

VETERAN DIRECTED CARE (VDC) BILLING AND INVOICING GUIDE

Veteran Directed Care (VDC) Billing and
Invoicing Guide



Table of Contents

I. Introduction	3
II. Overview	4
III. VAMC Referrals and VDC Authorizations	5
<i>VAMC Authorizations</i>	5
<i>Authorization Annotation</i>	5
<i>HealthShare Referral Manager (HSRM)</i>	6
<i>VA Purchased HCBS Case-Mix and Budget Tool</i>	7
<i>Case-Mix Rate Components</i>	7
IV. VDC Spending Plan Submissions and Approvals.....	9
<i>Person-Centered Counseling Assessment</i>	9
<i>VDC Spending Plan</i>	9
<i>VDC Workers and Authorized Representatives</i>	10
<i>VDC Authorized Budget, Planned Purchases, and Emergency Back-up Care</i>	10
<i>VDC Assessment Fee</i>	12
V. VDC Monthly Service Reports	13
<i>Monthly Documentation of Spending</i>	13
<i>Calculating Daily Rate</i>	14
<i>VDC Invoices Based on Actual Spending and Tracking of Total Spending</i>	14
<i>First and Last Month of Enrollment: VDC Monthly Administrative Rates</i>	15
<i>Hospital and Nursing Home Admissions for Veterans Enrolled in VDC</i>	15
VI. VDC Invoices	16
<i>Completing a VDC Invoice and Providing Supporting Documentation</i>	16
<i>VDC Invoice Submission</i>	17
<i>Corrected Bills</i>	17
VII. Monitoring of VDC Accounts Receivable	19
<i>VA Customer Engagement Portal (CEP)</i>	19
<i>Timeliness of Submitting VDC Invoices and Receiving Reimbursement</i>	20
Appendix A. Switching from Paper to Electronic VDC Invoices	21
Appendix B. Common Billing Issues and Recommendations for Reaching a Resolution.....	22
Appendix C. Veteran Directed Care Case Mix Rate Calculator	23

Appendix D. Veterans Health Administration Office of Community Care Provider Claim Resubmission Guide	24
Appendix E. Step-by-Step Guide for Completing Paper Invoices Using the UB-04 Claim Form	26
Appendix F. Sample UB-04 Claim Form and Accompanying Monthly Services Report Documentation	30
Appendix G. Veteran Directed Care Billing and Invoicing Guide Glossary of Terms	34

I. Introduction

The Veteran Directed Care (VDC) Billing and Invoicing Guide, hereinafter referred to as the “Guide,” is a resource that outlines billing and invoicing procedures to assist with and ensure timely and accurate reimbursement for VDC invoices. The Guide supplements guidance from the U.S Department of Veterans Affairs’ (VA) that standardizes VA billing requirements, payment processes, the use of the Purchased Home and Community Based Services (HCBS) Case-Mix and Budget Tool, as well as associated case-mix rates, assessment rates, emergency back-up care and planned purchases, and the submission of VDC invoices to VA. While the VA guidance is primarily targeted towards VA Medical Centers (VAMCs), the Guide provides detailed information regarding billing and invoicing procedures for both VAMCs and VDC providers¹ developing or operating VDC programs.

The Guide includes details on:

- VA resources to assist with managing VA referrals and tracking VDC invoices:
 - The HealthShare Referral Manager (HSRM), a VA online portal for community providers to manage VA referrals; and
 - The Customer Engagement Portal, an online VA portal for tracking the status of VDC invoices.
- Budgeted amounts for VDC authorizations;
- Additional items to be included in a Veteran’s spending plan;
- Clarifying the use of the emergency back-up care and planned purchases;
- Monthly Service Report submission guidelines; and
- Strategies for submitting VDC invoices electronically using Electronic Data Interchange (EDI) 837 and switching from paper VDC invoices, using UB-04 (also known as the CMS 1450) Claim Form, to electronic VDC invoices.

¹ VDC providers include Aging and Disability Resource Centers (ADRCs), Area Agencies on Aging (AAAs), Centers for Independent Living (CILs), or State Units on Aging (SUA) that have a signed Veteran Care Agreement with a VA Medical Center.

II. Overview

There are five steps in the VDC billing and invoicing process (**Figure 1**):

Step 1: VDC providers **receive a Veteran authorization** from a VAMC. The Veteran authorization includes a VA authorization number required to be included on all VDC invoices and demographic and health information pertaining to the Veteran and, in some circumstances, the Veteran’s caregiver.

Step 2: VDC providers complete a person-centered counseling (PCC) assessment and facilitate a process that supports the Veteran to **develop a VDC spending plan** that must be approved by the VAMC and updated during the Veteran’s enrollment in VDC.

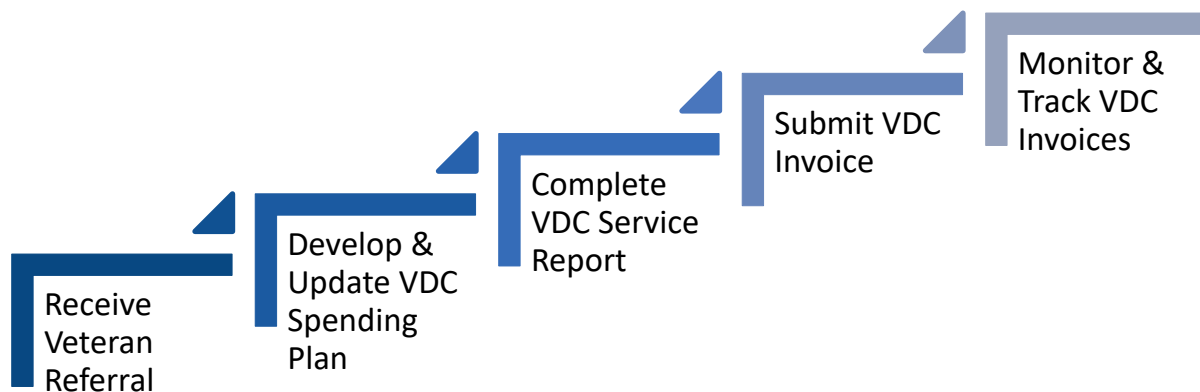
Step 3: After the VAMC approves the VDC spending plan, VDC providers **complete a VDC Monthly Service Report** that lists goods and services purchased during the month, the monthly administrative fee, and the days in the month when care was provided.

Step 4: VDC providers **submit the VDC invoice** and **VDC Monthly Service Report** electronically to the VAMC for payment. VA strongly encourages the electronic submission of invoices to improve the accuracy and timeliness of payment.

Step 5: VDC providers **monitor and track VDC invoices** to verify timely payment and follow-up promptly with any outstanding invoices greater than 45 days.

This guide provides more information regarding each of these five major processes.

Figure 1. VDC Billing and Invoicing Processes



III. VAMC Referrals and VDC Authorizations

VAMCs refer Veterans to VDC providers for VDC enrollment. At the time of referral, VAMCs send VA authorizations and accompanying information about the Veteran and caregiver to the VDC provider. This section provides more information on the process for receiving Veteran referrals, authorizations for VDC, HSRM, and the VA Purchased HCBS Case-Mix and Budget Tool.

VAMC Authorizations

VAMCs refer Veterans to VDC providers for enrollment in VDC. At the time of referral, the VAMC sends the VDC provider a Veteran authorization that includes the authorization number, the authorization period, amount of the full and partial assessment fees, the Veteran's authorized budget for the authorization period, and the average monthly budget. Veteran authorizations cover specific time periods, which are noted in the authorization and vary by VAMC. Most VAMCs send Veteran authorizations for twelve-months, although it's critical that VDC providers check the actual period which could vary based on local practices. Additionally, VAMCs send other information pertaining to the Veteran and caregiver including contact information, demographics, diagnostic code (using ICD-10 classification), and other pertinent health information. VDC providers and VAMCs can use the Veteran Information Sheet (see call-out box) as a resource for discussing documentation that would be helpful to share at the time of referral to support VDC enrollment.

VA developed a Veteran Information Sheet that can be used to share information on the Veteran and caregiver between the VAMC and VDC provider at the time of referral.

If the Veteran's case-mix level is not determined at the time of referral, the VAMC will only send a Veteran authorization with the full and partial assessment fee (see next section for more information on case-mix levels). In this situation, the VAMC will send a second authorization once the case-mix level is determined with the Veteran's authorized budget and monthly budget.

Many VAMCs are using VA [REFDOC](#), an information technology (IT) solution, which sends the Veteran's electronic medical record and other information in PDF format to the VDC provider. If you are a VDC provider not using VA REFDOC, you can discuss with your VAMC if VA REFDOC is available for your VDC program.

The VAMC and VDC provider track the expiration date for authorizations and ensure re-authorizations are sent and received for Veterans who stay enrolled in VDC beyond the initial authorization period. At least 30 days before the end of the authorization, the VDC provider verifies with the VAMC that a new authorization is anticipated. **VA is not required to pay for any care provided if there is no authorization covering the date of service.**

Authorization Annotation

As of June, 2019, VA requires an authorization number on all 837 Electronic Data Interchange (EDI) and paper claim submissions using the UB-04 Form for preauthorized services. For

electronic claim submissions using the EDI 837, the Referral Number is Loop = 2300, Segment = REF*9F, Position = REF02 or Prior Authorization, Loop = 2300, Segment = REF*G1, Position = REF02. If submitting a paper claim, VDC providers **must** list the authorization number on Field #63 of the UB-04 claim form, titled “Treatment Authorization Codes.”

HealthShare Referral Manager (HSRM)

[HSRM](#) is a secure online portal for managing referrals and authorizations and is available to all VA community providers at no cost. HSRM facilitates the exchange of health care information and provides a platform for VAMCs to send referrals to VDC providers and issue authorizations. Through HSRM, VAMCs have the ability to share important information about the Veteran including their authorization and authorization number, case-mix level, budgeted amount, and standard episode of care (SEOC).

HSRM allows for up-to-date status tracking for every referral and reduces time spent using slower means of communication such as fax, phone, or email before serving a Veteran, and reduces turnaround time for authorizations and reimbursement.

HSRM Referral Page

Referring Facility	Last Name	First Name	Date of Birth	SSN	Service	Priority	Optional Task(s)	Date Added	Referral Number	Category of Care	Status	Community Provider / Facility	Appt Date
Canandaigua VA Medical Center	ONE	Veteran	01/01/1900	000000000	Hematology SEOC 1.0.2 PRCT	Routine		02/07/2019	VA0000000718	HEMATOLOGY	First Appointment Made	ACUTE & WELLNESS CHIROPRACTIC CLINIC	03/13/2019
Canandaigua VA Medical Center	ONE	Veteran	01/01/1900	000000000	Newborn Care SEOC 1.0.2 PRCT	Routine		02/07/2019	VA0000000712	NEWBORN CARE	Sent	ACUTE & WELLNESS CHIROPRACTIC CLINIC	
Canandaigua VA Medical Center	ONE	Veteran	01/01/1900	000000000	Lab and Pathology SEOC 1.0.2 PRCT	Routine		02/07/2019	VA0000000719	LAB AND PATHOLOGY	Sent	ACUTE & WELLNESS CHIROPRACTIC CLINIC	
Canandaigua VA Medical Center	ONE	Veteran	01/01/1900	000000000	Emergency/Urgent Care SEOC 1.0.2 PRCT	Routine		03/07/2019	VA0000000804	ER VISIT/URGENT CARE	Sent	ACUTE & WELLNESS CHIROPRACTIC CLINIC	
Canandaigua VA Medical Center	ONE	Veteran	01/01/1900	000000000	Allergy and Immunology SEOC 1.0.3 PRCT	Routine		05/31/2019	VA0000001171	ALLERGY AND IMMUNOLOGY	Sent	ACUTE & WELLNESS CHIROPRACTIC CLINIC	
Canandaigua VA Medical Center	THREE	Veteran	01/01/1900	666010003	Cardiology - Cath/PCI SEOC 1.0.4	Routine		05/31/2019	VA0000001173	CARDIOLOGY TESTS, PROCEDURES, STUDIES	Sent	ACUTE & WELLNESS CHIROPRACTIC CLINIC	

HSRM continues to be deployed across VAMCs on a phased development schedule, therefore, VDC providers are encouraged to communicate with their VAMC partners regarding the implementation timeline and other relevant information. Community providers can register for the HSRM training by signing up and viewing the weekly webinar (every Tuesday 1-3 PM Eastern) through the [VHA TRAIN website](#). For more information about HSRM, visit the [OCC Website](#).

VA Purchased HCBS Case-Mix and Budget Tool

VAMCs use the [Purchased Case-Mix & Budget Tool](#) to determine the Veteran's level of need for in-home assistance to maximize their independence and avoid costly nursing home services. Completion of this tool leads to a case-mix level, which provides a dollar amount that is the average monthly authorized service spending amount for the individual Veteran (i.e., the case-mix rate). The case-mix rate is inclusive of the Veteran's monthly spending plan to purchase goods and services as well as the monthly administrative costs for the VDC provider (The [Case-Mix Rates Components](#) section includes more information on case-mix rates).

The VA Purchased Case-Mix & Budget Tool description and scoring criteria can be found on [ACL's VDC webpage on the No Wrong Door \(NWD\) website](#)

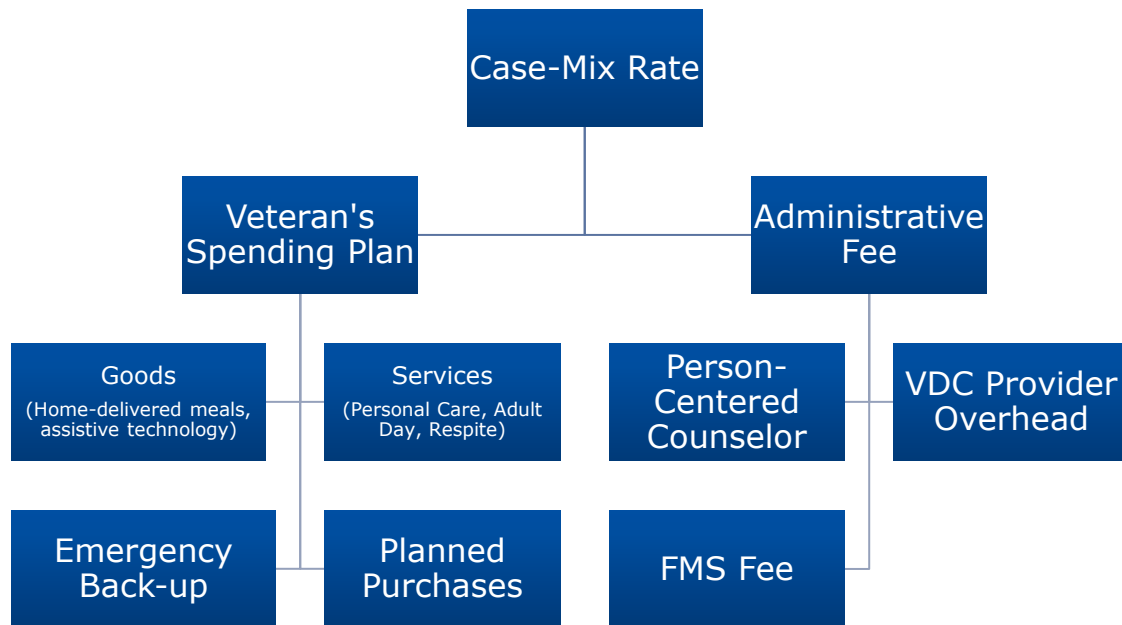
The Purchased Case-Mix and Budget Tool is an activities-of-daily-living (ADL) based instrument that screens for appropriate funding based on a Veteran's clinical and functional needs. The VDC provider's person-centered counselor facilitates a much more in-depth assessment of actual service needs and preferences with the Veteran after the case-mix determination is made. Completed independently of the case-mix instrument, this assessment is also known as a person-centered counseling (PCC) assessment. More information about the PCC assessment is included in [Section IV](#).

VAMCs are responsible for completion of the Purchased Case-Mix & Budget Tool before enrolling Veterans in the VDC program. VDC providers should collaborate with their partnering VAMC to determine if there is any clinical information and/or change in the functional status that may impact the Veteran's case-mix level.

Case-Mix Rate Components

After the Purchased Case-Mix & Budget Tool is completed, the Veteran is assigned a case-mix rate. The case-mix rate is a bundled rate that includes the Veteran's estimated monthly budget and administrative costs of the VDC provider. **Figure 2** provides an overview of the different components that make up the Veteran's estimated monthly budget and monthly administrative fee. VA Case-Mix Rates are published by VA Central Office and are available online at the [ACL NWD Website](#). The Veteran Health Administration (VHA) developed the Fiscal Year (FY) 2020 Case Mix Rate Calculator to locate Veteran Directed Care case-mix rates by state, county and case-mix level. Please refer to [Appendix C](#) for more information on the VDC Case Mix Rate Calculator.

Figure 2. VDC Case-Mix Rate Components



How This Works!

After completion of the Purchased HCBS Case-Mix and Budget Tool, a Veteran living in Seattle, Washington, is assigned to case-mix "E"

- A Veteran living in King County in Seattle, WA for case-mix "E" has a case-mix rate of \$3,555.
 - \$2,846 is the Veteran's average monthly spending plan to purchase goods and services but may be higher and lower depending on the month (further described in Section IV).
 - \$709 covers the VDC provider's administrative fees to include the person-centered counselor, VDC provider administration and overhead, and the FMS fee.

IV. VDC Spending Plan Submissions and Approvals

After receiving a Veteran referral and authorization, the VDC provider conducts a PCC assessment with the Veteran, facilitates a process that supports the Veteran to develop a spending plan for VAMC approval, and an invoice for either the full or partial assessment fee. This section provides information on these processes in further detail.

Person-Centered Counseling Assessment

After the Purchased Case-Mix Budget Tool is completed and the Veteran is assigned a case-mix rate, the VDC provider's person-centered counselor completes a PCC assessment with the Veteran.² The purpose of the in-person PCC assessment is to:

- Engage with the Veteran to identify who shall be part of the planning process;
- Facilitate a process that helps the Veteran identify their goals, strengths, and preferences of care;
- Conduct a comprehensive review of resources and informal supports; and
- Provide the Veteran with information and support to make an informed choice of available services and goods in the development of a person-centered plan.

More information on the PCC assessment is included in the VDC Policy and Procedures Manual.

VDC Spending Plan

After completing the PCC assessment, the person-centered counselor either helps the Veteran (a) develop a person-centered spending plan that the VAMC will review, edit and/or approve; or, (b) learn that the Veteran does not want to self-direct their care and notify the VAMC VDC Coordinator so they can discuss other options that may meet the Veteran's needs and preferences.³

If the Veteran enrolls in VDC and a spending plan is developed, the spending plan will include:

- Information about the employees the Veteran hired, how much the worker(s) will be paid, and an estimate of the number of hours worked per month;
- An estimate of other personal care services and/or goods that the Veteran will purchase monthly;
- Information about back-up or emergency workers, in the case that a primary worker or caregiver is unable to provide care;

² In some VDC programs, the VDC provider may complete the [VHA Purchased HCBS Case-Mix Budget Tool](#) during the same visit at the PCC assessment.

³ See Section IV's subsection, [VDC Assessment Fee](#), which describes the process for invoicing the VAMC if the Veteran does not meet eligibility requirements for VDC enrollment.

- An estimate of any one-time goods or services by dollar amount and estimated date of purchase;
- Estimated average monthly spending by individual worker, good, and service;
- Estimated average monthly invoice; and
- Estimated total Veteran spending during the period of the authorization, including all Veteran spending including one-time goods or services, and monthly administrative fees.

Example: If a Veteran hires two individual workers, the supporting documentation can explain how one worker will support improving the Veteran’s engagement in the community by driving and supervising activities outside of the home and the other worker will support the Veteran with bathing and dressing needs on a daily basis.

VDC programs can use the [VDC Monthly Services Report Template](#) to build the Veteran’s spending plan. Supporting documentation from the PCC assessment must also be submitted with the VDC spending plan so that the VAMC understands how the Veteran intends to use their VDC budget to meet their individualized goals.

VDC Workers and Authorized Representatives

VDC workers hired by the Veteran will not be paid an hourly rate that exceeds the hourly rate allowed by the state program for agency services (excluding employer tax costs). The average VDC worker hourly rate ranges from \$15.00 – \$20.00/hour (excluding employer tax costs) but may be exceeded if necessary. The hourly rate will directly impact the hours of service allotted for the VDC worker as calculated in the Veteran’s VDC budget. Additionally, any Veteran who is uncomfortable, or, unable to independently manage the VDC employer responsibilities can select a designated representative to manage the budget on his or her behalf. A designated representative may be an individual’s legal guardian, family member, friend, or any other person identified by the individual to manage the program on their behalf and in their best interest. Veteran-designated representatives cannot serve as paid workers.

State and local policy requirements regarding background checks may vary but it is recommended that Veterans complete a background check on all VDC workers. VDC providers should follow state guideline requirements for workers and background checks. Individuals with any history of fraud or abuse should not be employed as a worker in VDC. Costs for background checks can be paid for using a Veteran’s budget. In addition, costs for background checks do not require pre-approval from the VAMC but should be included in the Veteran’s spending plan and can be invoiced for after approval of the VDC spending plan by the VAMC.

VDC Authorized Budget, Planned Purchases, and Emergency Back-up Care

VAMCs issue authorizations to include the amount of the full and partial assessment fees, the time period when the Veteran is authorized to receive care, the Veteran’s authorized budget for the authorization period, and the average monthly budget. The box below provides an example for how a Veteran’s authorized budget for the authorization period is calculated.

How This Works!

The Veteran's authorized VDC budget for the authorization period is calculated based on the applicable average monthly case-mix rate multiplied by the length of the authorization.

- A Veteran living in Seattle, WA (King County) for case-mix "E" has a case-mix rate of \$3,555.
 - If the Veteran were granted a six-month authorization period, then their authorized VDC budget would be \$21,330 for six months ($\$3,555 \times 6$ months).
 - If the Veteran were granted a twelve-month authorization period, then their VDC budget would be \$42,600 for twelve months ($\$3,555 \times 12$ months).

Veteran spending in a given month may exceed the average monthly case-mix rate. This is permissible as long as all spending is documented in the approved spending plan (see [Section V](#)) and does not exceed the Veteran's total authorized budget. This guidance eliminates the need to account for "planned savings" that was previously used in VDC.

Veteran spending in a given month that exceeds the average monthly case-mix rate can happen for several reasons to include routine care, planned purchases, and emergency back-up care. Several examples are provided below:

1. A Veteran receives care every Monday (as documented in the approved VDC spending plan). Some months during the authorization period will have four Mondays while others will have five. In months where there are five Mondays, routine spending may exceed the average monthly case-mix rate.
2. A Veteran's primary caregiver plans to take a two-week vacation. As outlined in the VDC spending plan, the Veteran will need to temporarily use a care agency to help with their personal care needs, which is more expensive than the hourly wage of the caregiver going on vacation. Therefore, this increase in spending may exceed the average monthly case-mix rate during this month.
3. A Veteran includes a one-time purchase of \$800 in their approved VDC spending plan for a modified lift bed. In the month in which this purchase is made, spending will exceed the average monthly case-mix rate.

It is the responsibility of the Veteran, with support of the VDC provider, to develop a VDC spending plan that is below the authorized amount, track and monitor VDC spending, and make any necessary changes to the VDC spending plan to ensure spending does not exceed the authorized budget. **VAMCs are not required to reimburse for any VDC spending that exceeds the Veteran's authorized budget.**

VDC Assessment Fee

Once the VAMC approves the Veteran's person-centered spending plan, the VDC provider sends the VAMC an invoice for the full assessment fee. The assessment fee is invoiced to the VAMC to reimburse the ADNA and FMS for supporting the Veteran with the person-centered assessment, VDC enrollment, in-home visit, development of the spending plan, and paperwork for employees of the Veteran.

If the Veteran does not enroll in VDC, the VDC provider submits an invoice for the partial assessment fee. The partial assessment fee only includes the rate to reimburse the VDC provider for the PCC assessment conducted with the Veteran.

Effective June 1, 2018, VA no longer pays the VDC provider the "Service Transition Assessment Rate" fee, also known as the STAR fee. The STAR fee previously included the full-assessment fee and an additional amount to cover start-up costs prior to receiving reimbursement from the VAMC for monthly VDC invoices. For Veteran referrals to VDC on June 1, 2018 and after, the VDC provider submits invoices for the full or partial assessment fee to cover any costs associated with enrolling or partially-enrolling a Veteran in VDC.

V. VDC Monthly Service Reports

VDC providers are required to develop Monthly Service Reports to track Veteran VDC spending. Monthly Service Reports are crucial for monitoring Veteran spending against their authorized budget and approved spending plan. This section outlines the key components of developing Monthly Service Reports in accordance with VA procedures.

Monthly Documentation of Spending

Monthly Service Reports document actual spending. VA currently does not provide standards for VDC providers to guide development of Monthly Service Reports. **VDC providers are required to send VDC Coordinators a Monthly Service Report every month.** VDC providers should discuss with their VAMC the preferred method for sending this information. Several options include uploading Monthly Service Reports to HSRM, sending via secure email, fax, or secure mail. Therefore, VDC providers are encouraged to discuss documentation requirements with the VAMC VDC Coordinator or their VAMC finance office to ensure appropriate accounting of monthly spending consistent with VAMC operations.

At a minimum, Monthly Service Reports shall include:

- The Veteran's monthly case-mix rate;
- The monthly administrative rate;
- A breakout of goods and services purchased in the month by employee, good, and service;
- The total Veteran spending during the authorization period (not including the monthly administrative fee); and
- The total amount of invoices (which includes Veteran spending as well as the monthly administrative fee).

The Monthly Service Report can also be used to calculate the daily rate that is used to build the invoice (see [Section VI](#)).

Monthly Service Reports are submitted to the referring VAMC for two purposes:

- First, VAMCs are required to verify that all spending incurred by the Veteran is included in the approved spending plan. VAMCs will not reimburse for any services that are not included in the spending plan.
- Second, VAMCs are required to verify that reimbursement to the VDC provider for a Veteran does not exceed the Veteran's authorized budget. Tracking total spending during the authorization is crucial for monitoring spending and ensuring that total spending does not exceed the total authorized budget.

An example Monthly Service Report is available to support VDC providers in collecting the recurring variables needed to develop monthly invoices. An example monthly template is located in [Appendix F](#) and is also found on the [ACL NWD website](#).

Calculating Daily Rate

VDC providers are required to have monthly VDC invoices computed as a daily rate based on the number of days when direct care was provided to the Veteran in his or her home. When completing the EDI 837 or UB-04, the VDC provider only bills the daily rate for days when direct care was provided to the Veteran.

The number of days when direct care was provided to the Veteran is defined as days when the Veteran paid for a personal care worker (e.g., worker hired and employed by the Veteran) to assist with ADLs or instrumental ADLs (IADLs). Direct care also includes days when the person-centered counselor completes an in-home visit with the Veteran.

- Examples of **direct care** provided in the Veteran's home include assistance with bathing, dressing, eating (to include food-prep), lawn/yard care (mowing, shoveling), and transportation to and from the Veteran's home to attend health care visits or social activities.
- Examples of **care that would not count toward direct care** include home-delivered meals, the purchase of goods (such as delivery and installation of an A/C unit), home technology purchases, and other purchases where a personal care worker is not required to visit a Veteran's home.

How This Works!

A Veteran enrolled in VDC with a case-mix rate "C" that lives in Taylor County in Abilene, Texas has a monthly case-mix rate of \$2,356.

- The monthly administrative fee for this Veteran is \$535.
- In March 2020, the Veteran made purchases for goods and services that total \$1,100.
- Based on the monthly administrative fee and Veteran purchases, the monthly invoice for VDC is: \$1,635.
- The Veteran received direct care in their home for personal care services in 21 out of the 31 days in March.
 - The daily rate for VDC will be:
 - $\$1,635 / 21 = \underline{\$77.86}$

VDC Invoices Based on Actual Spending and Tracking of Total Spending

VDC providers only bill for actual services and goods purchased by the Veteran and for the monthly administrative fee. The example below provides additional guidance for tracking actual spending, total spending in the authorization, and remaining budget.

How This Works!

A Veteran enrolled in VDC with a case-mix rate “C” that lives in Taylor County in Abilene, Texas has a monthly case-mix rate of \$2,356. The Veteran is authorized to receive services from January 1, 2020 through December 30, 2020. The monthly administrative fee for this Veteran is \$535.

- In January 2020, the Veteran made purchases for goods and services that total \$1,200. Based on the monthly administrative fee and Veteran purchases, the monthly invoice for January 2020 is \$1,735.
- In February, the VAMC approves the purchase of a new microwave for \$400. The Veteran also spends \$1,821 as outlined in their approved spending plan.
 - The monthly invoice for February 2020 is \$2,756. This includes \$400 for the purchase, \$1,821 in spending and \$535 monthly admin fee.
- The Veteran’s total authorized budget for the authorization period is \$21,852 (\$1,821x12). After February, the Veteran has \$18,431 (\$21,852 – \$3,421) remaining to spend for VDC from March 1 – December 31.

First and Last Month of Enrollment: VDC Monthly Administrative Rates

Veterans can enroll in VDC and start receiving services any day of the month. Veterans may also be discharged on any day of the month. The administrative fee is paid in full regardless of the number of days in the month that the Veteran uses his or her budget.

Hospital and Nursing Home Admissions for Veterans Enrolled in VDC

While enrolled in VDC, some Veterans may need inpatient (hospital and/or nursing home) care. When a Veteran is admitted to an inpatient setting, VA reimburses the full administrative fee for the month when the Veteran was admitted. A change in the Veteran’s case-mix can be authorized and approved by the VAMC if the Veteran’s needs change. For an inpatient stay that continues beyond 15 days, the Veteran shall be placed in an inactive status starting the month after the 15th day of the inpatient stay, at which time all payments to the provider shall cease until the Veteran’s status is reactivated by the VAMC. The VA may discharge the Veteran from the VDC program if the VAMC VDC coordinator determines that VDC is no longer clinically appropriate.

While VA does not reimburse any services that occur during the Veteran’s inpatient stay, there may be circumstances that require the Veteran to receive personal care services during the first (admission) or last (discharge) day of the Veteran’s inpatient stay. If this is required, VA is allowed to reimburse for services provided but will require approval from the VAMC.

VI. VDC Invoices

VDC providers invoice VAMCs on a monthly basis. VDC providers submitting invoices electronically use the EDI 837.⁴ VDC providers using the UB-04 claim form to submit paper VDC invoices should review the guidance in the call-out box to the right, consider local strategies for converting to electronic invoices, and contact veterandirected@acl.hhs.gov if there are any questions or if assistance is required. Additionally, invoices include only actual spending in a month and are based on a daily rate based on the number of days when the Veteran received personal care services. This section outlines requirements for developing invoices including procedures for electronic invoice submission and submitting revised or corrected invoices.

VDC providers are strongly encouraged to submit VDC claims electronically. Electronic claims submission reduces the processing times and likelihood of rejections. [Appendix A](#) provides guidance for converting from a paper claim to an electronic claim submission process.

Completing a VDC Invoice and Providing Supporting Documentation

VDC invoices are required to be completed using the EDI 837 or UB-04 claim form (also known as the CMS 1450). Please visit [VA's Office of Community Care](#) website for more information on filing an electronic claim for Veteran care. A step-by-step guide for completing the UB-04 claim form is included in [Appendix E](#), although VDC Providers are encouraged to review the guidance in Appendix A and switch to submitting invoices electronically.⁵ In addition to the EDI 837 or UB-04 claim form, Monthly Service Reports are submitted to the VAMC VDC Coordinator or VAMC Office of Community Care.⁶ VA and ACL recommend that the VAMC and VDC provider discuss and establish local procedures for sharing monthly documentation including invoices and Monthly Service Reports.

Currently, VDC providers submit Monthly Service Reports for supporting documentation on VDC invoices to either: (1) the VAMC VDC Coordinator; (2) the billing, finance, or Office of Community Care's Payment Operations and Management (POM);⁷ or (3) both the VAMC VDC Coordinator and the billing, finance, or Office of Community Care's POM. This communication strategy allows the VAMC to answer any questions once the invoice is submitted by the VDC provider.

⁴ The EDI 837 is the electronic transaction format established to comply with HIPPA requirements for the electronic submission of health care claims. Please visit [VA's Community Care website for more information on filing a claim for Veteran care](#).

⁵ As of June, 2019, VA requires an authorization number on all 837 Electronic Data Interchange (EDI) and paper claim submissions for preauthorized services. For EDI 837, Referral Number is Loop = 2300, Segment = REF*9F, Position = REF02 or Prior Authorization, Loop = 2300, Segment = REF*G1, Position = REF02. VDC providers must list the authorization number on Field #63 of the UB-04 claim form, titled "Treatment Authorization Codes."

⁶ VDC providers can discuss with their VAMCs whether Monthly Service Reports will be sent with the UB-04 to either the VAMC VDC Coordinator, the VAMC Office of Community Care, or both.

⁷ There is no standard name for the VAMC Office responsible for processing payments for non-VA Care services.

VDC Invoice Submission

VA accepts and encourages electronic submission of health care claims in accordance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA). VA contracts with Change Healthcare, formerly Emdeon, to provide clearinghouse services for electronic medical care claims.

These software packages can support VDC providers with streamlining the development of VDC invoices by allowing VDC providers to save the completed bill so the biller only has to complete the new billing dates and amounts each time.

VDC providers can purchase available software packages to assist in

completing and electronically submitting the EDI 837, which generally cost \$100-\$200 per month. Several VDC providers have purchased software packages from Change Healthcare and Office Ally to submit their invoices electronically. Before purchasing software, VDC providers must confirm that the software is compatible to upload to Change Healthcare to assist in electronic billing.

VDC providers are encouraged to submit VDC invoices electronically as it will reduce processing times and the likelihood of rejections. If you are submitting a paper invoice, please review Appendix A and [VA's Office of Community Care's guidance regarding the paper invoice submission process for Veteran community care claims](#) for up-to-date information on submitting paper invoices.

Corrected Bills

There are rare instances where timesheets and receipts are submitted to the FMS entity after the VDC provider submits invoices to VAMCs or where a billing error occurs. VDC providers will work with the FMS to ensure timesheets are submitted in a timely manner to avoid delaying the ability to invoice VAMCs. In addition, VDC providers shall consider and wait an adequate amount of time after the month to submit monthly invoices to ensure that the need to submit corrected bills does not happen frequently. However, when this occurs, the VDC provider needs to alert the VAMC VDC Coordinator that the VDC provider needs to submit a corrected invoice for a particular month and Veteran.

The VHA's Office of Community Care developed a guide for provider claim resubmissions which can be found in [Appendix D](#). The VDC provider and the VAMC shall discuss and approve procedures

To register or submit an EDI claim to your local VA health care facility, visit the [Change Healthcare Payer Lists website](#) or call 1-800-845-6592. While registering, you will need the Non-VA Medical Care Program Payer ID which includes 12115 for submission of medical claims authorized by a Veteran Care Agreement. For more information on how to submit invoices electronically, visit [VA's community care page for filing a claim for Veteran care](#).

Corrected invoices should reflect new total spending amounts for the month when spending occurred, rather than supplemental invoices that only account for the new charges. For example, if the VDC provider submitted a monthly VDC invoice for \$2,000 and had \$100 of previously unaccounted invoices, the VDC provider needs to submit a revised invoice for \$2,100 to accurately reflect total spending in that month.

to correct bills to ensure that corrected bills are reimbursed timely. Additionally, the VDC provider shall notify the VAMC VDC Coordinator and/or billing office that a corrected bill needs to be submitted before submitting a corrected bill.

VII. Monitoring of VDC Accounts Receivable

VDC providers are responsible for tracking and monitoring VDC invoices that have been submitted to VAMCs. VA has systems, such as the VA Customer Engagement Portal (CEP) to track the status of claims received by VA. This section provides more information on CEP as well as policies for following-up on outstanding invoices greater than 45 days.

VA Customer Engagement Portal (CEP)

VA has an online system available for tracking the status of claims received by the VA. This system includes information on previous, current, and future payments, and provides the option to check the status of EDI 837 electronic claims and CMS 1500 (HSCFA 1500) or CMS 1450 (UB-04) paper claim forms. The CEP home page can be accessed at:

<https://www.cep.fsc.va.gov/>. The two main sections of the welcome screen include the left navigation panel and the Medical Claims Inquiry.

CEP requires a username and password to access the system. You can create a new account through the CEP Welcome screen by selecting "Login," and then "Continue" which will take you to a page to "Register for a Sign-in Partner."

Once your account is approved, you will be able to access CEP and begin using the system to monitor and track VDC invoices. When you log into your account, you will reach a home page where you can research a claim, run scheduled reports, add Vendor IDs, access Frequently Asked Questions (FAQs), forms, other contacts, and contact the Customer Engagement Center.

Medical Claims Inquiry

Medical Claims Inquiry Link

The Medical Claims Inquiry link leads to the reporting tool for researching a claim. The Medical Claims Inquiry screen provides four different options for running a report including a Medical Claim Inquiry, Treasury Offset Program Report, Payment Paid Report, and Payment Scheduled Report.

Left Navigation Panel

Home

The Home tab provides a link to the CEP home page.

Scheduled Reports

The Scheduled Reports tab offers an option to schedule an offline report when more than 500 claims are available to view. If there are more than 500 results for a particular search, an error message will display that provides an option to adjust search parameters or schedule the report to retrieve the details of claims found. Once the scheduled report is selected, an email will be delivered to notify once a report is available to review and extract.

My Profile

The My Profile tab provides access to the user profile and allows you to edit or add certain information (e.g., Vendor IDs).

General Info

The General Info tab includes links to FAQs, downloadable forms, and contact information that may be useful to help with an inquiry.

Contact Us

The Contact Us tab provides contact information for the VA's Financial Services Center (FSC).

The following contacts are available through the VA for additional information and guidance regarding the CEP payment tracking system:

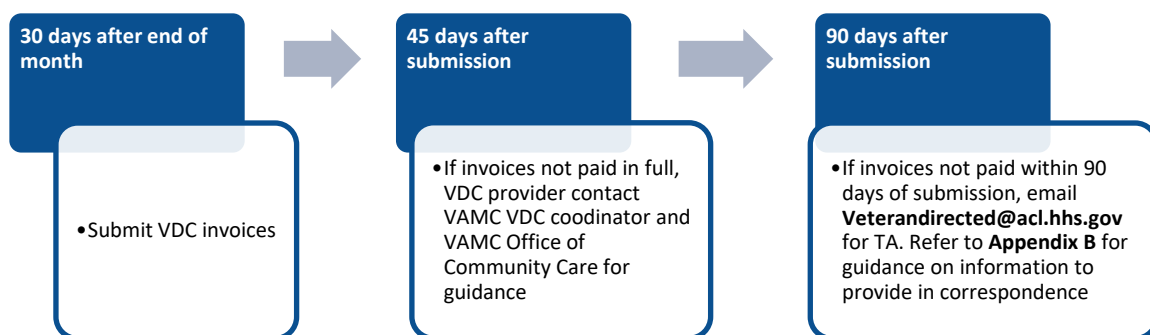
- CEP Help Desk Contacts
 - Phone Number: 512-460-5380 or 877-353-9791
 - Email: vafscshd@va.gov

Timeliness of Submitting VDC Invoices and Receiving Reimbursement

If VDC providers are caring for Veterans in VDC under a Veteran Care Agreement (VCA, VA Form 10-10171), VDC providers are required to submit invoices within 180 days as outlined in Section J of the VCA.⁸ VDC providers are *recommended* to submit VDC invoices no later than the 30 days after the end of the month. The faster the invoice is submitted, the sooner the VDC provider is likely to be paid for the services provided. Additionally, VDC providers shall submit VDC invoices monthly and minimize instances where multiple months of VDC invoices are simultaneously submitted to the VAMC.

If invoices are not paid in full⁹ within 45 days from the date they are submitted, VDC providers shall contact the VAMC VDC Coordinator and the VAMC Office of Community Care to discuss and identify any actions needed to receive payment. Refer to [Appendix B](#) for guidance if invoices are not paid within 90 days of submission.

Figure 3: VDC Invoice Submission Timeline



⁸ Please review Section J of the Veteran Care Agreement ([VA Form 10-10171](#)) for more information regarding requirements for billing and invoicing.

⁹ This would include any invoices that are not adjudicated, rejected, or partially paid.

Appendix A. Switching from Paper to Electronic VDC Invoices

VA strongly encourages the electronic submission of VDC invoices. Electronic claims submission reduces the processing times and likelihood of rejections. The following steps describe considerations of moving to VDC electronic claims submission for VDC providers who are currently submitting paper invoices using the UB-04 claim form (also known as the CMS 1450 form).

Action	Consideration
<p>Consider whether your ADNA or your FMS subcontractor has the capability and/or expertise to submit electronic VDC invoices.</p>	<p>If your ADNA does not have experience invoicing electronically or does not desire to gain the capability, your FMS provider may be able to assist with the electronic submission of VDC invoices. VDC providers are also encouraged to reach out to other VDC providers to discuss their experience and processes for invoicing electronically.</p> <p>Remember, the VDC provider’s name, address and banking information should always be used for submitting VDC invoices. In addition, the VDC provider should always review VDC invoices for accuracy prior to submitting the invoice to VA. If you desire to have your FMS provider submit VDC invoices on your behalf, you may need to adjust any subcontracts, agreements or other documents used with the FMS Provider.</p>
<p>Explore software options to submit VDC invoices electronically</p>	<p>VA contracts with Change Healthcare, formerly Emdeon, to provide clearinghouse services for electronic medical care claims (EDI 837 and 275 claims). VDC providers can use Change Healthcare, or another clearinghouse software of choice to submit VDC invoices.</p> <p>Use of software clearinghouses will be an additional cost absorbed in the monthly administrative reimbursement paid by the VA and cannot be invoiced as part of the Veteran’s spending. VDC providers must confirm that the software is compatible to upload to Change Healthcare to assist in electronic billing.</p>
<p>Learn about and follow VA requirements for completing the EDI 837</p>	<p>VA’s OCC website includes information for providers to learn more about how to file claims electronically. Guidance includes using VA’s national payer ID and authorization annotation.</p>
<p>Track VDC invoices</p>	<p>Follow the processes outlined in Section VII. Monitoring of VDC Accounts Receivable to track the timeliness and accuracy of payment and reimbursement from VA for VDC. If you experience any issues with timeliness and accuracy of payment, it’s critical that you follow up with the VA immediately to resolve any issues. Please refer to other sections of this Guide to determine appropriate timelines for following up with VA and with ACL if you are not able to resolve issues with reimbursement.</p>

Appendix B. Common Billing Issues and Recommendations for Reaching a Resolution

The U.S Department of Veterans Affairs (VA) has helpful resources for common billing issues and rejections that VDC providers may encounter during the billing and invoicing process. These resources include:

1. Information for finding an explanation of codes for rejected claims:
https://www.va.gov/COMMUNITYCARE/revenue_ops/rejected_claims.asp
2. Factsheet for preventing paper claims rejections:
https://www.va.gov/COMMUNITYCARE/docs/pubfiles/factsheets/FactSheet_25-05.pdf

Some billing issues may require further support to reach a resolution. The following guidance provides recommended steps to take to reach a resolution.

1. Check the Customer Engagement Portal (CEP):
 - a. CEP is VA's online system for tracking the status of claims received by the VA. This includes information on previous, current, and future payments, and provides the option to check the status of CMS 1500 (HSCFA 1500) or CMS 1450 (UB-04) claim forms.
 - b. The CEP home page can be accessed at: <https://www.cep.fsc.va.gov/>.
 - c. For more information on CEP, please refer to [Section VII of the VDC Billing Guide](#).
2. Follow-up with the VDC Coordinator at your partnering VAMC for guidance on the desired approach for denied claims (i.e., tackle existing issues until they are resolved locally or wait for completion of the late and partial payment resolution process).
3. If you are unable to reach a resolution through your partnering VAMC, please email Veterandirected@acl.hhs.gov and provide the following information:
 - a. How many invoices greater than 60 days are not paid in full?
 - i. Of the invoices greater than 60 days, how many have been rejected?
 - ii. Of the invoices greater than 60 days, how many have been partially paid?
 - iii. Of the invoices greater than 60 days, how many have not been rejected or partially paid?
 - b. If you have received rejections, please provide information on the rejected codes received thus far.
 - i. Please also provide a sample invoice that was rejected (de-identified to remove any patient identifying information).
 - c. Please provide a brief summary of the action you have taken with the VA Medical Center (VAMC) or any other VA stakeholders regarding outstanding invoices.
 - d. Have you registered for HealthShare Referral Manager (HSRM) or the Customer Engagement Portal (CEP)?

Appendix C. Veteran Directed Care Case Mix Rate Calculator

The Veterans Health Administration (VHA) released the [Fiscal Year \(FY\) 2021 Veteran Directed Care \(VDC\) Case Mix Budget, Administrative Fee, and Assessment Fee Calculator \(VDC Case Mix Rate Calculator\)](#) effective for new referrals starting October 1, 2020.

- These rates are effective for Standard Episodes of Care (SEOCs) established starting October 1, 2020 for medical center level budgeting purposes, but SEOCs are not bound by fiscal years.

State	New York
County or City	New York County
Case Mix Level	D
Start Date of SEOC^ (MM/DD/YYYY)	10/1/2015
End Date of SEOC (MM/DD/YYYY)	9/30/2016
Number of Months in SEOC	12.0
Prorated First Month Veteran Budget	\$2,688
Average Monthly Veteran Budget	\$2,688
Monthly Administrative Fee	\$758
Average Monthly VA Obligation	\$3,446
Total Veteran Budget for SEOC	
	\$32,341
Full Assessment Fee	\$1,068
Partial Assessment Fee	\$534
Total VA Obligation for SEOC (if includes Full Assessment Fee)	
	\$42,507
Total VA Obligation for SEOC (if DOES NOT include Full Assessment Fee)	
	\$41,439
- This version of the VDC Case Mix Rate Calculator should be used for newly referred Veterans and for Veterans who are renewing their referrals.
- Similarly to the FY2020 rates, the FY2021 rates are based on the most recent [Minnesota Elderly Waiver Case Mix Rates published 1 July 2020](#), and the Calendar Year 2021 Medicare Home Health Prospective Payment System (HHPPS) regional wage indices and labor-share percentage, as published in the [HHPPS regulations and notices](#). These rates were updated since the FY2020 Case Mix Rate Calculator was published, leading to rate changes for the FY2021 calculator (mostly increases).
- The term “Average Monthly Veteran Budget” does not include the “Monthly Administrative Fee,” as detailed in the glossary found in **Table 2** of the “Calculator” tab.
- In the tab titled “Calculator,” the “Average Monthly Veteran Budget” is listed on row 9 and the “Monthly Administrative Fee” is listed in row 10. **Table 2** on this tab provides further instruction and definitions.
- The calculator includes instructions for how to use the tool and determine VDC rates and fees.
- If your VDC program has questions about reimbursement rates, you may contact the local VA VDC Coordinator or local Veterans Care Agreement point of contact in the Office of Community Care.

Appendix D. Veterans Health Administration Office of Community Care Provider Claim Resubmission Guide



U.S. Department of Veterans Affairs
Veterans Health Administration
Office of Community Care

Provider Claim Resubmission Guide

The VHA Office of Community Care requires the usage of Frequency Codes on claims resubmitted for late charges, replacement (correction), or voidance. Replacement and Void claims require reference to the claim number that was originally submitted and processed. To locate original claim numbers, please use the Customer Engagement Portal website at <https://www.cep.fsc.va.gov> or Explanation of Payment (EOP) which are located at this website at <https://www.vahcps.fsc.va.gov/Login.aspx>. Please use the below guidance when resubmitting claims.

Frequency Codes 5,7 and 8 identify what actions are necessary to correct reimbursement on original claims that were already processed by the payer. The chart below shows the name of the field from the various standardized billing forms which identifies the frequency code.

Claim Form	Media Type	Field for Frequency Code
CMS-1500 (HCFA)	Paper	Resubmission Code
CMS-1450 (UB-04)	Paper	Type of Bill (last digit)
EDI 837 Institutional	Electronic	Claim Frequency Code
EDI 837 Professional	Electronic	Claim Frequency Code
EDI 837 Dental	Electronic	Claim Frequency Code

Frequency Code 7 and 8

Frequency Codes 7 and 8 require reference to the original claim number (or TCN) in order for the system to generate the appropriate reimbursement for services rendered.

Frequency Code	Frequency Description	Billing Guidelines
7	Replacement/Correction	Use to replace an entire claim. Submit the claim with all of the services that were provided, even if payment was already received for the services on the original claim, the system will calculate the difference in reimbursement from the original claim.
8	Void/Cancel	Use to cancel a previously submitted claim for a specific billing NPI, EIN, or patient. Include all charges that were submitted on the original claim.

Claims billed with 7 and 8 Frequency Code that are missing the original claim number (or TCN) are automatically denied for Missing Parent TCN. Please follow the proceeding guidance regarding correct submission of paper and electronic claims to avoid claim rejections.



Paper Claim: CMS-1500 (HCFA)

1. In field 22 on form CMS-1500, enter the Frequency Code as the Resubmission Code.
2. In field 22, enter the original VA Claim number (TCN) as the Original Reference Number.

22. RESUBMISSION CODE	ORIGINAL REF. NO.
23. PRIOR AUTHORIZATION NUMBER	

Paper Claim: CMS-1450 (UB-04)

1. In field 4, on CMS-1450, enter the Frequency Code as the last digit of the Type of Bill.

3a PAT. CNTRL.#	Text	4 TYPE OF BILL	XXXX
6. MED. REC.#			
5 FED. TAX NO.	6 STATEMENT COVERS PERIOD FROM	7 THROUGH	

2. In Field 64, enter the original VA Claim number (TCN) as the Document Control Number.

63 TREATMENT AUTHORIZATION CODES	64 DOCUMENT CONTROL NUMBER
Authorization Code	

Electronic Claim: 837 Institutional, 837 Professional, 837 Dental

1. In Loop 2300, Segment CLM05-3, enter the Frequency Code.
2. In Loop 2300, Segment REF02 – Payer Claim Control Number with qualifier F8 in Segment REF01, enter the original VA Claim number (TCN).

Frequency Code 5

Frequency Code 5 for late charges may only be used on Institutional billing; CMS-1450 (UB-04) and 837 Institutional. This code is most commonly used for Veteran-Directed Care Program billing. Reference to an original claim number is not applicable for Frequency Code 5.

Frequency Code	Frequency Description	Billing Guidelines
5 (Institutional Only)	Late Charges	Use to submit additional charges for the same date(s) of service as a previous claim. Bill only the additional late charges that were not included on the original claim.

Appendix E. Step-by-Step Guide for Completing Paper Invoices Using the UB-04 Claim Form

The UB-04 claim form (also known as the CMS 1450 form) is used as the monthly paper invoice form for VDC. The UB-04 claim form contains 81 sections, not all of which are required when submitting invoices to the VA for VDC reimbursement. Below is a list of fields from the UB-04 claim form with their corresponding title, whether or not the field must be completed for VDC, a brief definition, and input values.¹⁰ For electronic submissions, please visit [VA's Community Care website for information on filing an electronic claim using the EDI 837](#).

Field Number	Title	Required (Y/N)	Brief Definition	Input Values
#01	Provider Information	Y	Information specific to the Provider of Care	Line 1: [Provider Name] Line 2: [Provider Street Address] Line 3: [Provider City, State, Zip] Line 4: [Provider Telephone, Fax]
#02	-	N	-	-
#03a	Patient Control Number	Y	Number assigned to Veteran	Any number assigned by VDC provider
#4	Type of Bill	Y	This three-digit code represents the type of facility, type of clinic and frequency of claim submitted	-The first digit signals the type of facility. For VDC, this shall be: 3 = Home Health -The second digit signals the type of clinic. For VDC, this shall be: 4 = Other (part B) - includes HHA medical and other health services not under a plan of treatment, hospital and SNF for diagnostic clinical laboratory services for "nonpatients," and referenced diagnostic services. -The third digit signals the frequency of claim. For VDC, this could be: 2 = Assessment – First Claim 3 = Interim – Continuing Claims 4 = Interim – Last Claim 7 = Replacement of Prior Claim 8 = VOID/Cancel
#05	Federal Tax Number	Y	Every provider is required to have a federal tax number in order to receive payment	Example format: NN-NNNNNNNN
#06	Statement Covers Period (From-Through)	Y	Statement period date based on when care was provided	Example format: MM/DD/YY

¹⁰ This list is based on current guidance provided by VA and the experience of VDC providers with using this form to date. As a result, VAMCs may not follow every direction provided here depending on their local billing practices.

Field Number	Title	Required (Y/N)	Brief Definition	Input Values
#07	-	N	-	-
#08	Patient's Name	Y	Name of Patient (Veteran)	Name (Text)
#09	Patient's Address	Y	Address of Patient (Veteran)	Address (Text)
#10	Patient's Birth Date	Y	Birthdate of Patient (Veteran)	Example Format: MM/DD/CCYY
#11	Patient's Sex	Y	Sex of Patient	M for male; F for female
#12	Admission Date	Y	Date of Admission. This would be the day that the Veteran initiated services in the VDC program (e.g., purchased first good or service)	Example Format: MM/DD/YY
#13	-	N	-	-
#14	-	N	-	-
#15	Point of Origin for Admission or Visit	Y	Used to identify the type of facility where the admission was initiated	For VDC, input '6'. "6": The patient was referred to this facility for services by (a physician of) another health care facility not defined elsewhere in this code list where he or she was an inpatient or outpatient.
#16	-	N	-	-
#17	Patient Status Through Billing Period	Y	Status of patient for period of billing	For VDC, potential inputs are: 02: discharge/transferred to a short-term general hospital for inpatient care 06: left against medical advice or discontinued care 20: expired 30: still patient or expected to return for outpatient services
#18-28	-	N	-	-
#29	-	N	-	-
#30	-	N	-	-
#31-34	-	N	-	-
#35-36	-	N	-	-
#37	-	N	-	-
#38	-	N	-	-
#39-41	-	N	-	-
#42	Revenue Code	Y	Signifies the appropriate revenue code to identify specific accommodation and/or ancillary charges	Multiple types of revenue are applicable for VDC. Generally, the following code shall be used unless otherwise specified by the VAMC: 3109 If code '3109' is not accepted, the following code can be used: 0571

Field Number	Title	Required (Y/N)	Brief Definition	Input Values
#43	Revenue Description	Y	Text to match with corresponding revenue code (field #42)	For code 3109, enter "Other Adult Care" For code 0571, enter "Aide/Home Health/Visit"
#44	HCPCS/Rate/HIPPS Code	Y	Type of care provided to Veteran. For VDC, only two codes are used.	The following two codes shall be used only for VDC: T2024 – Service Assessment/Plan of Care Development (This is a one-time code – for initial assessment fee) T1020 – Other Adult Care. (Used for monthly claims)
#45	Service Date	Y	Date when a single day of care is provided. A single day of care to be included in the UB-04 is defined in the section "Calculating the Daily Rate for VDC"	Example Format: MM/DD/YY
#46	Units of Service	Y	Number of Units. This field shall be completed for each row where a daily rate is billed to VA	For VDC, the unit of service for each row will be "1"
#47	Total Charges	Y	Daily Rate for VDC. Further defined in the section "Calculating the Daily Rate for VDC"	Example Format: \$DDD.CC
#48	Non-Covered Charges	Y	Will be left blank	Leave blank
#49	-	N	-	-
#50-55	-	N	-	-
#56	NPI	Y	National Provider Index. The NPI is listed by the Individual Provider or Agency. NPI is a unique 10-digit identification number used for Medicare services and other payers. If you have questions regarding NPI, please reach out to your VDC State TA Lead or ACL Project Officer.	NPI is a unique 10-digit identifier.
#57	-	N	-	-
#58a-c	Insured's Name	Y	Veteran's Name	Name of Veteran
#59a-c	-	N	-	-
#60a-c	Insured's Unique ID	Y	Veterans SSN or other Unique Identifier	Most likely SSN of Veteran unless otherwise instructed by VAMC
#61a-c	-	N	-	-
#62a-c	-	N	-	-

Field Number	Title	Required (Y/N)	Brief Definition	Input Values
#63	Treatment Authorization Codes	N	Veteran Care Agreement authorization	The Veteran's authorization number as listed on the authorization
#64	-	N	-	-
#65	-	N	-	-
#66	Diagnostic and Procedure Code Qualifier	Y	ICD 10 is a standard tool for mapping health conditions which can be up to six characters long. ICD-10 is maintained by the World Health Organization.	ICD-10 Code will be provided by the VAMC at time of referral.
#68-75	-	N	-	-
#76 ¹¹	Attending Provider Name and Identifiers (including NPI)	Y	Required when claim contains any services other than nonscheduled transportation services	NPI is a unique 10-digit identifier.
#77-79	-	N	-	-

¹¹ Several VAMCs require that NPI's be entered into fields #56 and #76. Your VAMC may request that this information be placed in only one, or both, fields.

Appendix F. Sample UB-04 Claim Form and Accompanying Monthly Services Report Documentation

This appendix provides an example of a completed UB-04 claim form and accompanying monthly services report.

Randy King is a 90-year-old World War II Veteran with progressive Alzheimer's disease who lives in New Haven County in New Haven, Connecticut with his wife. In early December 2020, Mr. King was identified as a potential VDC enrollee due to his increasing need for assistance with Activities of Daily Living (ADLs)/Instrumental ADLs (IADLs) after a primary care appointment at the VAMC. Mr. King and his wife were excited for the opportunity to self-direct his care to include hiring their children and grandchildren to provide assistance with ADLs/IADLs. After the West Haven VAMC completed the Purchased HCBS Case-Mix Budget Tool, Mr. King was assigned to Case-Mix "D" with a monthly rate of \$3,000.

The VDC Coordinator at the West Haven VAMC referred Mr. King, along with his case-mix level, medical history, contact and demographic information, and primary ICD-10 code to the South Central Community Choices ADRC's Person-Centered Counselor to complete a person-centered assessment for VDC. The ADRC PCC assisted Mr. King with developing a spending plan for VDC that included hiring his daughter, Sandy Sue, for personal care services. Additionally, Mr. King will use his VDC budget for lawn services, meals, and medication.

Mr. King was officially enrolled in the program on January 1, 2021. The monthly services report and UB-04 below are an example of Mr. King's VDC spending in January 2021, the first month when Mr. King begin utilizing his VDC monthly budget. Based on timesheets and invoices submitted by the Veteran to the FMS and provided to South Central Community Choices, Mr. King spent a total of \$561. With a monthly administrative fee of \$500, South Central Community Choices' VDC invoice for Mr. King based on January 2021 services will be \$1,061. Mr. King received "hands-on" personal care, day care, or respite services on 16 unique days in January 2021 based on the FMS reports that were received. As a result, the daily VDC rate for Mr. King in January 2021 is \$66.31 ($\$1,061 / 16$).

South Central Community Choices		3a. PATIENT #		1234567		4. Type of Bill	
1 Long Wharf Dr		b. Med Rec #				343	
New Haven, CT 06511		5. FED TAX NO.		6. STATEMENT COVERED PERIOD FROM		7	
(888) 756-4321		03-5555555		11/1/2020		11/30/2020	
B. PATIENT NAME		a. Randy		9. PATIENT ADDRESS		a. 624 Hope Street	
b. King		b. New Haven		c. RI		d. 06501	
e. US		10. BIRTH DATE		11. SEX		12. DATE	
10/29/1944		M		3/1/2020		G	
13. STAT		14. OCCURANCE DATE		15. OCCURANCE DATE		16. OCCURANCE DATE	
30							
17. ICD-9-CM		18. ICD-9-CM		19. ICD-9-CM		20. ICD-9-CM	
21. ICD-9-CM		22. ICD-9-CM		23. ICD-9-CM		24. ICD-9-CM	
25. ICD-9-CM		26. ICD-9-CM		27. ICD-9-CM		28. ICD-9-CM	
29. ICD-9-CM		30. ICD-9-CM		31. ICD-9-CM		32. ICD-9-CM	
33. ICD-9-CM		34. ICD-9-CM		35. ICD-9-CM		36. ICD-9-CM	
37. ICD-9-CM		38. ICD-9-CM		39. ICD-9-CM		40. ICD-9-CM	
41. ICD-9-CM		42. ICD-9-CM		43. ICD-9-CM		44. ICD-9-CM	
45. ICD-9-CM		46. ICD-9-CM		47. ICD-9-CM		48. ICD-9-CM	
49. ICD-9-CM		50. ICD-9-CM		51. ICD-9-CM		52. ICD-9-CM	
53. ICD-9-CM		54. ICD-9-CM		55. ICD-9-CM		56. ICD-9-CM	
57. ICD-9-CM		58. ICD-9-CM		59. ICD-9-CM		60. ICD-9-CM	
61. ICD-9-CM		62. ICD-9-CM		63. ICD-9-CM		64. ICD-9-CM	
65. ICD-9-CM		66. ICD-9-CM		67. ICD-9-CM		68. ICD-9-CM	
69. ICD-9-CM		70. ICD-9-CM		71. ICD-9-CM		72. ICD-9-CM	
73. ICD-9-CM		74. ICD-9-CM		75. ICD-9-CM		76. ICD-9-CM	
77. ICD-9-CM		78. ICD-9-CM		79. ICD-9-CM		80. ICD-9-CM	
81. ICD-9-CM		82. ICD-9-CM		83. ICD-9-CM		84. ICD-9-CM	
85. ICD-9-CM		86. ICD-9-CM		87. ICD-9-CM		88. ICD-9-CM	
89. ICD-9-CM		90. ICD-9-CM		91. ICD-9-CM		92. ICD-9-CM	
93. ICD-9-CM		94. ICD-9-CM		95. ICD-9-CM		96. ICD-9-CM	
97. ICD-9-CM		98. ICD-9-CM		99. ICD-9-CM		100. ICD-9-CM	
101. ICD-9-CM		102. ICD-9-CM		103. ICD-9-CM		104. ICD-9-CM	
105. ICD-9-CM		106. ICD-9-CM		107. ICD-9-CM		108. ICD-9-CM	
109. ICD-9-CM		110. ICD-9-CM		111. ICD-9-CM		112. ICD-9-CM	
113. ICD-9-CM		114. ICD-9-CM		115. ICD-9-CM		116. ICD-9-CM	
117. ICD-9-CM		118. ICD-9-CM		119. ICD-9-CM		120. ICD-9-CM	
121. ICD-9-CM		122. ICD-9-CM		123. ICD-9-CM		124. ICD-9-CM	
125. ICD-9-CM		126. ICD-9-CM		127. ICD-9-CM		128. ICD-9-CM	
129. ICD-9-CM		130. ICD-9-CM		131. ICD-9-CM		132. ICD-9-CM	
133. ICD-9-CM		134. ICD-9-CM		135. ICD-9-CM		136. ICD-9-CM	
137. ICD-9-CM		138. ICD-9-CM		139. ICD-9-CM		140. ICD-9-CM	
141. ICD-9-CM		142. ICD-9-CM		143. ICD-9-CM		144. ICD-9-CM	
145. ICD-9-CM		146. ICD-9-CM		147. ICD-9-CM		148. ICD-9-CM	
149. ICD-9-CM		150. ICD-9-CM		151. ICD-9-CM		152. ICD-9-CM	
153. ICD-9-CM		154. ICD-9-CM		155. ICD-9-CM		156. ICD-9-CM	
157. ICD-9-CM		158. ICD-9-CM		159. ICD-9-CM		160. ICD-9-CM	
161. ICD-9-CM		162. ICD-9-CM		163. ICD-9-CM		164. ICD-9-CM	
165. ICD-9-CM		166. ICD-9-CM		167. ICD-9-CM		168. ICD-9-CM	
169. ICD-9-CM		170. ICD-9-CM		171. ICD-9-CM		172. ICD-9-CM	
173. ICD-9-CM		174. ICD-9-CM		175. ICD-9-CM		176. ICD-9-CM	
177. ICD-9-CM		178. ICD-9-CM		179. ICD-9-CM		180. ICD-9-CM	
181. ICD-9-CM		182. ICD-9-CM		183. ICD-9-CM		184. ICD-9-CM	
185. ICD-9-CM		186. ICD-9-CM		187. ICD-9-CM		188. ICD-9-CM	
189. ICD-9-CM		190. ICD-9-CM		191. ICD-9-CM		192. ICD-9-CM	
193. ICD-9-CM		194. ICD-9-CM		195. ICD-9-CM		196. ICD-9-CM	
197. ICD-9-CM		198. ICD-9-CM		199. ICD-9-CM		200. ICD-9-CM	
201. ICD-9-CM		202. ICD-9-CM		203. ICD-9-CM		204. ICD-9-CM	
205. ICD-9-CM		206. ICD-9-CM		207. ICD-9-CM		208. ICD-9-CM	
209. ICD-9-CM		210. ICD-9-CM		211. ICD-9-CM		212. ICD-9-CM	
213. ICD-9-CM		214. ICD-9-CM		215. ICD-9-CM		216. ICD-9-CM	
217. ICD-9-CM		218. ICD-9-CM		219. ICD-9-CM		220. ICD-9-CM	
221. ICD-9-CM		222. ICD-9-CM		223. ICD-9-CM		224. ICD-9-CM	
225. ICD-9-CM		226. ICD-9-CM		227. ICD-9-CM		228. ICD-9-CM	
229. ICD-9-CM		230. ICD-9-CM		231. ICD-9-CM		232. ICD-9-CM	
233. ICD-9-CM		234. ICD-9-CM		235. ICD-9-CM		236. ICD-9-CM	
237. ICD-9-CM		238. ICD-9-CM		239. ICD-9-CM		240. ICD-9-CM	
241. ICD-9-CM		242. ICD-9-CM		243. ICD-9-CM		244. ICD-9-CM	
245. ICD-9-CM		246. ICD-9-CM		247. ICD-9-CM		248. ICD-9-CM	
249. ICD-9-CM		250. ICD-9-CM		251. ICD-9-CM		252. ICD-9-CM	
253. ICD-9-CM		254. ICD-9-CM		255. ICD-9-CM		256. ICD-9-CM	
257. ICD-9-CM		258. ICD-9-CM		259. ICD-9-CM		260. ICD-9-CM	
261. ICD-9-CM		262. ICD-9-CM		263. ICD-9-CM		264. ICD-9-CM	
265. ICD-9-CM		266. ICD-9-CM		267. ICD-9-CM		268. ICD-9-CM	
269. ICD-9-CM		270. ICD-9-CM		271. ICD-9-CM		272. ICD-9-CM	
273. ICD-9-CM		274. ICD-9-CM		275. ICD-9-CM		276. ICD-9-CM	
277. ICD-9-CM		278. ICD-9-CM		279. ICD-9-CM		280. ICD-9-CM	
281. ICD-9-CM		282. ICD-9-CM		283. ICD-9-CM		284. ICD-9-CM	
285. ICD-9-CM		286. ICD-9-CM		287. ICD-9-CM		288. ICD-9-CM	
289. ICD-9-CM		290. ICD-9-CM		291. ICD-9-CM		292. ICD-9-CM	
293. ICD-9-CM		294. ICD-9-CM		295. ICD-9-CM		296. ICD-9-CM	
297. ICD-9-CM		298. ICD-9-CM		299. ICD-9-CM		300. ICD-9-CM	
301. ICD-9-CM		302. ICD-9-CM		303. ICD-9-CM		304. ICD-9-CM	
305. ICD-9-CM		306. ICD-9-CM		307. ICD-9-CM		308. ICD-9-CM	
309. ICD-9-CM		310. ICD-9-CM		311. ICD-9-CM		312. ICD-9-CM	
313. ICD-9-CM		314. ICD-9-CM		315. ICD-9-CM		316. ICD-9-CM	
317. ICD-9-CM		318. ICD-9-CM		319. ICD-9-CM		320. ICD-9-CM	
321. ICD-9-CM		322. ICD-9-CM		323. ICD-9-CM		324. ICD-9-CM	
325. ICD-9-CM		326. ICD-9-CM		327. ICD-9-CM		328. ICD-9-CM	
329. ICD-9-CM		330. ICD-9-CM		331. ICD-9-CM		332. ICD-9-CM	
333. ICD-9-CM		334. ICD-9-CM		335. ICD-9-CM		336. ICD-9-CM	
337. ICD-9-CM		338. ICD-9-CM		339. ICD-9-CM		340. ICD-9-CM	
341. ICD-9-CM		342. ICD-9-CM		343. ICD-9-CM		344. ICD-9-CM	
345. ICD-9-CM		346. ICD-9-CM		347. ICD-9-CM		348. ICD-9-CM	
349. ICD-9-CM		350. ICD-9-CM		351. ICD-9-CM		352. ICD-9-CM	
353. ICD-9-CM		354. ICD-9-CM		355. ICD-9-CM		356. ICD-9-CM	
357. ICD-9-CM		358. ICD-9-CM		359. ICD-9-CM		360. ICD-9-CM	
361. ICD-9-CM		362. ICD-9-CM		363. ICD-9-CM		364. ICD-9-CM	
365. ICD-9-CM		366. ICD-9-CM		367. ICD-9-CM		368. ICD-9-CM	
369. ICD-9-CM		370. ICD-9-CM		371. ICD-9-CM		372. ICD-9-CM	
373. ICD-9-CM		374. ICD-9-CM		375. ICD-9-CM		376. ICD-9-CM	
377. ICD-9-CM		378. ICD-9-CM		379. ICD-9-CM		380. ICD-9-CM	
381. ICD-9-CM		382. ICD-9-CM		383. ICD-9-CM		384. ICD-9-CM	
385. ICD-9-CM		386. ICD-9-CM		387. ICD-9-CM		388. ICD-9-CM	
389. ICD-9-CM		390. ICD-9-CM		391. ICD-9-CM		392. ICD-9-CM	
393. ICD-9-CM		394. ICD-9-CM		395. ICD-9-CM		396. ICD-9-CM	
397. ICD-9-CM		398. ICD-9-CM		399. ICD-9-CM		400. ICD-9-CM	
401. ICD-9-CM		402. ICD-9-CM		403. ICD-9-CM		404. ICD-9-CM	

Appendix G. Veteran Directed Care Billing and Invoicing Guide

Glossary of Terms

The following glossary of terms provides definitions for terms and acronyms used throughout the Veteran Directed Care (VDC) Billing and Invoicing Guide.

Term	Acronym	Definition
Activity of Daily Living	ADL	Basic personal task of daily life such as bathing, dressing, transferring, etc.
Aging and Disability Resource Center	ADRC	These centers provide information and counseling to help individuals make informed decisions about long-term services and supports and help accessing programs.
Area Agency on Aging	AAA	These agencies address the needs of older adults at the regional and local level through services and supports (like home-delivered meals and homemaker assistance) to support independent living.
Center for Independent Living	CIL	These centers provide tools, resources, and supports for integrating people with disabilities fully into their communities to promote equal opportunities, self-determination, and respect.
Customer Engagement Portal	CEP	VA's online system available for tracking the status of claims received by the VA.
Centers for Medicare and Medicaid Services	CMS	A federal agency providing health coverage to people through Medicare, Medicaid, the Children's Health Insurance Program, and the Health Insurance Marketplace.
Electronic Data Interchange	EDI	Electronic exchange of information between businesses.
Financial Services Center	FSC	The VA's Office of Finance center for financial management, professional, and administrative services.
Fiscal Year	FY	One-year account period used for budgeting purposes.
Home and Community Based Services	HCBS	Services provided for Medicaid beneficiaries of various population groups, including people with intellectual or developmental disabilities, physical disabilities, and/or mental illness, to receive services in their own home or community.
HealthShare Referral Manager	HSRM	A secure online portal for managing referrals and authorizations and is available to all VA community providers at no cost.
Health Insurance Portability and Accountability Act of 1996	HIPPA	A federal law requiring national privacy standards that protect sensitive patient health information from being disclosed without consent.
Information Technology	IT	Use of technology to transfer information.
Instrumental Activity of Daily Living	IADL	Task in everyday life including housework, managing money, taking medication, preparing and cleaning up after meals, etc.
Long-Term Services and Supports	LTSS	Services and supports that enable people who are aging and people with disabilities live at home or in their communities.
No Wrong Door	NWD	A collaborative effort of ACL, CMS, and the VHA that builds upon the ADRC program and CMS' Balancing Incentive Program No Wrong Door requirements that support state efforts to streamline access to LTSS options for older adults and individuals with disabilities.
Person Centered Counseling	PCC	Planning process that allows individuals to be engaged in the decision making process about their options, preferences, values, and financial resources. Individuals in need of services or who are

Term	Acronym	Definition
		planning for the future have access to one-on-one counseling in a variety of settings, including within the home, community residence, acute care hospital, school settings, or several other settings based on the individual's needs.
Standard Episode of Care	SEOC	An authorized bundle of services approved for one year, outlined in a Veteran referral from the VA.
State Unit on Aging	SUA	These state-level agencies develop and administer plans to provide assistance for older adults, families, and in many states also adults with physical disabilities.
U.S Department of Veterans Affairs	VA	An agency of the federal government that provides benefits, health care and cemetery services to military Veterans.
Veterans Affairs Medical Center	VAMC	A health care facility operated by the Veterans Health Administration serving Veterans and their families.
Veteran Care Agreement	VCA	An agreement signed by eligible non-VA providers and VAMCs to cover Veteran community care not covered by VA's contracted community care network.
Veterans Health Administration	VHA	An integrated health care system in the United States, consisting of 1,255 health care facilities serving over nine million Veterans enrolled in the VA health care program.
Veteran Directed Care	VDC	The Veterans Health Administration (VHA) and the Administration on Aging, now part of the Administration for Community Living (ACL), developed the Veteran Directed Care (VDC) program in 2008 to provide Veterans with nursing home level of care needs the opportunity to have choice and control over their services and supports in the community. The VDC program leverages a nationwide network of Aging and Disability Network Agencies (ADNAs) within states' No Wrong Door (NWD) Systems to support Veterans as they plan for and direct their long-term services and supports (LTSS).