veterans

winning the new patient war

aac

Info Network

S A M
C O L L I N S

5.2024

About Us

American Acupuncture Council Network (AACN) is an Acupuncture management consultant firm that has been involved with the Acupuncture industry for over 30 years. Its core focus is to streamline insurance operations for thousands of Acupuncturists nationwide through its information helpline, acupuncture insurance billing education seminar and products.

Through the years, our clients have always depended on AACN to develop a simpler way to cope with the overwhelming changes in the insurance industry. AACN has one goal in mind; to provide its clients with cost-effective, high- quality, time-saving products and services. We set the industry standard because we provide the most professional, accurate and ethical services available. Attend our Acupuncture insurance billing education seminar today.

Our philosophy is to strengthen and grow the Acupuncture profession by providing education, tools, and support that continually improve the productivity, profitability, and well-being of the alternative health community as a whole. AACN is committed to its members to be accurate and ethical in its advice and information.

Pain and Opioid Use: Evidence for Integrating Acupuncture Into Treatment Planning

Acupuncture has been used in the United States for at least 50 years as part of comprehensive treatment approaches to address substance use disorder.[22] It may have a role as an adjuvant in treatment of individuals with OUD as well. Effects of acupuncture treatment on decreasing depression and anxiety related to OUD are being investigated

The authors conclude that integrating acupuncture into comprehensive recovery services favorably impacted treatment retention and completion as well as exerting favorable influences on morbidity and mortality of individuals in recovery from OUD. Similar benefits of acupuncture in treating OUD were reported in another systematic review by Chen et al.[25] This review identified specific symptoms of OUD that were associated with favorable responses following acupuncture treatment. These included decreasing the severity of withdrawal symptoms, reducing opioid cravings, promoting sleep, and mitigating anxiety and depression. It is important to note that the Veterans Administration (VA) medical system and the U.S. military recently included acupuncture in pain management and substance use disorders.

Glob Adv Health Med. 2021; 10: 21649561211042571.

Published online 2021 Aug 24. doi: 10.1177/21649561211042571

PMCID: PMC8392795

PMID: 34458014

About 5,000 Medicare Part D beneficiaries per month suffered an opioid overdose during the first 8 months of 2020.

National Governor's Association, 37 State Attorney Generals, State and National treatment guidelines recommend non-pharmaceutical chiropractic/acupuncture treatment for both acute and chronic pain and dysfunction.

"Average per-episode costs for care that begins with a DC / PT / acupuncturist is **only $619,** compared **with $728 for primary care and $1,728 for specialist care.** If you make the initial investment in chiropractic / PT **acupuncture**, significant total-episode savings occur."

"However, first contact with a DC / PT**/acupuncturist** only occurs in 30 percent of cases, compared to 70 percent for primary (30 percent) or specialist (40 percent) care."

"The actuaries have done the work, it's presented at the actuarial conference, the net of the increased conservative care will take out about 230 million in annual medical expenditures and reduce opiate prescribing for back pain by 25-26 percent."

- **American College of Physicians Back Treatment Guidelines** - The ACP updated prior guidelines, recommending non-drug treatment first for back pain, including chiropractic manipulative therapy (CMT), osteopathic manipulative therapy (OMT), exercise therapy, acupuncture, massage and yoga.

- **FDA Education Blueprint for Health Providers Involved in Pain Management -** The Blueprint recommends "The [health care provider] should be knowledgeable about which therapies can be used to manage pain and how these should be implemented." Chiropractic and acupuncture are specifically noted as non-pharmacologic therapies that can play an important role in managing pain.

Acupuncture is one of the complementary and integrative health (CIH) approaches within the VHA Whole Health System of care included in VA Directive 1137 — Provision of Complementary and Integrative Health (recertified December 2022). This allows acupuncture care to be covered by the Veteran's medical benefits package, when clinically necessary, as determined by the patient's care team.

- Acupuncture is often associated with pain management, but it is also may be useful for other conditions, and the body of literature for acupuncture effectiveness is growing. Acupuncture may be effective as a stand-alone treatment or as an adjunctive treatment to other medical interventions. An evidence map of acupuncture was developed by VA Health Services Research & Development (HSR&D) in 2014. This systematic review identified evidence of potentially positive effect for several pain conditions, including chronic pain and headaches, mental health conditions such as depression, anxiety and PTSD, and wellness indicators such as insomnia.
- Acupuncture is generally considered safe when practiced by appropriately trained acupuncture providers.

Who Is Eligible?

Veterans only with community care benefits

Does not include spouses or children

VA Community Care Acupuncture

Acupuncture services are part of the standard Medical Benefits Package available to all eligible Veterans. Like other specialties, access to VA chiropractic services is by referral from a VA primary care or specialty provider. VA provides these services on-site at one or more VA facilities in each Veterans Integrated Service Network (VISN). VA facilities that do not have on-site acupuncture clinics to provide these services via the VA Community Care Program or other community care mechanisms.

Community Care

- Veterans may be eligible for care through a provider in their local community depending on their health care needs or circumstances, and if they meet specific eligibility criteria. Even if a Veteran is eligible for community care, they generally still have the option to receive care from a VA medical facility.
- In most cases, **Veterans must receive approval from VA** before receiving care from a community provider to avoid being billed for the care. VA staff members generally make all eligibility determinations for community care.
- Care must be preauthorized, and the provider will receive a specific written authorization for care.

Veteran Eligibility

Veteran's eligibility for community care depends on his/her individual health care needs or circumstances. ***Please note the following about eligibility for community care:***

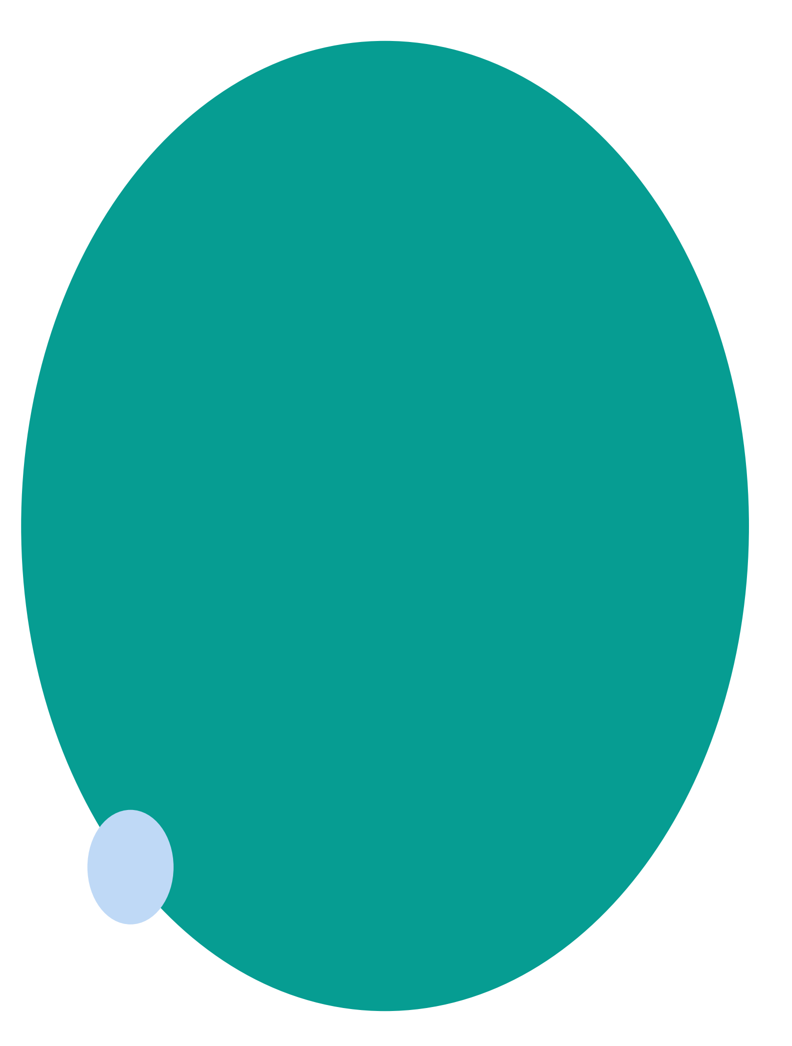
- Veterans must receive approval from VA prior to obtaining care from a community provider, in most circumstances.
- Veterans must either be enrolled in VA health care or be eligible for VA care without needing to enroll to be eligible for community care.
- Eligibility for community care will continue to be dependent upon a Veteran's individual health care needs or circumstances.
- VA staff members generally make all eligibility determinations.

https://www.va.gov/COMMUNITYCARE/

VA Community Care Contact Center: 877-881-7618 Option 1 (8 a.m. – 9 p.m. Eastern Standard Time)

There are six criteria that can qualify a Veteran to receive community care

- The Veteran needs a service not available at a VA Medical Facility
    - In this situation, a Veteran needs a specific type of care or service that VA does not provide in-house at any of its VA medical facilities.
        - For example: The patient needs dialysis, but there is no dialysis at any of our facilities. The Veteran may get dialysis from an in-network community provider.



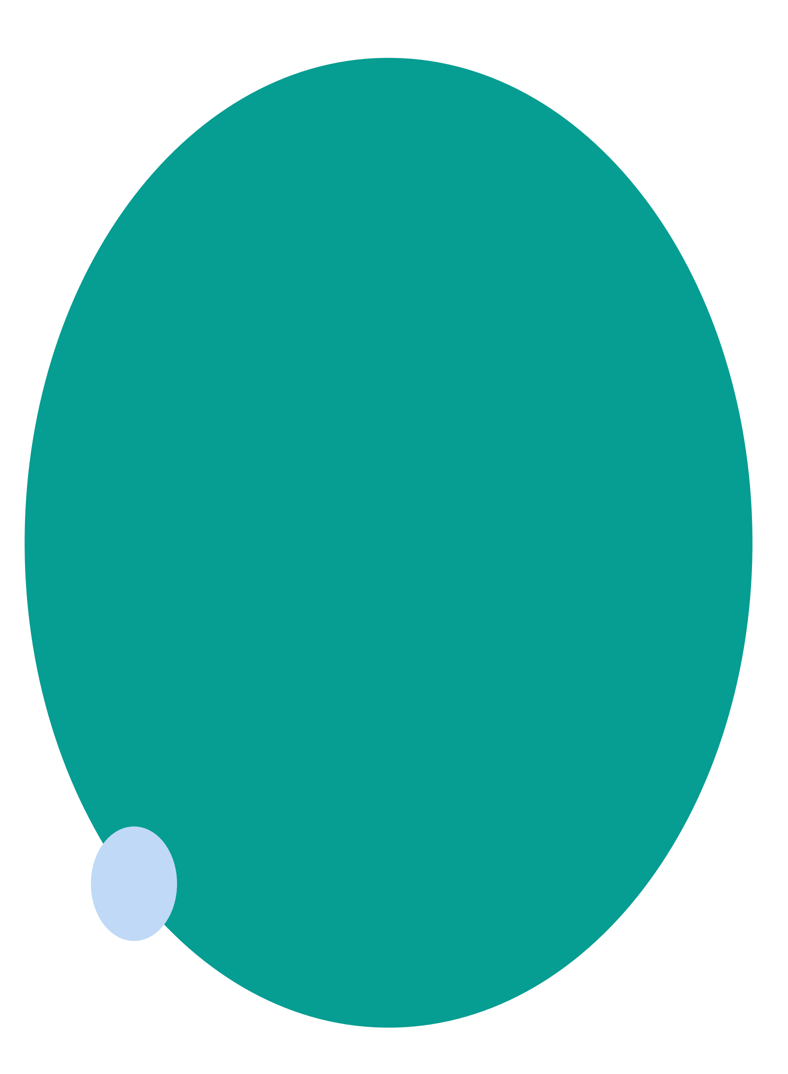
- Veteran lives in a US State or territory without a full-service VA Medical Facility
    - Veteran lives in Alaska, Hawaii, New Hampshire, Guam, American Samoa, the Northern Mariana Islands, or the U.S. Virgin Islands. These regions don’t have a full-service VA health facility in the state or territory. Veteran eligible to get care from an in-network community provider.

Distance and Appointment Eligibility

- For this element, there are a few different ways that a Veteran could be eligible for community care.
  - Veteran needs a primary care or mental health appointment. One can’t schedule an appointment at a VA health facility that’s within a 30-minute average drive from their home, or an appointment cannot be scheduled within the next 20 days. In these cases, veteran is eligible to get primary or mental health care from an in-network community provider.
  - Specialty care such as cardio has a 60-minute average drive time and 28 days.

Referring Provider Authorization

- Veteran may be referred to a community provider when the Veteran and the referring clinician agree that it is in the best medical interest to see a community provider.
  - Veteran has certain health condition that the VA provider doesn't have experience treating. But they live near an in-network community provider who specializes in this condition. If VA provider and Veteran agree it's in the best medical interest.



- VA has identified a medical service line is not meeting VA's standards for quality based on specific conditions, Veterans can elect to receive care from a community provider under certain limitations.

Approved Referrals and Authorizations

- The Veteran must have an approved referral/authorization from VA BEFORE an appointment can be scheduled. The approved referral/authorization is the process starting point. Providers must have an approved referral/authorization on file before rendering care, unless the Veteran needs urgent or emergent care. Providers may check the status of an approved referral/authorization using HSRM. (Health Services Referral Manager)

There are Three Ways to Generate an Approved Referral/Authorization

1. **The provider determines a Veteran patient needs additional care beyond what was originally authorized.**
   - Request additional or extended care by submitting an RFS form directly to VA, preferably through **HSRM** or via an EDI 278 compliant interface.

2. **The Veteran contacts his or her local VAMC to confirm CCN eligibility.**
   - If the Veteran is eligible, VA may refer the Veteran to a community provider, and either appoints the Veteran to a CCN provider, delegates appointing to TriWest, or allows the Veteran to self-schedule.

3. **VA assesses the Veteran's need and makes the determination to refer the Veteran for care in the community, therefore generating an approved referral/authorization.**
   - VA will then send the authorization information to TriWest/Optum for administrative purposes

Veterans Affairs Medical Center

1. VAMC Direct Appointing

- Veteran's VAMC approves care.
- Veteran's VAMC contacts the provider's office, schedules an appointment on behalf of the Veteran, and sends the authorization letter to the provider

2. TriWest/Optum Appointing

- Veteran's VAMC approves care and delegates the appointment process to carrier.
- Carrier contacts the CCN provider on behalf of the Veteran to schedule the appointment and then sends VA's authorization letter to the provider.

3. Veteran Self-Appointing

- Both the VAMC and TriWest/Optum offer self-appointing options for Veterans. A Veteran can self-appoint when he/she has an approved referral/authorization.
- Veterans MUST have an approved referral/authorization in order to self-appoint; otherwise, the provider risks not being reimbursed.
- If the Veteran does not self-appoint within 90 days after the approved referral/authorization was generated, the approved referral/authorization will be returned to VA.
- Either TriWest or VA sends the provider an authorization letter after receiving appointment information.
- If the provider hasn't received an approved referral/authorization letter within a week of a Veteran self-scheduling an appointment, the provider should contact the VAMC or TriWest to ensure the appointment information is available.
- A Veteran may also self-appoint through the Veteran self-service website or phone app.

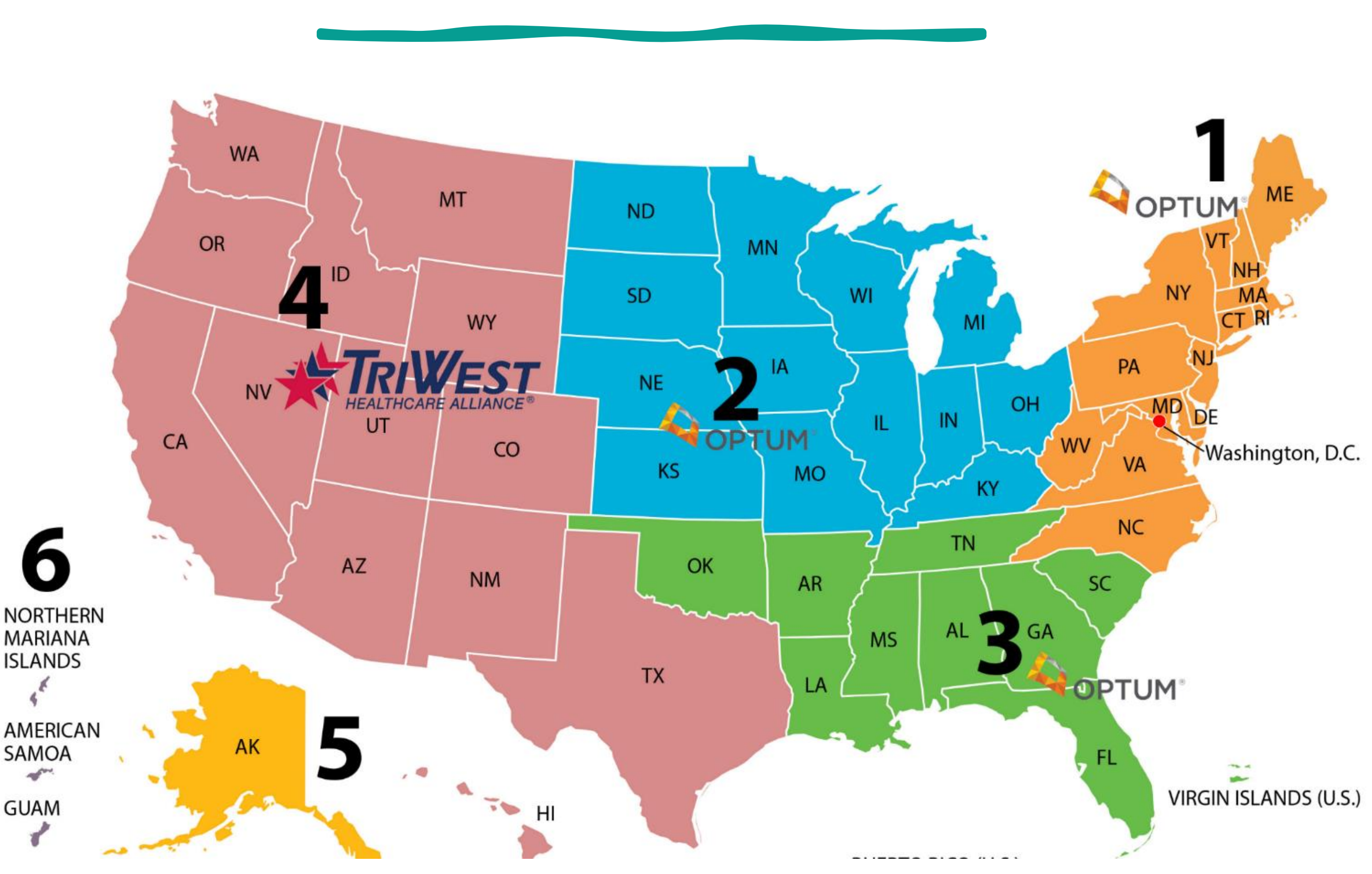
Veteran Must Advocate For Care

- Veterans should make a demand for acupuncture care specifically
- Indicate they do not wish to use any further medication or other medical services (including physical therapist care)
- When possible, request specifically with their provider of choice
- Veteran patients may use **https://www.myhealth.va.gov/mhv-portal-web/user-login** to make requests or get help in accessing care

Authorization

Veteran patient may use:
https://www.myhealth.va.gov/mhv-portal-web/user-login to make requests or get help in accessing care

Provider Enrollment



Regional Networks

CCN is comprised of five regional networks that serve as the contract vehicle for VA to purchase care for Veterans from community providers.

Region 1	Region 1 map	Connecticut, Delaware, District of Columbia, Maine, Maryland, Massachusetts, New Hampshire, New Jersey, New York, North Carolina, Pennsylvania, Rhode Island, Vermont, Virginia, West Virginia
Region 2	Region 2 map	Illinois, Indiana, Iowa, Kansas, Kentucky, Michigan, Minnesota, Missouri, Nebraska, North Dakota, Ohio, South Dakota, Wisconsin
Region 3	Region 3 map	Alabama, Arkansas, Florida, Georgia, Louisiana, Mississippi, Oklahoma, Puerto Rico, South Carolina, Tennessee, Virgin Islands (U.S.)
Region 4	Region 4 map	American Samoa, Arizona, California, Colorado, Guam, Hawaii, Idaho, Montana, New Mexico, Nevada, Northern Mariana, Islands, Oregon, Texas, Utah, Washington, Wyoming
Region 5	Region 5 map	Alaska

Community Care Network Regions

NOTE: Optum Public Sector Solutions, Inc. (Optum), part of UnitedHealth Group, Inc., serves as the third party administrator (TPA) for CCN regions 1, 2, and 3. TriWest Health Care Alliance (TriWest) serves as the TPA for regions 4 and 5.

Optum Health

Contact Information:

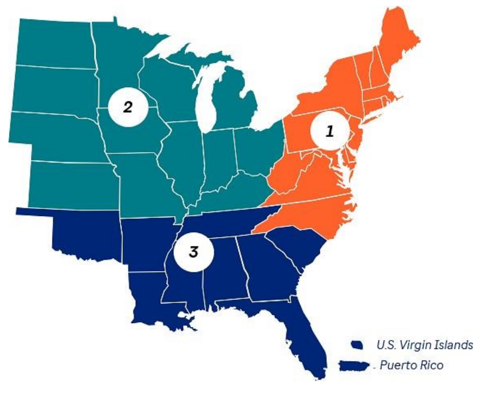
- Region 1: 888-901-7407
- Region 2: 844-839-6108
- Region 3: 888-901-6613

- https://vacommunitycare.com/provider
- https://www.myvaccn.com/site/vaccn/main/public/login#/home (registration page)

What is VA CCN?

VA recognizes that while the health care landscape is constantly changing, VA's unique population and broad geographic demands will continue to require community-based care for Veterans. VA is committed to providing eligible Veterans with the care they need when and where they need it. A significant component of having one method for Veterans to receive care from community providers is the ability for VA to purchase community services through the CCN contracts awarded to Third-Party Administrators (TPAs). Optum was awarded Region 1, Region 2 and Region 3.

Region 1	Region 2	Region 3
• Connecticut	• Illinois	• Alabama
• Delaware	• Indiana	• Arkansas
• District of Columbia	• Iowa	• Florida
• Maine	• Kansas	• Georgia
• Maryland	• Kentucky	• Louisiana
• Massachusetts	• Michigan	• Mississippi
• New Hampshire	• Minnesota	• Oklahoma
• New Jersey	• Missouri	• Puerto Rico
• New York	• Nebraska	• South Carolina
• North Carolina	• North Dakota	• Tennessee
• Pennsylvania	• Ohio	• U.S. Virgin Islands
• Rhode Island	• South Dakota	
• Vermont	• Wisconsin	
• Virginia		
• West Virginia		



Regions are based on provider locations. The provider may receive referrals for Veterans residing in a different state than the provider's location. To determine the appropriate phone number for the provider's region, click here.

VA CCN gives Veterans the opportunity to receive care from a network of community health care professionals, facilities, pharmacies, and suppliers.

Veterans have sacrificed to serve our country, and this is an opportunity to provide them with the timely, accessible and high-quality care they deserve. Providers can help Veterans access a network of community health care through their contract with Optum or another Network Partner. VA CCN only covers Veterans, not their families or dependents. VA determines a Veteran's eligibility to get care from community providers.

Network Resources

Optum's complete and comprehensive health care provider network includes, but not limited to:

UnitedHealthcare

UnitedHealthcare provides the network for traditional medical services for VA CCN. The UnitedHealthcare network includes:

- Primary care providers
- Specialty and sub-specialty providers
- Acute care hospitals
- Laboratories
- Specialty pharmacies
- Ambulatory surgery centers
- Long-term acute care facilities

- Federally Qualified Health Centers
- Rural Health Clinics
- Urgent care facilities
- Ancillary services, including home health, DME, hospice care, dialysis and diagnostic radiology

United Behavioral Health

United Behavioral Health (UBH) provides a network of behavioral health and substance use disorder facilities and providers who perform Complementary and Integrative Healthcare Services (CIHS) for VA CCN.

The UBH network includes:

- Psychiatric hospitals
- Inpatient and outpatient mental health and substance use disorder programs
- Psychiatrists
- Psychologists
- Social workers
- Marriage and family therapists
- Counselors

VA CCN CIHS includes biofeedback, hypnotherapy, relaxation techniques and Native American healing.

UBH serves all areas, except Puerto Rico and the U.S. Virgin Islands. Those areas are covered by a leased network.

OptumHealth Care Solutions, LLC

OptumHealth Care Solutions, LLC, (OHCS) provides a network of freestanding physical health providers and services for VA CCN, which includes:

- Physical therapy
- Occupational therapy
- Speech therapy
- Chiropractic services

The OHCS network also includes providers who provide some CIHS, including:

- Massage therapy
- Acupuncture
- Tai chi

Note: Chiropractic, Massage Therapy, and Acupuncture specialties are contracted on an individual NPI level only.

OHCS provides tai chi in all areas. All other specialties listed above are provided by OHCS in all areas, except Puerto Rico and the U.S. Virgin Islands. Those areas are covered by a leased network.

Optum Serve

Optum Serve (formally known as Logistics Health Inc. (LHI) provides a network of general and specialized dental providers covering all geographic areas. This network provides outpatient dental care to all eligible Veterans.

CVS Caremark Pharmacy

CVS Caremark Pharmacy serves as a Pharmacy Benefits Manager (PBM) and a retail pharmacy network covering all geographic areas for the VA CCN. The retail pharmacies provide prescription fulfillment services for urgent or emergent prescriptions from VA CCN and VA providers with an approved referral or Urgent Care Eligibility Record Number (UCERN).

VA Directive 1137 — Provision of Complementary and Integrative Health (recertified December 2
establishes national VHA policy regarding the provision of CIH approaches.

VA facilities may provide the required CIH approaches internally, on-site, via telehealth, or in the community through volunteers, community partners or the Community Care Network. The CIH approaches included in the Veterans medical benefits package if deemed appropriate by their ca include:

Approaches for Treatment:

Acupuncture

Biofeedback

Clinical hypnosis

Massage therapy

Approaches for Well-Being:

Meditation

Guided imagery

Tai Chi / Qigong

Yoga

IHCC has reviewed these approaches and found evidence of benefits to Veteran care.

To download the 2024 Optum Community Care Provider Manual:

https://vacommunitycare.com/doc/ccnProvManual/ccnPrManual

TriWest Customer Service: 877-266-8749

Enrollment

https://joinournetwork.triwest.com/

Sign Up to Join the TriWest Healthcare Alliance Network

Complete and submit the form below to start the process of joining TriWest's network of health care professionals who care for military families and Veterans. More details on TriWest's areas of responsibility are on the Join the TriWest Healthcare Alliance Network page. Our provider contracting team looks forward to working with you.

Want to learn more about TriWest and its role in delivering access to care for the U.S. Department of Defense and the U.S. Department of Veterans Affairs? Go to the network overview page.

Provider Contract Request

Fields with an asterisk (*) are required.

Date of Submission: 4/3/2024

Type of Practice *

(Select One)

Federal Tax ID *

CAQH Number

States/Locations Served * *Hold 'CTRL' key down to select multiple items*

(Select One Or Multiple)
AK
AL
American Samoa

Credentialing Requirements

1. Provider must meet the requirements of state and local laws and if applicable must have a full, current, non-probationary and unrestricted license in the state where services are delivered.
2. Provider must remain in compliance with the seven (7) elements of the OIG's Compliance Program Guidance.
    1. Implementing written policies, procedures and standards of conduct.
    2. Designating a compliance officer and compliance committee.
    3. Conducting effective training and education.
    4. Developing effective lines of communication.
    5. Conducting internal monitoring and auditing.
    6. Enforcing standards through well-publicized disciplinary guidelines.
    7. Responding promptly to detected offenses and undertaking corrective action.
3. If applicable, provider cannot have had any state license termed for cause or have relinquished any state license after being notified in writing by that state of potential termination for cause.
4. If applicable, providers shall meet all Medicare Conditions of Participation (CoP) and Conditions for Coverage (CfC), where such conditions exist, subject to CMS modifications, as required by the U.S. Department of Health and Human Services (HHS). Chiropractors however are exempt and need not be enrolled in Medicare.

- Nursing home care including state Veterans' Home per diem, which implies that when the Veteran is in a domicile/residence, the services would be excluded. When a person is at an unskilled site for a skilled need, it can be included.
- Home deliveries and deliveries by direct entry midwives, also known as lay midwives or certified professional midwives.
- Ambulance services. All ambulance services must always be referred directly to VA for payment consideration.

Specific Credentialing Requirements for Professional Providers

Most providers will have to fulfill the following two credentialing requirements along with other sets of unique requirements, mentioned in the tables below:

- State license, full, current, and unrestricted license in the state where services are delivered.
- If a provider is or has been licensed in more than one state, TriWest must always confirm that the provider certifies that none of those states has terminated such license for cause, and that the provider has not involuntarily relinquished such license in any of those states after being notified in writing by that state of potential termination for cause.

Type/Specialty	VA Specialty-Specific Requirements
Chiropractor, Clinical Psychologist (PHD, EdD, PsyD, EdS), Physicians, Physical Therapist, Podiatrists	No additional requirement other than the two requirements mentioned above.
Acupuncture, Licensed Acupuncturist/Doctor of Oriental Medicine	•Physician Acupuncturists (MD/DO) must hold a valid unrestricted license to practice medicine including acupuncture, and either be a member of the American Academy of Medical Acupuncture (AAMA) or be certified by the American Board of Medical Acupuncture. •State license, full, current, unrestricted license is required in the state where services are delivered or National Certification Commission for Acupuncture and Oriental Medicine (NCCAOM) certification

Providers must maintain, during the term of their Provider Agreement, professional liability insurance issued by a responsible insurance carrier of not less than (per specialty per occurrence):

- $1,000,000 per occurrence
- $3,000,000 aggregate

Provider Credentialing

Veterans Affairs Community Care Network (VA CCN)

Optum, United Healthcare or its designee must credential Providers and facilities, according to requirements of nationally recognized accrediting organizations. Credentialing is generally not required for health care professionals who are permitted to furnish services only under the direct supervision of another licensed independent practitioner or for hospital-based or facility-based health care professionals who provide service to covered persons incidental to hospital or facility services. Providers who are currently credentialed and participating with Optum or United Healthcare, as applicable, are not required to complete a separate credentialing application for VA CCN.

The credentialing process involves obtaining primary-source verification of the Provider's education, board certification, license, professional background, malpractice history and other pertinent data.

New VA CCN Providers who are not currently credentialed and participating with one of our network partners will have to complete a standardized, applicable, nationally accredited credentialing process.

All services, facilities, and Providers must adhere to all applicable federal and state regulatory requirements. Optum will monitor the U.S. Department of Health and Human Services Office of Inspector General (OIG) exclusionary list. If the provider is on the exclusionary list the provider won't be eligible to participate in the network. See oig.hhs.gov/exclusions for more information about the exclusionary list. If Provider doesn't maintain active credentialing status, the contract could be terminated.

If a VA CCN Provider is licensed, registered or certified in more than 1 state, the Provider must confirm that:

- None of the Provider's licenses, registrations or certifications in those states have been terminated for cause
- Provider has not involuntarily relinquished the provider's license, registration or certification in any of those states after being notified in writing by that state of a potential termination for cause

The Provider must notify the appropriate network partner within 5 business days of the occurrence of an action, lapse or limit impacting the Provider license, registration or certification. If any state in which a Provider is licensed, registered or certified terminates such license, registration or certification, the Provider will be removed from VA CCN.

If a VA CCN Provider's specialty is not subject to an accredited credentialing process, the Provider must operate within the scope of the Provider's professional license. The VA CCN Provider must maintain and provide to the appropriate network partner, upon request, the following documentation:

- Proof of identity with a government-issued photo and I-9 documentation
- An active, unrestricted license from the state where the service is provided, if applicable (Unskilled home health excluded)
- Criminal background disclosure
- Current national provider identifier (NPI) number. (Unskilled home health excluded)
- Drug Enforcement Agency (DEA) number if controlled substances are prescribed
- Education and training, if applicable (unskilled home health excluded)
- Professional references

- Proof of professional liability insurance in an amount in accordance with the laws of the state in which the care is provided
- Tax identification number (TIN)
- Work history

Contact Information

For more information about the credentialing process or to become a participating Provider with VA CCN, please contact the appropriate network based on your Provider type:

Table 1: Participating Provider Networks

Network	Provider Type	Website or email address
United Healthcare	Medical professionals, facilities, and ancillary providers	UHCprovider.com/Join
United Healthcare	National laboratory and national ancillary providers	naspi@uhc.com
United Healthcare Home and Community Based Services	Adult day care Homemaker/Personal Care Private duty nursing (non-Medical Certified Home Health)	hcbsprovidernetwork@uhc.com
United Healthcare Vision	Routine vision services	spectera.com > Join Our Network
United Behavioral Health	Mental health and substance abuse	providerexpress.com > Our Network
Optum Serve	Dental providers	providers.optumserve.com > Join Our Network
Optum Complex Care Management	Skilled nursing facilities	UHCprovider.com/Join
Optum Health Care Solutions	Acupuncture, chiropractic, massage therapy, occupational therapy, physical therapy, speech pathology, tai chi	myoptumhealthphysicalhealth.com > Interested in becoming a Provider?

optum.com
Optum is a registered trademark of Optum, Inc. in the U.S. and other jurisdictions. All other brand or product names are the property of their respective owners. Because we are continuously improving our products and services, Optum reserves the right to change specifications without prior notice. Optum is an equal opportunity employer.

Patient Nomination

If you have difficulty in credentialing based upon the "network is full". The patient or veteran may nominate and request for your office to be part of the program and this may be the spark to allow your office to be credentialed.

They request Acupuncture and specifically indicate you (The LAc) with their reasons why:

- Past experience, reputation, access, location, etc
  - VA PTP
  - Triwest or Optum
  - Ombudsmen (myhealthevet.com)

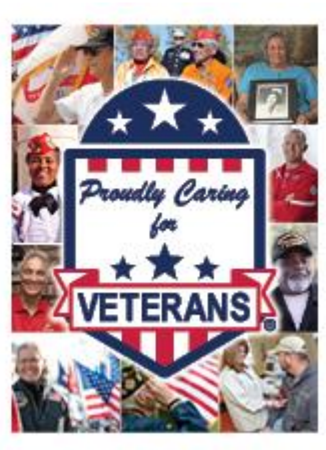
How Will Anyone Know or Find You?

Your now enrolled but how do you get a patient?

Tell Your Community You Proudly Care for Veterans

Thank you for joining our mission and proudly caring for Veterans!

If you want to let your community know that you're treating Veterans at your clinic, office, or organization, please feel free to use the tools below.



https://www.triwest.com/en/provider/training-and-help/proudly-caring-for-veterans/

Print Ready Signs and Embed

Find VA locations

Find a VA location or in-network community care provider. For same-day care for minor illnesses or injuries, select Urgent care for facility type.

Coronavirus update: Please call first to confirm services or ask about getting help by phone or video. We follow CDC guidelines for wearing masks at our facilities.

City, state or postal code (*Required) Use my location

Facility type (*Required)

Choose a facility type

Service type

Search

Please enter a location (street, city, state, or postal code) and facility type, then click search above to find facilities.

https://www.va.gov/find-locations

All Care Must Be Authorized

VA Office of Community Care

UNDERSTANDING THE VA COMMUNITY CARE PROCESS

Consult Creation and Review

A consult is a request from a VA provider that refers a Veteran for specialty medical and/or behavioral care.

The VA medical center referral coordination team reviews the request and determines if the care can be delivered locally, face to face or virtually and assesses the Veteran's community care eligibility.

VA then contacts the Veteran. If the Veteran is deemed to be community care eligible and opts-in to receive community care, the referral is prepared for scheduling with an in-network community provider.

Scheduling

After the referral has been reviewed and the modality confirmed, the Veteran may proceed to self-schedule their appointment. If the Veteran prefers, VA can schedule the appointment for them.

If the Veteran decides to self-schedule, they are either given the contact information of the applicable providers near them in the community network or can use https://www.va.gov/find-locations/ to find acceptable providers.

The Veteran is asked to inform VA of the details of the appointment within 14 days to add to the Veteran's chart. This allows VA staff to help coordinate care when needed or requested by the Veteran.

Authorization

After the appointment is scheduled, an authorization is created.

Authorizations are approvals from VA for Veterans to receive care from a community provider.

Veterans receive a letter with:

- An authorization number
- The approved in-network community provider info
- A description of the authorized care
- The time period the Veteran is authorized to receive care.

Community Care Visit

At the scheduled day and time, Veterans attend their community care appointment.

VA will have already sent relevant medical records to the community provider.

However, if instructed by the community provider, the Veteran may be asked to bring copies of diagnostic imaging (CT or MRI) with them.

The wait time is calculated from the date of the referral to the date the appointment is completed

1 → 2 → 3 → 4

Day 1 | **Up to 14 Days** | **Dependent upon community provider availability and Veteran's scheduling preference**

Receiving a Referral

Eligibility	VA contacts CCN provider	Schedule appointment	Reviews consult order
VA confirms a Veteran's eligibility to receive Community Care	VA requests CCN provider accept referral and confirms provider's preferred method to receive referral	Veteran, VA staff member or Optum schedules an appointment with a CCN Provider	Provider reviews consult order included with the approved referral for services being requested by VA

Upon a CCN provider accepting a referral from VA, an approved referral packet will be sent, using the provider's preferred method to receive it. Options for preferred methods are:

- HealthShare Referral Manager (HSRM)
- Secure fax
- Secure email (VA only)
- Direct messaging (VA only)

CCN providers can find more information about the methods directly from VA at va.gov/COMMUNITYCARE/providers/index.asp.

Standard Episode of Care

What is an SEOC?

- An SEOC is a set of clinically related healthcare services for a specific unique illness or medical condition (diagnosis and/or procedure) provided by an authorized provider during a defined, authorized period of time not to exceed one year.
- This will be sent to you and specifically define the diagnoses and services for that patient

Standard Episode of Care (SEOC)

- Acupuncture Initial
- Acupuncture Continuation
- Acupuncture Chronic Care Pain Management

Service Requested: Acupuncture Initial SEOC 1.0.12

Category of Care: COMPLEMENTARY AND INTEGRATIVE HEALTH

Procedural Overview - Standardized Episode of Care (SEOC)

Acupuncture Initial SEOC 1.0.12 Duration: 60 Days

No.	Service/Procedure	Number Of Visits Authorized
1	1. One (1) initial outpatient evaluation for this episode of care.	1
2	2. Twelve (12) acupuncture visits maximum is approved for this episode of care. Approved services include acupuncture with or without electrostimulation. Additional units of acupuncture must be medically necessary and require documentation of face to face provider time and evidence of re-insertion. If indicated, approved modalities that can be performed by the acupuncturist, as part of their plan of care, during the approved acupuncture visit can include manual therapy and therapeutic exercise procedures including but not limited to: cupping, thermal and myofascial therapies, and therapeutic exercises.	12
3	3. Outpatient re-evaluation during this episode of care (limit of 2 re-evaluations). It is not expected that re-evaluation is appropriate at each acupuncture visit as a portion of E&M is imbedded in the acupuncture codes. Re-evaluation is appropriate when a patient has an exacerbation or evaluation is needed for determination of future care. ** Note: Additional episode of care may be requested by the referring provider or the Community Care provider via RFS, as clinically necessary. ** Note: Additional acupuncture care beyond this trial must provide documentation of: Objective measures demonstrating the extent of meaningful clinical improvement to date; AND rationale for the additional treatment requested (e.g. to reach further durable improvement, or for ongoing pain management); AND any further information supporting the need for additional care.	2

SEOC Disclaimer

* Please visit the VHA Storefront www.va.gov/COMMUNITYCARE/providers/index.asp for additional resources and requirements pertaining to the following: * Pharmacy prescribing requirements * Durable Medical Equipment (DME), Prosthetics, and Orthotics prescribing requirements * Precertification (PRCT) process requirements * Request for Services (RFS) requirements

Acupuncture Initial

- **20560, 20561** (Dry Needling)
- **97810, 97811, 97813, 97814**
- **97016, 97026, 97110, 97112, 97124, 97140, 97530**
- **99202, 99203, 99204, 99205, 99211, 99212, 99213, 99214, 99215**
- **0552T** (Laser)
- **S8930** (Electrical stimulation of auricular acupuncture points)

Category of Care: COMPLEMENTARY AND INTEGRATIVE HEALTH

Procedural Overview - Standardized Episode of Care (SEOC)

Acupuncture Continuation of Initial Care SEOC 1.11.10 Duration: 90 Days

No.	Service/Procedure	Number Of Visits Authorized
1	1. Outpatient re-evaluation during this episode of care (limit of 2 re-evaluations). It is not expected that re-evaluation is appropriate at each acupuncture visit as a portion of E&M is imbedded in the acupuncture codes. Re-evaluation is appropriate when a patient has an exacerbation or evaluation is needed for determination of future care.	2
2	2. A maximum of eight (8) acupuncture visits is approved for this episode of care. Approved services include acupuncture with or without electrostimulation. Additional units of acupuncture must be medically necessary and require documentation of face to face provider time and evidence of re-insertion. If indicated, approved modalities that can be performed by the acupuncturist, as part of their plan of care, during the approved acupuncture visit can include manual therapy and therapeutic exercise procedures including but not limited to: cupping, thermal and myofascial therapies, and therapeutic exercises. ** Note: Additional episode of care may be requested by the referring provider or the Community Care provider via RFS, as clinically necessary. ** Note: Additional acupuncture care beyond this trial must provide documentation of: Objective measures demonstrating the extent of meaningful clinical improvement to date; AND rationale for the additional treatment requested (e.g. to reach further durable improvement, or for ongoing pain management); AND any further information supporting the need for additional care.	8

Acupuncture Continuation of Initial & Chronic Care Management

- **20560, 20561** (Dry Needling)
- **97810, 97811, 97813, 97814**
- **97016, 97026, 97110, 97112, 97124, 97140, 97530**
- **99211, 99212, 99213, 99214, 99215**
- **0552T** (Laser)
- **S8930** (Electrical stimulation of auricular acupuncture points)

Standard 12 visits in 60 days

Continuing care there will be 8 visits allowed over 90 days.

For any further "chronic" pain management care, the limit will be 8 visits over 180 days.

Fee Schedule

VA payment will be at Medicare rates

If there is no Medicare rate for the service, it will default to UCR

Southern California – Area 17 (Ventura County)

Code	Amount
97810	$ 40.77
97811	$ 29.83
97813	$ 48.64
97814	$ 39.09

Code	Amount
99202	$ 77.88
99203	$ 118.75
99204	$ 176.71
99205	$ 232.69
99211	$ 26.02
99212	$ 61.21
99213	$ 97.33
99214	$ 136.83
99215	$ 191.72

Code	Amount
97012	$14.81
97016	$12.46
97018	$6.10
97022	$18.71
97024	$8.04
97026	$7.26
97028	$9.10
97032	$15.20
97033	$20.96
97034	$15.02
97035	$15.02
97036	$39.06
97110	$31.60
97112	$36.38
97113	$39.97
97116	$31.60
97124	$33.28
97140	$28.99
97150	$19.25
97530	$40.17

Southern California – Area 18 (LA/OC)

Code	Amount
97810	$ 41.31
97811	$ 30.25
97813	$ 49.28
97814	$ 49.27

Code	Amount
99202	$ 78.89
99203	$ 120.37
99204	$ 179.36
99205	$ 235.95
99211	$ 26.31
99212	$ 61.99
99213	$ 98.61
99214	$ 138.66
99215	$ 196.82

Code	Amount
97012	$15.01
97016	$12.62
97018	$6.18
97022	$18.93
97024	$8.14
97026	$7.36
97028	$9.21
97032	$15.40
97033	$21.22
97034	$15.21
97035	$15.21
97036	$39.49
97110	$32.00
97112	$36.83
97113	$40.45
97116	$32.00
97124	$33.67
97140	$29.36
97150	$19.50
97530	$40.65

Florida Medicare & VA 2024

Code	Local 99 (1&2)	Local 3	Local 4
97810	37.88	39.27	40.74
97811	28.12	29.04	30.08
97813	44.55	46.25	47.87
97814	36.22	37.61	39.07

Code	Local 99 (1&2)	Local 3	Local 4
99202	71.16	74.21	77.27
99203	110.82	115.51	120.93
99204	166.48	173.11	181.05
99205	219.92	228.64	239.35
99211	22.44	23.52	24.26
99212	55.64	58.06	60.43
99213	89.77	93.35	97.06
99214	126.76	131.63	136.76
99215	179.04	185.90	193.56

Code	Local 99 (1&2)	Local 3	Local 4
97012	13.82	14.23	14.62
97016	11.49	11.90	12.29
97018	5.61	5.91	6.25
97022	16.47	17.21	17.77
97024	7.18	7.57	7.96
97026	6.55	6.91	7.27
97028	8.16	8.57	8.96
97032	14.13	14.56	14.97
97033	18.84	19.54	20.08
97034	13.74	14.22	14.66
97035	13.74	14.22	14.66
97036	33.59	35.16	36.13
97110	28.61	29.52	30.17
97112	32.78	33.84	34.57
97113	35.55	36.83	37.66
97116	28.61	29.52	30.17
97124	29.35	30.51	31.29
97140	26.38	27.19	27.79
97150	17.65	18.22	18.69
97530	35.47	36.83	37.70

Locality 99 (1 & 2)

Alachua	Duval	Highlands	Mario	Seminole	
Baker		Escambia	Hillsboroug	Nassau	St. Johns
Bay		Flagler	Holmes	Okaloosa	Sumter
Bradford	Franklin	Jackson	Okeechobee	Suwannee	
Brevard	Gadsden	Jefferson	Orange	Taylor	
Calhoun	Gilchrist	Lafayette	Osceola	Union	
Charlotte	Glades	Lake	Pasco	Volusia	

VA Fee Schedule

This is the link to the fees for services that do not have a Medicare rate

- https://www.va.gov/COMMUNITYCARE/revenue_ops/Fee_Schedule.asp

Diagnoses

Will be indicated on the authorization and ensure the primary diagnosis is on your claim

Order Information
To Service: COMMUNITY CARE-ACUPUNCTURE
From Service:
Requesting Provider:
Service is to be rendered on an OUTPATIENT basis
Place: Consultant's choice
Urgency: Routine
Clinically Ind. Date: May 31, 2022
DST ID:
Orderable Item: COMMUNITY CARE-ACUPUNCTURE
Consult: Consult Request
Provisional Diagnosis: Tobacco use(ICD-10-CM Z72.0)
Reason For Request:
Is the patient able to transfer themselves to the treatment table?
(Limited treatments can be offered in a wheelchair)
Yes

The condition is:Chronic

What are the specific diagnoses for this consult?
Other (describe below) to assist w/smoking cessation

Goals should be discussed with the patient prior to placing a consult.
What is the goal for this referral?
symptom management

What treatments have already been attempted? Select all that apply
Other...NRT, hypnotherapy

Are you requesting more than one CIH modality (Chiropractic, Massage Therapy, Acupuncture) for a single diagnosis?
No
If yes what is your justification

Back pain is often associated with multiple complicating factors and comorbidities. Increased number of which decrease the likelihood of successful treatment and may require co-treatment. What other related consults are you placing for this patient? Select all that apply:
None

ACUPUNCTURE CODES

CPT Codes

97810	Acupuncture, one or more needles: without electrical stimulation, initial 15 minutes of personal one-on-one contact with the patient.
97811	without electrical stimulation, each additional 15 minutes of personal one-on-one contact with the patient, with re-insertion of needle(s) (List separately in addition to code for primary procedure)
97813	Acupuncture, one or more needles, with electrical stimulation, initial 15 minutes of personal one-on-one contact with the patient
97814	with electrical stimulation, each additional 15 minutes of personal one-on-one contact with the patient, with re-insertion of needle(s) (List separately in addition to code for primary procedure)

How is the 15-minute session defined?

The 15-minute increment of time is defined as personal one-on-one contact with the patient. This means that the physician acupuncturist is in the room with the patient, and is actively performing a medically necessary activity that is a component of acupuncture or electroacupuncture (this would include a review of history, day-to-day evaluation, hand washing, choosing, and cleaning points, inserting and manipulating needles, removal, disposal as well as completion of the chart notes while the patient is present). The time that the needles are retained is specifically excluded to determine the time and consequently reimbursement.

1 unit (set) must include a minimum of 8 minutes face to face time with insertion (8-22 minutes = 1 unit)
2 units (sets) must be at least 23 minutes of face-to-face time (23-37 2 units)
3 units (sets)must be at least 38 minutes of face-to-face time (38-52 = 3 units)
4 units (sets) must be at least 53 minutes face-to-face (53-67 = 4 units)

Do I need to reinsert needle(s) to bill the add-on codes 97811 or 97814?

Yes. According to the CPT Assistant, June 2005/Volume 15, Issue 6, "re-insertion of the needle(s) is required for the use of add-on codes 97811 and 97814.

May I mix and match electrical and non-electrical stimulation procedures in the same session?

Yes. However, only one initial insertion of the needles is permitted per session per day. Therefore, per CPT, you should never code 97810 and 97813 on the same claim. If the first set is manual then code 97810 and if the subsequent set is electrical then 97814. You may code 97810 with 97811 or 97814. The same applies to 97813 it too can be coded with 97811 or 97814.

A simple rule of thumb is to never combine 97810 and 97813 on a single claim for acupuncture services because these two codes both describe an **initial** 15-minute treatment with the insertion of one or more needles.

ACUPUNCTURE CODES

CPT Codes	
97810	Acupuncture, one or more needles: without electrical stimulation, initial 15 minutes of personal one-on-one contact with the patient.
97811	Without electrical stimulation, each additional 15 minutes of personal one- on-one contact with the patient, with re-insertion of needle(s) (List separately in addition to code for primary procedure)
97813	Acupuncture, one or more needles, with electrical stimulation, initial 15 minutes of personal one-on-one contact with the patient
97814	With electrical stimulation, each additional 15 minutes of personal one-on- one contact with the patient, with re- insertion of needle(s) (List separately in addition to code for primary procedure)

How is the 15-minute session defined?

The 15-minute increment of time is defined as personal one-on-one contact with the patient. This means that the physician acupuncturist is in the room with the patient, and is actively performing a medically necessary activity that is a component of acupuncture or electroacupuncture (this would include a review of history, day-to-day evaluation, hand washing, choosing, and cleaning points, inserting and manipulating needles, removal, disposal as well as completion of the chart notes while the patient is present). The time that the needles are retained is specifically excluded to determine the time and consequently reimbursement.

1 unit (set) must include a minimum of 8 minutes face to face time with insertion (8-22 minutes = 1 unit)
2 units (sets) must be at least 23 minutes of face-to-face time (23-37 2 units)
3 units (sets)must be at least 38 minutes of face-to-face time (38-52 = 3 units) 4 units (sets) must be at least 53 minutes face-to-face (53-67 = 4 units)

Do I need to reinsert needle(s) to bill the add-on codes 97811 or 97814?

Yes. According to the CPT Assistant, June 2005/Volume 15, Issue 6, “re-insertion of the needle(s) is required for the use of add-on codes 97811 and 97814.

May I mix and match electrical and non-electrical stimulation procedures in the same session?

Yes. However, only one initial insertion of the needles is permitted per session per day. Therefore, per CPT, you should never code 97810 and 97813 on the same claim. If the first set is manual then code 97810 and if the subsequent set is electrical then 97814. You may code 97810 with 97811 or 97814. The same applies to 97813 it too can be coded with 97811 or 97814.

A simple rule of thumb is to never combine 97810 and 97813 on a single claim for acupuncture services because these two codes both describe an **initial** 15-minute treatment with the insertion of one or more needles.

Dry Needling

20560 Needle insertion without injection in 1 or 2 muscles.

20561 Needle insertion without injection but focuses on 3 or more muscles

Assure all services coded are properly documented

Evaluation & Management

- The exam must be documented above and beyond the day-to-day evaluation associated with treatment
- The level billed must be reflected
    - Medical decision making (severity)
    - Time

NEW PATIENT
A new patient is one who has not received any professional services from the physician or other qualified health care professional or another physician or other qualified health care professional of the exact same specialty and subspecialty who belongs to the same group practice, within the past three years.

99202 **Office or other outpatient visit** for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and straightforward medical decision making. When using total time on the date of the encounter for code selection, 15 minutes must be met or exceeded.

99203 **Office or other outpatient visit** for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and low level of medical decision making. When using total time on the date of the encounter for code selection, 30 minutes must be met or exceeded.

99204 **Office or other outpatient visit** for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making. When using total time on the date of the encounter for code selection, 45 minutes must be met or exceeded.

99205 **Office or other outpatient visit** for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and high level of medical decision making. When using total time on the date of the encounter for code selection, 60 minutes must be met or exceeded.

ESTABLISHED PATIENT
An established patient is one who has received professional services from the physician or other qualified health care professional or another physician or other qualified health care professional of the exact same specialty and subspecialty who belongs to the same group practice, within the past three years.

99211 **Office or other outpatient visit** for the evaluation and management of an established patient, that may not require the presence of a physician or other qualified health care professional.

99212 **Office or other outpatient visit** for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and straightforward medical decision making. When using total time on the date of the encounter for code selection, 10 minutes must be met or exceeded.

99213 **Office or other outpatient visit** for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and low level of medical decision making. When using total time on the date of the encounter for code selection, 20 minutes must be met or exceeded.

99214 **Office or other outpatient visit** for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making. When using total time on the date of the encounter for code selection, 30 minutes must be met or exceeded.

99215 **Office or other outpatient visi**t for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and high level of medical decision making. When using total time on the date of the encounter for code selection, 40 minutes must be met or exceeded.

Time

99202 Meet or exceed15 min

99203 30 minutes

99204 45 minutes

99205 60 minutes

Medical Decision Making

99202 1 self limited or minor problem

99203 2 or more / acute injury

99204 Acute complicated injury

99205 Threat to life or bodily function

Therapies

- What
- Where
- Time if a timed service
- Purpose

Modalities and Procedures

- **97016**
- **97026**

- **97110**
- **97112**
- **97124**
- **97140**
- **97530**

2024 ACUPUNCTURE
PHYSICAL MEDICINE & REHABILITATION
(97010 - 97799)

ACUPUNCTURE

97810 Acupuncture, one or more needles without electrical stimulation, initial 15 minutes of personal one-on-one contact with patient

97811 Each additional 15 minutes of personal one-on-one with patient, with re-insertion of needles

97813 Acupuncture, one or more needles; with electrical stimulation, initial 15 minutes of personal one-on-one contact with patient

97814 Each additional 15 minutes of personal one-on-one with patient, with re-insertion of needles

DRY NEEDLING

20560 Needle insertion without injection 1-2 muscle(s)

20561 3 or more muscles

MODALITIES

Any physical agent applied to produce therapeutic changes to biologic tissue; includes but not limited to thermal, acoustic, light, mechanical, or electric energy.

SUPERVISED

The application of a modality that *does not* require direct (one on one) patient contact by the provider.

Application of a modality to one or more areas;

97010 Hot or cold packs
97012 Traction, mechanical
97014 Electrical stimulation, (unattended)
G0283 Electrical stimulation, (**VA, MC, UHC**)
97016 Vasopneumatic devices
97018 Paraffin bath
97022 Whirlpool
97024 Diathermy (Includes Microwave)
97026 Infrared
97028 Ultraviolet

CONSTANT ATTENDANCE

The application of a modality that requires direct. (one on one) patient contact by the provider.

Application of a modality to one or more areas.

97032 Electrical Stimulation (manual), 15 min.
97033 Iontophoresis, each 15 minutes
97034 Contrast baths, each 15 minutes
97035 Ultrasound, each 15 minutes
97036 Hubbard tank, each 15 minutes
97039 Unlisted modality (specify type and time if constant attendance)

LASER

S8948 Application of a modality with constant attendance to one or more areas; Low-level laser; each 15-minute

0552T Low-level laser therapy dynamic photonic and dynamic thermokinetic energies, provided by physician or other qualified health professional.

THERAPEUTIC PROCEDURES

A manner of effecting change through the application of clinical skills and or services that attempt to improve function.

Physician or therapist required to have direct (one on one) patient contact.

Therapeutic procedure, one or more areas, 15 min;

97110 Therapeutic exercises to develop strength and endurance, range of motion, and flexibility.

97112 Neuromuscular reeducation of movement, balance, coordination, kinesthetic sense, posture, and proprioception.

97113 Aquatic therapy with therapeutic exercises

97116 Gait training (includes stair climbing)

97124 Massage, including effleurage, petrissage, tapotement (stroking, compression, percussion)

97139 Unlisted therapeutic procedure (specify)

97140 Manual therapy techniques, one or more regions.(for example: mobilization, manipulation, manual traction, manual lymphatic drainage)

2024 ACUPUNCTURE
PHYSICAL MEDICINE & REHABILITATION
(97010 - 97799)

Additional Procedures

97150	Therapeutic procedure(s), group (2 or more)
97530	Therapeutic activities, direct (one one-on-one) patient contact by the provider (use of dynamic activities to improve functional performance), each 15 min.
97535	Self-care/home management training (e.g. activities of daily living (ADL) and compensatory training, safety procedures, and instructions in use of adaptive equipment) direct one one-on-one contact by provider, each 15 minutes.
97537	Community/work reintegration training (e.g. avocational activities and/or work environment/modification analysis, work task analysis), direct one one-on-one contact by provider, each 15 minutes.
97542	Wheelchair management/propulsion training, each 15 min.
97545	Work hardening/conditioning; initial 2 hours.
97546	*each additional hour*
97799	Unlisted physical medicine/rehabilitation service.

GP
Always Therapy Modifier

All physical medicine services 97010-97799 require modifier GP

This is in addition to any need for other modifiers

97140 59 GP

order does not matter but that they both must appear

Billing

Regardless of the appointing pathway, providers may NEVER charge a Veteran for not keeping a scheduled appointment under CCN.

- Providers must submit claims within 30 days after rendering services. There is a 180-day timely filing limit
- Appeal of a claim also requires it be submitted within 180 days of the denial

Claims
PO Box 42270
Phoenix, AZ 85080-2270

- corrected claim vs rebill ?

March 13, 2023

Veteran:
Date(s) of Service: 07/13/2020
Total Charge: $190.00

Dear Patient Accounts Manager:

TriWest has received your request for timely filing reconsideration on the above referenced claim. Unfortunately our denial stands. The documentation submitted does not meet the guidelines set forth by the VA. The VA EOB denial must have been submitted to TriWest within 180 days of the date of the denial.

Also please be advised that TriWest can no longer override timely filing for claims that were originally submitted to non-VA payers, such as TRICARE, Medicare, or other health insurers.

Mail to the following address:
TriWest Claims
ATTN: Reconsideration
P.O. Box 42270
Phoenix, AZ 85080-2049

If you have any questions, please contact TriWest Claims Customer Service at 1-877-226-8749.

Sincerely,

TriWest Healthcare Alliance

Exceptions to Timely Filing

If you have a claim that was denied for timely filing, and it meets **ALL** of the requirements below, you may submit a corrected claim

1. TriWest denied your claim(s) because it exceeded the 180-day timely filing deadline.
2. Your original claim submission was filed TIMELY with VA, Optum, or TriWest.
3. You have documentary evidence to validate your original claim(s) was TIMELY filed with the wrong VA payer entity.

Billing for Services Rendered to Veterans

- All care requires an approved referral/authorization with the exception of urgent care. A claim submitted without a VA referral/authorization number will be denied/rejected.
- Providers should not collect copays, cost-shares or deductibles. CCN reimburses up to 100% of the allowed amount, including any patient obligation.
- Payments made by TriWest/Optum or VA shall be considered payment in full under CCN. Providers may not impose additional charges to TriWest or the Veteran for covered services.
- Providers are required to share the VA referral/authorization number with the ancillary providers included in a Veteran's episode of care. The ancillary provider is also required to use this same VA referral/authorization number when submitting their claim for the specific episode of care.
- For CCN, TriWest/Optum follows Medicare billing guidelines, fee schedules and payment methodology when applicable.
- Remember, providers are not allowed to balance bill Veterans or TriWest/Optum for services provided under the CCN contract, including any remaining balances or after a timely filing denial.

Claims Submission Options

- TriWest/Optum has designated PGBA as the claims payer for all authorized claims. Providers will submit all claims to PGBA either through the electronic claims submission process, or via a paper claim form.
- All CCN claims process electronically, regardless of the method of submission. This is a requirement and, therefore, filing claims electronically is preferred and encouraged. If you choose to submit paper claims, they must scan to an electronic format. Claims that cannot be scanned cleanly may reject.

Electronic Claim Submission

- Claims submitted electronically are less likely to be rejected compared to paper claims. Improve your claim submission accuracy and get your payments faster by signing up for electronic claim submission and funds transfer.
- Providers can submit electronic claims without a clearinghouse account through Availity's Basic Clearinghouse option. The Basic Clearinghouse option is FREE to CCN providers.

- E Payer ID: VACCN

Mailing Address:

VA CCN Optum P.O. Box 202117

Florence, SC 29502

- Secure Fax: 833-376-3047

- Correspondence

VA CCN Correspondence
PO Box 202118
Florence, SC 29501

- PGBA Claims Submission Details
- **Payer ID**
  TWVACCN
- Address to Submit Paper Claims to PGBA
  TriWest VA CCN Claims
  PO Box 108851
  Florence, SC 29502-8851

Clean Claim Requirements

- Once the provider receives an authorization letter from either TriWest/Optum or VA, the referral/authorization number is the unique identifier assigned for each approved referral/authorization's episode of care.
- Billing requires that the provider include this number on the claim or the claim will be denied/rejected.

- VA referral number (Proper format example: VA1234567890) AND one of the following:
    - 17-digit Master Veteran Index (MVI) ICN
    - Social Security number (SSN)
    - 10-digit Electronic Data Interchange Personal Identifier (EDIPI)
    - Last 4 digits for SSN with preceding 5 zeros (e.g., 00000XXXX)
- It is extremely important that you do not use any extra characters, spaces, or words with the referral/authorization number or the claim will deny. For example, if the correct referral/authorization number is VA0001234567, referral numbers included in the following format would be denied/rejected:
    - Auth VA0001234567
    - Auth # VA0001234567
    - Ref VA0001234567
    - Ref # VA0001234567
    - VA 0001234567

Save and Print Options

VA Claim
Note GP modifier on PT

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

PICA | PICA

1. MEDICARE (Medicare#) | MEDICAID (Medicaid#) | TRICARE (ID#/DoD#) | CHAMPVA (Member ID#) | GROUP HEALTH PLAN (ID#) | FECA BLK LUNG (ID#) | OTHER (ID#)

1a. INSURED'S I.D. NUMBER (For Program in Item 1): 55555555A

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Beasley, Joe

3. PATIENT'S BIRTH DATE MM DD YY: 03 13 1960 SEX M [X] F [ ]

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street): 1234 Maine

6. PATIENT RELATIONSHIP TO INSURED: Self [X] Spouse [ ] Child [ ] Other [ ]

7. INSURED'S ADDRESS (No., Street)

CITY: Any City | STATE

8. RESERVED FOR NUCC USE

CITY | STATE

ZIP CODE: 00000 | TELEPHONE (Include Area Code): (555) 555-1212

ZIP CODE | TELEPHONE (Include Area Code) ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) YES [ ] NO [X]

a. INSURED'S DATE OF BIRTH MM DD YY | SEX M [ ] F [ ]

b. RESERVED FOR NUCC USE

b. AUTO ACCIDENT? YES [ ] NO [X] PLACE (State)

b. OTHER CLAIM ID (Designated by NUCC)

c. RESERVED FOR NUCC USE

c. OTHER ACCIDENT? YES [ ] NO [X]

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. CLAIM CODES (Designated by NUCC)

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES [ ] NO [ ] *If yes*, complete items 9, 9a, and 9d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED Signature on file DATE

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED Signature on file

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY: 05 02 2023 QUAL.

15. OTHER DATE QUAL. MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE | 17a. | 17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OUTSIDE LAB? YES [ ] NO [ ] $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind. 0

A. M5450 B. C. D.
E. F. G. H.
I. J. K. L.

22. RESUBMISSION CODE | ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER: ABC12345678

	24. A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1	05 02 23	05 02 23	11		99203	25	A	135 00	1		NPI	
2	05 02 23	05 02 23	11		97810		A	75 00	1		NPI	
3	05 02 23	05 02 23	11		97811		A	120 00	2		NPI	
4	05 02 23	05 02 23	11		97124	GP	A	60 00	1		NPI	
5	05 02 23	05 02 23	11		97016	GP	A	35 00	1		NPI	
6									1		NPI	

25. FEDERAL TAX I.D. NUMBER: 123456789 SSN [X] EIN [ ]

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES [X] NO [ ]

28. TOTAL CHARGE: 425 00

29. AMOUNT PAID

30. Rsvd.for NUCC Use

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION
John Smith LAc
54321 Spine Ave
Any City
a. NPI b.

33. BILLING PROVIDER INFO & PH # (555) 111-2222
John Smith LAc
54321 Spine Ave
Any City
a. 111222333 b.

CARRIER | PATIENT AND INSURED INFORMATION | PHYSICIAN OR SUPPLIER INFORMATION

Claim Status Check

Providers can check the status of claims through Availity.

- Login to Availity and then click on the Claims & Payments option located on the top-left
  - Under Claims & Payments, select the Claim Status option
- Providers can also search claims by:
  - Member ID
  - Tax ID Service date
  - Claim number

Claims Processing Time

- CCN strives to pay all clean claims within 30 days
- Notification of denial 45 days
- Claims are exempt for penalties and interest

- VA CCN providers should maintain medical records in a manner that is current, detailed, and organized. Medical documentation must be presented in a legible format.
- As part of the required VA CCN medical documentation, providers must have a release of medical records with the Veteran's signature on file. *(block 12 of the CMS1500)*
- When a Veteran has signed a release of information statement, providers should indicate "Signature on File" on the claim submission. A new signature is required every year.

- Medical records and documentation are required for all provided services. Providers are required to submit medical documentation directly to the authorizing VAMC, preferably via upload to the HSRM.
- VA requires providers submit medical documentation to the authorizing VAMC within the following timeframes:
  - Initial medical documentation for outpatient care – **30 days** of the initial appointment
  - Final outpatient medical documentation – **30 days** of the completion of the SEOC

Extent Of Meaningful Improvement

- Significant durable pain intensity decrease
- Functional improvement by clinically meaningful improvement on validated disease-specific outcomes instruments; return to work; and/or documented improvement in activities of daily living
- Documented decreased utilization of pain-related medications
- Objective measures demonstrating the extent of meaningful clinical improvement today and the rational for additional treatment requested example to reach further durable improvement or for ongoing pain management and any further information supporting the need for additional care
- Include any barriers to recovery such as complicating conditions or comorbidities but also how the patient has changed to date and how the care would continue the same trajectory

Dear Provider,

Veteran Information:
Patient name:
Date of birth:

The Boise VA has received the request for the above veteran to continue Acupuncture care.

Upon review, the following determination has been made:

REVIEW REQUESTED: ACUPUNCTURE CARE
RECOMMENDATION: DENIAL
RATIONALE: Documents provided by community clinician reviewed. Unable to identify evidence of improvement based on the requested use of an outcome tool. Provider notes reviewed in CPRS as well. No specific goals of care identified nor comments on improvement/status.

PCP/Community clinician welcomed to submit additional information via Office of Community Care.

PER POLICY, RECOMMEND THAT PCP/REQUESTING PROVIDER CONTACT VETERAN TO DISCUSS ALTERNATE CARE OPTIONS.

Should you have questions, please contact us at (208) 422-1000 to speak with a patient service representative. As a reminder, if applicable, return medical records within 30 days for routine services.

Sincerely,

Data Driven Care

PROMIS
Patient Reported Outcome Measurement Instruments

- General Pain Index
- Patient Specific Functional Scale
- PROMIS Short Form – Pain Interference
- Pain and Functional Rating Scale (VA & DOD)
- Oswestry (LBP index)
- Neck Disability Index

GENERAL PAIN INDEX QUESTIONNAIRE

We would like to know how much your pain ***presently*** prevents you from doing what you would normally do. Regarding each category, please indicate the ***overall*** impact your present pain has on your life, not just when the pain is at its worst.

Please ***circle the number*** which best describes how your typical level of pain affects these six categories of activities.

1. **FAMILY / AT-HOME RESPONSIBILITIES** SUCH AS YARD WORK, CHORES AROUND THE HOUSE OR DRIVING THE KIDS TO SCHOOL –

0 1 2 3 4 5 6 7 8 9 10

COMPLETELY ABLE TO FUNCTION — TOTALLY UNABLE TO FUNCTION

2. **RECREATION** INCLUDING HOBBIES, SPORTS OR OTHER LEISURE ACTIVITIES –

0 1 2 3 4 5 6 7 8 9 10

COMPLETELY ABLE TO FUNCTION — TOTALLY UNABLE TO FUNCTION

3. **SOCIAL ACTIVITIES** INCLUDING PARTIES, THEATER, CONCERTS, DINING –OUT AND ATTENDING OTHER SOCIAL FUNCTIONS –

0 1 2 3 4 5 6 7 8 9 10

COMPLETELY ABLE TO FUNCTION — TOTALLY UNABLE TO FUNCTION

4. **EMPLOYMENT** INCLUDING VOLUNTEER WORK AND HOMEMAKING TASKS –

0 1 2 3 4 5 6 7 8 9 10

COMPLETELY ABLE TO FUNCTION — TOTALLY UNABLE TO FUNCTION

5. **SELF -CARE** SUCH AS TAKING A SHOWER, DRIVING OR GETTING DRESSED –

0 1 2 3 4 5 6 7 8 9 10

COMPLETELY ABLE TO FUNCTION — TOTALLY UNABLE TO FUNCTION

6. **LIFE –SUPPORT ACTIVITIES** SUCH AS EATING AND SLEEPING –

0 1 2 3 4 5 6 7 8 9 10

COMPLETELY ABLE TO FUNCTION — TOTALLY UNABLE TO FUNCTION

PATIENT NAME ____ DATE ___________

SCORE_______ [60] BENCHMARK =5 _____________

The Patien-tSpecific Functional Scale

This useful questionnaire can be used to quantify activity limitation and measure functional outcome for patients with any orthopaedic condition.

Clinician to read and fill in below: Complete at the end of the history and prior to physical examination.

Initial Assessment:

I am going to ask you to identify up to three important activities that you are unable to do or are having difficulty with as a result of your__problem. Today, are there any activities that you are unable to do or having difficulty with because of your_________ ______________________________problem? (Clinician: show scale to patient and have the patient rate each activity).

Follow-up Assessments:

When I assessed you on (state previous assessment date), you told me that you had difficulty with (read all activities from list at a time). Today, do you still have difficulty with: (read and have patient score each item in the list)?

Patient-specific activity scoring scheme (Point to one number):

0 1 2 3 4 5 6 7 8 9 10

Unable to perform activity

Able to perform activity at the same level as before injury or problem

(Date and Score)

Activity	Initial					
1.						
2.						
3.						
4.						
5.						
Additional						
Additional						

Total score = sum of the activity scores/number of activities Minimum detectable change (90%CI) for average score = 2 points
Minimum detectable change (90%CI) for single activity score = 3 points

PSFS developed by: Stratford, P., Gill, C., Westaway, M., & Binkley, J. (1995). Assessing disability and change on individual patients: a report of a patient specific measure. Physiotherapy Canada, 47, 258-263.

Reproduced with the permission of the authors.

Pain Interference – Short Form 6a

Please respond to each question or statement by marking one box per row.

In the past 7 days…

		Not at all	A little bit	Somewhat	Quite a bit	Very much
1	How much did pain interfere with your day to day activities?	☐	☐	☐	☐	☐
2	How much did pain interfere with work around the home?......................................	☐	☐	☐	☐	☐
3	How much did pain interfere with your ability to participate in social activities?	☐	☐	☐	☐	☐
4	How much did pain interfere with your household chores?....................................	☐	☐	☐	☐	☐
5	How much did pain interfere with the things you usually do for fun?	☐	☐	☐	☐	☐
6	How much did pain interfere with your enjoyment of social activities?..................	☐	☐	☐	☐	☐

Pain Interference – Short Form 6b

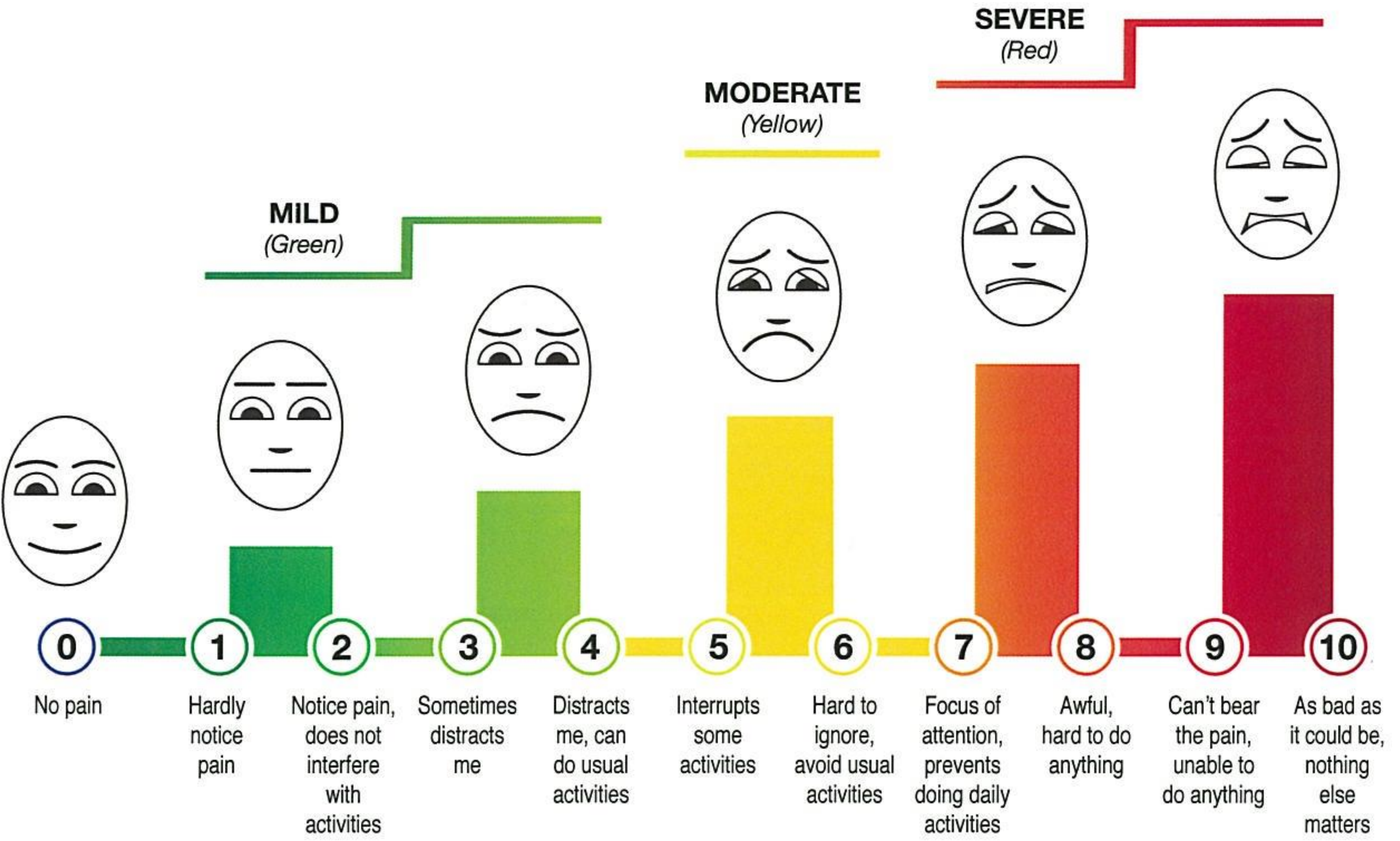
Please respond to each item by marking one box per row.

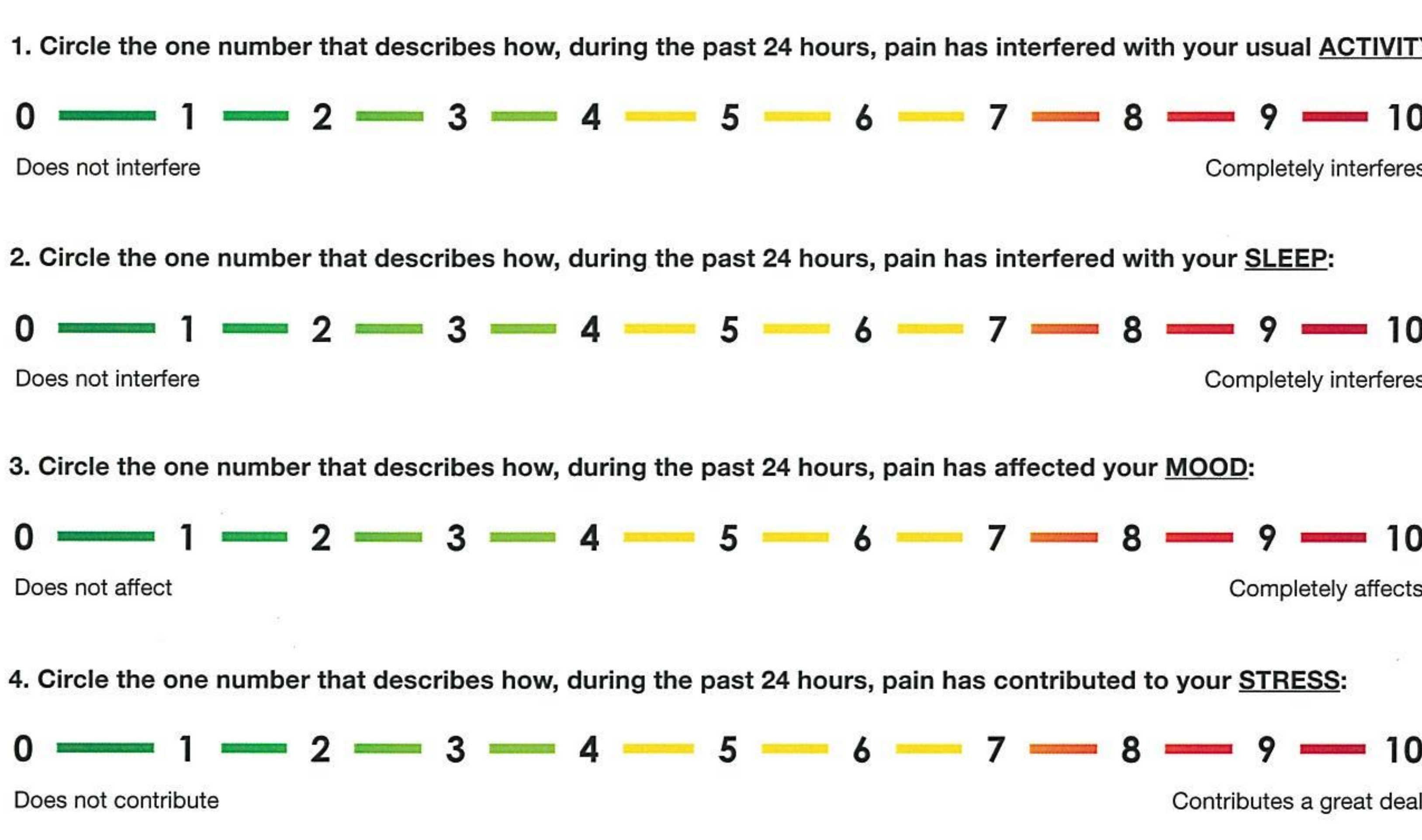
In the past 7 days…

		Not at all	A little bit	Somewhat	Quite a bit	Very much
PAININ3	How much did pain interfere with your enjoyment of life?……	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
PAININ8	How much did pain interfere with your ability to concentrate?……	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
PAININ9	How much did pain interfere with your day to day activities?……	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
PAININ10	How much did pain interfere with your enjoyment of recreational activities?……	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
PAININ14	How much did pain interfere with doing your tasks away from home (e.g., getting groceries, running errands)?……	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5

In the past 7 days…

		Never	Rarely	Sometimes	Often	Always
PAININ26	How often did pain keep you from socializing with others?……	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5


Defense and Veterans Pain Rating Scale
MILD
(Green)
MODERATE
(Yellow)
SEVERE
(Red)
0
No pain
1
Hardly notice pain
2
Notice pain, does not interfere with activities
3
Sometimes distracts me
4
Distracts me, can do usual activities
5
Interrupts some activities
6
Hard to ignore, avoid usual activities
7
Focus of attention, prevents doing daily activities
8
Awful, hard to do anything
9
Can't bear the pain, unable to do anything
10
As bad as it could be, nothing else matters
v 2.0



DoD/VA Pain Supplemental Questions

For clinicians to evaluate the biopsychosocial impact of pain

1. Circle the one number that describes how, during the past 24 hours, pain has interfered with your usual ACTIVITY:

0 — 1 — 2 — 3 — 4 — 5 — 6 — 7 — 8 — 9 — 10

Does not interfere | Completely interferes

2. Circle the one number that describes how, during the past 24 hours, pain has interfered with your SLEEP:

0 — 1 — 2 — 3 — 4 — 5 — 6 — 7 — 8 — 9 — 10

Does not interfere | Completely interferes

3. Circle the one number that describes how, during the past 24 hours, pain has affected your MOOD:

0 — 1 — 2 — 3 — 4 — 5 — 6 — 7 — 8 — 9 — 10

Does not affect | Completely affects

4. Circle the one number that describes how, during the past 24 hours, pain has contributed to your STRESS:

0 — 1 — 2 — 3 — 4 — 5 — 6 — 7 — 8 — 9 — 10

Does not contribute | Contributes a great deal

**Reference for pain interference: Cleeland CS, Ryan KM. Pain assessment: global use of the Brief Pain Inventory. Ann Acad Med Singapore 23(2): 129-138, 1994.*

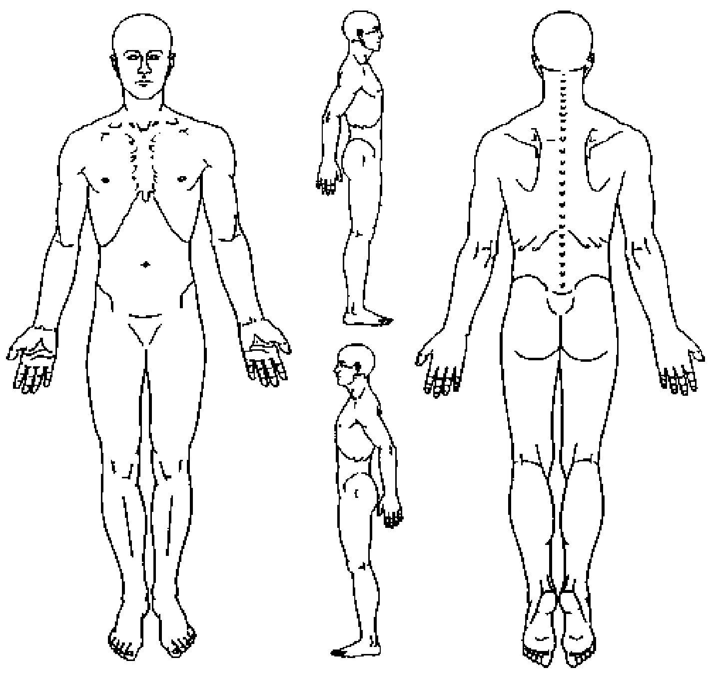
v 2.0

THE NECK DISABILITY INDEX QUESTIONNAIRE

NAME____ DATE ____________

How long have you had neck pain ______years ________months ______weeks

On the diagram below, please indicate where you are experiencing pain or other symptoms, right now. Please complete both sides of this form.



A = ACHE	**B** = BURNING	**N** = NUMBNESS
P = PINS & NEEDLES	**S** = STABBING	**O** = OTHER

OVER PLEASE ⇒

Please Read: This questionnaire is designed to enable us to understand how much your neck pain has affected your
ability to manage everyday activities. Please answer each Section by circling the **ONE CHOICE** that most applies to you. We realize that you may feel that more than one statement may relate to you, but Please just **circle the one choice which closely describes your problem *right now*.**

SECTION 1--Pain Intensity

A. I have no pain at the moment
B. The pain is mild at the moment.
C. The pain comes and goes and is moderate.
D. The pain is moderate and does not vary much.
E. The pain is severe but comes and goes.
F. The pain is severe and does not vary much.

SECTION 2--Personal Care (Washing, Dressing etc.)

A. I can look after myself without causing extra pain.
B. I can look after myself normally but it causes extra pain.
C. It is painful to look after myself and I am slow and careful.
D. I need some help, but manage most of my personal care.
E. I need help every day in most aspects of self-care.
F. I do not get dressed, I wash with difficulty and stay in bed.

SECTION 3--Lifting

A. I can lift heavy weights without extra pain.
B. I can lift heavy weights, but it causes extra pain.
C. Pain prevents me from lifting heavy weights off the floor but I can if they are conveniently positioned, for example on a table.
D. Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
E. I can lift very light weights.
F. I cannot lift or carry anything at all.

SECTION 4 --Reading

A. I can read as much as I want to with no pain in my neck.
B. I can read as much as I want with slight pain in my neck.
C. I can read as much as I want with moderate pain in my neck.
D. I cannot read as much as I want because of moderate pain in my neck.
E. I cannot read as much as I want because of severe pain in my neck.
F. I cannot read at all.

SECTION 5--Headache

A. I have no headaches at all.
B. I have slight headaches which come infrequently.
C. I have moderate headaches which come in-frequently.
D. I have moderate headaches which come frequently.
E. I have severe headaches which come frequently.
F. I have headaches almost all the time.

SIGNATURE:____________________ **DATE:** ________

DISABILITY INDEX SCORE: % __________

SECTION 6 -- Concentration

A. I can concentrate fully when I want to with no difficulty.
B. I can concentrate fully when I want to with slight difficulty.
C. I have a fair degree of difficulty in concentrating when I want to.
D. I have a lot of difficulty in concentrating when I want to.
E. I have a great deal of difficulty in concentrating when I want to.
F. I cannot concentrate at all.

SECTION 7--Work

A. I can do as much work as I want to.
B. I can only do my usual work, but no more.
C. I can do most of my usual work, but no more.
D. I cannot do my usual work.
E. I can hardly do any work at all.
F. I cannot do any work at all.

SECTION 8--Driving

A. I can drive my car without neck pain.
B. I can drive my car as long as I want with slight pain in my neck.
C. I can drive my car as long as I want with moderate pain in my neck.
D. I cannot drive my car as long as I want because of moderate pain in my neck.
E. I can hardly drive my car at all because of severe pain in my neck.
F. I cannot drive my car at all.

SECTION 9--Sleeping

A. I have no trouble sleeping
B. My sleep is slightly disturbed (less than 1 hour sleepless).
C. My sleep is mildly disturbed (1-2 hours sleepless).
D. My sleep is moderately disturbed (2-3 hours sleepless).
E. My sleep is greatly disturbed (3-5 hours sleepless).
F. My sleep is completely disturbed (5-7 hours sleepless).

SECTION 10--Recreation

A. I am able engage in all recreational activities with no pain in my neck at all.
B. I am able engage in all recreational activities with some pain in my neck.
C. I am able engage in most, but not all recreational activities because of pain in my neck.
D. I am able engage in a few of my usual recreational activities because of pain in my neck.
E. I can hardly do any recreational activities because of pain in my neck.
F. I cannot do any recreational activities all all.

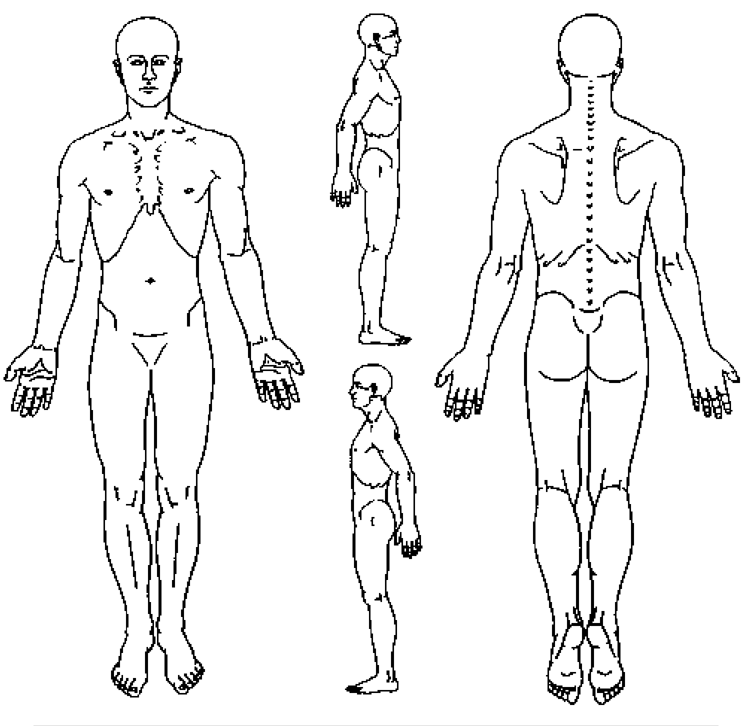
© Vernon H and Hagino C, 1991
(with permission from Fairbank J)

THE LOW BACK PAIN QUESTIONNAIRE

NAME ______________________________ DATE ___________

How long have you had back pain _______years _____months _____weeks

On the diagram below, please indicate where you are experiencing pain, right now. Please complete both sides of this form.



A = ACHE **B** = BURNING **N** = NUMBNESS
P = PINS & NEEDLES **S** = STABBING **O** = OTHER

Please Read: This questionnaire is designed to enable us to understand how much your low back has affected your ability to manage everyday activities. Please answer each Section by circling the **ONE CHOICE** that most applies to you. We realize that you may feel that more than one statement may relate to you, but Please **just circle the one choice which closely describes your problem *right now*.**

SECTION 1--Pain Intensity
A. The pain comes and goes and is very mild.
B. The pain is mild and does not vary much.
C. The pain comes and goes and is moderate.
D. The pain is moderate and does not vary much.
E. The pain is severe but comes and goes.
F. The pain is severe and does not vary much.

SECTION 2--Personal Care
A. I would not have to change my way of washing or dressing in order to avoid pain.
B. I do not normally change my way of washing or dressing even though it causes some pain.
C. Washing and dressing increase the pain, but I manage not to change my way of doing it.
D. Washing and dressing increase the pain and I find it necessary to change my way of doing it.
E. Because of the pain, I am unable to do any washing and dressing without help.
F. Because of the pain, I am unable to do any washing or dressing and essentially remain in bed.

SECTION 3--Lifting
A. I can lift heavy weights without extra pain.
B. I can lift heavy weights, but it causes extra pain.
C. Pain prevents me from lifting heavy weights off the floor.
D. Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned, e.g. on the table.
E. Pain prevents me from lifting heavy weights , but I can manage light to medium weights if they are conveniently positioned.
F. I can only lift very light weights, at the most.

SECTION 4 --Walking
A. Pain does not prevent me from walking any distance.
B. Pain prevents me from walking more than one mile.
C. Pain prevents me from walking more than 1/4 mile.
D. Pain prevents me from walking more than 100 yards.
E. I can only walk while using a cane or on crutches.
F. I am in bed most of the time and have to crawl to the toilet.

SECTION 5--Sitting
A. I can sit in any chair as long as I like without pain.
B. I can only sit in my favorite chair as long as I like.
C. Pain prevents me from sitting more than one hour.
D. Pain prevents me from sitting more than 1/2 hour.
E. Pain prevents me from sitting more than ten minutes.
F. Pain prevents me from sitting at all.

SECTION 6 -- Standing
A. I can stand as long as I want without pain
B. I have some pain while standing, but it does not increase with time.
C. I cannot stand for longer than one hour without increasing pain.
D. I cannot stand for longer than ½ hour without increasing pain.
E. I can't stand for more than 10 minutes without increasing pain.
F. Pain prevents me from standing at all.

SECTION 7--Sleeping
A. I get no pain in bed.
B. I get pain in bed, but it does not prevent me from sleeping.
C. Because of pain , my normal night's sleep is reduced by less than one-quarter.
D. Because of pain, my normal night's sleep is reduced by less than one-half.
E. Because of pain, my normal night's sleep is reduced by less than three-quarters.
F. Pain prevents me from sleeping at all.

SECTION 8--Social Life
A. My social life is normal and gives me no pain.
B. My social life is normal, but increases the degree of my pain.
C. Pain has no significant effect on my social life apart from limiting my more energetic interests, e.g., dancing, etc.
D. Pain has restricted my social life and I do not go out very often.
E. Pain has restricted my social life to my home.
F. I have no social life due to pain.

SECTION 9--Traveling
A. I get no pain while traveling.
B. I get some pain while traveling, but none of my usual forms of travel make it any worse.
C. I get extra pain while traveling, but it does not compel me to seek alternative forms of travel.
D. I get extra pain while traveling which compels me to seek alternative forms of travel.
E. Pain prevents all forms of travel except that done lying down.
F. Pain prevents all forms of travel.

SECTION 10--Changing Degree of Pain
A. My pain is rapidly getting better.
B. My pain fluctuates, but overall is definitely getting better.
C. My pain seems to be getting better, but improvement is slow at present.
D. My pain is neither getting better nor worse.
E. My pain is gradually worsening.
F. My pain is rapidly worsening.

DISABILITY INDEX SCORE: %______

Additional Visits? Chronic Care?

1. An initial or prior success with acupuncture services
2. Continued durable improvement in the condition being treated
3. Assessment of patient function after a withdrawal of care
4. Consideration of other care (medical, social, behavioral, PT, Chiro Psych- Likely already done)
5. Inclusion of active care strategies
6. Functional improvement by clinically meaningful improvement on validated disease-specific outcomes instruments; return to work; and/or documented improvement in activities of daily living
7. Documented decreased utilization of pain-related medications

Plan of Care

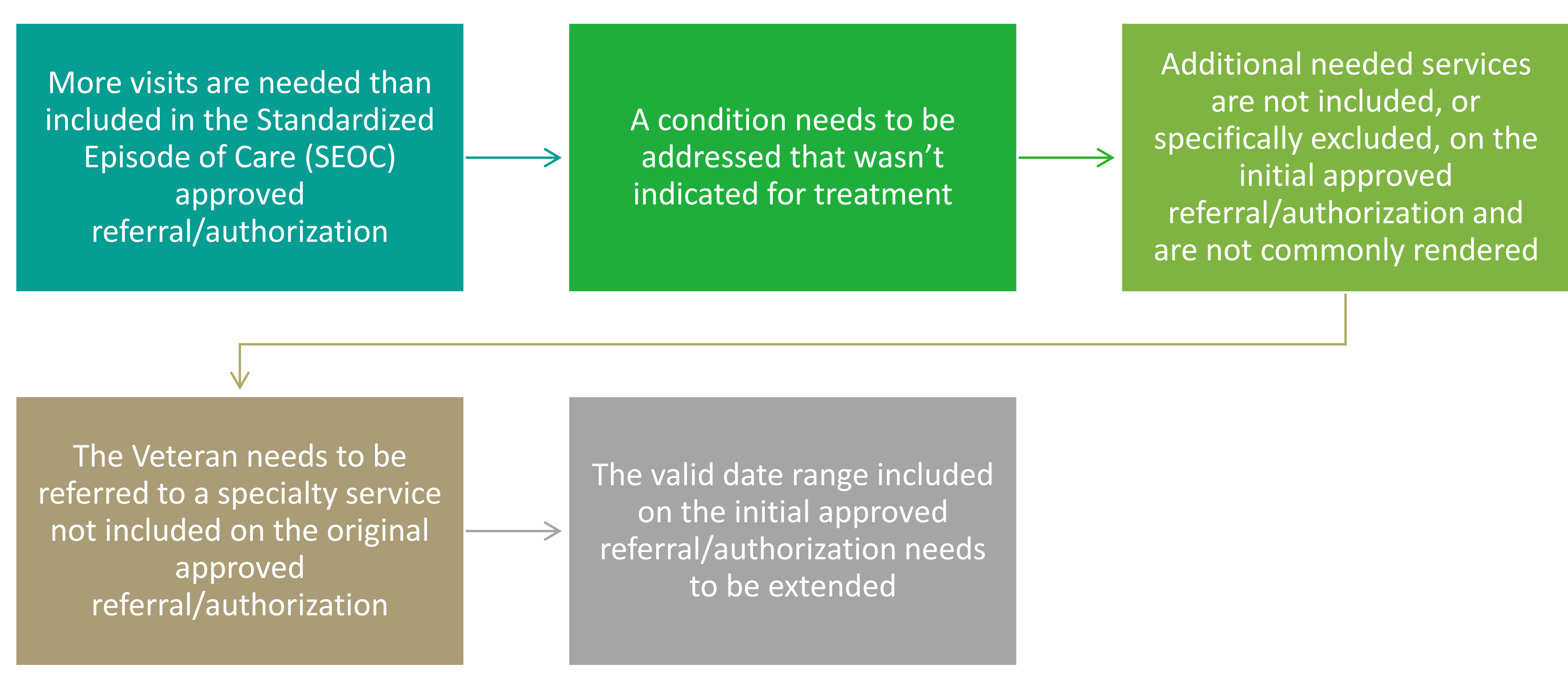
A multi-modal treatment approach, ideally addressing each of the biggest contributors to their pain, with interventions that are:

- Most effective (compared to other interventions in their category)
- Simple (complexity reduces compliance)
- Easily understood (if patients can't understand why they're doing them, they may not do them at all)
- Low-friction (low-tech/no-tech, easily done at home, more likely to get done)
- Reproducible across providers and patients (no guru needed – easily scalable across the MSK world and patient world)

Request For Additional Visits

Do not make any request for added visits before the visits that are preauthorized are completed or the time of authorization has elapsed.

Reasons to Submit an RFS to the VAMC



Request For Additional Visits

Requesting approval for additional services Providers must submit a Request for Service (RFS) form 10-10172 to VA

- RFS may be submitted online (preferred) via the HSRM
- VA will process all requests within three business days, and the provider will be notified of the decision or outcome through their preferred method of communication. The notification will also indicate if the care will be provided within VA or in the community. The provider is required to send the completed form to VA the same day the provider determines care is needed.
- Use this link to download the form
  - https://www.va.gov/find-forms/about-form-10-10172/

Department of Veterans Affairs

REQUEST FOR SERVICES (RFS) FORM

PREVIOUS AUTHORIZATION NUMBER:

TODAY'S DATE *(MM/DD/YYYY)*:

NOTE: The Request for Services (RFS) Form 10-10172 must be submitted via an approved method (HSRM, Electronic fax, Direct Messaging, traditional fax, or mail). Completion of this form is **REQUIRED and MUST BE SIGNED** by the requesting provider for further care to be rendered to a Veteran patient.

SECTION I: VETERAN INFORMATION

1. VETERAN'S LEGAL FULL NAME *(First, MI, Last)*:
2. DOB *(MM/DD/YYYY)*:
3. VA FACILITY:
4. VA LOCATION:

SECTION II: ORDERING PROVIDER INFORMATION

5. REQUESTING PROVIDER'S NAME:
6. NPI #:
7. SPECIALTY:
8. OFFICE NAME & ADDRESS:
9. SECURE EMAIL ADDRESS:
10. PHONE NUMBER:
11. FAX NUMBER:
12. ☐ INDIAN HEALTH SERVICES (IHS) PROVIDER?

SECTION III: TYPE OF CARE REQUEST

13. **PLEASE INDICATE CLINICAL URGENCY** *(Urgent care is only applicable for requests that require less than 3 days to process. If care is needed within 48 hours or if Veteran is at risk for Suicide/Homicide, please call the VA directly on the same day as completed RFS form submission. Do NOT mark urgent for administrative urgency)*:
☐ ROUTINE ☐ URGENT
14. DIAGNOSIS *(ICD-10 Code/Description)*:
15. DATE OF SERVICE *(MM/DD/YYYY)* &/OR ANTICIPATED LENGTH OF CARE:
16. CPT/HCPCS CODE &/OR DESCRIPTION OF REQUESTED SERVICES *(Include units/visits, add second list page, if needed)*:
17. HOW MANY VISITS HAVE OCCURRED SO FAR? *(If known)*
18. IS THIS A REFERRAL TO ANOTHER SPECIALTY?
☐ YES *(If "YES," please fill out the Servicing Provider/Specialty information below)* ☐ NO
19. SERVICING PROVIDER'S NAME:
20. NPI #:
21. SPECIALTY:
22. OFFICE NAME & ADDRESS:
23. SECURE EMAIL ADDRESS:
24. PHONE NUMBER:
25. FAX NUMBER:

SECTION IV: TYPE OF SERVICE REQUESTED

26. OUTPATIENT CARE: ☐ PT ☐ OT ☐ SPEECH THERAPY
FREQUENCY & DURATION:
27. SURGICAL PROCEDURE: ☐ INPATIENT ☐ OUTPATIENT
FACILITY NAME:
28. ☐ IN-OFFICE PROCEDURE
29. INPATIENT CARE: ☐ LTACH ☐ ACUTE REHAB ☐ BH
30. ☐ ADDITIONAL OFFICE VISITS *(List # needed)*:
31. ☐ EXTENSION OF VALIDITY DATES
32. ☐ EMERGENCY ROOM CARE
33. ☐ LABS *(If done outside of office, please provide facility above)*
34. ☐ RADIOLOGY/IMAGING *(If done outside of office, please provide facility above)*
35. ☐ PRE-OPS LABS ☐ CHEST XRAY ☐ EKG
☐ OTHER:
36. JUSTIFICATION FOR REQUEST *(To avoid delays in care, include appropriate documentation such as office notes, current treatment plans, clinical history, laboratory results, radiology results &/or medications to support the medical necessity of services requested).*

VETERAN'S LEGAL FULL NAME *(First, MI, Last)*:

SECTION V: GERIATRICS AND EXTENDED CARE SERVICES *(If applicable)*

37. ☐ COMMUNITY ADULT DAY HEALTH CARE ☐ COMMUNITY NURSING HOME ☐ HOMEMAKER/HOME HEALTH AIDE
☐ HOME INFUSION ☐ HOSPICE/PALLIATIVE CARE ☐ RESPITE
☐ SKILLED HOME HEALTH CARE ☐ OTHER:

FREQUENCY & DURATION:

38. JUSTIFICATION FOR REQUEST *(To avoid delays in care, include appropriate documentation such as office notes, current treatment plans, clinical history, laboratory results, radiology results &/or medications to support the medical necessity of services requested).*

SECTION VI: HOME OXYGEN INFORMATION *(If applicable)*

39. PA02 AT REST:	40. O2 SAT AT REST:	41. OXYGEN FLOW RATE:

42. EXTENT OF SUPPORT *(Continuous, Intermittent, Specific Activity)*:

43. OXYGEN EQUIPMENT *(Stationary/Portable)*:

44. DELIVERY SYSTEM *(Cannula, Mask, Other)*:

SECTION VII: DME & PROSTHETICS INFORMATION *(If applicable)*

45. HCPS FOR THE ITEM(S) BEING PRESCRIBED:

46. BRAND, MAKE, MODEL, PART NUMBERS:

47. MEASUREMENTS:

48. QUANTITY:	49. ICD-10:	50. PROVISIONAL DIAGNOSIS:

51. DELIVERY/PICKUP OPTIONS:

☐ DELIVER TO ORDERING PROVIDER'S ADDRESS ☐ VETERAN WILL PICKUP AT THE VA MEDICAL CENTER
☐ DELIVER TO COMMUNITY VENDOR FOR DELIVERY & SETUP FOR DME ☐ DELIVER TO VETERAN'S HOME

SECTION VIII: DURABLE MEDICAL EQUIPMENT *(DME)* EDUCATION & TRAINING *(If applicable)*

Please see DME Requirements/Pharmacy Requirements - Community Care (va.gov) for URGENT DME requests.

NOTE: Failure to thoroughly complete the RFS for DME will result in delayed patient care & prevent the VA from DME fulfillment.

52. BEFORE DME WILL BE ISSUED, EDUCATION, TRAINING, &/OR FITTING OF DME *(as applicable for the specific DME being ordered)* TO THE VETERAN MUST BE COMPLETE. PLEASE INDICATE WHETHER THE FOLLOWING HAS BEEN COMPLETED FOR THE VETERAN. **NOTE:** If not completed, DME will be mailed to requesting provider's address to coordinate an alternative time for proper instruction on DME use.	A. EDUCATION: ☐ YES ☐ NO B. TRAINING: ☐ YES ☐ NO ☐ N/A C. FITTING: ☐ YES ☐ NO ☐ N/A

53. JUSTIFICATION FOR REQUEST *(To avoid delays in care, include appropriate documentation such as office notes, current treatment plans, clinical history, laboratory results, radiology results &/or medications to support the medical necessity of services requested).*

VETERAN'S LEGAL FULL NAME *(First, MI, Last)*:

SECTION IX: THERAPEUTIC FOOTWEAR ASSESSMENT INFORMATION *(If applicable)*

54. FILL OUT THE INFORMATION BELOW *(If applicable)*:

☐ LEFT FOOT ☐ RIGHT FOOT ☐ BILATERAL

☐ PREFABRICATED THERAPEUTIC FOOTWEAR

☐ CUSTOM THERAPEUTIC FOOTWEAR

NOTE: For prescription of therapeutic footwear for severe or gross foot deformity which cannot be accommodated with conventional footwear.

DESCRIBE FOOT DEFORMITY AND ADDITIONAL DETAILS:

NOTE: For prescription of therapeutic footwear due to disease pathology resulting in neuropathy or peripheral artery disease.

55. CHECK APPROPRIATE DIABETIC/AMPUTATION RISK SCORE:

☐ RISK SCORE 2: PATIENT DEMONSTRATED SENSORY LOSS *(inability to perceive the Semmes-Weinstein 5.07 monofilament)*, DIMINISHED CIRCULATION AS EVIDENCED BY ABSENT OR WEAKLY PALPABLE PULSES, FOOT DEFORMITY, OR MINOR FOOT INFECTION, & A DIAGNOSIS OF DIABETES.

☐ RISK SCORE 3: PATIENT DEMONSTRATED PERIPHERAL NEUROPATHYWITH SENSORY LOSS *(i.e., inability to perceive the Semmes-Weinstein 5.07 monofilament)*, AND DIMINISHED CIRCULATION, AND FOOT DEFORMITY, OR MINOR FOOT INFECTION & A DIAGNOSIS OF DIABETES, OR ANY OF THE FOLLOWING BY ITSELF: (1) PRIOR ULCER, OSTEOMYELITIS OR HISTORY OF PRIOR AMPUTATION; (2) SEVERE PERIPHERAL VASCULAR DISEASE *(PVD) (intermittent claudication, dependent rubor with pallor on elevation, or critical limb ischemia manifested by rest pain, ulceration or gangrene)*; (3) CHARCOT'S JOINT DISEASE WITH FOOT DEFORMITY; & (4) END STAGE RENAL DISEASE.

NOTE: Only patients who are experiencing medical conditions noted in the risk scores can be prescribed therapeutic/diabetic footwear.

***ATTESTATION:** I do hereby attest that the forgoing information is true, accurate, & complete to the best of my knowledge & I understand that any falsification, omission, or concealment of material fact may subject me to administrative, civil, or criminal liability.

I do hereby acknowledge that VA reserves the right to perform the requested service(s) if the following criteria are met: (1) The patient agrees to receive services from VA (2) Service(s) are available at VA facility & are able to be provided by the clinically indicated date (3) It is determined to be within the patients best interest. Upon completion of the requested service(s), VA will provide all resulting medical documentation to the ordering provider. If all criteria listed are not true & VA agrees the service(s) are clinically indicated, VA will provide a referral for services to be performed in the community.

I do hereby attest that upon receipt of order/consult results, I will assume responsibility for reviewing said results, addressing significant findings, & providing continued care.

56. REQUESTING PROVIDER SIGNATURE *(Required)*:	57. TODAY'S DATE *(MM/DD/YYYY)*:

To facilitate timely review of this request, the most recent office notes & plan of care must accompany this signed form.

For more information please visit: https://www.va.gov/COMMUNITYCARE/providers/Care_Coordination.asp.

VA Community Care Medical Policies describe standard VA health care benefit for services and procedures that community providers may recommend as necessary for a Veteran. Prior to providing care, providers should use the Community Care Medical Policies as a reference when determining if a Veteran meets VA clinical criteria. When additional services are requested, Community Care Medical Policies will be used to determine approval by a clinical reviewer. Community Care Medical Policies & supporting information can be found at: https://www.va.gov/COMMUNITYCARE/providers/Medical-Policy.asp

- VA prefers providers submit an RFS via **HSRM**.
- To access and submit an RFS online:
- Go to the **VA Storefront**
  - Click “Request and Coordinate Care” on the left-hand navigation bar under “For Providers”
  - Click “Request for Service (RFS) Requirements”
  - Navigate to the link to the RFS form at the bottom of the section
- Send the RFS directly to the authorizing VAMC via:
  - VA’s **HSRM portal** (preferable) or an EDI 278 transaction
  - Direct messaging
  - Secure email
  - Secure online file exchange
  - eHealth Exchange
- Once approved, providers will receive an authorization letter from either your VAMC or TriWest. Providers can also check the RFS status through VA’s **HSRM** (which is preferable), EDI 278 transaction, or by calling the VAMC.

Self-Service Resources and Educational Videos

https://vacommunitycare.com/training-and-guides

Acupuncturists: 8 Criteria to Include in All Medical Documentation

If you're an acupuncturist treating a Veteran, did you know VA uses your medical documentation as evidence that your patient needs more care?

This is why ensuring your medical documentation is complete and thorough is so important. In order to provide effective information to VA when making a request for additional care through use of a RFS, include these eight criteria in your medical documentation every time:

1. Date of treatment
2. Specific treatment
3. Total treatment time
4. Response to treatment
5. Reassessment of progress
6. Progress toward goals
7. Barriers
8. Name and credentials

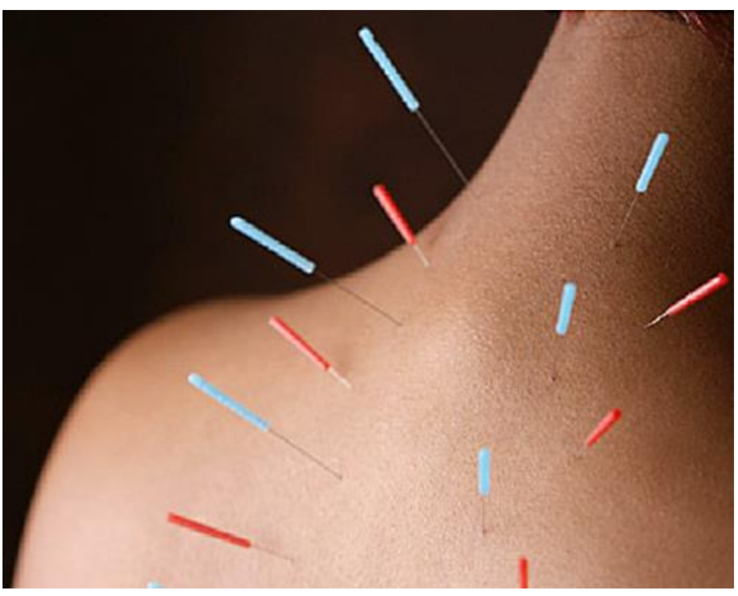
Of these eight criteria, providers in the TriWest network are most commonly forgetting to include these three important items:

- Reassessment of progress
- Progress towards goals
- Barriers to improvement

These items speak heavily toward the need for additional care. If VA is unable to verify that clinical need, it is unlikely to approve additional care.

A Final Note on Needles

TriWest reminds our network acupuncturists to please remember to remove all needles from patients after completing a session. Through TriWest's Clinical Quality Management, Complaints, and Grievances processes, several Veterans have reported leaving a treatment site and later finding one or more needles that were not removed by the practitioner.



Functional Change

Questions?

- What if care is not authorized?
- Is their post-authorization?
- What provides the best chance to get care authorized?
- What happens if they have an unrelated accident or condition?
- What can I do if they indicate “network” is full?