The U.S. Department of Veterans Affairs (VA) Veterans Choice Program (VCP) and Patient-Centered Community Care (PCCC) program provide eligible veterans access to care through a comprehensive network of community-based providers. These programs augment VA’s ability to provide specialty inpatient and outpatient health care services to veterans.

Health Net Federal Services, LLC (HNFS) was awarded its PCCC contract in 2013. In 2014, HNFS expanded its services with VA in support of the Veterans Access, Choice and Accountability Act, which funded VCP, a subset of PCCC.

This handbook is effective July 1, 2018, through Sept. 30, 2018.

**Proud to Support VA in Regions 1, 2 and 4**

HNFS is proud to support VA in Regions 1, 2 and 4, which encompass all or portions of the following 37 states, and the District of Columbia, Puerto Rico and the U.S. Virgin Islands:

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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 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 (HNFS) coordinates with eligible veterans to obtain authorization for all care under Veterans Choice Program (VCP). To be eligible for VCP, a veteran must be enrolled in VA health care and meet at least one (1) of the following criteria:

- The veteran is told by his/her local VA medical facility he/she will not be able to schedule an appointment for care either:
  - Within 30 days of the date the veteran's physician determines he/she needs to be seen, or
  - Within 30 days of the date he/she wishes to be seen.

- The veteran lives more than 40 miles driving distance from a VA medical facility with a full-time primary care physician.

- The veteran needs to travel by air, boat or ferry to the VA medical facility closest to his/her home.

- The veteran faces an unusual or excessive burden in traveling to a VA medical facility based on geographic challenges, environmental factors or a medical condition. Staff at the veteran's local VA medical facility will work with him/her to determine if he/she is eligible for any of these reasons.

- The veteran's specific health care needs, including the nature and frequency of the care needed, warrants participation in the program. Staff at the veteran’s local VA medical facility will work with him/her to determine if he/she is eligible for any of these reasons.

- The veteran lives in a state or territory without a full-service VA medical facility (currently Alaska, Hawaii, and New Hampshire).

  \textbf{o Note:} Veterans are not eligible under this criterion if they live in New Hampshire and live within 20 miles of the White River Junction VAMC or in United States territories (excluding Puerto Rico which has a full-service VA medical facility).

The authorization received from HNFS is the provider's confirmation of eligibility and approval to render the services to the veteran. No additional eligibility verification is required.

The Purpose of this Document

The \textit{Veterans Choice Program Participating Provider Handbook} defines 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 HNFS authorization of services.

Responsibility for Provision of Services

Providers and HNFS 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 Federal Services 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. Providers must agree to the Participation Agreement for Services under the Veterans Access, Choice and Accountability Act of 2014, available at www.hnfs.com/go/VA > Register as a Veterans Choice Provider prior to rendering authorized services. Please review this document in its entirety for complete program details and requirements.
• Provider must have an active, unrestricted license in the state in which the authorized service is performed.
• Provider must have a current National Provider Identifier.
• As applicable, any prescribing provider must have a Drug Enforcement Agency number.
• Except for those provider categories otherwise authorized to participate in VCP, 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).
• 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.
• If provider is an employee of VA, provider cannot act within the scope of such employment while providing hospital care or medical services through VCP.
• Providers must make routine appointments available for veterans within 30 days of a request by HNFS.
• Office wait times for appointments should not exceed 20 minutes beyond their scheduled appointment time.
• HNFS will issue authorizations to the provider for VCP services.
• HNFS will issue a provider notification packet to the scheduled provider with each authorization after scheduling the appointment with the provider. The notification packet outlines the specific clinical and other requirements for the authorized care. Note: When VA refers the veteran for care, such as for waitlist-eligible veterans, a reference copy of VA’s referral documents will be faxed under separate cover.
• The provider must render only the hospital care or medical services authorized by HNFS.
• Most services will be covered under the initial authorization, even if the veteran must be seen by a different provider. Please see “Requests for Additional Services” and www.hnfs.com/go/VA > Authorizations for guidelines as to when to request approval for additional services
• An episode of care may be valid for up to one (1) year from the date of the first appointment. Providers should continue to refer to the approved authorization dates in the provider notification packet for specific details. (Note: The authorization period starts from the date of the first appointment, not the date the authorization is sent/received.)
• Providers will be paid for all authorized services according to the Participation Agreement for Services.
• Reconsideration requests regarding payment of care rendered to a veteran or denial of care rendered to a veteran must be submitted to HNFS. Anyone who disagrees with a denial may submit a reconsideration request in writing to HNFS 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.
• 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 the Veterans Choice Call Center at 1-866-606-8198.
• Providers must submit claims directly to HNFS electronically by using electronic data interchange (EDI) or manually by mailing in a paper claim.
• Claims must be submitted within 120 days of the date of service or upon the conclusion of a series of authorized visits. All claims with dates of service Sept. 30, 2018 and earlier to be submitted to HNFS no later than March 26, 2019.
• A copy of the HNFS authorization must be provided to the veteran for all pharmacy prescriptions written by the provider for filling in a VA pharmacy.
Provider Tools

Please review this section for information on the following:

• www.hnfs.com
• Provider Education
• Requirements for Maintaining Accurate Information

www.hnfs.com

The Health Net Federal Services, LLC (HNFS) website provides information about Veterans Choice Program (VCP) benefits, processes, requirements, and operations, as well as access to business tools and forms. Visit www.hnfs.com/go/VA for more program details and important updates.

Provider Education

There are various online provider education opportunities available to providers, including webinars, videos and continuing medical education courses:

• HNFS offers a PCCC/VCP Provider Orientation webinar a minimum of twice per month. Visit www.hnfs.com/VA > Online Education.
• Providers interested in no-cost continuing medical education are invited to visit www.vha.train.org. Offered courses are relevant to health care, public health, safety and emergency preparedness, and include topics such as post-traumatic stress disorder and opioid overdose education.

Requirements for Maintaining Accurate Information

It is important VCP participating providers keep their demographic information up to date to ensure HNFS provides accurate information to veterans and to ensure accurate claims adjudication. Demographic information includes:

• practice address
• telephone number
• fax number
• Tax Identification Number
• billing address
• location addition
• location deletion
• practitioner deletion

Providers participating in VCP only should update demographic information by sending an email to HNFSProviderRelations@Healthnet.com, identifying what needs to be updated (for example, updating the phone number, adding a location, deleting a practitioner, or changing the provider name or specialty). Please put “Demographic Update” in the subject line of the email, and include the following information and the effective date of the change:

• practice address
• telephone number
• fax number (for authorizations and reminders)
• Tax Identification Number
• billing address

Note: Network providers under VA’s Patient-Centered Community Care (PCCC) should use the HNFS Provider Demographic Update Form to submit any changes electronically.
Important Provider Information

Please review this section for information on the following:

- General Administrative Requirements
- Privacy or Security Incidents
- Eligibility
- Office and Appointment Access Standards
- Choice Card
- Copayments
- No-Show, Rescheduled and Canceled Appointments

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 Veterans Choice Program (VCP) participation. See www.oig.hhs.gov/exclusions/index.asp for further detail.

Participating providers are required to report to Health Net Federal Services, LLC (HNFS) within 10 days, in writing, the loss of or other adverse impact to a provider’s certification, credentialing, privileging, or licensing.

Privacy or Security Incidents

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

Eligibility

Eligibility for VCP is determined by VA and dependent upon certain criteria such as distance from the closest VA medical facility, wait times of more than 30 days or availability for needed health care services at your local VA medical facility.

Veterans should visit VA’s Health Benefits application at www.va.gov/healthbenefits/apps/choice to check eligibility.

Office and Appointment Access Standards

Providers must comply with the following office and appointment access standards:

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

Choice Card

For this program, VA will issue identification (ID) cards, referred to as Choice Cards, to veterans. Appointments must be coordinated with HNFS and an authorization for care must be given before rendering services.

Copayments

Veterans will receive an invoice from VA for any copayments associated with care. Providers should not collect a copayment from the veteran at the time of service.

No-Show, Rescheduled and Canceled Appointments

Providers must report all no-show, rescheduled or canceled appointments to HNFS at 1-866-606-8198 or by fax at 1-855-300-1705. Providers must not bill the veteran, VA or HNFS for no-show, rescheduled or canceled appointments. Note: Effective July 3, 2018, for distance-eligible veterans, contact the veterans local or assigned VA Medical Center.
Covered Services

Please review this section for information on the following:

- Guidelines for Specific Services
- Pharmacy
- Exclusions

Covered services under Veterans Choice Program (VCP) are limited to the health care services set forth on the authorization received from Health Net Federal Services, LLC (HNFS). Unless otherwise indicated, initial authorizations cover services related to evaluation and treatment for the episode of care, including routine care, clinical procedures and other necessary diagnostic services (for example, anesthesiology, radiology and pathology/laboratory services). Visit www.va.gov/HEALTHBENEFITS/access/medical_benefits_package.asp for benefit details.

Guidelines for Specific Services

Ambulance

Ground and air ambulance transports are a covered benefit when authorized under VCP and when an eligible veteran:

- arrives at a contracted emergency facility seeking emergency care,
- is being seen for authorized care and during treatment the provider/facility must seek emergency treatment, or
- is receiving authorized services and the treating provider/facility determines the veteran needs a higher level of care than what the current facility is capable of providing. Transportation to a facility that is the same level of care (for example, inpatient facility to a rehabilitation facility) is only a covered benefit if the subsequent care is authorized under VCP.

Providers must notify HNFS immediately following a transport for authorization.

The following ambulance services are not covered:

- when the patient's condition would have permitted use of regular private transportation,
- when the transfer/transport is to have the patient closer to home, family, friends or personal physicians, or
- for medicabs or ambicabs which primarily transport patients to and from their medical appointments.

Note: Travel reimbursement is separate from ambulance coverage. Veterans interested in seeking travel reimbursement should contact their local VA medical facility.

Dental Care

Dental care is not a covered benefit under VCP; however, there may be some dental services related to medical conditions that may be authorized.

Durable Medical Equipment

Routine: Coordinate routine durable medical equipment, prosthetics and orthotics (DMEPOS) requests through the referring VA facility.

Urgent Emergent: VA allows for treating physicians and facilities, and independent suppliers to provide veterans with urgently or emergently needed DMEPOS as part of an authorized episode of care, when provided to the veteran prior to him or her leaving the treating provider’s location. These items may include, but are not limited to, splints, crutches, canes, slings, and soft collars. Note: Failure to plan or coordinate in advance of a scheduled procedure shall not constitute as an urgent or emergent need.

Emergency Care

Under VCP, emergency care is only covered when connected to an authorized episode of care (and within the authorization validity dates). Emergency care not connected with an episode of care must be authorized by VA in advance of the care taking place.

Eye Examinations, Eye Glasses and Contact Lenses

An evaluation for prescription eye glasses or contact lenses is a covered benefit when authorized under VCP; however eye glasses or contact lenses are not a covered benefit.

Hearing Aids

An evaluation for hearing aids, to include a hearing test, fitting and ear mold impressions is a covered benefit when authorized under VCP; however, the hearing aid device itself is not a covered benefit.

Newborn Care

Newborn care is a covered benefit for seven days after birth, when the mother was receiving authorized maternity care under VCP.
**Opiate Replacement Therapy**

Opiate replacement therapy may be authorized under VCP. This includes the drug treatment provided as part of the outpatient treatment program when appropriately administered by an authorized provider for an approved condition. Note: The medication included in this treatment is authorized under VCP and not the VA pharmacy program.

**Pharmacy**

VA is primarily responsible for supplying the veteran with all prescribed non-urgent/non-emergent medications, medical/surgical supplies and nutritional products. Participating providers must prescribe in accordance with the **VA National Formulary (VANF)**, which includes provisions for requesting non-formulary drugs.

**Routine Prescriptions**

Routine prescriptions may be needed to treat a variety of medical conditions. VA requires veterans fill all routine (non-urgent/non-emergent) prescriptions at VA pharmacies. Veterans who fill routine prescriptions elsewhere may not be reimbursed. To help veterans obtain routine prescriptions, providers should follow the steps identified below:

1. Consult the **VANF** to see which medications are available for prescribing.
2. Providers are encouraged to prescribe VANF drugs whenever clinically possible to avoid prescription fulfillment delays and inconvenience to veterans. Providers will be contacted by a VA pharmacist if the prescriptions they issue do not follow the VANF. In these situations, the provider can re-write the prescription for a VA National Formulary drug or they can complete a request for a medically necessary non-formulary drug.

**Note:** It may take up to four (4) days after receiving a completed non-formulary request to render an approval/disapproval decision.

1. The provider should fax or mail the veteran’s prescription to the host VAMC. Contact information is available on our website.

**Note:** See “Controlled Substances” for exception. Alternately, the provider can issue a written prescription to the veteran who can mail or physically present it to their VAMC pharmacy for processing. The provider must also give the veteran a copy of the HNFS authorization letter/fax, which must accompany all prescriptions presented for filling in a VA pharmacy.

**Note regarding the New York state law requiring prescriptions for controlled and non-controlled medications be processed in electronic format for in-state pharmacies:** Pharmacy guidelines under PCCC and VCP have not changed when submitting prescriptions to be processed at a VA pharmacy located within a federal facility. We ask you to adhere to the guidelines outlined in this Handbook when prescribing medications for your PCCC and VCP patients, as VA pharmacies are currently not set up to accept electronic prescriptions.

**Urgent Prescriptions**

Urgent prescriptions could be required for a variety of medical conditions such as acute pain management and infections. An urgently needed prescription is one which in the provider’s clinical opinion cannot wait to be filled by a VA pharmacy and mailed to the veteran. (It takes approximately four [4] days for a prescription to reach a veteran by mail after it is transmitted to a VA pharmacy by the provider.)

To help veterans obtain urgently needed prescriptions, providers should follow these steps:

1. Consult the **VANF** to see which medications are available for prescribing.

**Note:** There are two (2) file options: sorted alphabetically by generic drug name and sorted by VA drug class.

2. Issue a prescription for up to a 14-day supply of VANF medication and instruct the veteran that he/she may take the prescription to any non-VA pharmacy of their choice to be filled at their own expense, after which they may seek reimbursement from the purchased care office at their host VAMC.

If a veteran chooses to take an urgently needed prescription to a VA pharmacy to avoid out-of-pocket expenses, it will be filled if it follows the VANF. In these cases, the provider is required to provide a patient with a copy of the HNFS authorization, which is required for prescriptions to be filled in a VA pharmacy.

**Prescription Requirements**

VA requires providers include the following information on all routine and urgent prescriptions (consider faxing prescriptions to VA directly to better protect your personal information):
• provider’s name and address,
• provider’s personal DEA number,
• provider’s telephone and fax numbers,
• provider’s National Provider Identifier,
• provider’s Social Security number, and
• provider’s date of birth and gender. VA cannot fill incomplete prescriptions.

 Controlled Substances

Remember the following protocol when prescribing scheduled medications.

• Prescriptions for Schedule II medications must be mailed or presented in person in their original form. Faxed Schedule II prescriptions are not accepted.

• Prescriptions for Schedule III-IV medications may be faxed by the provider and must have a pen and ink provider’s signature. Electronic signatures are not accepted.

Medications Administered in an Office Setting

Medications administered in an office setting as part of an authorized office visit are covered under the VCP authorization and not the VA pharmacy program (for example, an allergy injection administered during an office visit).

Exclusions

The following services are not covered under VCP:

• abortions and abortion counseling
• chronic dialysis treatments
• compensation and pension examinations
• cosmetic surgery, except where determined by VA to be medically necessary
• dental care
• medication, and biological and medical devices not approved by the Food and Drug Administration, unless part of formal clinical trial under an approved research program or when prescribed under a compassionate use exemption.
• gender alteration
• health club or spa membership
• in-vitro fertilization (this is separate from intrauterine insemination)
• homemaker or home health aides (these are not considered skilled nursing care or skilled home care)
• hospice
• inpatient hospital or outpatient care for a veteran who is either a patient or inmate in an institution of another government agency, if that agency has a legal obligation to provide the care or services.
• long-term acute care
• nursing home care
Authorization Process

Please review this section for information on the following:

- Appointment Scheduling
- Provider Notification Packets
- Initial Authorization for an Episode of Care
- Primary Care
- Requesting Authorization for Additional Services
- Inpatient Prior Authorization and Continued Stay Review
- Additional Requirements for Specific Services

The U.S. Department of Veterans Affairs (VA) assumed care coordination for mileage-eligible veterans, also referred to as distance-eligible veterans, effective July 3, 2018. Providers and veterans can visit VA’s website, www.vets.gov/facilities, to locate the appropriate phone number to the veteran’s local or assigned VA Medical Center (VAMC). Distance-eligible authorizations approved prior to July 3, 2018 remain valid.

Information in this section applies to non distance-eligible veterans as of July 3, 2018.

Health Net Federal Services, LLC (HNFS) authorizes care for veterans who meet VA’s Veterans Choice Program (VCP) eligibility criteria. Choice Cards alone do not represent eligibility. All veterans must have an authorization form and an initial appointment scheduled by HNFS before seeking care from a provider or facility. Prior authorization requirements are subject to change as a result of VCP modifications and/or during annual prior authorization requirement reviews. HNFS cannot authorize services past its contract end date with VA.

Appointment Scheduling

Note: HNFS’ scheduling team will not schedule any appointments for veterans that occur on or after Oct. 1, 2018.

HNFS is responsible for coordinating the initial appointment with a provider’s office or facility (see “Scheduling Initiatives” section for exception). Providers are strongly encouraged to contact veterans with a courtesy appointment reminder. Providers must comply with the following access standards for care:

- Routine veteran appointments must be completed within 30 calendar days of scheduling.
- Urgent care appointments must be completed within 48 hours of scheduling.
- Office wait time for appointments should not exceed 20 minutes.

Report all no-show, rescheduled or canceled appointments by calling 1-866-606-8198 or faxing notification to 1-855-300-1705.

Note: Providers must not bill veterans, or request reimbursement from VA or HNFS for no-show, rescheduled or canceled appointments.

Bundled Services

VA implemented standardized episodes of care, also referred to as bundled services, on certain authorizations issued on or before June 24, 2018. Certain courses of treatment can be reasonably predicted. For example, a veteran who requires joint replacement can be expected to receive physical therapy as part of his or her treatment. With bundled services, also referred to as standardized episodes of care, predictive treatment (outlined in the authorization) will be covered without the need for additional approval. Bundled services often have fewer restrictions on visit limits or other care parameters. Look for the phrase “bundled service” in the clinical notes on page two of the provider notification packet. Find a complete list of services covered under each bundle at www.hnfs.com/go/VA > Authorizations > Bundled Services.

Provider Notification Packets

HNFS will issue a provider notification packet to the initial servicing facility or provider after scheduling the appointment with the provider. Provider notification packets provide case-specific clinical requirements, VA standards and guidelines of the authorized care. Packets may include, but are not limited to:

- the 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,
• instructions for communicating 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 required medical documentation,
• instructions for ongoing treatment and/or extended service requests,
• instructions for reporting critical findings,
• instructions for notifying the veteran of test results,
• instructions on filing claims.

When VA refers the veteran for care, such as for waitlist-eligible veterans, a reference copy of VA’s referral documents will be faxed under separate cover.

**Note:** Authorizations alone do not guarantee payment.

### Initial Authorization for an Episode of Care

All initial care under VCP requires prior authorization and scheduling. In general, VCP authorizations cover services related to evaluation and treatment for the episode of care, including routine clinical procedures and other necessary diagnostic services (for example, anesthesiology, radiology and pathology/laboratory services).

Providers may request approval for services not covered by the initial authorization (the provider notification packet will indicate excluded services). See the “Requesting Authorization for Additional Services” section for details.

**Note:** HNFS’ VCP contract with VA ends Sept. 30, 2018. As a result, HNFS can only authorize care through Sept. 30, 2018.

### Primary Care

Primary care includes initial visits and follow-up visits, including, but not limited to, routine diagnostic tests, routine radiology services and preventive care services.

**Note:** Due to its contract end date, HNFS can only authorize care through Sept. 30, 2018.

### Specialty Care Consultations

Specialty care consultations (for non-primary care services) 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.

**Note:** The authorization period starts from the date of the first appointment, not the date the authorization is sent/received.

**Note:** Due to its contract end date, HNFS can only authorize care through Sept. 30, 2018.

### Requesting Authorization for Additional Services

Under VCP, additional prior authorization from VA is required when the veteran:

- requires care beyond the approved dates;
- requires care beyond the number of visits/units authorized;
- needs care for another medical condition or body part (including other joints); and/or
- requires an inpatient admission, when specifically excluded on an existing authorization. (**Note:** If inpatient services are not specifically excluded, providers should only submit an Inpatient Notification Form to HNFS.)

Providers also must request additional authorization for the following:

- services specifically excluded from the authorization,
- urgent consultations required as a result of a newly identified critical finding (such as cancer).

### How to Request Additional Services

Effective July 3, 2018, HNFS will no longer accept requests for additional services for VCP and PCCC authorizations. Providers must submit these requests to the veteran’s local or assigned VAMC. Visit [www.vets.gov/facilities](http://www.vets.gov/facilities) to locate the appropriate VAMC’s phone number. If asked to submit the request in writing, providers can submit their requests to the VAMC via Virtru Pro secure mail or fax. Written requests should include supporting medical documentation to support the request, specify which additional services are being requested and be signed by the requesting provider.
Inpatient Notification and Continued Stay Review

HNFS requires notification of all inpatient facility admissions. While not an authorization request, HNFS requires this step to coordinate discharge planning, obtain medical documentation in a timely manner and discuss other requirements to ensure proper veteran care. HNFS will conduct continued stay reviews and will require clinical information supporting the continued stay at intervals that are based on the veteran's condition.

To notify HNFS of an admission, fax an Inpatient Notification Form to HNFS at 1-855-300-1705 within the following time frames:

- For scheduled admissions, notification is requested at the time of scheduling.
- For emergency admissions, notification is requested within 24 hours or the next business day.

Exception: If VA has specifically excluded inpatient services on a VCP authorization, the provider must submit a secondary authorization request. See the “Requesting Authorization for Additional Services” section for more information.

Note: Notify VA (not HNFS) of inpatient admissions with an admit date on or after Oct. 1, 2018.

Additional Requirements for Specific Services

Audiology

Initial testing results relating to potential hearing aid needs must be submitted directly to VA within two (2) 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 within 14 business days.

Under VCP, audiology assistants are not eligible to treat or screen veterans. Provider offices must decline the authorizations if they do not have licensed audiologists available to render the required services. Veterans must be held harmless from financial liability, should a claim be denied for this reason.
Claims Procedures

Please review this section for information on the following:

- Provider Claims Process
- Other Health Insurance (OHI)
- Claims Submission Tips
- Claims Questions and Status Updates
- Electronic Funds Transfer/Electronic Remittance Advice
- Corrected Claims
- Appeals

Provider Claims Process

Health Net Federal Services, LLC’s (HNFS’) process for receiving and paying providers is designed to ensure the medical claims received by the U.S. Department of Veterans Affairs (VA) are complete and accurate. A clean claim is a claim that complies with billing guidelines and requirements, has no defects or improprieties, and does not require special processing that would prevent timely payment. Clean claims will be processed within 30 days.

Timely Filing

Claims must be submitted directly to HNFS within 120 days of the date of service or upon the conclusion of a series of authorized visits. All claims with dates of service Sept. 30, 2018 and earlier to be submitted to HNFS no later than March 26, 2019.

Note: HNFS cannot accept claims with dates of service on or after Oct. 1, 2018. All claims for dates of service on or after Oct. 1, 2018, must be sent to VA for processing, even if the services were initially authorized by HNFS. HNFS will not forward claims received with dates of service Oct. 1, 2018, and later to VA. Exception: HNFS can accept and process claims for authorized inpatient stays with an admission date prior to Oct. 1, 2018, that extend beyond Sept. 30 2018.

How to Submit

Electronic data interchange claim submissions through Change Healthcare are accepted and encouraged.

To register, visit http://www.changehealthcare.com/legacy/resources/enrollment-services/medical-hospital-enrollment.

Change Healthcare Payer Name/Payer ID:

- Payer Name: Health Net – VA Patient-Centered Community Care Program
- Payer ID: 68021

Paper claim submissions may be mailed to:

Veterans Choice Program – VACAA
PO Box 2748
Virginia Beach, VA 23450

Before preparing a claim, note the following:

- Providers must not bill veterans or VA for services rendered.
- Providers must not bill veterans, VA or HNFS for no-show, rescheduled or canceled appointments, or for rendered care excluded from the authorization.
- Authorizations alone do not guarantee payment.
- Health care services are limited to that set forth in the authorization.
- Only the authorized practitioner may render and bill for services.
- HNFS cannot accept claims received via fax or certified mail.

Claims Submission Tips

HNFS offers tips to reduce common claim submittal errors (paper and electronic) and common denial code explanations. Visit www.hnfs.com/go/VA > Claims > Claims Tips.

Claims Questions and Status Updates

Providers can check the status of VCP claims at www.availity.com. Registration is required. Search by the veteran’s information or claim number to obtain the status. Note: Choose “Patient-Centered Community Care” in the payer field when submitting your claim status inquiry.

Claims inquiries (for dates of service prior to Oct. 1, 2018):

- Through Sept. 30, 2018: Contact HNFS at 1-866-606-8198
- After Sept. 30, 2018: HNFS will offer a new provider support line to assist providers with claims inquiries after its contract end date. Visit www.hnfs.com/go/VA for details.
**Other Health Insurance (OHI)**

The following billing guidelines are effective for services rendered on or after April 20, 2017 (regardless if the service was authorized prior to April 20, 2017):

- Veterans Choice Program is primary for authorized care, and will coordinate benefits should a veteran have other health insurance (OHI).
- Providers should not bill OHI carriers or collect OHI copayments from veterans receiving care through VCP. VA will bill veterans directly for any applicable VCP copayments.
- Submit all VCP claims only to HNFS for processing. Do not bill a veteran’s OHI carrier (as primary or secondary) or include that carrier’s Explanation of Benefits with your claim to HNFS.

**Electronic Funds Transfer**

To request, make changes to or cancel payments via electronic funds transfer (EFT), complete an Electronic Funds Transfer Authorization Agreement form, available at [www.hnfs.com/go/forms](http://www.hnfs.com/go/forms). Fax the completed form with a voided check or bank letter to (916) 353-6829.

For new enrollments, please allow four (4) weeks for the registration process to be completed, which includes pre-note verification. If after four (4) weeks you do not start receiving EFT, please email the HNFS Finance Team at HNFS_VA.Provider_EFT_ERA@healthnet.com.

**Electronic Remittance Advice**

HNFS offers a choice of clearinghouses from which to receive electronic remittance advice (ERA)/835s statements for VCP and PCCC claims. We encourage you to research each to determine which one meets the needs of your practice.

You may only be enrolled with one clearinghouse with HNFS from the list below for VCP and PCCC claims. If you switch from one clearinghouse to another, your previous enrollment will be canceled. Please allow 30 days to begin receiving your ERAs from the clearinghouse with which you registered.

View current ERA registration options at [www.hnfs.com/go/VA > Claims](http://www.hnfs.com/go/VA > Claims).

**Note:** Do not fax medical documentation or claims containing patient information to the HNFS Finance Team.

**Corrected Claims**

To resubmit an electronic claim with a correction, make the correction and submit. To resubmit a paper claim with a correction, make the correction on an original claim form and submit to HNFS for processing.

**Appeals**

VA program benefits are determined by VA and cannot be appealed through HNFS.
Medical Documentation

Please review this section for information on the following:

- Medical Documentation Requirement
- Return of Medical Documentation
- Medical Documentation Checklist
- Additional Medical Documentation Requirements
- Critical Findings

Medical Documentation Requirement

Participating providers must submit medical documentation to HNFS that includes:

- veteran identification; to include name, sex, last four (4) digits of Social Security number, and date of birth;
- a summary of the encounter, including any procedures performed and recommendations for further testing or follow up (such as, discharge summary for inpatient);
- results of any ancillary studies/procedures which would impact recommended follow up (for example, positive biopsy results from a gastroenterology provider who recommends surgery); and
- any recommended prescriptions and treatment plans.

Return of Medical Documentation

Timely return of medical documentation is necessary to ensure coordination of care with VA providers.

Providers must fax medical documentation to 1-855-300-1705 within the time frame indicated in the provider packet. This provides HNFS sufficient time to review and deliver medical documentation to VA, per contract requirement.

Note: Medical documentation for veterans attached to the Fargo, North Dakota, Ft. Harrison, Montana, and Madison and Tomah, Wisconsin VA Medical Centers (VAMCs), should be submitted to the respective VAMC for review. (See “Scheduling Initiative” section.) VA may request medical documentation that cannot be scanned or faxed, for example a CD of images. In these cases, the non-scannable medical documentation must be mailed to the VAMC requesting information.

Health Net Federal Services includes a bar-coded fax cover sheet with each provider notification packet issued to the initial servicing provider, to use when returning medical documentation to HNFS. Use of this veteran-specific cover sheet can help expedite medical documentation processing. For providers who do not have access to the bar-coded fax cover sheet, HNFS offers a downloadable, generic, medical documentation fax cover sheet at www.hnfs.com/go/forms.

Providers must submit medical documentation within the following time frames to avoid recoupment efforts:

- **Inpatient care**: Submit medical documentation within 25 days of discharge (include a discharge summary).
- **Outpatient care**: Submit initial medical documentation within 60 days of the completion of the first scheduled appointment. Submit final medical documentation, which summarizes the results of medical care provided, within 60 days after completion of the episode of care.

Note: Due to its contract end date of Sept. 30, 2018, HNFS will forward medical documentation received on or after Dec. 15, 2018, to VA for processing.

Medical Documentation Checklist

Refer to the Required Medical Documentation Content checklist to ensure all elements are complete. The checklist can be found at www.hnfs.com/go/forms.

Additional tips for returning medical documentation:

- Include date, time and person contacted at VA when a critical finding is reported. (See “Critical Findings.”)
- Return medical documentation to HNFS, even if VA has also requested a copy.
- When possible, use the bar-coded fax cover sheet included with each provider notification packet. Use of this veteran-specific cover sheet can help expedite medical documentation processing. For providers who do not have access to the bar-coded fax cover sheet, HNFS offers a downloadable generic fax cover sheet at www.hnfs.com/go/forms.
- Do not combine documentation for multiple authorizations.
- Do not submit claims with medical documentation as HNFS cannot accept faxed claims for processing.
Additional Medical Documentation Requirements

Visit www.hnfs.com/go/forms for the following medical documentation requirements forms:

- Audiology
- Blind/Low Vision Rehabilitation
- Gastroenterology
- Inpatient Admissions
- Mental Health
- Oncology
- Pathology
- Radiology
- Skilled Home Health

Blind/Low Vision Rehabilitation

The VA Low Vision Visual Functioning (VA LV VFQ20) Survey is to be administered at baseline, and again within two (2) to four (4) 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 within the VA Low Vision Visual Functioning Questionnaire.

Gastroenterology

Medical documentation submitted to HNFS for veterans referred for gastroenterology procedures (for example, colonoscopy, sigmoidoscopy, esophagogastrroduodenoscopy, endoscopic retrograde cholangiopancreatography), and endoscopic ultrasonography must include information stated in the Additional Medical Documentation for Gastroenterology Procedures form.

Oncology

Medical documentation submitted to HNFS 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 HNFS within 48 hours.

Pathology

Participating providers are not normally required to return pathology slides to the authorizing VA facility. However, providers must ensure pathology slides for biopsies performed under VCP are made available to VA within five (5) business days of HNFS’ receipt of a VA request for the slides.

Radiology

Films and reports must each be identified by veteran name, date of birth, last four (4) 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 HNFS 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 facility within five (5) business days of HNFS’ receipt of a VA request.

Skilled Home Health

The initial plan of care must be submitted to VA and HNFS within three (3) business days of authorization. Discharge summary must be submitted within five (5) 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 HNFS.

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; and
- 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 [http://www.mentalhealth.va.gov/docs/VA_Safety_planning_manual.pdf](http://www.mentalhealth.va.gov/docs/VA_Safety_planning_manual.pdf).

The plan must include the Veterans Crisis Line telephone number 1-800-273-8255.

**Critical Findings**

VA defines critical findings as a test result value or interpretation that, if left untreated, could be life threatening or place the veteran at serious health risk. Critical values/results are those results from laboratory, cardiology, radiology departments, and other diagnostic areas that, upon analysis, are determined to be critical, regardless of the ordering priority.

Please refer to the chart in this section for critical findings reporting deadlines. Any initial findings must be followed up by submission of complete medical documentation within the time frame indicated in each individual provider packet.

Contact with VA (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. To report a critical finding, call the VA clinical contact indicated on page two of the provider notification packet (issued by HNFS to the initial servicing provider).

<table>
<thead>
<tr>
<th>Critical Finding</th>
<th>Return Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Veteran requires one (1) of the following:</td>
<td>24 hours, or one (1) business day</td>
</tr>
<tr>
<td>• urgent follow-up care after completion of the authorized episode of care</td>
<td></td>
</tr>
<tr>
<td>• urgent additional care during the authorized episode of care</td>
<td></td>
</tr>
<tr>
<td>Critical findings on outpatient imaging or laboratory testing, or during evaluation and treatment</td>
<td>24 hours by phone, upon completion of the test, evaluation or treatment</td>
</tr>
<tr>
<td>Newly-identified suicide risk in a veteran not referred for inpatient mental health treatment</td>
<td></td>
</tr>
<tr>
<td>A new diagnosis of cancer</td>
<td>48 hours</td>
</tr>
</tbody>
</table>
Health Care Management and Administration

Please review this section for information on the following:

• Utilization Management
• Prospective Review
• Initial Inpatient Clinical Review
• Discharge Planning
• Retrospective Review
• Policy on Separation of Medical Decisions and Financial Concerns

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 Federal Services, LLC (HNFS) 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; and
• provider and veteran eligibility.

Initial Inpatient Clinical Review

The HNFS process for initial inpatient clinical review may require hospital providers to submit clinical information to establish the care’s medical necessity. Assigned HNFS 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

Medical necessity and appropriateness of setting and treatment review is performed at the time of the prospective review by the care manager utilizing InterQual® Level of Care Criteria.

An HNFS 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 HNFS.

The initial inpatient 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), as well as VA, to facilitate timely and
appropriate discharge. HNFS will initiate discharge planning for all admissions during the first review of the case. **Note:** Applies to inpatient admissions with a discharge date on or before September 30, 2018.

**Retrospective Review**

VA has designated HNFS 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-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**

HNFS has a strict policy:

- Utilization management decisions are based on medical necessity and medical appropriateness.
- HNFS does not compensate physicians or nurse reviewers for denials.
- HNFS 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 veteran, including the decision of who will render the service, must be made by qualified medical providers, and unhindered by fiscal or administrative concerns. HNFS monitors compliance with this requirement as part of its quality-improvement process.
Scheduling Initiatives

The U.S. Department of Veteran Affairs (VA) has implemented various scheduling initiatives for Veterans Choice Program (VCP) and Patient-Centered Community Care (PCCC). Under these scheduling initiatives, the care coordination and appointment scheduling responsibilities are slightly different.

Visit www.hnfs.com/go/VA > Scheduling Initiatives.

The following benefits are included under these initiatives:

- skilled home health care/home infusion therapy (supports VCP and PCCC) – effective Oct. 31, 2017

The following areas are included under these initiatives:

- Fargo, North Dakota (supports VCP and PCCC) – effective Oct. 3, 2016
- Fort Harrison, Montana (supports VCP) – effective Sept. 13, 2017
- Madison, Wisconsin (supports VCP) – effective Oct. 18, 2017
- Tomah, Wisconsin (supports VCP) – effective Dec. 5, 2017

For all other Health Net Federal Services, LLC (HNFS) managed regions, please refer to our general VCP and PCCC information.

Program Overview

Eligibility/Appointments

- Eligibility for veterans is determined by VA.
- The VA Medical Centers (VAMCs) are responsible for scheduling appointments.

Authorizations

- Once an appointment is scheduled, the VAMC will send HNFS the authorization request and appointment information for processing. The VAMC will also fax the provider necessary clinical information needed for the appointment.
- HNFS will send an authorization letter to the veteran and a VAMC-specific provider packet to the provider.

Medical Documentation

Medical documentation must be submitted to the VAMC. (Refer to the provider notification packet for return time frames.)

Skilled home health care exception: For skilled home health care/home infusion therapy services, providers are to return medical documentation to the VAMC only if that VAMC is participating in a scheduling initiative (for example, Tomah, Wisconsin). Otherwise, return medical documentation to HNFS.

Critical Findings

Submit critical findings to the referring provider.

Claims

Submit claims to HNFS for processing. Note: HNFS can only accept claims for dates of service prior to Oct. 1, 2018.

Requests for Additional Services

If additional services are required, including inpatient care, providers must submit the VAMC Specific Secondary Authorization Request form to the VAMC for review.

Note: This form is specific to each VAMC.
<table>
<thead>
<tr>
<th>VAMC/Benefit</th>
<th>Geographic Area</th>
<th>Scheduling and Clinical Inquiries</th>
<th>Secondary Authorization Request</th>
<th>Medical Documentation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fargo (PCCC/VCP)</td>
<td>Fargo, North Dakota</td>
<td>1-866-517-9363, Monday–Friday, 8:00 a.m.–4:30 p.m. Central time, excluding certain holidays</td>
<td>Fax: (612) 725-1319</td>
<td>Fax: (612) 725-1344</td>
</tr>
<tr>
<td>Ft. Harrison (VCP only)</td>
<td>All 56 counties in Montana. Some restrictions may apply to those veterans residing in Lincoln County which falls under the purview of the Spokane VAMC.</td>
<td>(406) 447-7400 Monday–Friday, 8:00 a.m.–4:00 p.m. Mountain time, excluding certain holidays</td>
<td>Fax: (406) 845-8995</td>
<td>Fax: (406) 845-8999</td>
</tr>
<tr>
<td>Madison (VCP only)</td>
<td>Madison, Wisconsin</td>
<td>(608) 256-1901 Monday–Friday, 8:00 a.m.–4:30 p.m. Central time, excluding certain holidays</td>
<td>Fax: (608) 830-6657</td>
<td>Fax: (608) 830-6657</td>
</tr>
<tr>
<td>Tomah (VCP only)</td>
<td>Tomah, Wisconsin</td>
<td>(608) 374-8182 Monday–Friday: 8:00 a.m.–4:00 p.m. Central time, excluding certain holidays</td>
<td>Fax: (608) 372-1249</td>
<td>Fax: (608) 372-1134</td>
</tr>
<tr>
<td>Skilled Home Health Care/Home Infusion (PCCC/VCP)</td>
<td>N/A</td>
<td>Refer to the provider notification packet for the VAMC-specific information</td>
<td>Refer to the provider notification packet for the VAMC-specific information</td>
<td>For VAMCs not listed here, submit to HNFS at 1-855-300-1705. Otherwise, submit to the appropriate VAMC.</td>
</tr>
<tr>
<td>All Other Inquiries</td>
<td><a href="http://www.hnfs.com/go/VA">www.hnfs.com/go/VA</a> Veterans Choice Program: 1-866-606-8198 Monday–Friday, 8:00 a.m.–8:00 p.m. Eastern time, excluding certain holidays Patient Centered Community Care: 1-800-979-9620 Monday–Friday, 6:00 a.m.–10:00 p.m. Eastern time, excluding certain holidays</td>
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</table>
Complaint and Grievance Process

Please review this section for information on the following:

- Telephone Support
- Veteran Safety Measures
- Clinical Quality
- Questions or Comments

Grievances

The health care quality organization, URAC, defines a complaint as “an expression of dissatisfaction by a consumer expressed verbally or in writing regarding an organization’s products or services that is elevated to a complaint resolution system.” This term is sometimes referred to as a “grievance” and is separate from an appeal process. Complaints about any aspect of Veterans Choice Program (VCP) care can be submitted to Health Net Federal Services, LLC (HNFS) by contacting the Veterans Choice Call Center (see below).

HNFS 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.

Note: Anyone can file a grievance; however, if the grievance is from someone other than the involved veteran, HNFS may not be able to give a full response without authorization to disclose medical information on file.

Participating providers agree to participate and comply with HNFS policies, including, but not limited to HNFS’ 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 HNFS 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 HNFS using FDA Form 3500, and a copy of the completed form submitted to FDA online must also be submitted to HNFS. 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 HNFS. HNFS and VA 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 HNFS 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 HNFS not later than the date of publication by the JC. The CMS and ORYX metrics must be reported to HNFS 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 ORXY measures listed of in the Patient-Centered Community Care (PCCC) Network Provider Handbook.

Telephone Support

The Veterans Choice Call Center provides customer service between the hours of 8:00 a.m.–8:00 p.m. Eastern time, Monday–Friday (excluding certain holidays). Telephone support is available through the toll-free number, 1-866-606-8198.
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.

Questions or Comments
Questions, comments or suggestions regarding this document or its contents should be directed to HNFS at 1-866-606-8198.