Fact Sheet

VA
U.S. Department of Veterans Affairs
Veterans Health Administration
*Office of Community Care*

# Emergency Medical Care

During a medical emergency, Veterans should immediately seek care at the nearest medical facility. A medical emergency is an injury, illness or symptom so severe that without immediate treatment, you believe your life or health is in danger. If you believe your life or health is in danger, **call 911 or go to the nearest emergency department** (ED) right away.

Veterans do not need to check with VA before calling for an ambulance or going to an ED. During a medical emergency, VA encourages all Veterans to seek immediate medical attention without delay. A claim for emergency care will never be denied based solely on VA not receiving notification prior to seeking care.

It is, however, important to promptly notify VA after receiving emergency care at a community ED. Notification should be made within 72 hours of admission to a community medical facility. This allows VA to assist the Veteran in coordinating necessary care or transfer, and helps to ensure that the administrative and clinical requirements for VA to pay for the care are met.

**Important:** An emergency department (ED) is a facility that is staffed and equipped to provide emergency treatment and does not include community facilities that provide medical treatment in situations other than emergencies.

## Service-Connected Emergency Care

In general, VA can pay for emergency medical care at a local ED for a Veteran's service-connected condition, or if the care is related to a Veteran's service-connected condition. Specifically, emergency medical care for a Veteran's service-connected or related (adjunct) condition(s) is eligible for VA payment as long as VA wasn't reasonably available to provide the care.

In accordance with the following situations and requirements, VA can pay emergency care costs for:

1. A Veteran who receives emergency treatment of a service-connected, or adjunct condition* in a community emergency department; **or**
2. A Veteran who is Permanently and Totally disabled (P&T) as the result of a service-connected condition is eligible for emergency treatment of ANY condition; **or**
3. A Veteran who is participating in a VA Vocational Rehabilitation Program, and who requires emergency treatment to expedite their return to the program, is eligible for emergency treatment for any condition; **and** (scenarios 1-3 must all meet #4)
4. The emergency was of such a nature that the Veteran (or other prudent layperson without medical training) would reasonably believe that any delay in seeking immediate medical attention would cause their life or health to be placed in jeopardy.

*A service-connected condition is one that has been adjudicated by the Veterans Benefits Administration (VBA) and a disability rating has been granted. An adjunct condition is one that, while not directly service-connected, is medically considered to be aggravating a service-connected condition.

*Note: Legal authorities and payment methods for VA payment for emergency care for service-connected conditions are contained in* Title 38 U.S.C. §1728, 38 CFR §17.120 *and* 38 CFR §17.132.

## Nonservice-connected Emergency Care

VA can also pay for emergency medical care at a community ED for a Veteran's nonservice-connected condition. However, there are several requirements and factors that affect the extent to which VA can cover those services. Specifically, emergency medical care for a Veteran's nonservice-connected condition(s) is eligible for VA payment when all of the five following elements are true:

1. Care was provided in a hospital emergency department (or similar public facility held to provide emergency treatment to the public); **and**
2. The emergency was of such a nature that the Veteran (or other prudent layperson without medical training) would reasonably believe that any delay in seeking

immediate medical attention would cause their life or health to be placed in jeopardy; **and**

3. A VA medical facility or another Federal facility was not reasonably available to provide the care; **and**
4. The Veteran is enrolled and has received care within a VA facility during the 24 months before the emergency care; **and**
5. The Veteran is financially liable to the provider of emergency treatment.

There are limitations on VA's ability to provide coverage when a Veteran has other health insurance (OHI). If OHI does not fully cover the costs of treatment, VA can pay certain costs for which the Veteran is personally liable. **By law, VA cannot pay:**

- Copayments
- Coinsurance
- Deductibles
- Similar payments a Veteran may owe to the provider as required by their OHI

VA is also legally prohibited from providing coverage for individuals covered under a health-plan contract because of a failure by the Veteran or the provider to comply with the provisions of that health-plan contract, e.g., failure to submit a bill or medical records within specified time limits, or failure to exhaust appeals of the denial of payment

*Note: Legal authorities and payment methods for VA payment for emergency care for nonservice-connected conditions are contained in* Title 38 U.S.C. §1725 *and* 38 CFR §17.1000

## Emergency Care in Foreign Counties

VA can pay for emergency medical care outside the United States if the emergency is related to a Veteran's service-connected condition. Contact the Foreign Medical Program at 1-877-345-8179 or visit www.va.gov/communitycare for more information.

## After Receiving Care

Once a Veteran's immediate emergency medical care needs have been addressed, the Veteran, a family member, friend, or hospital staff member should contact the nearest VA medical facility within 72-hours. Once notified, VA staff will assist the Veteran and/or his/her representatives in understanding eligibility and how eligibility relates to services rendered in the community. VA staff will also ensure that, if desired, the Veteran is transferred to a VA medical center upon stabilization and that the Veteran is set up to receive additional care, post discharge, without interruption.

**Important:** When a Veteran receives emergency medical care, notifying VA as quickly as possible is always best. It ensures maximum VA coverage and assists VA in providing the Veteran the care they need.

## Filing a Claim

Claims for emergency medical care should be submitted to VA as soon as possible after care has been provided. The deadline for filing a claim depends on whether care was provided for a service-connected condition or a nonservice-connected condition. The charts below describe the requirements, how to file a claim, and payment rates.

| Requirements | |
|---|---|
| **Service-Connected Condition** | **Nonservice-Connected Condition** |
| Claim must be submitted to VA within two (2) years of the date emergency medical care was received. However, filing the claim as soon as possible after care has been provided is highly recommended because it helps make sure that all required documentation is readily available and that providers receive their payment in a timely manner. | Claim must be submitted to VA within 90 days of the date of discharge, or 90 days from the date that all attempts to receive required payments from a liable third party are completed and not successful in eliminating the Veteran's personal liability to the provider. A liable third party includes an other health insurer, worker's compensation, civil litigation, etc. |

| Filing a Claim | |
|---|---|
| **Veterans/Veteran's Representatives** | **Providers** |
| Veterans or their personal representatives may file a claim for reimbursement of emergency treatment costs that they have incurred and paid to the provider.<br>• In this situation, Veterans should obtain and submit all related treatment and billing records to the closest VA medical facility.<br>• In most cases, providers will submit a claim directly to VA, and the Veteran will not have to take further action. | Submit claims for services not pre-authorized by VA to the VA medical facility closest to where the emergent treatment was provided.<br>• Submission must include a standard billing form (such as a CMS 1450 or CMS 1500), containing false claims notice.<br>• Submit claims via Electronic Data Interchange (EDI) transaction (such as an 837I or 837P)<br>• Documentation related to the medical care may be required prior to claim processing. |

| Payment Rates | |
|---|---|
| **Service-Connected Condition** | **Nonservice-Connected Condition** |
| Generally, 100% Medicare rates. | Generally, 70% Medicare rates. |

## Receiving Payment from VA

Once a claim for emergency treatment is received by VA, the claim will be administratively reviewed to determine Veteran eligibility. If the Veteran meets the administrative eligibility criteria to receive emergency care in the community, the treatment documentation will then be reviewed by VA clinical staff to determine if the treatment received meets the clinical criteria necessary for VA to pay for the care.

VA makes every effort to adjudicate claims for emergency treatment quickly and accurately. When further information or clarification is needed by VA, claims processing may be delayed.

If a Veteran is charged for emergency care received in the community and believes the charges should be covered by VA, they should contact the nearest VA medical facility as soon as possible. VA staff will assist the Veteran in understanding eligibility and in determining whether the bill received is appropriate. VA will assist the Veteran and work to resolve any billing issues with the community provider.

## Support

- For additional information, please reach out to the nearest VA medical center responsible for processing the claims.
- Visit www.va.gov/communitycare

# Fact Sheet 20-03

# Claims Process for Emergency Medical Services

## What are emergency medical services?

Emergency medical services are medical services that are necessary on an emergency basis. Such services should be reported to the nearest VA Medical Center (VAMC) by phone or fax within 72 hours after treating the Veteran. The information provided will enable VA to determine Veteran eligibility and the appropriate payment authority. Veterans are reminded to go to the nearest emergency room if they are experiencing an injury or illness that threatens their life or health, and requires immediate treatment.

Claims and the emergency department report should contain sufficient information to enable the VA review to:

- properly identify the Veteran,
- confirm the need for the emergency treatment,
- determine the condition treated and medical necessity of the treatment rendered, *AND*
- determine whether the Veteran could have been discharged, transferred to the local VAMC or needed to remain at the community hospital.

Once all documentation has been received, VA will make a determination as to what charges are eligible to be paid based on the individual Veteran's specific circumstances and eligibility. Claims for emergency services are reviewed and verified by the VA prior to payment. Please notify your local VAMC regarding the need for emergency medical services.

## What is the claims process for emergency care?

The graphic below and the following description explains the process for emergency care claims. Visit the website, ***http://www.va.gov/purchasedcare/***, for information on the various Purchased Care programs as well as information on how to file claims with VA.

### Required information

When VA is notified about emergency care for a Veteran, they will request the following information (at a minimum):

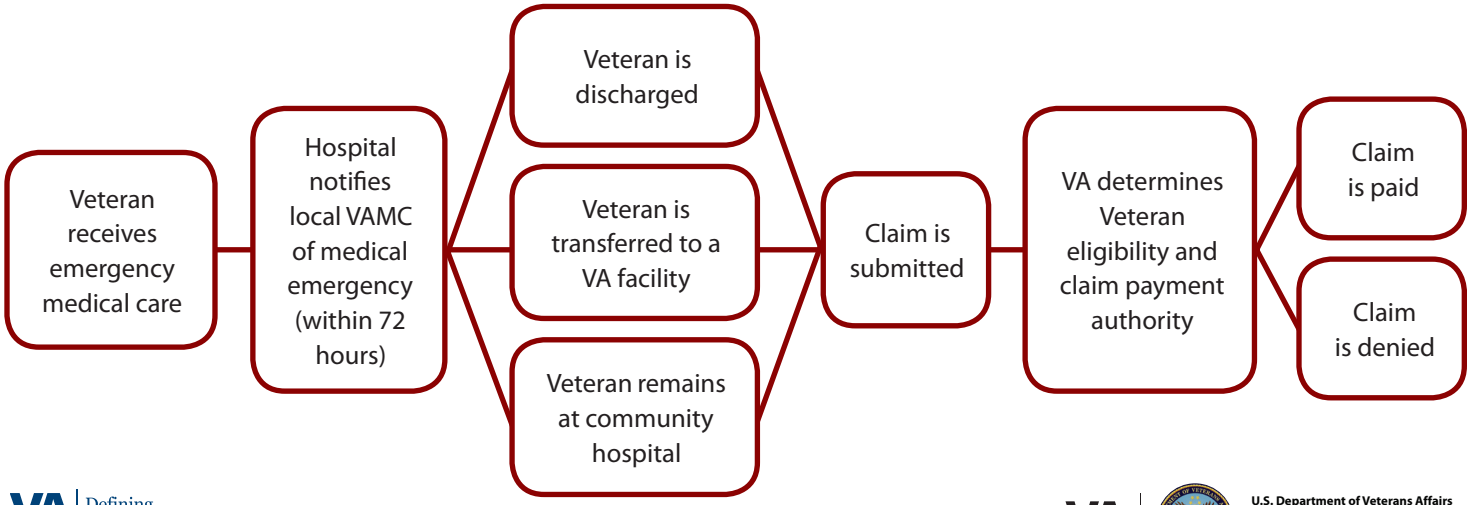
- Patient name, ID and demographics
- Hospital ID, name and address
- Hospital point of contact
- Provider name and NPI
- Patient's chief complaint
- Clinical presentation of patient
- Stabilization for transfer
- Care coordination information

### Process for non-VA emergency care

1. Veteran receives emergency medical care
2. Hospital notifies local VAMC of medical emergency (within 72 hours)
3. Veteran is discharged *OR* Veteran is transferred to a VA facility *OR* Veteran remains at community hospital
4. Claim is submitted
5. VA determines Veteran eligibility and claim payment authority
6. Claim is paid *OR* claim is denied

## How do I get more information?

Visit the Chief Business Office Purchased Care website at ***http://www.va.gov/purchasedcare/*** to read information on the various non-VA medical care programs as well as for more information on how to file claims with VA.




VA HEALTH CARE Defining EXCELLENCE in the 21st Century

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VA U.S. Department of Veterans Affairs
Veterans Health Administration
*Chief Business Office Purchased Care*
**Non-VA Medical Care Program**

Fact Sheet 20-06

# Ambulance Transport at VA Expense – A Guide for Community Ambulance Providers

The Department of Veterans Affairs (VA) has authority to provide or reimburse ambulance transport (land or air) of certain eligible Veterans in relation to VA care or VA-authorized community care.

## VA payment criteria for ambulance transport

VA pays for ambulance transport when the transport has been preauthorized and in certain emergency situations without preauthorization.

Two criteria must be met in order for VA to pay for ambulance transport:

- A claimant must meet appropriate administrative eligibility, *and*
- A VA provider must determine medical need for ambulance transport.

*NOTE: VA must be providing medical care or paying a community care provider for medical care in order to pay for the transport in relation to that care.*

## Preauthorized ambulance transport

Transport is arranged for eligible Veterans in advance of care, and service is provided to and from a VA facility or VA-authorized community care facility. To qualify, a Veteran must meet the following administrative requirements:

- Veteran has a service-connected (SC) disability or combined rating of 30 percent or more (travel for care relating to any condition), *or*
- Veteran is in receipt of a VA pension, *or*
- Previous calendar year income does not exceed maximum VA pension rate, *or*
- Projected income in travel year does not exceed maximum VA pension rate, *or*
- Travel is in connection with care for a SC disability, *or*
- Travel is for a Compensation and Pension exam, *or*
- Travel is to obtain a service dog, *or*
- Travel is in relation to VA transplant care, *and*
- A VA clinician must determine and document that special mode transportation is medically required.

## Unauthorized ambulance transport

Transport must be preauthorized by VA unless it is in relation to a medical emergency. Veterans do not have to contact VA in advance of a medical emergency and are encouraged to call 911 or go to the nearest medical emergency room.

VA may pay for ambulance transport that is not preauthorized in the following emergency situations:

- Transport from point of community emergency *to a VA facility* if claimant meets administrative and medical travel eligibility criteria noted under "Preauthorized ambulance transport"
- Transport from point of community emergency *to a community care facility* if VA pays for the emergency care in the community care facility under the nonservice-connected (NSC) or SC authorities detailed below
- VA is contacted within 72 hours of care at a community care facility and retroactively authorizes the community care for payment, and the Veteran meets administrative and medical travel eligibility criteria noted under "Preauthorized ambulance transport."

In order for VA to pay for unauthorized ambulance transport, the related care must meet one of the following authorities:

### Emergent care for NSC conditions (38 United States Code (U.S.C.) 1725)

- Based on an average knowledge of health and medicine (prudent layperson standard), it is reasonably expected that delay in seeking immediate medical attention would have been hazardous to life or health, *and*
- The episode of care cannot be paid under another VA authority, *and*
- A VA or other federal facility/provider was not feasibly available, *and*
- VA medical care was received within a 24-month period preceding the community emergency care, *and*
- The services were furnished by an Emergency Department or similar facility held out to provide emergency care to the general public, *and*
- Veteran is financially liable for the emergency care, *and*
- Veteran has no other coverage under a health care plan (including Medicare, Medicaid and Worker's Compensation), *and*
- There is no contractual or legal recourse against a third party that could, in whole, extinguish a Veteran's liability.

**Emergent care for SC conditions (38 U.S.C. 1728)**

- Care is for a service-connected disability, *or*
- Care is for a nonservice-connected condition associated with and aggravating a service-connected condition, *or*
- Care is for any condition of an active participant in the VA Chapter 31 Vocational Rehabilitation program, and care is needed to make possible entrance into a course of training or to prevent interruption of a course of training, *or*
- Care is for any condition of a Veteran rated as having a total disability permanent in nature resulting from a service-connected disability, *and*
- Based on an average knowledge of health and medicine (prudent layperson standard), it is reasonably expected that delay in seeking immediate medical attention would have been hazardous to life or health, *and*
- A VA or other federal facility/provider was not feasibly available.

**Retroactive preauthorization (38 CFR 17.54)**

In the case of an emergency which existed at the time of treatment, VA may retroactively preauthorize the care if:

- An application for VA payment of care provided is made within 72 hours after the emergency care initiated, *and*
- Veteran meets the eligibility criteria for community care at VA expense of 38 CFR 17.120.

## Reimbursement considerations

- If the emergency room visit and/or admission meets eligibility for VA reimbursement and the Veteran meets beneficiary travel requirements, the ambulance will be paid from the scene of the incident to the first community care facility providing necessary care
- If a Veteran arrives via ambulance, but leaves the hospital before being treated by a physician, the ambulance is not guaranteed to be covered by VA regardless of eligibility
- Accepted VA payments are payments in full. Balance due billing of VA or Veteran is prohibited. VA pays the authorized amount or not at all.

**Reimbursement payment rates**

Negotiated (contract) rate *or* "usual and customary" (billed charges) for:

- Preauthorized travel (includes retroactive preauthorization under 38 U.S.C 1703)
- Unauthorized transport to a VA facility when approved for payment
- Unauthorized claims approved for payment under 38 U.S.C. 1728 (transport to a community care facility).

Lesser of the amount for which the Veteran is liable *or* 70% of the appropriate CMS fee schedule for:

- Unauthorized claims approved for payment under 38 U.S.C. 1725 (transport to a community care facility).

*NOTE: Public Law 112-154 authorizes VA to pay, when there is no negotiated rate, the lesser of billed charges or appropriate CMS ambulance rate.*

## Documents needed to process claims

In order to consider a claim for VA payment of emergency care provided and associated ambulance transport, VA needs the following documents:

- Documented request or application for VA payment of emergency transportation (typically a Health Care Financing Administration (HCFA) form or a bill). Unless transport is preauthorized, the application must be made within 30 days of transport
- Ambulance trip report documenting circumstances of medical event and care provided by the ambulance service
- Invoice from ambulance service and community care provider
- Community care facility records of care provided to the Veteran. (VA will request these from the facility.)

*NOTE: All necessary documents must be received prior to payment consideration. Payment for associated ambulance transport cannot occur unless VA is providing or paying for the emergency care.*

## Appeals

If a claim does not meet VA payment criteria (is not payable), then it is denied and both the community care provider and Veteran are provided an explanation of denial and notified of the right to appeal the decision (VA Form 4107, *Notification of Rights to Appeal Decision*).

## Other resources

Visit the VA Chief Business Office Purchased Care provider page at ***http://www.va.gov/purchasedcare/programs/providerinfo/*** for more provider resources.

Fact Sheet 20-09

# Veterans Choice Program (VCP) Overview

## Background

Public Law (Pub. L.) 113-146, the Veterans Access, Choice, and Accountability Act of 2014 (Choice Act), as amended, establishes the Veterans Choice Program (VCP). Pub. L. 113-146 did not change the eligibility requirements for enrollment in the VA health care system and did not modify VA's existing authorities to furnish Community Care.

On November 5, 2014, VA published an interim final rule making, AP24 that amends sections 17.108, 17.110, and 17.111 of title 38 of the Code of Federal Regulations (CFR) and establishes new regulations at 38 CFR 17.1500 through 17.1540 to implement the Choice Program.

On December 16, 2014, the President signed Pub. L. 113-235, the Consolidated and Further Continuing Appropriations Act, 2015, which provides for another another Community Care provider payment rate in certain states.

On April 24, 2015, VA published another interim final rule making, AP24 that amends 38 CFR 17.1510 and the calculation of the mileage from a Veteran's residence to the VA medical facility for purposes of determining eligibility for VCP.

On May 22, 2015, the President signed Pub. L. 114-19, the Construction Authorization and Choice Improvement Act, which amends the Choice Act to give the Secretary flexibility to determine eligibility for the Choice Program when a Veteran faces an unusual or excessive burden in traveling to a VA medical facility based on factors set out in the law.

On July 31, 2015, the President signed Pub. L. 114-41, the Surface Transportation and Veterans Health Care Choice Improvement Act of 2015. Title IV, the VA Budget and Choice Improvement Act, makes several changes to the Choice Act that affect Veteran eligibility, including expanding eligibility for VCP to all enrolled Veterans who meet eligibility criteria based on their residence or wait-times.

## VCP Eligibility

VA will apply a two-step process to establish a Veteran's eligibility. A Veteran must meet the criterion in step 1 and at least one of the criteria in step 2.

**Step 1:**

The Veteran must be enrolled in the VA health care system.

***Note:*** *If the enrollment status is "pending," the Veteran will not be eligible until enrolled.*

**Step 2:**

The Veteran must:

- attempt to schedule an appointment for hospital care or medical services, and is unable to schedule an appointment within:
  - the wait-time goals of the Veterans Health Administration (VHA) for such care or services, or
  - the period determined clinically necessary for such care or services if this period is shorter than such VHA wait-time goals, OR
- reside **more** than 40 miles from:
  - the closest VA medical facility, defined as a VA hospital, community-based outpatient clinic, or VA health care center with **at least one full-time primary care physician**, OR
- reside 40 miles or **less** from:
  - the closest VA medical facility, and
  - must travel by air, boat, or ferry to reach such a facility, OR
- reside 40 miles or **less** from:
  - the closest VA medical facility, and
  - face an unusual or excessive burden in accessing such a facility, OR
- reside in a State without a full-service VA medical facility that provides hospital care, emergency services and surgical care having a surgical complexity of standard, and reside **more** than 20 miles from such facility. This criterion applies to Veterans residing in the following:
  - Alaska
  - Hawaii
  - New Hampshire, and
  - United States Territories (Guam, American Samoa, Commonwealth of the Northern Mariana Islands and the U.S. Virgin Islands).

***Note:*** *Veterans in New Hampshire who reside within 20 miles of a full-service VA medical facility that is located in a bordering state are not eligible under this criterion.*

U.S. Department of Veterans Affairs
Veterans Health Administration
Office of Community Care

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## Options for VA Care

Eligible Veterans can choose between the following options:

- schedule an appointment with a VA health care provider
- ask to be placed on an Electronic Wait List (EWL) for a VA appointment, OR
- receive authorized Community Care hospital care or medical services from an eligible provider under VCP.

## VCP Care and Exclusions

VCP covers hospital care and medical services under the Medical Benefits Package (see 38 CFR 17.38), which includes pharmacy and other benefits, such as beneficiary travel. For programs that have specific eligibility criteria, such as dental care, the specific eligibility criteria still applies. All care under VCP must be pre-authorized (see Authorizations).

VCP does not include Nursing Home Care or unscheduled emergency care.

The Patient-Centered Community Care (PC3) contract, which is the primary vehicle used to buy care for VCP, excludes the following services:

- unscheduled emergency care
- nursing home care
- long term acute hospitals (LTAC)
- homemaker and home health aide services
- chronic dialysis treatments
- pediatric services
- durable medical equipment (DME), including eyeglasses
- non-urgent/non-emergent medications, and
- compensation and pension (C&P) examinations.

## Other Health Insurance

To be eligible, all Veterans who are covered by other health insurance (OHI) must provide that information upon request for care under VCP.

If there is a change in the Veteran's health-care plan information, the Veteran must provide the new information to VA within **60 days** of when the change occurred.

## Authorizations

All hospital care or medical services under VCP must be pre-authorized prior to scheduling the Veteran's appointment. Veterans must receive authorization for care by contacting the VCP Call Center at 1-866-606-8198.

Eligible Veterans are authorized for a course of treatment, which must be considered medically necessary. The treatment will include any follow-up appointments, as well as any ancillary and specialty services for the episode of care.

An eligible Veteran may request a particular Community Care provider, but that provider must be eligible under 38 CFR 17.1530. If the Veteran does not request a specific provider, VA will refer the Veteran to an eligible provider.

## VA Copayments and Provider Payment

Veterans who are subject to the copayment requirements under 38 CFR 17.108, 17.110, and 17.111, will be subject to the same copayment requirements under VCP. The Veteran's copayment responsibility under VCP is determined the same as current VA policy, after the service is rendered.

Once an offset has been applied for any payment made by the Veteran's OHI, VA will bill the Veteran for the remainder of the charges. In addition, an eligible Veteran is responsible for any copayments, deductibles or cost shares required by their OHI. VA can reimburse the Veteran for any payments made by the Veteran to cover the cost of copayments, deductibles, or cost shares required by their OHI, as long as the total payment by VA does not exceed the negotiated or applicable Medicare rate (see 38 CFR 17.1535).

VA will reimburse the eligible Community Care provider up to an amount not to exceed the applicable Medicare rate with exceptions for eligible providers in highly rural areas and in Alaska and Maryland. VA's payment to the Community Care provider will be reduced by any payment made to the provider by the Veteran's OHI.

## Definitions

**40 Mile Determination.** This is calculated from the VA medical facility that is closest to the residence of the Veteran. A VA medical facility is defined as VA hospital, a VA community-based outpatient clinic, or a VA health care center, any of which must have at least one full-time

primary care physician. A Vet Center, or Readjustment Counseling Service Center, is not a VA medical facility. The distance is calculated using driving distance.

**Air, Boat, or Ferry.** A Veteran who is required to travel by air, boat, or ferry to reach a VA medical facility that is 40 miles or less from the Veteran's residence. By law, Veterans who reside in Guam, American Samoa, or the Republic of the Philippines cannot be eligible on this basis. (As noted above, however, residents of the United States Territories, Guam, American Samoa, Commonwealth of the Northern Mariana Islands and the U.S. Virgin Islands, are eligible based on residing in a state without a full-service VA medical facility.)

**Episode of Care.** Episode of care means a necessary course of treatment, including follow-up appointments and ancillary and specialty services, which lasts no longer than 1 calendar year from the date of the first appointment with a Community Care provider.

**Full-Service VA Medical Facility.** The facility provides, on its own and not through a joint venture, hospital care, emergency medical services, and surgical care having a surgical complexity of standard. A list of VA medical facilities complying with at least a standard level of surgical care can be found at ***www.va.gov/health/surgery***

**Unusual or Excessive Burden.** A Veteran who resides 40 miles or less from the closest VA medical facility (as defined above) may face an unusual or excessive burden in traveling to such a VA medical facility based on:

- Geographical challenges
- Environmental factors such as:
  - Roads that are not accessible to the general public, such as a road through a military base or restricted area
  - Traffic, or
  - Hazardous weather conditions
- A medical condition that impacts the ability to travel
- Other factors (as determined by the Secretary of VA), including but not limited to:
  - Nature or simplicity of the hospital care or medical services the Veteran requires
  - Frequency that such hospital care or medical services need to be furnished to the Veteran, or
  - Need for an attendant, which is defined as a person who provides required aid and/or physical assistance to the Veteran, for a Veteran to travel to a VA medical facility for hospital care or medical services

**Veteran's Residence.** This is the Veteran's legal residence or personal domicile. A residence may be "seasonal," and consequently, a Veteran may maintain more than one residence, but only one residence at a time. For purposes of determining eligibility, the Veteran's residence is the residence where the Veteran is staying at the time the Veteran wants to have an appointment. ***Note:*** *This excludes a PO Box or other non-residential location. If the Veteran changes his or her residence, the Veteran must update VA about the change within 60 days.*

**Wait Time Goals.** VHA wait-time goals are to schedule appointments within 30 days of the date that an appointment is deemed clinically appropriate by a VA health care provider, or if no such clinical determination has been made, the date a Veteran prefers to be seen.

## Additional Information

For more information, Veterans and Providers should contact the VCP Call Center at 1-866-606-8198, or visit ***http://www.va.gov/opa/choiceact/***

DEPARTMENT OF VETERANS AFFAIRS (VA)
VETERANS CHOICE PROGRAM PROVIDER NETWORK
FACT SHEET
FEBRUARY 8, 2017

## Background

The Veterans Access, Choice, and Accountability Act of 2014 (the Act) required that eligible providers meet specific criteria, including participating in Medicare, being an FQHC, or being a DoD or IHS facility, and having the 'same or similar' credentials to those of VA providers. The Act was amended in July 2015 to authorize VA to expand provider eligibility beyond these initial provider types based on criteria as determined by the VA. Therefore, in order to respond to the needs of our Veterans, the Office of Community Care defined additional provider types in federal regulations that published on December 1, 2015. Under the regulations, Medicaid providers may furnish care under the Veterans Choice Program (VCP) if they meet the other eligibility criteria in the law, including the 'same or similar' requirement. VA has implemented the regulatory change through specific contract modifications that address the "same or similar" criterion for certain categories of providers.

Additional criteria were also defined by means of contractual modifications as described below.

## Provider Network Update

- As of December 31, 2016, the Patient Center Community Care (PC3)/ VCP Provider Network has expanded by 57%.
- Between January 2016 and December 2016, the network grew from 267,866 providers and facilities to 419,240 providers and facilities.
- More than 112,000 provider participants are primary care providers (52% growth), more than 2,700 are pain management specialists (74% growth), and more than 22,000 are radiology/diagnostic imaging specialists (109% growth).

## Updated Provider Eligibility

Women's Health
Since January 2016, the Women's Health Provider Network has expanded by 55%. To achieve this growth, the Office of Community Care executed modifications on July 25, 2016 to the Choice contracts to expand provider eligibility for women's health services for the following provider specialties:

- Obstetrics and Gynecology
- Gynecologic Oncology
- Mammography
- Advanced Practice Nurses (i.e., Women's Health Nurse Practitioners or Certified Nurse Midwives)

This offers our female Veterans more choices and flexibility when choosing a community provider under VCP.

| Women's Health | Providers | | |
|---|---|---|---|
| | Jan-16 | Dec-16 | Growth |
| GYNECOLOGY | 732 | 1008 | 38% |
| MIDWIFE, CERTIFIED NURSE | 774 | 1128 | 46% |
| NURSE PRACTITIONER, WOMENS HEALTH | 115 | 353 | 207% |
| OBSTETRICS | 110 | 260 | 136% |
| OBSTETRICS AND GYNECOLOGY | 7327 | 11246 | 53% |
| ***Total*** | ***9058*** | ***13995*** | ***55%*** |

Mental Health

Since January 2016, the Mental Health Provider Network has expanded significantly. In February 2016, the Choice contracts were modified to include master's level behavioral health/counseling degrees and residential treatment facility providers. This modification increased Veteran access to care by permitting providers holding a full, current, and unrestricted license at the Master's level to independently practice mental health counseling, which includes diagnosis and treatment. With this change, the Patient Center Community Care (PC3)/ VCP Master's Level Counselor Provider Network has expanded by 31% (from 5798 providers to 7623 providers).

| Counselors | Providers | | |
|---|---|---|---|
| | Jan-16 | Dec-16 | Growth |
| LICENSED PROFESSIONAL COUNSELOR | 256 | 759 | 196% |
| MARRIAGE AND FAMILY THERAPIST | 2376 | 2789 | 17% |
| MENTAL HEALTH COUNSELOR | 3166 | 4075 | 29% |
| ***Total*** | ***5798*** | ***7623*** | ***31%*** |

Other Providers

VA is continuously working to ensure that the right mix of providers are included in the Network. Additional specialties including Pediatrics, Audiology, and Optometry that are either not typically enrolled in Medicare or have limited coverage under Medicare (diagnostic testing only) are included within the network. VA is working on efforts to expand VCP to include more providers from these specialties as well as those that provide Methadone/opioid replacement treatment. With upcoming Choice contract modifications, those provider groups will continue to grow for VCP. Since January 2016, an additional 32% of audiologists, 25% of optometrists, and 103% of pediatric subspecialists are in the PC3 network.

| Other Providers | Providers | | |
|---|---|---|---|
| | Jan-16 | Dec-16 | Growth |
| AUDIOLOGY | 1584 | 2091 | 32% |
| OPTOMETRY | 9395 | 11707 | 25% |
| PEDIATRIC SPECIALTIES | 852 | 1726 | 103% |
| ***TOTAL*** | ***11831*** | ***15524*** | ***31%*** |

# BILLING FACT SHEET FOR VA COMMUNITY CARE PROGRAMS

**This fact sheet** is a tool to help community providers delivering care through the Veterans Choice Program (VCP), VCP Provider Agreements, Patient-Centered Community Care (PC3), or Traditional VA Community Care submit claims and get paid faster. VA is working with Congress to further simplify and streamline the process. Until we get there, we will continue to provide tools like this fact sheet to help community providers and the Veterans they serve navigate VA Community Care.

## 1 Which Program?

Prior to receipt of care, you will receive a detailed authorization from either VA or one of VA's contractors (Health Net or TriWest) specifying which VA Community Care Program the specific episode of care is under. An authorization gives the community care provider the authority to provide health care to the Veteran and provides assurance of payment for those services.

| | |
|---|---|
| **Veterans Choice Program (VCP)** | The VCP, administered by VA's contractors, provides primary care, specialty care, and inpatient medical services to eligible Veterans in circumstances where:<br>✔ VA services are not available within the appropriate timeframe<br>✔ A Veteran faces an unusual or excessive travel burden<br>✔ A Veteran has to travel more than 40 miles to a VA primary physician |
| **Patient-Centered Community Care (PC3)** | PC3, administered by VA's contractors, is a nationwide program that provides Veterans access to medical care when local VA medical facilities cannot due to:<br>✔ VA services are not available within the appropriate timeframe<br>✔ Geographic inaccessibility or other factors |
| **VCP Provider Agreements** | VCP Provider Agreements, administered by local VA facilities, have to meet the VCP criteria above and one of the following circumstances:<br>✔ VCP contractors are unable to schedule<br>✔ Specific services are not available from the contract network |
| **Traditional VA Community Care** | Traditional VA Community Care, administered by local VA facilities, is a direct authorization with community providers to provide health services to Veterans. |

## 2 How to file a claim

### Where to File a Claim Electronically?

**Health Net**

Visit http://www.changehealthcare.com/solutions/providers to register with Change Healthcare.

Payer Name: Health Net – VA Patient-Centered Community Care. Payer ID: (68021)

**TriWest**

Step 1: Upload medical documentation to provider portal at http://www.TriWest.com/provider

Step 2: Set up an EDI to submit electronic claims by calling Wisconsin Physicians Service (WPS) at 1-800-782-2680 and select Option 2 to register

### Where to Mail a Paper Claim?

**Health Net**

VETERANS CHOICE PROGRAM – VACAA
PO Box 2748
Virginia Beach, VA 23450

PATIENT-CENTERED COMMUNITY CARE (PC3)
PO Box 9110
Virginia Beach, VA 23452

**TriWest**

VETERANS CHOICE PROGRAM AND PC3
WPS-VAPCCC
PO Box 7926
Madison, WI 53707-7926
Note: Must use form CMS 1500 or UB04.

### Where Can I find Detailed Instructions?

**Health Net**

Call 1-866-606-8198
Open 6:00am–7:00pm EST, Monday through Friday, excluding federal holidays
OR
Visit Health Net claims submission provider page

**TriWest**

Call 1-855-722-2838
Open 8:00am–10:00pm EST, Monday through Friday, excluding federal holidays
OR
Visit TriWest Claims and Reimbursement Quick Reference Guide

## VCP Provider Agreements and Traditional VA Community Care

### Where to File a Claim Electronically?

To register for Change Healthcare's EDI visit http://www.emdeon.com/contactform or Call 1-877-363-3666.
While registering you will need the VA Fee Program payer IDs which include:

- 12115 for submission of medical claims
- 12116 for submission of dental claims
- 00231 for submission of any inquiry transaction

### Where to Mail a Paper Claim?

Submitting claims electronically may help community providers receive payment faster and reduce administrative costs.

If you are unable to file a claim electronically, please complete the appropriate form (original CMS 1500 and/or CMS 1450 (UB-04)) and provide the codes for the treatment rendered just as you would when completing a Medicare claim. Contact the facility indicated in the authorization for further instruction on where to mail paper submissions.

### Where Can I find Detailed Instructions?

For information on authorizations, call the number indicated on your authorization letter/form. For information on claims payments, visit https://www.va.gov/COMMUNITYCARE/providers/info_claimsPay.asp

### To Contact Us

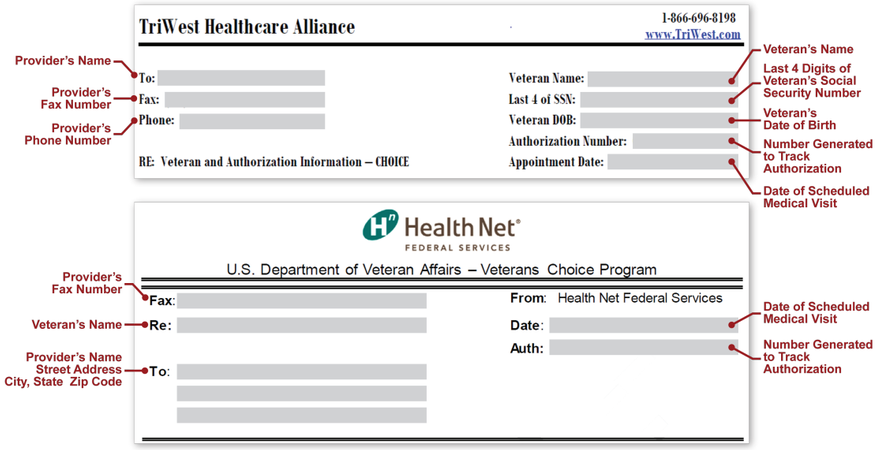
Find and contact your local medical center by using the VHA Facility Locator at http://www.va.gov/directory/guide/division.asp?dnum=1

VA | U.S. Department of Veterans Affairs

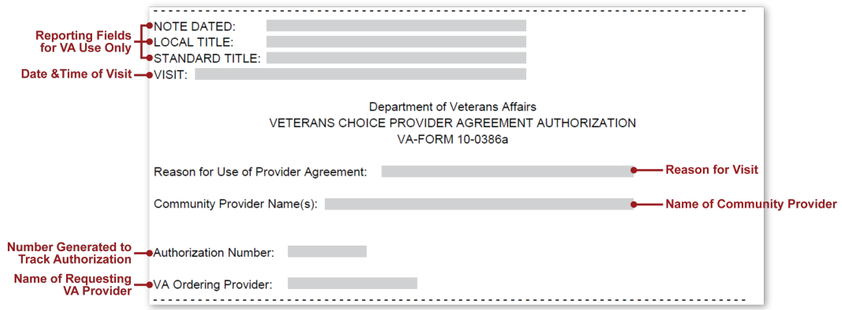
Current as of July 2017

# 3 Authorization Forms

## Appendix A: VCP/PC3 Authorization Forms




## Appendix B: VCP Provider Agreement Authorization Form

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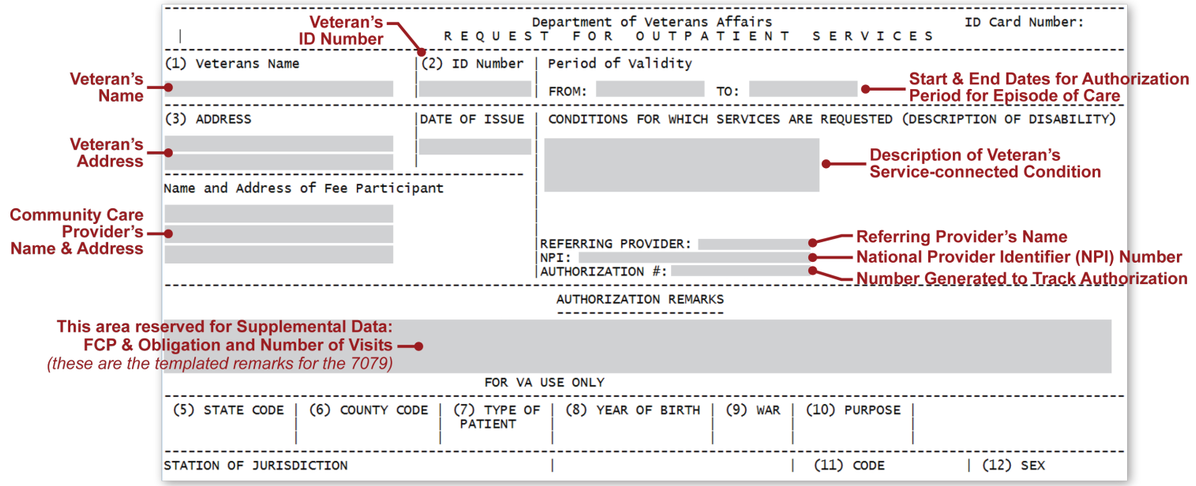
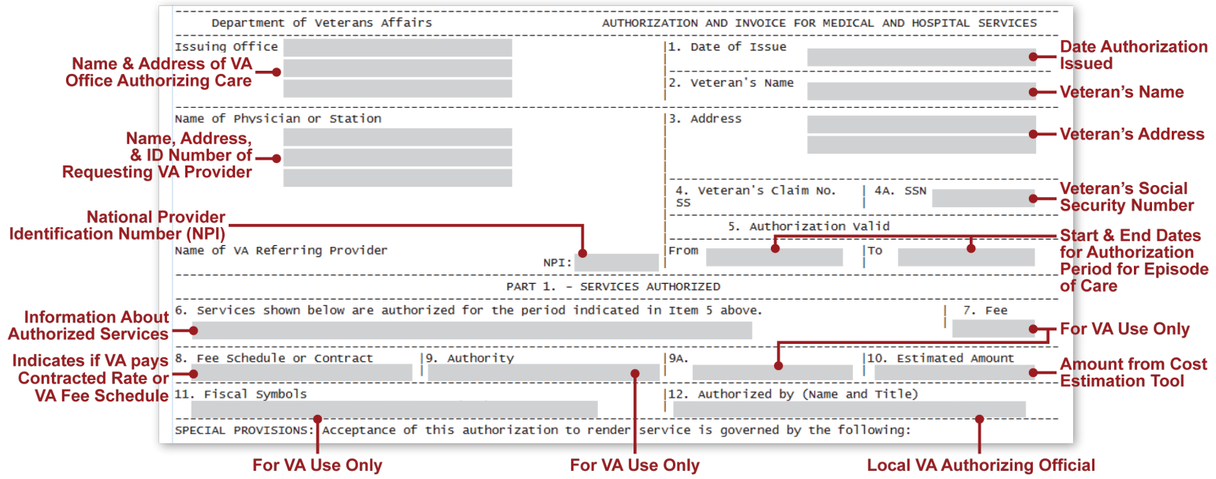
## Appendix C: Traditional VA Community Care Authorization Form

*Outpatient Care VA Form 10-7079*




*Inpatient Care VA Form 10-7078*



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# Health Net and TriWest Complaint Process

## Patient-Centered Community Care (PC3) and Veterans Choice Program (VCP)

### Health Net

Health Net Federal Service's (HNFS) grievance program is designed to review complaints, determine if errors were made or if poor service was provided, and take action to resolve issues and improve services in the future.

**Who can file a grievance?**

Anyone can file a grievance; however, if the grievance is from someone other than the involved Veteran, Health Net may not be able to give a full response without authorization to disclose medical information on file. This generally applies to spouses and parents writing on behalf of the Veteran.

**What is the grievance process?**

Once documentation is submitted, HNFS conducts a thorough investigation of the concerns and takes actions as necessary to resolve the issue. HNFS will contact the involved provider(s) and various Health Net departments to gather additional information.

**How is a grievance submitted?**

Phone: Providers can call **1–800–979–9620** to address questions regarding authorizations, authorization extensions, grievances, or claims questions or inquiries. They may also call the Veterans Choice Call Center at **1–866–608–8198**

In writing: Submit a claim via email, mail, or fax. Complete and print a Health Net Grievance Form and send via fax or mail

- Mail: Health Net Federal Services, LLC
  Veterans Choice Program Grievances
  2025 Aerojet Road
  Rancho Cordova, CA 95742
- Fax: (916) 353–6826

**Grievance Form**

https://www.hnfs.com/content/dam/hnfs/va/provider/pdf/PPN_Grievance.pdf

### TriWest

TriWest's grievance process allows for submission of a grievance regarding the quality of services received by the Veteran during a network care visit or any other issue related to service provided.

**Who can file a grievance?**

Grievance can be submitted by any Provider, Veteran, or an authorized representative of the Veteran. TriWest may not be able to provide a full response without an authorization to disclose medical information form on file.

**What is the grievance process?**

Once documentation is submitted, TriWest conducts a thorough investigation into the complaint and makes necessary steps to improve services. TriWest works with the appropriate departments to ensure matters are resolved and lessons learned are shared with appropriate TriWest and VA leadership.

**How is a grievance submitted?**

Phone: You can submit a grievance verbally by calling TriWest at **1–855–722–2838** or by calling the Veterans Choice Call Center **1–866–606–8198**

In writing: A VA PC3/VCP Complaint/Grievance Form can be accessed by visiting Forms and sent via fax or mail

- Mail: TriWest Healthcare Alliance
  Grievance Department
  P.O. Box 41970
  Phoenix, AZ 85080-1970
- Fax: (602) 564-2523

**Grievance Form**

http://www.triwest.com/globalassets/documents/veteran-services/complaint-grievance_form.pdf

**Provider Handbook**

https://www.triwest.com/en/VAPC3-Provider/Provider-Handbook/2013-HA-VAPC3-Provider-Handbook.pdf