Home Health Care

Quick Reference Guide – All Regions

Key Points:

- TriWest Healthcare Alliance ***cannot pay fee-for-service*** under the Veterans Choice Program (VCP) or Patient-Centered Community Care (PC3) program, even if providers previously directly billed the Department of Veterans Affairs (VA) in this fashion.
- Home health providers who see Veterans under the VCP or PC3 need to bill TriWest according to ***Medicare guidelines***.
- When completing the Request for Anticipated Payment (RAP) on the UB-04, providers should bill at minimum one penny, even though the Medicare requirement is zero.
- If a Veteran was previously referred directly from VA, providers must initiate a new Outcome and Assessment Information Set **(OASIS)** assessment once the Veteran has been referred.
- If TriWest calls a home health agency requesting care for a Veteran, or the provider receives an authorization from TriWest, VA has initiated transfer of the care from its facility to TriWest's community care provider under VCP or PC3.

TriWest Authorized Care versus Directly Authorized VA Care

If VA transfers Veterans from **directly** authorized home health care to the VCP or PC3 programs, providers should be aware that **TriWest** – ***not the VA Medical Center*** – is the administrator, and care should be provided in accordance with the guidelines defined in this Reference Guide. Additionally, TriWest is responsible for creating the authorization letter which defines the approved episode of care (in coordination with VA) and paying provider claims.

Home health care may be appointed in one of two pathways:

- In all regions, VA Medical Center (VAMC) staff may call the provider to set up the episode of care OR TriWest may call the provider to set up the episode of care. With confirmation, an authorization letter is generated by TriWest.
- Care not authorized through TriWest must be billed to the VAMC or, if authorized by Health Net, to Health Net.

Home Health Documentation:

Once a home health provider has been contacted (via phone or written authorization letter), VA has already initiated transfer of the Veteran's care to TriWest's community care provider under the VCP or PC3 programs.

View a map of PC3 and VCP Regions

With transition to VCP or PC3 program:

- Begin following the Medicare model immediately.
- Discontinue fee-for-service billing to the VA medical center once the VA authorization ends and the VCP or PC3 authorization from TriWest begins.
- Initiate a new episode of care (EOC), including a new OASIS assessment.
- Create a plan of care from the OASIS assessment and submit it to TriWest (Regions 3, 5 and 6) or VA (Regions 1, 2 and 4) as medical documentation.
  - **Within three business days** from the start of care – submit the initial plan of care (CMS 485 Form). The 485 should be signed by the clinician that performed the initial evaluation. This can be a registered nurse, physical therapist, occupational therapist, or a physician.
  - It is not necessary to wait until the ordering physician signs the plan. It is often a VA physician that needs to sign and by submitting the 485 to TriWest or VA, physician signature is facilitated
  - **Within five business days** of completing care, submit an end EOC record (a.k.a. discharge summary)
- TriWest is required by contract to follow Medicare as it pertains to billing practices only.
  - Veterans admitted to home health services under a TriWest authorization are not required to meet Medicare's skilling criteria.
  - There is no requirement for: homebound status, face-to-face documentation, skilled need certification, or the Medicare Provider and Supplier (PECOS) enrollment by the ordering physician.
- Bill TriWest's claims processor, WPS Military and Veterans Health (WPS MVH), on a UB-04 or electronic equivalent according to Medicare guidelines. Per contractual requirements, TriWest ***cannot pay fee-for-service***.

Additional Billing Guidelines

Home health providers also need to follow these additional billing guidelines:

- After completing the OASIS assessment, submit RAP claim using ***Type of Bill Code 322*** to WPS MVH.
- When completing the RAP on the UB-04, providers should bill at minimum one penny, even though the Medicare requirement is zero.
- At the end of the episode-of-care, submit final billing using ***Type of Bill Code 329***
- OASIS assessment details reveal a code required for billing. If the OASIS data/code is not included on the claim, then the claim will be denied.
- If a Home Health claim needs to be cancelled, you must submit a claim with a Type of Bill Code 328.
- All providers should make their best efforts to submit claims within 30 days.
- VCP and PC3 programs have a 180-day timely filing limit. Please ensure your claims are submitted within this timeframe.

When Are VA Programs Primary? Veterans may elect to use their Veteran benefits **over** Medicare, even if Medicare is listed as the primary payer. If you receive an authorization from TriWest, the Veteran has elected to use his or her VA benefits. For these authorizations, VA programs are primary. Claims should be sent to WPS MVH. Veteran benefits **cannot** pay secondary to Medicare.

View a map of PC3 and VCP Regions