VA Patient-Centered Community Care
and Veterans Choice Program

June 2016

Dear Provider:

Home health care billing practices may vary based on the patient's benefit program. Under U.S. Department of Veterans Affairs (VA) Veterans Choice Program (VCP) and Patient-Centered Community Care (PCCC), home health agency providers must follow Medicare guidelines when submitting claims for home health care to Health Net Federal Services, LLC (HNFS). This may be a change for providers who have billed VA directly for services prior to the implementation of VCP and PCCC.

Health Net Federal Services pays Medicare-certified home health agencies using a prospective payment system (PPS) modeled on Medicare's plan. Medicare-certified billing is handled in 60-day-care episodes, allowing home health agencies to receive two payments of 60 percent and 40 percent, respectively, per 60-day cycle. This two-part payment process is repeated with every new cycle, following the patient's initial 60 days of home health care.

Health Net Federal Services does not require an Outcome and Assessment Information Set (OASIS); however, providers must submit an initial claim, also called a Request for Anticipated Payment (RAP) and a final claim.

Tips for filing a RAP:*

- The bill type in Form Locator (FL) 4 of the UB-04 is always 322.
- The "To" and "From" date in FL 6 must be the same and must match the date in FL 45.
- FL 39 must contain code 61 and the Core-Based Statistical Area code of the beneficiary's residential address.
- There must be only one line on the RAP, and it must contain revenue code 023 and 0 dollars. On this line, FL 44 must contain the Health Insurance PPS code.
- The quantity in FL 46 must be 0 or 1.
- FL 63 must contain the authorization code assigned by the Outcome Assessment Information Set.

Tips for filing a final claim:*

- The bill type in FL 4 must always be 329.
- In addition to the blocks noted for the RAP above, each actual service performed with the appropriate revenue code must be listed on the claim form lines. The claim must contain a minimum of five lines to be processed as a final request for anticipated payment. The dates in FL 6 must be a range from the first day of the episode, plus 59 days. Dates on all of the lines must fall between the dates in FL 6.
- The claim must contain more than four billable visits to be processed as a full episode. Final claims with four or less billable visits will be processed as a low utilization payment adjustment (LUPA).

Providers whose home health care claims were previously denied due to incomplete or missing information may resubmit corrected claims to HNFS using these billing guidelines.

As a reminder, home health services require prior authorization. Visit **www.hnfs.com/go/VA** > *Claims* to learn more about VCP and PCCC claims. We appreciate your support of our Veteran community.

**Billing tips are based on current Centers for Medicare & Medicaid Services (CMS) guidelines. Please refer to* *www.cms.gov* *as requirements may change.*

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