



Veterans Choice Program

PROVIDER PARTICIPATION REQUIREMENTS



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Questions or Comments

Questions, comments or suggestions regarding this document or its contents should be directed to:
HNFSProviderRelations@HealthNet.com.

Overview

About Veterans Choice Program

The Veterans Access, Choice, Accountability Act (VACAA) of 2014 is a law that expands the number of options Veterans have for receiving care to ensure that Veterans have timely access to high-quality care. The VACAA allows eligible Veterans who live more than 40 miles from a U.S. Department of Veterans Affairs (VA) health care facility or are unable to get a VA appointment within 30 days of their preferred date, or within 30 days of the date determined medically necessary by their physician, to obtain approved care in their community instead.

Health Net Federal Services, LLC (Health Net) will coordinate with eligible Veterans to obtain authorization for all care under Veterans Choice Program (VCP). Veterans are encouraged to access health care through Health Net's comprehensive network of community-based, non-VA medical professionals who meet VA quality standards. These highly qualified providers are contracted as part of Health Net's URAC accredited Patient-Centered Community Care (PCCC) network and proudly serve our Veterans today in PCCC and VCP.

However, VCP allows a Veteran to choose a non-PCCC provider when a PCCC provider is not available or the Veteran has a preference for another community provider. Health Net must verify that the non-PCCC provider meets the credentials and license requirements of VCP and the provider must agree with the program requirements prior to scheduling the appointment.

While millions of Veterans will receive a Choice Card, only a subset of those who hold the card will be eligible to use it at any given time. Verification of eligibility and authorization from Health Net are required for reimbursement of costs associated with care provided to a Veteran.

It is important to understand that Veterans are eligible to use the Choice Card only under specific circumstances: either because they have been on a waiting list for more than 30 days or they cannot reach a VA health care facility because it is geographically inaccessible.

The Purpose of this Document

The Veterans Choice Program Participation Requirements define provider roles and responsibilities including appointment access standards; patient safety and safety events; health care services and prescriptions; authorization and care coordination requirements; medical documentation and report coordination with VA; and claims processing, billing and reimbursement information. This document is a supplement to the Participation Agreement for Services as agreed to as part of the Health Net Authorization of Services.

Responsibility for Provision of Services

Providers and Health Net do not have an employer-employee, principal-agent, partnership, joint venture, or similar arrangement. Providers make all independent health care treatment decisions and are responsible for the costs, damages, claims, and liabilities that result from their own actions. Health Net does not endorse or control the clinical judgment or treatment recommendations made by providers and not all services are contracted or covered services.

Key Requirements

The following items are key aspects specific to VCP. Please review this document in its entirety for complete program details and requirements.

- Provider must be a health care provider that is participating in the Medicare program under title XVIII of the Social Security Act (42 U.S.C. 1952 et seq.) and meet all Medicare Conditions of Participation (CoPs) and Conditions for Coverage (CfCs).
- Any provider on the CMS exclusionary list shall be prohibited from providing services for or receiving payment from Health Net.
- If provider is or has been licensed, registered, or certified in more than one state, provider must certify that none of those states has terminated such license, registration, or certification for cause, and that provider has not voluntarily relinquished such license, registration, or certification in any of those states after being notified by that state of potential termination for cause.
- Provider must notify Health Net within 10 days if any state in which the provider is licensed, registered, or certified terminates such license, registration, or certification for cause, or if the provider voluntarily relinquishes such license, registration, or certification after being notified in writing by that state of potential termination for cause.
- Providers must make appointments available for Veterans within 30 days of a request by Health Net.
- Office wait times for appointments should not exceed 20 minutes beyond their scheduled appointment time.
- Health Net will issue all authorizations to the provider for VCP services.
- A provider notification packet will be sent with each authorization after the appointment has been scheduled with the provider which outlines the specific clinical and other requirements for the authorized care.
- The provider must furnish only the hospital care or medical services authorized by Health Net. The provider must contact Health Net to receive authorization prior to providing any hospital care or medical services the provider believes are necessary that are not identified in the authorization Health Net submits to the provider. Care exceeding 60 days must be reauthorized by Health Net.
- The episode of care authorized by Health Net is not considered complete and payable until complete medical documentation, specified within the provider notification packet, is returned to Health Net.
- Providers will be paid for all authorized services according to the Participating Provider Agreement.
- Appeals regarding payment of care rendered to a Veteran or denial of care rendered to a Veteran, must be submitted to Health Net. Anyone who disagrees with a denial may submit a reconsideration request in writing to Health Net within 90 days of the date of the initial decision.
- Provider must not bill, charge, collect a deposit from, seek compensation, remuneration, or reimbursement from, or have any recourse against Veteran or persons acting on their behalf, other than Health Net or Other Health Insurance for Covered Services authorized by Health Net.
- To the extent provider utilizes any ancillary or other provider(s) to render services for the same episode of care for which provider has accepted an authorization, provider must (1) share with such other provider the terms and conditions of this program and the relevant authorization; (2) obtain assurance from other provider(s) that it will abide by the terms and conditions of this program; and (3) provide other provider's pertinent information to Health Net's Operation Center for VCP at 1-866-606-8198.
- All invoices from the provider should be electronically submitted to Health Net. Payments to the provider will be made only after the completion of the necessary course of treatment, including follow-up appointments and ancillary and specialty services, or after 60 days of such treatment, whichever comes first, and after submission by the provider of the medical records.
- A copy of the Health Net authorization must be provided to the Veteran for all pharmacy prescriptions written by the provider.

Provider Tools

Requirements for Maintaining Accurate Information

It is important network providers keep their demographic information up-to-date to ensure Health Net provides accurate information to Veterans and to speed accurate claims adjudication. Providers should use the Provider Demographic Update Form to submit any changes electronically. To ensure continuity of care, any provider leaving a network group must notify Health Net 90 days prior to his or her departure. During this time the provider is placed on a no referral status to ensure no additional cases are referred. This window is intended to allow sufficient time for the provider to complete authorized care or, if the care needs to be transitioned, to notify Health Net of a need to continue services with another provider.

Note: Participating providers are responsible for updating their contact information with Health Net. Go to www.hnfs.com to access the Provider Demographic Update Form.

www.hnfs.com

Health Net's website provides information about VCP benefits, processes, requirements, and operations, as well as access to business tools and forms. Visit www.hnfs.com > *Department of Veterans Affairs Programs* > *I'm a Provider* for more program details and important updates.

Important Provider Information

General Administrative Requirements

All services, facilities, and providers must be in compliance with all applicable federal and state regulatory requirements. Any provider on the Centers for Medicare and Medicaid Services (CMS) exclusionary list will be prohibited from network participation. See www.oig.hhs.gov/exclusions/index.asp for further detail.

Participating providers are required to report within 10 days, in writing, the loss of or other adverse impact to a provider's certification, credentialing, privileging, or licensing.

Fraud, Waste and Abuse

Refer to Health Net's Preferred Provider Network Provider Manual for definitions, details and reporting processes. The document is available online at www.hnfs.com > Department of Veterans Affairs Programs > I'm a Provider.

Privacy or Security Incidents

Providers must report to Health Net any privacy or security breaches containing Veteran information within 24 hours. Contact Health Net at hngss_incidents@healthnet.com.

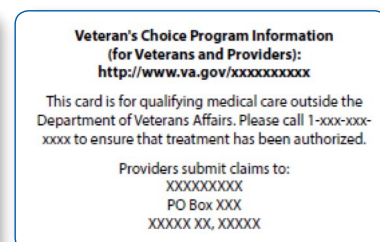
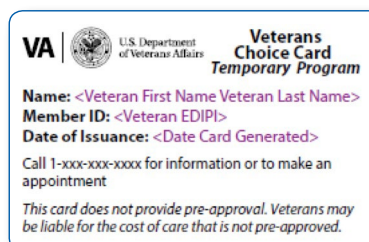
Office and Appointment Access Standards

Providers must comply with the following Office and Appointment Access Standards:

- Primary care appointments must be made within 30 calendar days.
- Specialty care appointments must be made within 30 calendar days.
- Preventive care appointments must be made within 30 calendar days.
- Office wait time for appointments should not exceed 20 minutes.

Choice Card

For this program, VA will issue identification (ID) cards to Veterans. Appointments must be coordinated with Health Net and an authorization for care must be given before rendering services.



Covered Services

Covered services under VCP are limited to the health care services set forth on the authorization received from Health Net. Any services that have not been authorized by Health Net will not be paid for under VCP.

Additional Requirements for Specific Services

Audiology

Initial testing results relating to potential hearing aids needs must be submitted directly to VA within two business days. All hearing aids will be ordered by VA through its national hearing aid contract. When hearing aids are issued, medical documentation for follow up appointments such as fittings and adjustments must be returned.

Authorization Process

Health Net authorizes all non-service connected care for Veterans who live more than 40 miles from a VA health care facility or are unable to get a VA appointment within 30 days.

Appointment Scheduling

Health Net is responsible for coordinating all appointments with a provider's office or facility, however, providers are strongly encouraged to contact Veterans with a courtesy appointment reminder. Providers must comply with the following access care standards for care:

- Veteran appointments must be within 30 calendar days.
- Urgent care appointments must be within 48 hours.
- Office wait time for appointments should not exceed 20 minutes.

Report all no-show, missed or canceled appointments to 1-866-606-8198 or by fax at 1-855-300-1705.

Note: Providers must not bill Veterans, or request reimbursement from VA or Health Net for no-show, missed or canceled appointments.

Provider Notification Packets

After an appointment is scheduled, Health Net will send a provider notification packet to each scheduled facility or provider. These provider notification packets provide case-specific clinical requirements, VA standards and guidelines of the authorized care. Packets may include, but are not limited to:

- Authorization, and any clinical notes or medical documentation provided with the authorization.
- The Veteran's name and demographics, diagnosis, specific services authorized, date and time of appointment already arranged, and authorization begin and end dates.
- Comprehensive information about provider options for completing and returning medical documentation.
- Instructions for communicating kept and no-show appointments.
- Reminder instructions that the Veteran should be seen within 20 minutes of the scheduled appointment time.
- Instructions and due dates for returning the required medical documentation as a pre-condition of payment and a reminder that claims for services rendered will not be considered until the return of accurate medical documentation is complete.
- Instructions for ongoing treatment and/or extended service requests.
- Instructions for reporting critical findings.
- Instructions for notifying the Veteran of test results.

For questions regarding an authorization, contact 1-866-606-8198.

Note: Authorizations alone do not guarantee payment. The provision of health care services is to be limited to that set forth in the authorization form. All claims must correlate with authorizations and returned medical documentation (faxed separate from claims). Only the authorized practitioner may render and bill for services.

Pharmacy

Providers must prescribe in accordance with the VA National Formulary (<http://www.pbm.va.gov/PBM/nationalformulary.asp>). If there is an urgent need for a Veteran to start a medication and it is not possible for the Veteran to obtain the medication from a VA pharmacy, provider may prescribe up to a 14-day supply, without refills. The prescribing provider is required to provide the Veteran a copy of the Health Net authorization along with any prescription(s) issued under VCP. The prescribing provider must provide, at a minimum, the following information to the rendering VA pharmacy prior to filling prescriptions: provider's name, address, personal DEA number (not a generic facility number), phone, fax, National Provider Identifier (NPI) number, provider's Social Security number, provider's date of birth, and provider's gender.

Requesting Additional Services

If the provider determines it is necessary to continue the care after the approved date(s) of service or additional services are needed, they must complete the Request for Additional Services. The form is available at www.hnfs.com/go/forms.

Health Care Management and Administration

Authorization

All Veterans must have an authorization from Health Net before seeking care from a provider or facility.

Specialty Care Consultations

Care for services that are not considered primary care may be authorized. An example of a specialty care consultation is when a Veteran needs to see a cardiologist for evaluation of a possible heart problem.

The specialty care consultation may be for either:

- Evaluation only – Initial evaluation of the patient, to include required diagnostic services, but not treatment. This type of referral also includes requests for second opinions.
- Evaluation and treatment – Initial evaluation, required diagnostic services and treatment related to a specific medical condition.

A new authorization is required for surgical care, inpatient care and care delivered by a provider other than the provider authorized for the evaluation and treatment request. Authorizations are valid for a 60 day period.

Prior Authorization Process and Requirements

Prior authorizations are required for certain services and/or procedures that require Health Net review and approval, prior to being provided. The following list will help to determine if a Health Net prior authorization is required. Prior authorization requirements are subject to change as a result of VCP modifications and/or during annual prior authorization requirement reviews. Prior authorization requirements are reviewed annually in accordance with Health Net policy to evaluate medical and behavioral health care trends and to better control health care costs for the government.

- Abortions or abortion counseling
- All elective acute care and behavioral health admissions
- All elective invasive procedures requiring conscious sedation or involving facility fees or professional care by other than the initially approved provider (pathology, anesthesia)
- All surgical procedures
- Ambulance transport using air ambulance or non-emergent ambulance services
- Assisted, non-coital, reproduction services (e.g., IVF)
- Chronic dialysis treatments
- Compensation and pension examinations
- Dental care
- Durable medical equipment
- Gender-assignment surgery and any related care
- Home health care
- Home infusion services
- Homemaker and home health aide services
- Hospice
- Long term acute care hospitals (LTAC)
- Nursing home care
- Pediatric services
- Pharmaceuticals (not included on VA formulary)
- Physical, occupational and speech therapy
- Preventive screening procedures, age and gender specific, as recommended by the U.S Preventive Services Task Force
- Specialty care consultations

Inpatient Prior Authorization and Continued Stay Review

Health Net requires prior authorization and notification of all inpatient facility admissions and discharge dates within 24 hours or by the next business day following the admission and discharge. Health Net will conduct continued stay reviews and will require clinical information supporting the continued stay at intervals that are based on the Veteran's condition.

Submitting Authorization Requests

Providers can request an authorization from Health Net by fax. Please submit requests for authorization to 1-855-300-1705.

Requesting Services

When services are needed that require authorization from Health Net, the requesting provider must include a written explanation of services requested to be performed and sufficient clinical information to evaluate treatment requested for the Veteran. Failure to submit clinical information beyond the chief complaint may result in delay in services.

- Be sure to complete every section of the service request form – including clinical history/previous treatment and supporting test results – for Health Net to process the request in a timely fashion. Health Net will contact the provider's office for further information or clarification if necessary.
- Include the Veteran's name, identification number (SSN or ID Number on the Choice card) and a description of the service(s) being requested (including the diagnosis and service codes).
- If completing the form by hand, be sure to write legibly so all letters and numbers are clear.
- If completing the fax form electronically to print and send by fax, you can click and type in each field without having to handwrite the information.
- You can also download the form to your computer and save the information for future requests.
- Once the form is complete, fax it to 1-855-300-1705.
- Do not include a fax cover sheet.
- Fax each patient referral request separately.

Health Net will contact the provider's office for further information or clarification, if necessary, to process the prior authorization request. If the services meet the required criteria, the Veteran and the provider will receive a notification letter that lists the provider's name, specialty services, and dates and/or visits approved.

The procedure codes listed on notification letters issued by Health Net are not a guarantee of payment. It is the provider's responsibility to bill the correct procedure code(s) for the actual services rendered.

The notification letter will include an authorization number for the approved service(s) or will provide guidance on how to request reconsideration or appeal a denied authorization.

Extending Prior Authorization Requests from Specialists

Services beyond the initial 60 day episode of care require a new request.

Utilization Management

Utilization Management (UM) is a process that manages the Veteran at the point of care through prospective review, concurrent review, discharge planning, and retrospective review activities.

Health Net will conduct UM, and care management activities for care administered outside of the VA Health System.

Prospective Review

Prospective review is the process of reviewing and assessing health care services before they are rendered.

Non-physician clinical reviewers perform benefit determination and medical necessity review using applicable criteria. Cases requiring medical judgment will be submitted to physician consultants and/or medical directors as an integral part of the provision of medical or psychological peer review.

The prospective review program involves review of requested services for:

- appropriate placement prior to delivery of care (that is, appropriateness of setting)
- assessment of level of care required
- assignment of expected length of stay or treatment duration benefit determination
- determination of medical or psychological necessity
- evaluation of proposed treatment or services
- identification of potential quality issues
- provider and Veteran eligibility

Initial Inpatient Clinical Review

Health Net's process for initial inpatient clinical review requires hospital providers to submit clinical information to establish the care's medical necessity. Health Net care managers will contact your facility and request the initial inpatient clinical review within 24 hours or the next business day following notification of admission, if the information has not been submitted.

Documents required may include any or all of the following:

- emergency room documentation
- history and physical
- physician orders
- diagnostic lab results
- diagnostic radiology results
- operative reports
- physician progress notes
- any other documentation that the reviewer considers essential to establish medical necessity

These documents are due to Health Net within 24 hours, or the next business day, of the admission. If you have any questions regarding this process, contact the care manager assigned to your facility. The care manager's contact information is included in the letter from Health Net.

Concurrent Review

Concurrent review is the evaluation of a patient's continued need for treatment and the appropriateness of current and proposed treatment, as well as the setting in which the treatment is being rendered or proposed. Concurrent review applies to all levels of inpatient care. If an admission or an extended stay does not meet the required criteria, a request for further review will be sent to the medical director or peer review panel.

When review is initiated, Health Net will secure the necessary medical information to support the medical, surgical or behavioral health care services. Medical necessity and appropriateness of setting and treatment review is performed by the care manager with each concurrent review utilizing InterQual® Level of Care Criteria.

A Health Net care manager will contact the hospital at the time of admission to obtain initial clinical information and to discuss discharge planning needs. Subsequent contacts are made to discuss goals for length of stay and/or confirm discharge. It is expected hospitals will arrange a specific aftercare appointment, to occur within 7–10 days for patients not discharging to another facility, by or before the discharge. This information should be included with the final discharge information transmitted to Health Net.

The concurrent review process focuses on early proactive interventions and discharge planning to ensure that the Veteran receives quality care and timely provision of care in the most appropriate setting.

Discharge Planning

As the patient's illness decreases in severity and/or begins to stabilize, the intensity of services will reflect that. If care may be delivered in a lower acuity setting, the care manager will coordinate efforts with the physician directing the care (and the patient and family members) to facilitate timely and appropriate discharge. Health Net will initiate discharge planning for all admissions during the first review of the case.

Retrospective Review

VA has designated Health Net as the multifunction peer review organization (PRO) for performance of retrospective review activities: medical record review (inpatient and outpatient), DRG/coding validation, and focused reviews (inpatient and outpatient).

All cases selected for focused retrospective review will undergo the following review activities:

- Admission review – The medical record must indicate that the inpatient hospital care was medically or psychologically necessary and provided at the appropriate level of care.
- Invasive procedure review – The performance of unnecessary procedures may represent a quality and/ or utilization problem. The medical record must support the medical necessity of the procedure performed. Invasive procedures are defined as all surgical and any other procedures that affect DRG assignment.
- Discharge review – Records will be reviewed using appropriate criteria (that is, InterQual) to determine potential problems with questionable discharges, as well as other potential quality problems.
- Diagnosis-related group validation – Selected records will be reviewed for focused and intensified reviews to assure that reimbursed services are supported by documentation in the patient's medical record. This review must determine if the diagnostic and procedural information and discharge status of the patient, as reported by the hospital, match the attending physician's description of care and services documented in the patient's record.
- Outlier review – Claims that qualify for additional payment as cost-outliers will be subject to review to ensure costs were medically necessary and appropriate and met all other payment requirements. In addition, claims which qualify as short-stay outliers shall be reviewed to ensure that the admission was medically necessary and appropriate and that the discharge was not premature or questionable.
- Procedures and services not covered by the DRG-based payment system – ICD-9/ICD-10 and CPT®-4 codes will provide the basis for determining whether diagnostic and procedural information is correct and matches the information contained in the medical record.

Policy on Separation of Medical Decisions and Financial Concerns

Health Net has a strict policy:

- Utilization management decisions are based on medical necessity and medical appropriateness.
- Health Net does not compensate physicians or nurse reviewers for denials.
- Health Net does not offer incentives to encourage coverage or service denial.
- Special concern and attention should be paid to underutilization risk.

Medical decisions regarding the nature and level of care to be provided to a beneficiary, including the decision of who will render the service, must be made by qualified medical providers, and unhindered by fiscal or administrative concerns. Health Net monitors compliance with this requirement as part of its quality-improvement process.

Claims Procedures

Provider Claims Process

Health Net's process for receiving and paying providers is designed to ensure the medical claims received by VA are complete and accurate. A clean claim is a claim that complies with billing guidelines and requirements, has no defects or improprieties, includes substantiating medical documentation as defined by the provider notification packet, and does not require special processing that would prevent timely payment. Clean claims will be processed within 30 days. Clean claims aged more than 30 days will be paid interest in addition to the payable amount.

Before preparing a claim, remember participating providers must not bill Veterans, VA or Health Net for:

- no-show, missed or canceled appointments
- rendered care not included on the authorization form

Note: Authorizations alone do not guarantee payment. The provision of health care services is to be limited to that set forth in the authorization form. All claims must correlate authorizations and returned medical documentation (faxed separate from claims). Only the authorized practitioner may render and bill for services.

Participating providers are encouraged to submit health care claims via HIPAA-compliant electronic data interchange transactions set through Health Net's designated clearinghouse, Emdeon.

To register, visit <http://www.emdeon.com/physicians>.

If already registered, providers may submit claims using the following information.

Payer Name: Health Net – VA Patient-Centered Community Care Program

Payer ID: 68021

Paper claim submissions must be mailed to:

Veterans Choice Program - VACAA

PO Box 2748

Virginia Beach, VA 23450

Other Health Insurance (OHI)

Non-service-connected claims must be filed with the other health insurance (OHI) carrier before submitting claims to Health Net with the Explanation of Benefits (EOB) from the primary payer for payment determination. It is appropriate to collect a copayment from the Veteran for the OHI, if applicable. VCP does not coordinate benefits with other government programs such as Medicare, Medicaid, and TRICARE.

Service-connected claims must be sent to Health Net and should not be submitted to the OHI.

Office Procedures

Return of Medical Documentation

Medical documentation recording an authorized episode of outpatient care must be submitted to Health Net within 25 calendar days after completion of the initial appointment. If additional appointments are conducted, medical documentation must be submitted to Health Net within 25 calendar days upon completion of the episode of care.

Return medical documents via fax to 1-855-300-1705. Remember:

- Use the cover sheet provided. It includes a bar code which is specific to a single episode of care.
- Do not combine documentation for multiple authorizations when using the provided cover sheet.
- Do not submit claims with medical documentation.

Content of Medical Documentation to be Transmitted to Health Net

At the completion of the authorized episode of care, participating providers must submit medical documentation to Health Net that includes:

- Veteran identification; to include name, sex, last four digits of Social Security number, and date of birth
- initial assessment and reassessments appropriate for clinical condition, including, but not limited to:
 - relevant medical history and physical examination, including inventory of body systems
 - vital signs
 - pain assessment (using 0–10 scale)
- initial and final diagnoses/diagnostic impressions
- therapeutic goals
- care plans and rationale, including rationale for diagnostic and therapeutic procedures
- diagnostic and therapeutic procedures, treatments, and tests and their results
- specific care/services provided, including medication use and medication allergies or sensitivities
- Veteran's response to care/services
- safety measures required to protect the Veteran from injury
- Veteran's functional limitations and activity restrictions related to the care or services provided
- list of all medications and recommended/ordered durable medical equipment /prosthetics
- instructions given to Veteran
- recommended follow up

Note: Medical documentation must contain the Veteran's name, date of birth and last four digits of the Veteran's Social Security number on each page of the documentation and be returned to Health via fax at 1-855-300-1705.

Additional Requirements for Medical Documentation

Critical Findings

Critical findings on outpatient imaging or laboratory testing, or during evaluation and treatment, must be transmitted to VA and Health Net by telephone within 24 hours upon completion of the test/evaluation/treatment. Contact with VA and Health Net (for example, name of person contacted, date and time of contact) must be documented in the impression section of the diagnostic imaging report, or elsewhere in the medical documentation for non-imaging-related critical findings. Any initial findings must be followed up by submission of complete medical documentation within 25 days. To report a critical finding, call 1-866-606-8198. Newly identified suicide risk in a Veteran not referred for inpatient behavioral health treatment is considered a critical finding. A new diagnosis of cancer must be reported to VA and Health Net within 48 hours of diagnosis. Immediate notification (within 24 hours) to the authorizing VA health care facility and Health Net is necessary if the provider determines the Veteran requires:

- Urgent follow up after completion of authorized episode of care.
- Urgent additional care during the authorized episode of care.

Note: Refer to the provider notification packet for contact information to the authorizing VA health care facility.

Pathology

Participating providers are not normally required to return pathology slides to the authorizing VA health care facility. However, providers must ensure pathology slides for biopsies performed under VCP are made available to VA within five business days of Health Net's receipt of a VA request for the slides.

Radiology

Films and reports must each be identified by Veteran name, date of birth, last four digits of the Social Security number, and date of procedure. The name of the procedure, description and interpretation results of the exam must also be listed on each report. Interpreted radiology results must be communicated as oral reports submitted to VA and Health Net within 48 hours of the examination, and the written report returned within 14 calendar days. Participating providers are required to make films available upon request from the authorizing VA health care facility within five business days of Health Net's receipt of a VA request.

Surgery

Upon the Veteran's discharge after an authorized surgical procedure, participating providers are required to complete and return to Health Net the VA Purchased Surgical Care Patient Outcome Form, along with the other required clinical feedback.

Oncology

Medical documentation submitted to Health Net for Veterans referred for medical/radiation oncology services must include information stated in the Oncology medical documentation requirements form.

All newly diagnosed cancer/carcinomas identified during test or treatment must be reported as critical findings to VA and Health Net within 48 hours.

Gastroenterology

Medical documentation submitted to Health Net for Veterans referred for gastroenterology procedures (for example, colonoscopy, sigmoidoscopy, esophagogastroduodenoscopy, endoscopic retrograde cholangiopancreatography, and endoscopic ultrasonography) must include information stated in the Gastroenterology medical documentation requirements form.

Skilled Home Health

The initial plan of care must be submitted to VA and Health Net within three business days of authorization. Discharge summary must be submitted within five days of completion of authorized episode of care.

Inpatient Rehabilitation

Functional status and functional status change from onset of treatment through discharge documented using CMS Inpatient Rehabilitation Facility Patient Assessment Instrument (IRF-PAI) must be documented and reported to VA and Health Net. The IRF-PAI example can be found at: <https://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/Downloads/CMS10036.pdf>.

Blind/Low Vision Rehabilitation

The VA Low Vision Visual Functioning Survey (VA LV VFQ 20) is to be administered at baseline, and again within two to four weeks post-discharge or end of treatment. Since many respondents would be visually impaired or blind, a mail-out version of this survey should be used only when it is certain the respondent has appropriate assistance, as described in the instructions contained within the instructions for the VA LV VFQ 20.

Behavioral Health

The following information should be provided in the medical documentation and does not require Veteran authorization for disclosure:

- medication prescription and monitoring (as appropriate)
- counseling session start and stop times
- modalities and frequencies of treatment
- results of clinical tests and any summary of diagnosis
- functional status
- treatment plans
- symptoms
- prognosis or progress

Inpatient Behavioral Health

If suicide risk is a clinical issue, the Veteran is to be provided a written copy of the Veteran's personal Suicide Prevention Safety Plan, located at www.mentalhealth.va.gov/docs/VA_Safety_planning_manual.pdf. The plan must include the Veterans Crisis Line telephone number, 1-800-273-8255.

Complaint and Grievance Process

Complaints about any aspect of VCP care can be submitted to Health Net by contacting the Veterans Choice Call Center. Health Net may temporarily refrain from referring Veterans to a participating provider involved in a complaint until the concern has been resolved. Participating providers may also contact the Veterans Choice Call Center to report a grievance about another provider or a general concern about the program.

The Veterans Choice Call Center provides customer service with knowledgeable, courteous and responsive staff, between the hours of 8:00 a.m.–10:00 p.m. Eastern time, Monday–Friday (excluding certain holidays). Telephone support is available through the toll-free number, 1-866-606-8198. Grievances may also be faxed to 1-888-244-4025.

Participating providers agree to participate and comply with Health Net policies, including, but not limited to Health Net’s credentialing and re-credentialing, quality improvement, peer review, medical and other record reviews, prior authorization, and other policies related to the rendition by participating providers of covered services to Veterans.

Veteran Safety Measures

Participating providers are required to report to Health Net via secure means within 24 hours of discovery of Veteran safety events that are sentinel events, adverse events (including adverse drug events) or intentionally unsafe acts. Adverse events involving administration of drugs are required to be reported to Health Net using FDA Form 3500, and a copy of the completed form submitted to FDA online must also be submitted to Health Net. The FDA reporting form can be found at www.fda.gov/Safety/MedWatch/HowToReport/default.htm.

All reported Veteran safety events will be investigated, confirmed and resolved by Health Net. VA and Health Net may perform random onsite visits to provider locations to inspect physical operations and/or review records of VA enrolled Veterans, speak with Veterans, and review the quality and completeness of accreditation, certification and credentialing, as well as privileging and licensing documentation.

Clinical Quality

Participating providers are required to provide Health Net with all Centers for Medicare and Medicaid Services (CMS)-reported data no later than the time of publication of the data on the CMS website. In addition, The Joint Commission’s (JC) ORYX measures results will be provided to Health Net not later than the date of publication by the JC. The CMS and ORYX metrics must be reported to Health Net regardless of whether the data is published on existing JC or CMS websites.

Furthermore, participating providers are required to report on those measures of focus in the CMS Partnership for Veterans Campaign that are not already covered in the CMS or ORYX measures listed on page 22 of the Patient-Centered Community Care (PCCC) Benefit Program Requirements.

In addition, participating providers are required to furnish the following Executive Summary PDFs from each of the clinical registry programs (STS and NCDR) at least annually for those facilities performing cardiac surgery, cardiac catheterizations/percutaneous coronary interventions (PCI), and/or implantation of cardioverter defibrillators:

- STS National Adult Cardiac Surgery Database annual report – data for previous year at start of health care delivery, then annually
- NCDR annual database reports for CathPCI (for cardiac catheterization and PCI) and ICD Data Registry (for implanted cardioverter defibrillators) – data for previous year at start of health care delivery, then annually.



Veterans Choice Program

PROVIDER PARTICIPATION REQUIREMENTS

