** of Veterans presenting to the emergency room via the [Emergency Care Reporting \(ECR\) portal](#), or by calling 844-72HRVHA (844-724-7842).

Providers also are required to include a valid email address for decision correspondence when reporting emergency treatment.

VA will no longer include Veteran's personal identification information in outgoing correspondence. Providers will need the notification identification number, assigned upon submission of reporting, to correlate authorization decisions to reported emergency events.

Email and fax notification will no longer be accepted to minimize vulnerabilities to Veterans' protected health information and streamline the process. VA will only accept emergency treatment information:

- Website: <https://emergencycarereporting.communitycare.va.gov>
- Phone: 844-72HRVHA (844-724-7842)

Questions? Contact the Emergency Treatment team at VHAOCCEmergencyCareTeam@va.gov.

VA will need to know:

- Veteran's full name
- Last four digits of the Veteran's SSN
- The condition for which the Veteran is being seen
- The mode of transportation by which the Veteran arrived. If arriving by ambulance, a copy of the trip report should be provided, if possible.
- TriWest strongly recommends that providers indicate in the Veteran's record who at the VA took the notification information or what number it was called into or faxed to, as this is a critical requirement for payment.
- Providers also should provide inpatient information in case the visit resulted in an admission.

VA health care staff will determine the Veteran's eligibility and, if appropriate, retroactively authorize care.

If the Veteran is being seen for authorized care and, during treatment, it is determined the Veteran is experiencing an emergency, the treating provider/facility must render emergency treatment immediately and notify VA. Additionally, the local ER that receives the Veteran must follow the steps above.

If a Veteran is receiving authorized services and the treating facility determines the Veteran needs a higher level of care than its facility is capable of providing, it must obtain authorization from VA prior to transferring the Veteran to another facility by submitting an RFS.

In the event that care is not authorized by VA to be paid by TriWest, the provider must submit claims within ninety (90) days of the encounter directly to VA for reconsideration. No separate payment will be made for ER facility charges for inpatient services authorized by VA that are subject to reimbursement under the VA Inpatient Acute Care Prospective Payment System.

Medication Process

Under CCN, VA will cover routine medically necessary medication that's part of an authorized episode of care and follows the rules of the [VA National Formulary](#). CCN also covers medication that's needed on an urgent and/or emergent basis.

- Urgent or emergent medication must be on the [Urgent/Emergent Formulary](#).
- If the Veteran needs a medication that's not on VA's National Formulary, the provider needs to contact the Veteran's authorizing VAMC, request a Formulary Request Review Form, fill out the form, and submit it back to the VAMC for approval or denial.

For all medications, including urgent and emergent, TriWest uses the Express Scripts (ESI) pharmacy network.

Urgent and emergent medications do **NOT** require an approved referral/authorization. However, for medication prescribed during an urgent care or retail walk-in clinic visit, clinic staff must **FIRST** call TriWest at 833-4VETNOW (833-483-8669) to confirm Veteran eligibility in order for the medication to be approved for fulfillment by the pharmacy.

Real-time urgent/emergent pharmacy dispensing information is available on the Availity portal in the TriWest Payer Space for CCN. As per U.S. Drug Enforcement Administration (DEA) policies, some controlled substances will require the Veteran bring a hard copy of the prescription to the overseeing VA medical facility or CCN pharmacy.

General/Routine Prescriptions

VA handles all general/routine medication fulfillments directly. To prescribe routine, non-urgent/non-emergent medicine:

- Prescribe the medicine in accordance with VA's National Formulary.
- Fax both the prescription and a copy of the approved referral/authorization to your local VA Pharmacy for processing and fulfillment **within one hour of seeing the Veteran**.
- The Veteran may pick up the medicine at the VA Pharmacy or an ESI pharmacy.
- You may NOT dispense medication samples to Veterans.
- You must be registered with your state's prescription monitoring program.

If the Veteran needs a medication that's NOT on VA's National Formulary, providers will need to take a few additional steps before prescribing:

- Contact the local VAMC and ask for a Formulary Request Review Form. Fill out the form and return it to the VAMC.
- VA will either approve or deny the request.
- If approved, continue prescribing the medication as described above.

Urgent/Emergent Medicine

When there is an urgent/emergent need to start a medication and it is not possible to fill the prescription at a VA Pharmacy, the provider may write a prescription for up to a maximum 14-day supply (without refills).

- Send the prescription and a copy of the approved referral/authorization to an ESI retail pharmacy, preferably through the Surescripts e-Prescribing tool. To learn more about Surescripts and to register, go to <http://surescripts.com>.
- When it is medically necessary to continue the medicine beyond the initial 14-day supply, write a second prescription and fax it to the VA's authorizing facility pharmacy **within one hour of seeing the Veteran**.
 - Community providers can now utilize e-prescribing to push prescriptions to a VA Pharmacy, which is VA's preferred method. VA's next preferred method is via fax.

CCN providers must check with their state's prescription monitoring program for any controlled substance utilization prior to writing any controlled substance prescription for a Veteran to ensure appropriate opioid/controlled substance use.

Veterans who consent to participate in Human Subject Research studies and are enrolled in clinical trials **CANNOT** be authorized for those services under the CCN. Veterans must be referred back to their respective Non-VA Care Office for the administration and coordination of non-VA care associated with clinical trials.

What to Include in All Prescriptions

VA requires that prescribing providers under CCN include the following information for prescriptions:

- Provider's Name (Family, Given, Middle Suffix) Provider Name Suffix (e.g., Sr., Jr., II., III.)
- Provider's National Provider Identifier (NPI)
- Provider's Tax ID Number (TIN)
- Provider's **personal** DEA Number and expiration date (not a generic facility number)
- Provider's office address
- Provider's office phone and additional phone number
- Provider's fax number (if applicable)
- Provider's discipline (e.g., physician, physician assistant, nurse practitioner)

Durable Medical Equipment (DME)

VA is the primary resource for all routine DME for Veterans. For urgent or emergent care, providers may directly supply Veterans with urgent/emergent DME and TriWest will reimburse providers. Examples of urgent or emergent DME include: splints, crutches, canes, slings, or soft collars.

To Order Non-Urgent or Non-emergent DME

- To have routine DME (to include eyeglasses) authorized and provided to the Veteran, complete the VA's RFS form. The RFS form is available on the VA Storefront (<https://www.va.gov/COMMUNITYCARE/providers/index.asp>).
- On the VA Storefront homepage under "For Providers" on the left-hand navigation bar, click the "Request and Coordinate Care" menu item.
- Next, click "Request for Service Requirements." The link to the RFS form will be at the bottom of that section.

An RFS form must be fully completed to include the DME section and, if ordering eyeglasses, the measurement for frames. After completing the RFS form, fax it to the authorizing VAMC **within 24 hours**. VA will then directly coordinate the DME between the provider and the Veteran.

Do NOT dispense non-urgent or non-emergent DME out of your office unless you receive VA approval.

Requests for exceptions to this requirement may be considered under special circumstances.

All DME and medical device prescriptions must include the following information:

- Date of Request
- Description and HCPCS Code for Each Prescribed Item
- Detailed Information (brand, make, model, part number, etc.)
- Diagnosis and International Classification of Diseases (ICD)-10 Code(s)
- Item Delivery Location/Address and Expected Delivery Date
- Medical Justification for Each Prescribed Item (if a specific brand/model/product is prescribed)
- Medical Provider's Signature
- Patient Education was completed or mailed to provider to finalize education
- Patient's Date of Birth
- Patient's Full Name
- Patient's Last 4 Digits of SSN
- Patient's MVI ICN
- Prescribing Provider's Address
- Prescribing Provider's Fax Number
- Prescribing Provider's Full Name
- Prescribing Provider's Phone Number

Providers are responsible for all necessary DME follow-up care, including patient education, training, fitting, and adjustment for the prescribed item. VA will procure and send the DME to the prescribing CCN provider, unless specified otherwise.

VA reserves the right to issue comparable, functionally equivalent DME and Medical Devices to what is prescribed by the CCN provider.

Hearing Aids: Prescriptions for hearing aids are to be submitted to VA for review and fulfillment. For hearing aids, providers shall provide to VA initial testing results related to potential hearing aid needs. CCN providers cannot purchase or provide hearing aids under this contract. VA will provide information for the hearing aid manufacturers that have current contracts with VA.

Home Oxygen: Requests for home oxygen are to be submitted to VA for review and fulfillment. For home oxygen, providers shall provide definitive testing results related to potential home oxygen needs and detailed home oxygen prescriptions. CCN providers cannot purchase or provide home oxygen equipment or supplies under this contract.

Oral Appliance Therapy: TriWest shall provide the capability for Eligible Veterans to receive Oral Appliance Therapy (OAT) for obstructive sleep apnea through the Dental Network (managed by Delta Dental). OAT is classified as medical treatment for a medical disorder, obstructive sleep apnea, which is provided by a licensed dentist.

To order urgent or emergent DME:

- DME must be provided to a Veteran by a treating physician, facility, or DME supplier at the time of treatment and before the Veteran leaves the provider's care site. A pre-approved referral/authorization for urgent/emergent DME is NOT required.
- Bill TriWest for the urgent or emergent DME and TriWest will reimburse according to the provider contract.
- ***Failure to plan or coordinate DME needs in advance of a scheduled procedure does not constitute an urgent or emergent need.***
- Any supplied DME must include follow-up care, patient education, training, fitting, and adjustment for the prescribed item as part of the supplier's responsibility.
- If authorized, no rentals are to exceed 30 days.

Medical Records and Documentation Requirements

Medical records and documentation are required for all provided services. Providers are required to submit medical documentation directly to the authorizing VAMC, preferably via upload to the HSRM.

Standard, Urgent and High-Priority timeframes may apply based on the type of care provided. However, submit urgent and emergent care documentation as soon as it is complete. Referrals to screen for cancer or to treat a suicidal Veteran are other examples of higher priority medical documentation to return quickly.

All medical documentation must be signed (written or electronic), and/or initiated by the submitting provider or practitioner.

Medical Documentation Timeframes

VA requires providers submit medical documentation to the authorizing VAMC within the following timeframes:

- Initial medical documentation for outpatient care – **30 days** of the initial appointment
- Final outpatient medical documentation – **30 days** of the completion of the SEOC
- Medical documentation for inpatient care – **30 days** and will consist of a discharge summary
- Any medical documentation requested by VA for urgent follow up – **upon request**

Medical Documentation – What to Submit

Requirements vary by type of care. In general, documents should include legible notes and recommendations on further testing or follow-up care, which should match the coding billed on the claim. VA requires that all medical documentation include the following on each page, at minimum:

- Veteran Unique Identifier
- Veteran Full Name (including suffix)
- Veteran Date of Birth
- Referral Number
- Provider/Practitioner Authentication (signature either electronic or on paper) – Alaska only
 - Include typed name and provider phone number
- THP Facility name (where applicable) – Alaska only

As for how often to submit, VA requires providers submit the following medical documentation for each episode of care:

- **Initial medical documentation** – associated with the **first** appointment of a Standardized Episode of Care (SEOC).
- **Final medical documentation** – covers the **entire** SEOC.

Critical Findings

VA defines critical findings as a test result, value or interpretation that, if left untreated, could be life-threatening or place the Veteran at serious risk.

- Providers are required to report Critical Findings to VA within the earlier of two (2) business days of the discovery or the timeframe required to provide any necessary follow-up treatment to the Veteran.
- Communication shall be either verbal or written.

Provider Claims Submission

TriWest's claims processor is WPS Military and Veterans Health (WPS MVH). Providers should submit claims to WPS MVH, preferably electronically. Providers should submit claims within **30 days** after rendering services. There is a **180-day timely filing** limit.

TriWest cannot pay claims for out-of-network providers. Additionally, all care requires an approved referral/authorization (except where the authorization is generated after the 72 hour notification for emergency care or at the time of verification of eligibility for urgent care); otherwise claims will be denied.

- Providers should not collect copays, cost-shares or deductibles. CCN reimburses up to 100% of the allowed amount, including any patient obligation.
- Payments made by TriWest or VA shall be considered payment in full under CCN. Providers may not impose additional charges to TriWest or the Veteran for covered services.
- For CCN, TriWest follows Medicare Fee-for-Service billing guidelines, fee schedules and payment methodology when applicable.

Timely Filing Requirements

Providers should use their best efforts to submit claims within 30 days of rendering services. Adhering to this recommendation will help increase provider offices' cash flow. VA CCN Prime Contract limits timely filing of initial claims to 180 days after rendering services. Providers have 90 days to appeal or re-submit a claim.

Claims Submission Options – WPS MVH

All CCN claims process electronically, regardless of the method of submission. This is a program requirement and therefore, filing claims electronically is preferred and encouraged. As a result, if you choose to submit paper claims, they must scan to an electronic format, creating a potential issue for handwritten or manually typed claims. Claims that cannot be scanned cleanly may reject.

TriWest, on behalf of VA, is the payer for in-network authorized claims associated with an approved referral/authorization filed under the CCN. WPS MVH processes these claims.

If you submit electronically through a clearinghouse, please use the WPS MVH Payer ID of **VAPCCC3**.

Providers can submit electronic claims without a clearinghouse account through Availity's Basic Clearinghouse option. The Basic Clearinghouse option is **FREE** to CCN providers.

Another submission option is PC-ACE, a standalone desktop software package developed by WPS. This allows submission of direct electronic claims.

If electronic submission is not an option, providers may mail paper claims to:

WPS MVH - CCN
PO Box 7926
Madison, WI 53707-7926

For best image scan results, complete the form using 10-point and 10-pitch Courier or Courier New 10 mono-space fonts.

Additionally, VA benefits do not coordinate with other Federal programs (TRICARE, Medicare, Medicaid, etc.). If a provider has an approved referral/authorization on file from TriWest, the provider should bill TriWest, as TriWest pays primary on behalf of VA.

Claim Status and Appeals

Providers can check the status of claims in real time through Availity. Availity offers on-demand training and webinars on these tools.

If providers cannot find a claim, there may have been errors with the submission. If providers can see a claim, it is in process. Please do not resubmit for in-process claims.

For missing claims please verify that:

- It has been at least 10 business days since you uploaded the claim or 15 business days since the provider mailed the claim.
- A paper claim was not handwritten and all information was typed correctly.

TriWest strives to pay all clean claims within 30 days.

- Due to our contract status, TriWest is exempt from penalties associated with Medicare's prompt payment requirements.
- If claims show as paid, but the provider has not received a remittance, please contact TriWest CCN Customer Service at 877-CCN-TRIW (877-226-8749) so that TriWest can verify the accuracy of the remit address in our system.
- Notification of denial is provided within 45 days of receipt of the claim in our systems.

To submit an appeal, download [TriWest's Claims Reconsideration Form](#), available under the "Resources" tab on the TriWest Payer Space on Availity.

- Providers must submit separate appeals for each disputed item.
- Reconsiderations must be submitted within 90 days of claim processed date as indicated on the Provider Remittance Advice (PRA) as an "unsolicited" claims attachment within Availity. Be sure to include all supporting documentation.

Clean Claim Requirements

In order for a claim to process and pay, TriWest must have visibility to the appointment in our systems.

Once the provider receives an authorization letter from either TriWest or VA, the referral/authorization number is the unique identifier assigned for each approved referral/authorization's episode of care. Include this number on your claim.

Submit claims with the Veteran's full name, date of birth and last four digits of his or her Social Security number (SSN). If available, use the Veteran's Electronic Data Interchange Patient Identifier (EDIPI) in place of the SSN.

Ensure all coding aligns with Medicare criteria, if applicable. When Medicare policy does not apply, please follow language in your authorization information, VA consult notes, the Provider Handbook or other training materials provided by TriWest and VA.

Returns and Recoupments

When TriWest or WPS MVH identifies an overpayment, a recoupment is initiated. A letter is sent to the provider's office with information regarding the reason for recoupment.

- If a provider promptly returns funds, the recoupment case is closed.
- For an overpayment balance, WPS MVH offsets against current and future claims. Your Provider Remittance Advice (PRA) will detail these amounts.

For overpayments owed to TriWest, send monies to WPS-VA, PO Box 14491, Madison, WI 53708-0491. **A copy of the PRA must be sent with the refund.**

To ensure refund credit to the correct claim, include a copy of the remittance advice. If the remittance advice is not available, include the claim number and the Veteran's EDIPI number or the last four digits of the SSN and the Veteran's date of birth.

Claims for Out-of-Network Providers

TriWest Healthcare Alliance can reimburse certain out-of-network providers under the VA's Community Care Network (CCN) for services provided under a CCN-approved referral. The only out-of-network providers who are eligible for this type of reimbursement are:

- Ancillary providers when their services are provided as an adjunct to medical or surgical services provided by in-network providers; and
- Out-of-network facilities, at which the services provided, are performed by an in-network physician performing scheduled, non-emergent care.

Ancillary providers are defined as those providers who perform diagnostic or therapeutic services as an adjunct to basic medical or surgical services such as facility-based physicians, assistant surgeons, anesthesiologists, specialty physicians, radiologists, pathologists, and emergency care physicians.

Out-Of-Network Billing

An approved referral/authorization from VA supports a specific plan of care as it relates to a specified number of visits and/or services related to a Standard Episode of Care (SEOC), as long as the services are provided by a CCN provider. Providers should always include the original VA referral number from the approved referral/authorization when billing TriWest. If out-of-network providers do not know the original referral number, they should contact the CCN provider who received the approved referral/authorization to acquire it.

Out-of-network providers must submit health care claims directly to TriWest by billing WPS Military and Veterans Health (WPS MVH), TriWest's claims processor. Medical documentation related to care should be submitted to VA, preferably through the HealthShare Referral Manager (HSRM) online portal. Under VA community care regulations, payment from TriWest is considered payment in full from VA, and out-of-network providers are never allowed to balance bill a Veteran. The scope of care provided to a Veteran by an out-of-network provider must be included on an approved CCN referral/authorization.

VA Quarterly Satisfaction Survey

Providers who have filed a CCN claim to care for Veterans will be encouraged to take a VA quarterly satisfaction survey about CCN. TriWest highly recommends providers take this survey, as the results will help improve how VA and TriWest administer CCN for providers and Veterans. Providers who have filed a CCN claim with TriWest may receive a notice from TriWest at the end of each quarter asking them to take the VA survey; which may be sent to the email address of record for the provider.

Behavioral Health Care Services

For inpatient and outpatient behavioral health care, providers should follow the Department of Veterans Affairs/ Department of Defense (VA/DoD) clinical practice guidelines, found at: <http://www.healthquality.va.gov>.

Veterans with a history of Military Sexual Trauma (MST) may receive care from a provider of the gender of their choice.

All psychotherapy notes **shall be kept separate** from the Veteran's medical record, per Health Insurance Portability and Accountability Act (HIPAA) regulations.

A newly identified suicide risk in a Veteran not referred for inpatient behavioral health treatment is considered a critical finding and must be called into VA Non-VA Care Coordination (NVCC) Staff/VA POC directly by the provider **within 24 hours**.

Tele-Behavioral Health

If a provider is interested in providing tele-behavioral health care, please email TriWest Telehealth at telehealth@TriWest.com. All tele-behavioral health must comply with state regulations and any additional criteria established by VA or TriWest. This may include Veteran culture training, platform compatibility and compliance with billing and medical document timeframes.

Behavioral Health Medical Documentation

VA requires specific medical documentation for behavioral health. This allows VA providers to integrate the services provided within the community into VA managed care.

- Submit all documentation directly to VA through its online HSRM portal, when available.
- Providers access HSRM through the VA's website.
- Upload documentation as soon as possible to ensure clean payment of your claims.
- Upload documents within 30 days from date of service.

Keep all psychotherapy notes separate from the Veteran's medical record, per HIPAA regulations. The areas listed below do **not** fall into this protected category, do **not** need additional Veteran authorization to disclose to VA, and **should** be included in the Veteran's medical documentation.

- Medication prescription and monitoring (as appropriate)
- Counseling session start and stop times
- Modalities and frequencies of treatment
- Results of clinical tests
- Any summary of diagnosis, functional status, treatment plans, symptoms, prognosis or progress.

Provider Requirements for Behavioral Health

Evidence-Based Psychotherapy

VA has placed great emphasis on Evidence-Based Psychotherapy (EBP) and often will request a specific intervention. Providers of EBP must have received specialized training and experience in the EBP. Some of the most common requests are for:

- Cognitive Processing Therapy (CPT) for Post-traumatic Stress Disorder (PTSD)
- Prolonged Exposure Therapy (PE) for PTSD
- Cognitive Behavioral Therapy (CBT) for depression, chronic pain and insomnia

Suicide Risk/the Veterans Crisis Line

A newly identified suicide risk in a Veteran not referred for inpatient behavioral health treatment is considered a critical finding and must be called into VA NVCC Staff/VA POC directly by the Clinical Care Provider **within 24 hours**.

If suicide risk is a clinical issue, provide the Veteran a written copy of his or her personal Suicide Prevention Safety Plan.

The prevention plan includes the contact information for the [Veterans Crisis Line](#), which:

- Is available 24/7/365 in the event of a crisis
- Can assist in connecting the Veteran to services
- Can be reached at 800-273-8255 (press 1 for Veterans), or <http://www.veteranscrisisline.net/>

Important Contact Information

- TriWest Behavioral Health Phone: 866-606-8198, option "2," then option "4"
- TriWest Behavioral Health Fax: 866-284-3736
- TriWest Behavioral Health Email: BHHelp@TriWest.com



Addendum

TriWest Provider Contract Provisions

The following provisions are applicable to services rendered pursuant to authorizations for care under the Department of Veterans Affairs (“VA”) Community Care Network Program (“CCN”), as administered by TriWest Healthcare Alliance Corp. (“TriWest”), and will be incorporated by reference into the Provider’s Network Agreement as if fully set forth therein. The Spanish version of the Provider Handbook is provided for convenience only; the English version of all contractual documents between TriWest and the provider, including but not limited to the Provider Handbook, shall be exclusively used for legal interpretation. For avoidance of doubt, in the event of any ambiguity or disagreement between the terms of the Spanish version of the Provider Handbook and the original English version, the English version shall take precedence and control.

Definitions

All defined terms herein have the same meaning as they have in the Provider Network Agreement or Program Terms & Conditions unless otherwise defined below.

1. **Beneficiary** – Any individual enrolled and authorized to receive care through the TriWest Provider network by any Program incorporated into the Provider Agreement.
2. **CCN Covered Services** – Services, items and supplies for which benefits are available to VA Beneficiaries in accordance with the rules, regulations, policies and instructions of Veterans Administration and the Veterans Health Administration.
3. **DME** – Durable Medical Equipment to include any 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.
4. **Emergency Care** – Medical care required within twenty-four hours or less that is essential to evaluate and stabilize conditions of an Emergency/Emergent Need that if not provided may result in unacceptable morbidity/pain if there is significant delay in evaluation or treatment.
5. **Emergency/Emergent 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.
6. **Network Subcontractor** – An entity that is a party to a Provider Network Agreement and operates as a subcontractor to TriWest to manage provider data, credentialing, and certain other functions as may be designated by TriWest. Some Provider Network Agreements may not have a Network Subcontractor as a party to the agreement, in such cases, references to Network Subcontractor in this Provider Handbook should be interpreted as a reference to TriWest.
7. **Party** – Any individual or entity that is a party or a third-party beneficiary to the Provider Network Agreement.
8. **Prior Authorization** – A required process through which VA reviews and approves certain medical services to ensure the medical necessity and appropriateness of care prior to services being rendered within a specified timeframe from a non-VA provider or additional resources in the community. This type of process requires a Prior Authorization be obtained “prior to” the specified service.
9. **Provider** – Any individual or entity providing healthcare services pursuant to an authorization for care issued by TriWest, or who is otherwise subject to the terms and conditions of a Program or this Handbook
10. **Urgent Care** – The medical services defined in 38 C.F.R. § 17.4600(b)(5) provided in an outpatient setting to treat acute or chronic illness or injury.
11. **VA Beneficiary** – Any person eligible to receive CCN Covered Services under the rules, regulations, policies and instructions of the VA.
12. **Veterans Health Administration (VA)** – The division of the Department of Veterans Affairs that provides health care services and administers health care benefits for eligible Beneficiaries.

Termination

TriWest and Network Subcontractor shall have the right to immediately terminate Provider Agreements upon written notice to provider upon the occurrence of any of the events listed below:

1. Provider’s state or federal license or authorization to do business is reduced, restricted, suspended, or terminated (either voluntarily or involuntarily), or Provider’s other applicable license or accreditation necessary to perform any services contemplated by the Provider’s Agreement is reduced, restricted, suspended, or terminated (either voluntarily or involuntarily); or
2. Provider’s professional liability coverage as required under Provider’s Agreement is reduced below required amounts or is no longer in effect; or

3. Provider fails to meet TriWest's or Network Subcontractor's credentialing, re-credentialing, quality management or utilization management criteria, or fails to comply with quality management or utilization management processes; or
4. Provider fails to provide material information or provides erroneous information on Provider's credentialing application or re-credentialing application; or
5. Provider is no longer Medicare-eligible, Medicaid-eligible, or is not eligible to participate in another government program; or
6. Provider or any one of its officers is arrested or indicted on felony charges that directly or indirectly relate to provisions of services under Provider's Agreement, and TriWest and Network Subcontractor makes a reasonable and good faith determination that the nature of the charges are such that termination or necessary to avoid unnecessary risk or harm to Beneficiaries that could occur during the pendency of the criminal proceedings.

Notification

- A. All notices and other communications to a Party must be in writing, hand delivered, delivered by prepaid commercial courier services with tracking capabilities, faxed, or delivered by the U.S. mail to the address listed on the signature page of the Provider's Agreement. The Parties may change the address of record by notifying the other Party of the new address. Notice shall be complete upon the earlier of actual receipt or five (5) days after being deposited into the U.S. mail. Notices and other communications in writing need not be mailed either by registered or certified mail, although a signed return receipt received through the U.S. Post Office shall be conclusive proof between the Parties of delivery of any notice or communication and of the date of such delivery.
- B. Provider shall notify TriWest or Network Subcontractor in writing immediately upon learning of any action, policies, determinations or internal or external developments that may have a direct impact on Provider's ability to perform its obligations under the Provider's Agreement. Such matters shall include, but are not limited to:
 1. Any change in ownership, specialty services provided, Medicare designation (including but not limited to sole community, critical access, etc.) or location of facility(ies);
 2. Action against or lapse of Provider's license, certification, accreditation or certificate of authority;
 3. Loss of hospital privileges;
 4. Arrest or indictment;
 5. Reduction in insurance coverage below the required limits set forth for the applicable Program, or termination of insurance coverage;
 6. Any activity that compromises the confidentiality and security of the medical records of Beneficiaries;
 7. Exclusion or any other penalty from Medicare, Medicaid, or any other federal health care program.
- C. Provider shall complete VA required training that will be determined at a later date and reflected in the next version of the TriWest Provider Handbook.

Provider Directory

TriWest may periodically include provider's name, gender, work address, work fax number, work telephone number, whether the provider is accepting new patients, specialty and sub-specialty and willingness to accept Beneficiaries in a directory of Network Providers. Provider is responsible for notifying TriWest or Network Subcontractor of any changes of address, phone or fax number, or specialty services rendered within ten (10) business days.

Compliance

Provider shall comply with all applicable state and federal laws as well as regulations and all rules, policies and procedures of the applicable program including without limitation to credentialing, peer review, referrals, utilization review/management, clinical practice guidelines, case management and quality assurance programs and procedures established by TriWest or the applicable health care program including submission of information concerning provider and compliance with Preauthorization requirements, care approvals, pharmacy, dental and DME utilization requirements, care approvals, concurrent reviews, retrospective reviews, discharge planning for inpatient admissions, critical event notifications, quality of care audits, return of medical records and Prior Authorization of referrals.

Ancillary Providers

When provider utilizes any ancillary providers to render services for the same episode of care for which provider has accepted an authorization, the referring provider must ensure that the ancillary provider is provided with the authorization number and billing information for the applicable episode of care. Provider should make reasonable efforts to utilize ancillary providers that are CCN contracted providers. Ancillary providers that are not CCN contracted

providers must agree to be reimbursed at the Medicare allowable rate for the services billed and in no event can TriWest pay an ancillary provider more than VA's allowable rate. Ancillary providers may not bill Veterans, including any balance billing; the referring provider is responsible for ensuring that ancillary providers are aware of CCN payment rates and the restrictions against billing the Veteran beneficiary.

Medical Records and Documents

- A. Provider shall submit medical documentation to VA in an EDI 278 transaction format, where available. Providers, who do not have the capability to submit EDI 278 transactions, shall submit via secure e-mail or fax.
- B. Initial outpatient medical documentation is medical documentation associated with the first appointment of an episode of care. Initial medical documentation for outpatient care shall be returned within thirty (30) days of the initial appointment.
- C. Final outpatient medical documentation is medical documentation that summarizes the result of any medical care provided. Final medical documentation of outpatient care shall be returned within thirty (30) days of the completion of the episode of care.
- D. Medical documentation associated with inpatient care shall be returned within thirty (30) days of discharge and shall consist of a Discharge Summary.
- E. Medical documentation requested on an urgent basis must be returned to the requesting party within one (1) business day of the request.
- F. Ancillary providers who are unable to return medical documentation to VA must send medical documentation to the referring provider for proper care coordination. Please refer to VA's [Facility Contact Information for Care Coordination](#) for assistance.

Credentialing Requirements

- A. Provider must meet the requirements of state and local laws and if applicable must have a full, current, non-probationary and unrestricted license in the state where services are delivered.
- B. Provider must remain in compliance with the seven (7) elements of the OIG's Compliance Program Guidance.
 - 1. Implementing written policies, procedures and standards of conduct.
 - 2. Designating a compliance officer and compliance committee.
 - 3. Conducting effective training and education.
 - 4. Developing effective lines of communication.
 - 5. Conducting internal monitoring and auditing.
 - 6. Enforcing standards through well-publicized disciplinary guidelines.
 - 7. Responding promptly to detected offenses and undertaking corrective action.
- C. If applicable, provider cannot have had any state license termed for cause or have relinquished any state license after being notified in writing by that state of potential termination for cause.
- D. If applicable, providers shall meet all Medicare Conditions of Participation (CoP) and Conditions for Coverage (CfC), where such conditions exist, subject to CMS modifications, as required by the U.S. Department of Health and Human Services (HHS). These conditions may be met through CMS certification or accreditation by organizations deemed by CMS to meet or exceed the CMS Medicare standards set forth in the CoP/CfC. For additional details regarding these requirements see <http://www.cms.gov>.

Professional Liability Coverage

Provider shall provide and maintain professional liability insurance *in an amount in accordance with the laws of the state in which the care is provided*.

OHI Billing and Claim Submission Requirements

When VA determines it is secondary payer as indicated by the authorization for services, the provider must first invoice VA Beneficiary's other health insurance (OHI), and invoice TriWest second as described herein. When the VA is secondary payer, TriWest will reimburse provider only up to the difference between the amount paid by Beneficiary's OHI and the rate(s) that provider has negotiated with TriWest for the services. When claims are denied by VA Beneficiary's OHI, provider must submit the Explanation of Benefits (EOB) or remittance advice (RA) statement indicating the dates of service, amounts of the claim, and reason(s) for denial to TriWest. Provider will be permitted up to ninety (90) days after the other insurer's adjudication to file claims with TriWest when, (i) provider first submitted the claim to the VA Beneficiary's OHI, in accordance with this section, and (ii) the adjudication occurred past the CCN claims submission deadline. Any claims submitted to TriWest past this ninety (90) day period will be denied.

Claims Submission Policies and Procedures

The following guidelines are necessary in order to submit claims electronically to TriWest via WPS MVH:

1. In transmitting EDI, provider will transmit such claims edited and formatted according to the specifications indicated within the most current Provider User Guide or the ANSI X12 837 Implementation Guide and EDI Companion Guide supplied by WPS MVH. Provider understands the WPS Provider User and EDI Companion Guide are proprietary and are authorized for use only by provider and its employees working on its behalf to transmit such EDI and that any other use or distribution of the WPS MVH Provider User Guide or EDI Companion Guide is strictly prohibited without the express written consent of WPS MVH. WPS MVH shall be the final authority in resolving any disputes about how electronic data shall be submitted.
2. Provider agrees that all claims submitted via EDI, for all legal and other purpose, will be considered signed by the provider or provider's authorized representative.
3. Provider agrees to maintain a patient signature file. Provider understands WPS MVH may validate through file audits, those claims submitted via EDI which are included in any quality control or sampling method required by WPS. Provider understands if no signed authorization is on file, an authorization must be obtained by the provider from the patient prior to EDI submission to WPS MVH.
4. Provider acknowledges that WPS MVH and Network Subcontractor shall have no obligation with respect to the content of the information in claims either to verify, check, or otherwise inspect the information supplied by the health care provider, except to reformat the claim data to the specification required by TriWest. Provider further acknowledges that TriWest will determine whether provider has submitted enough information in the EDI claims in order to determine the completeness, accuracy, and validity of the information and claims, and that source documents for claims data are the responsibility of the provider.
5. The following guidelines are necessary in order for providers to receive Approved Referral/Authorization or Prior Authorization electronically from the VA via the EDI 278 Electronic submission process. The VA shall submit Approved Referral/Authorization or Prior Authorization to provider in an EDI 278 transaction format, where available. Those providers, who do not have the capability to receive EDI 278 transactions, may receive Approved Referral/Authorization or Prior Authorization via secure e-mail or fax.



Alaska Appendix to the TriWest Provider Contract Provisions

This Alaska Appendix to the TriWest Provider Contract Provisions (“Alaska Appendix”) are applicable to services rendered pursuant to authorizations for care under the Department of Veterans Affairs (“VA”) Community Care Network Program (“CCN”), as administered by TriWest Healthcare Alliance Corp. (“TriWest”) in Alaska, and will be incorporated by reference into the Alaska Provider’s Network Agreement as if fully set forth therein. The TriWest Provider Contract Provisions, and the TriWest CCN Provider Handbook shall remain in full force and effect. In the event of a conflict between the TriWest Provider Contract Provisions, or TriWest CCN Provider Handbook, and the Alaska Appendix, the Alaska Appendix shall control.

Definitions

1. **Extended Care** – Extended care services mean geriatric evaluation; nursing home care; domiciliary services; adult day health care; non-institutional palliative care, non-institutional hospice care, and home health care when they are non-institutional alternatives to nursing home care; and respite care.
2. **Mental Healthcare** – Services include psychological and social interventions, rehabilitation, and support services, per 38 C.F.R. 17.98.

Credentialing for Tribal Health Services

Alaska Tribal Health Programs (THP) have established accreditation and credentialing standards established by the Indian Health Service (IHS) which are acceptable within the scope of this contract for CCN participation and Veteran care.

CCN providers shall be accredited by a nationally recognized accrediting organization for the healthcare services and providers that are within scope of an accreditation. All services, facilities, and CCN providers are in compliance with the accrediting organizations’ standards or applicable Federal and State laws, where accreditation is not required, and VA approves, for a service provider prior to serving Veterans under this contract. National certification, in lieu of accreditation, is sufficient for THPs to meet this requirement.

THPs participating in CCN shall satisfy only those generally applicable State or other requirements for participation as a provider of healthcare services, provided THP, and its providers, may not be subject to licensure by the State of Alaska as provided for in 25 U.S.C. 1621d(a)(1)(A), 162 It, and 1647a(2) or other applicable State or Federal law. THP satisfies the Centers for Medicare and Medicaid Services (“CMS”) conditions of participation/conditions of coverage. THP providing inpatient services shall be accredited by The Joint Commission or another equivalent accrediting body.

Professional Liability Coverage

Provider shall provide and maintain professional liability insurance with a responsible insurance carrier of not less than the following amount(s) per specialty per occurrence: \$1,000,000 per occurrence; \$3,000,000 aggregate. However, if the provider is an entity or a subdivision of a State that either provides for self-insurance or limits the liability or the amount of insurance purchased by State entities, then the insurance requirement of this contract shall be fulfilled by incorporating the provisions of the applicable State law.

Medication Process

Alaska providers need to follow the medical documentation provisions stated earlier in this handbook and are encouraged to use VA’s e-Prescribing and mail order pharmacy options for Veterans. Physicians will need to contact their Electronic Health Records (**EHR**) vendor for information on their e-prescribing capabilities.

In addition to the online formulary, an [online formulary search tool](#) is available. This application provides formulary alternatives to non-formulary drugs in the same VA drug class.

Medical Documentation – What to Submit

Alaska providers should follow the medical documentation provisions stated earlier in this handbook along with the following two that are unique to Alaska:

- Provider/Practitioner Authentication (signature either electronic or on paper) – Alaska only
 - Include typed name and provider phone number
- THP Facility name (where applicable) – Alaska only

Please refer to VA’s [Facility Contact Information for Care Coordination](#) for assistance in returning medical documentation.

Provider Reimbursement

Your Provider Agreement specifies the contractual rates for services provided to CCN beneficiaries by incorporating references to the Alaska VA Professional Fee Schedule, the Alaska VA Fee Schedule and VA Maximum Allowable (Allowed) Charges. These VA fee schedules may be found at the following links:

Alaska VA Professional Fee schedule:

<https://www.triwest.com/globalassets/ccn/provider/va-alaska-fee-schedule-rates.xlsx>

Alaska VA Fee Schedule:

https://www.va.gov/COMMUNITYCARE/revenue_ops/Fee_Schedule.asp

VA Maximum Allowable (Allowed) Charges:

<https://www.triwest.com/globalassets/ccn/provider/education/ccn-region-5-maximum-allowable-charges.xlsx>

Drive-Time and Appointing for Veterans in Alaska

The following are VA standards for drive-time and appointing for Veterans in Alaska:

Average Drive-Time Standards

Primary Care	30 minutes
Mental Health Care	30 minutes
Extended Care	30 minutes
Specialty Care	60 minutes

* **Note:** The following services are **EXCLUDED** from the drive-time standards: telehealth, non-urgent neurosurgery and cardiothoracic surgery, rheumatology, and dermatology.

Maximum Appointment Availability Times

Type	Actual Wait Time
Primary Care	20 days
Mental Health Care	20 days
Extended Care	20 days
Specialty Care	28 days



Behavioral Health Care Services

Integrated Care Connections

TriWest's Integrated Care Connections program offers technology-enabled information, decision support, and consultation to network primary care providers in Region 5 to assist them in engaging with, and meeting the needs of, Veterans presenting with mental health and substance abuse conditions like life stressors and crises, stress-related physical symptoms, and health behaviors.

“Integrated primary care” or “integrated behavioral health care” is sometimes referred to as “behavioral health integration,” “integrated care,” “collaborative care,” or “primary care behavioral health.”

No matter what it is called, the goal is the same: Better care and health for the whole person. Integrated care blends care for both physical medical conditions and behavioral health conditions in one setting, typically the primary care clinic. The program goal is to have primary care and behavioral health providers work together to recognize both physical and behavioral health issues with Veterans.

Integrated Care Connections seeks to inform and support the health care decision-making of our primary care providers, particularly sole practitioners. The program can be administered virtually and remotely with both medical and behavioral health subject matter expertise in the treatment of Veterans through online, email and telephone consultation.

Integrated Care Connections will offer network primary care providers and their office staff three options:

- The Integrated Care Connections website offers behavioral health resources on psychological conditions common among the military and Veteran community.
- Support for providers in Region 5 is available 24/7 by calling 877-226-8749, and selecting option 1 for providers, then option 1 again for someone on the Integrated Care Connections team.
- PsychArmor website offers courses on military lifestyle and culture, psychological conditions prevalent in the military community, and care delivery issues with Veterans and military service members.

Visit <https://www.triwest.com/integratedconnections> to learn more.





For questions regarding this information, please email us at providerservices@triwest.com or call 877-226-8749.

Department of Veterans Affairs (VA) Community Care Network (CCN)

877-226-8749



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