VD-HCBS Billing & Invoicing Procedures Guide:

VD-HCBS Aging & Disability Network Providers

Table of Contents

Introduction and Overview

This guide is intended to serve as an overview for Veteran-Directed Home and Community Based Services (VD-HCBS) billing and procedures, directed to VD-HCBS Providers[1], to ensure timely and accurate reimbursement for VD-HCBS invoices.

VA published guidance that standardizes the use of the Purchased HCBS Case-Mix & Budget Tool and associated case-mix rates, assessment rates, the emergency back-up and planned savings fund, and the UB-04 (also known as the CMS 1450) Claim Form. The VA guidance is primarily targeted to VAMCs and covers a portion of billing & invoicing procedures. This guide was developed to address all processes related to billing and invoicing for VD-HCBS and is directed to both VA Medical Centers (VAMCs) and VD-HCBS Providers that are interested in developing, currently developing, or have operational VD-HCBS Programs.

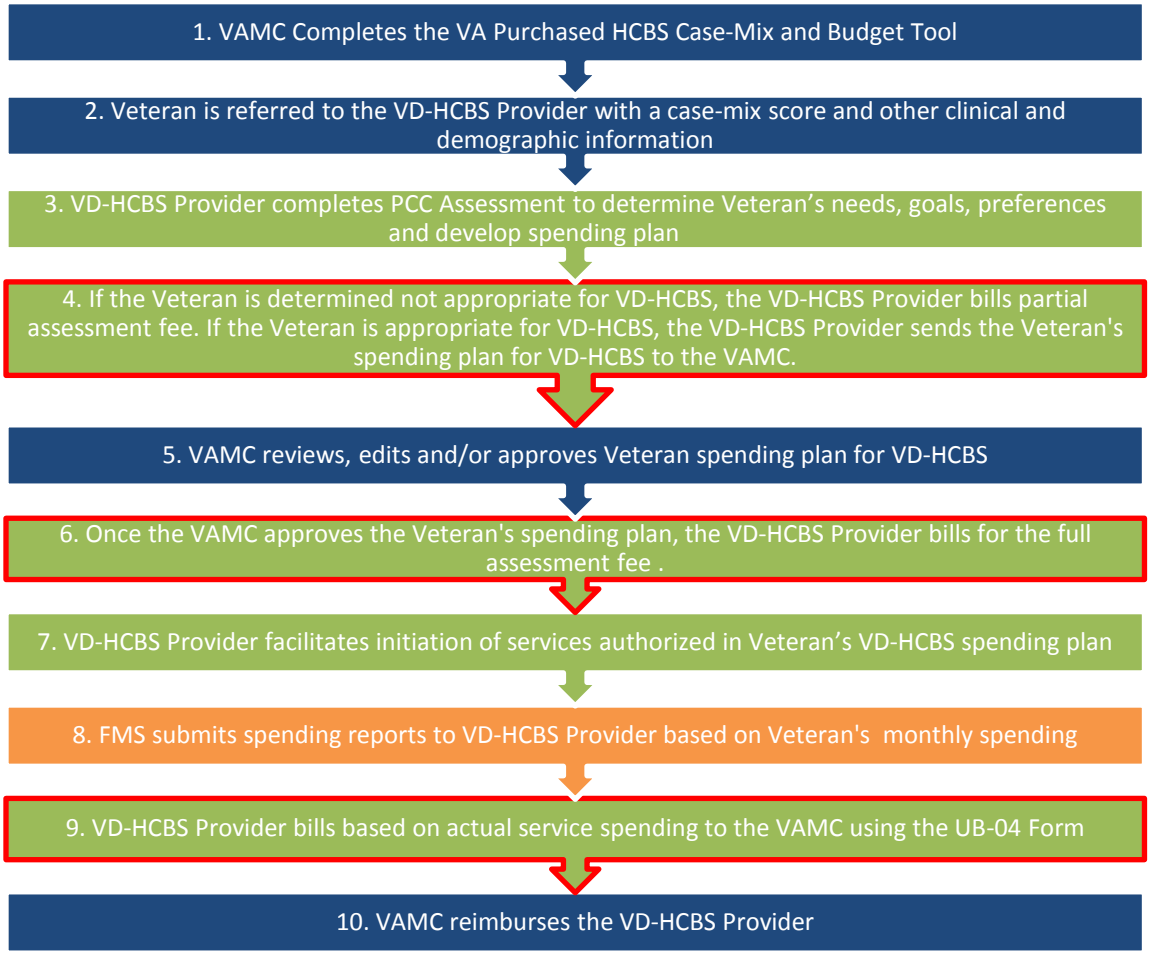
Billing and Invoicing Process

Figure 1 below provides an overview of the key steps involved in billing & invoicing for VD-HCBS. Steps completed by the VAMCs are in blue while steps completed by the VD-HCBS Provider and Fiscal Management Service are in green and orange, respectively. Additionally, three steps highlighted in red depict when the VD-HCBS Provider should bill the VAMC for either the assessment fee or monthly invoices.[2]

[1] VD-HCBS Providers include Aging & Disability Resource Centers (ADRCs), Area Agencies on Aging (AAAs), Centers for Independent Living (CILs) or Stat Units on Aging (SUA) that operate as either Sole-Proprietors or Hubs delivering VD-HCBS.

[2] If you have questions related to non-billing procedures relates to any of these steps (such as completing a PCC assessment), please contact your ACL Project Officer, ADRC State TA lead for VD-HCBS, or veterandirected@acl.hhs.gov for more information and additional guidance.

Figure 1. Key Steps for VD-HCBS Billing and Invoicing



VD-HCBS Case-Mix Rate

Completing the Purchased HCBS Case-Mix & Budget Tool for VD-HCBS

The Purchased Case-Mix & Budget Tool is used by the VAMC to determine the Veteran's level of need for in-home assistance in order to maximize their independence and avoid costly nursing home services. Completion of this tool leads to a case-mix score or level which also provides a dollar amount that is the monthly authorized service spending amount for the individual Veteran. For VD-HCBS, this case-mix rate is inclusive the Veteran's monthly spending plan to purchase goods and services and also the administrative costs for the VD-HCBS Provider.

For VD-HCBS, this ADL-based case mix instrument is intended to screen for appropriate funding based on the Veteran's clinical and functional needs. A much more in-depth assessment of actual service

needs is completed by the VD-HCBS Provider's Person-Centered Counselor after the case-mix determination is made. This assessment is also known as a Person-Centered Counseling (PCC) Assessment and is completed independently of the case mix instrument to capture information on the Caregiver needs, Veteran goals, in-home accessibility and other factors.

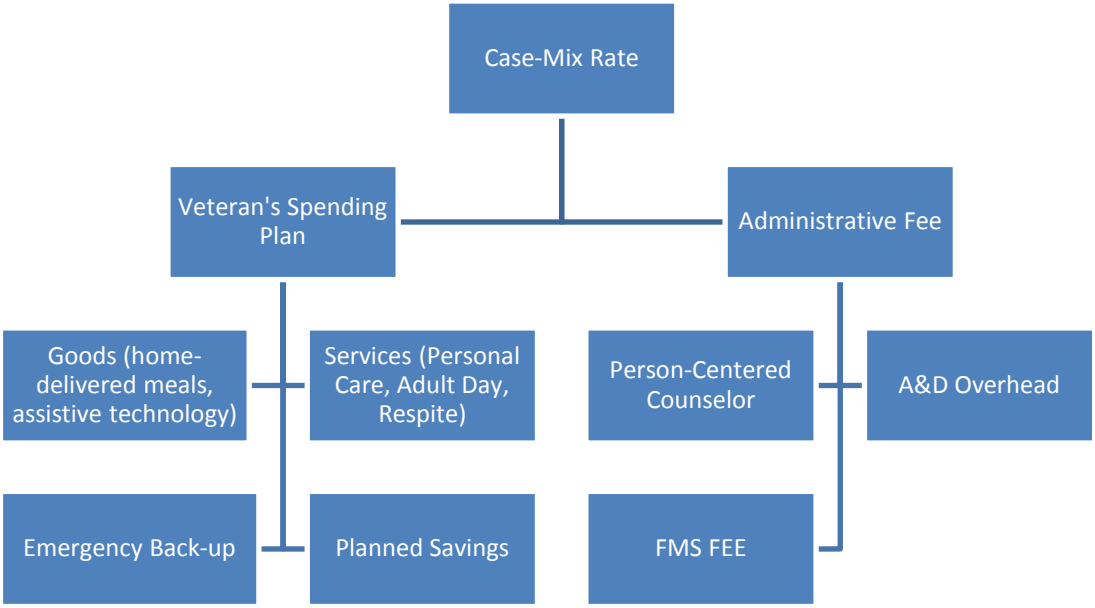
VAMCs are responsible for completion of the Purchased HCBS Case-Mix & Budget Tool prior to referring Veterans to the VD-HCBS Program. VAMCs and their VD-HCBS Provider partners will need to discuss whether the VAMC will complete the Purchased Case-Mix & Budget Tool independently or with the Person-Centered Counselor from the VD-HCBS Provider during the person-centered assessment. Additionally, VD-HCBS Programs can decide whether to have the VD-HCBS Provider complete the case-mix and budget tool for VD-HCBS. Along with the Purchased HCBS Case-Mix & Budget Tool, VAMCs will send to the VD-HCBS Provider the VA authorization for VD-HCBS. This authorization outlines the period of authorization for VD-HCBS, total authorized budget for the period of the authorization, and monthly case-mix rate. As discussed in the sections below, the VD-HCBS Provider is responsible for tracking the total amount spent per Veteran in the authorization period and for ensuring that the Veteran does not spend over their authorized budget.

Components of the Case-Mix Rate

After the VAMC completes the Purchased HCBS Case-Mix & Budget Tool, the Veteran will be assigned a case-mix rate. For VD-HCBS, this case-mix rate is a bundled rate which includes the Veteran's spending plan and administrative costs of the VD-HCBS Provider. The Veteran's spending plan includes funds for purchasing services and goods and emergency back-up and planned savings that cannot be supported in a single month's budget.

Figure 2 provides an overview of the different components that make up the Veteran's case-mix rate. The case-mix rate is broken down into two components (Veteran's spending plan and administrative fee), each with subcomponents, as depicted below.

Figure 2. VD-HCBS Case-Mix Rate Components



VA Case Mix Rates are published by VA Central Office and are available online at the ACL NWD Website (https://nwd.acl.gov/vd-hcbs.html).

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 Seattle, WA (King County) for case-mix "E" has a case-mix rate of $3,202
  - $2,559 is for the Veteran's monthly spending plan to purchase goods, services and contribute to their emergency back-up and planned savings fund.
  - $643 is for the VD-HCBS Provider administrative fees to include the person-centered counselor, VD-HCBS Provider, overhead and the FMS.

Conducting a Person-Centered Counseling Assessment

A key component of VD-HCBS is the person-centered assessment conducted by the VD-HCBS Provider Person-Centered Counselor (PCC). Many local organizations have their own distinct title for this individual, which may include options counselor or support broker, but serve the same purpose as the PCC. After the Purchased HCBS Case-Mix Budget Tool is completed and the Veteran is assigned a case-

mix rate, the VD-HCBS Provider completes a person-centered assessment of the Veteran. The purpose of the person-centered assessment, conducted in-person is to: engage with the Veteran to identify who should be part of the planning process; identify the goals, strengths and preferences of the Veteran; conduct a comprehensive review of resources and informal supports; and facilitate an informed choice of available services and goods in the development of a person-centered plan.

After completion of the person-centered assessment, the Person-Centered Counselor will either (a) have developed a person-centered spending plan for the Veteran that the VAMC will review, edit and/or approve; or, (b) determine that the Veteran does not meet eligibility requirements.

Once the VAMC approves the Veteran's person-centered spending plan, the VD-HCBS Provider sends the VAMC an invoice, using the UB-04[3], for the full assessment fee which is submitted prior to the Veteran receiving VD-HCBS. The assessment fee is invoiced to the VAMC to reimburse the ADNA and FMS for supporting the Veteran with VD-HCBS enrollment, the person-centered assessment, in-home visit, development of the VD-HCBS spending plan and paperwork for employees of the Veteran.

If the Veteran is not eligible for VD-HCBS enrollment, the VD-HCBS Provider should submit an invoice, using the UB-04, for the partial assessment fee. The partial assessment fee only includes a rate to reimburse the VD-HCBS Provider for the person-centered assessment conducted with the Veteran.

Invoicing for the VD-HCBS Assessment Rate

Effective June 1, 2018, VA will no longer pay the VD-HCBS Provider the "Service Transition Assessment Rate" Fee, also known as the STAR Fee. The STAR Fee included the full-assessment fee and an additional amount to cover start-up costs prior to receiving reimbursement from the VAMC for monthly VD-HCBS invoices. For Veteran referrals to VD-HCBS on June 1, 2018 and after, the VD-HCBS Provider should submit invoices for the full or partial assessment feeto cover any costs associated with enrolling or partially-enrolling a Veteran in VD-HCBS. In addition to billing the full or partial assessment fee, VD-HCBS providers should continue to submit monthly bills that include the Veteran's actual expenditures plus the monthly administrative fee. Please contact the VD-HCBS mailbox at veterandirected@acl.hhs.gov with any questions pertaining to assessment fees.

Monthly VD-HCBS Invoices

After each month that a Veteran is enrolled in VD-HCBS, the VD-HCBS Provider submits invoices to the VA for the purchases made as part of the Veteran's spending plan and the administrative rate (more information is provided below on this subject). The VD-HCBS Provider should receive information from

[3] More information on completing the UB-04 is included in Appendix B

the FMS on all the services and goods that the Veteran purchased in the prior month. As a result, the VD-HCBS Provider will most likely require 5-14 days after the end of the month to receive this information from the FMS and complete the UB-04 invoices before submitting to the VA.

A step-by-step guide to completion of the UB-04 is provided in Appendix B. Below is information on VD-HCBS monthly billing procedures based on common questions that arise when completing monthly VD-HCBS invoices.

Pro-Rating VD-HCBS Budgets

Veterans can enroll in VD-HCBS and start receiving services on any given day in the month. For instances where the Veteran begins using their VD-HCBS budget on a day other than the first of the month, the portion of the case-mix rate that applies to the Veteran's spending plan is prorated based on the number of days in the month that the Veteran used his or her VD-HCBS budget. The administrative fee is paid in full regardless of the number of days in the month that the Veteran uses his or her budget.

How This Works!

A Veteran enrolled in VD-HCBS with a case-mix rate "C" that lives in Abilene, Texas (Taylor County) has a monthly case-mix rate of $1,777. The Veteran is enrolled and begins using their VD-HCBS on March 14, 2015.

- The monthly administrative fee for this Veteran is $406.
- The Veteran's total spending plan for a full-month is $1,370. Since the Veteran was enrolled on March 14:
  - There are 17 out of 31 days in which the Veteran can use their VD-HCBS spending plan. This accounts for 54.84% (17/31) of the month.
  - Therefore, the amount of the Veteran spending plan available for the Veteran is $751.55 ($1,370 * 54.84%).
- The maximum that the VD-HCBS Provider Aging & Disability Network can invoice the VAMC for this Veteran based on spending in March, 2015 is $1,054.87 ($751.55 + 406).

Monthly Documentation of Spending

VA currently does not provide any minimum documentation standards to support the interface between the VAMC and the VD-HCBS Provider. Therefore, VD-HCBS Providers are encouraged to discuss documentation requirements with the VAMC VD-HCBS Coordinator or their finance office to ensure appropriate accounting of monthly spending consistent with VAMC operations.

VD-HCBS Providers should keep a monthly record of the Veteran's VD-HCBS monthly budget and expenses. At a minimum, this should include: the Veteran's monthly case-mix rate; the monthly administrative rate; the dollar amount of purchases for goods & services made in the month; the dollar amount in the month that was spent or saved towards the Veteran's emergency back-up and planned savings fund; and, the total balance of the Veteran's emergency back-up and planned savings funds. In addition, monthly documentation of spending should track total expenses through the Veteran's authorization period[4] and the remaining balance of the total authorized budget.

An example monthly spending plan report is available to support VD-HCBS Providers in collecting the recurring variables needed to develop monthly invoices for VD-HCBS. This monthly template is located in Appendix A and is also found on the ACL NWD website (https://nwd.acl.gov/vd-hcbs.html).

Calculating the Daily Rate for VD-HCBS

Per recent VA guidance, VD-HCBS Providers are required to have monthly VD-HCBS invoices computed as a daily rate based on the number of days in which direct care was provided to the Veteran in his/her home. When completing the UB-04, the VD-HCBS Provider will only bill the daily rate for days in which this direct care was provided to the Veteran. Previously, a daily rate for monthly VD-HCBS bills was based on the number of days in the month for which the Veteran was enrolled.

The number of days in which direct care was provided to the Veteran is defined as a day when the Veteran paid for a personal care worker (e.g. worker hired and employed by the Veteran) to assist with activities of daily living or instrumental activities of daily living or when the VD-HCBS Provider completed 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.

[4] VAMCs will authorize VD-HCBS for a period of time, often for a 12-month period, for an individual Veteran. VD-HCBS Providers must document the authorization period, monthly case-mix rate, and total authorized spending amount for the authorization period.

How This Works!

A Veteran enrolled in VD-HCBS with a case-mix rate "C" that lives in Abilene, Texas has a monthly case-mix rate of $1,777.

- The monthly administrative fee for this Veteran is $406.
- In May 2015, 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 VD-HBS is: $1,506.
- The Veteran received direct care in their home for personal care services in 21 out of the 30 days in May.
- The daily rate for VD-HCBS will be:
    - $1,506 / 21 = **$71.71**
    - The VD-HCBS Provider does not bill for the $271 ($1,777 - $1506) the Veteran saved in their emergency back-up and planned savings fund. The VD-HCBS Provider will track monthly spending and balance of the back-up and planned savings fund. The VAMC is expected to be aware of these balances so invoices will not be denied for months when the Veteran makes purchases using this fund, particularly because the invoice will likely exceed the monthly case-mix rate.

Emergency Back-up and Planning Savings Fund

A key feature of the Veteran's spending plan is allowing the Veteran to save funds in order to purchase goods, which can often exceed the one month's budget (e.g. case-mix rate), and for situations where the Veteran may require emergency supports (i.e. short-term change in needs or to hire/use a worker temporarily to replace an unpaid Caregiver that goes on vacation). This single account is called the Veteran's "emergency back-up and planned savings funds." Contributions to the emergency back-up and planned savings fund are tracked as part of the Veteran's spending plan and cannot exceed a value of $100 less than their monthly case-mix rate. For example, a Veteran living in Boston, MA who is assigned to case-mix "D" can save a maximum of $3,029 in their emergency back-up and planned savings fund (Case-mix "D" Budget is $3,129).

Contributions to the emergency back-up and planned savings are only available to the Veteran during the period that VA authorized VD-HCBS for that Veteran. For example, if a Veteran is authorized to receive VD-HCBS from January 1, 2016 – December 30, 2016, his/her emergency back-up and planned savings is only available until December 30, 2016. If a Veteran has a balance of $500 but does not use those funds within the authorization period, the $500 is zeroed out in the new authorization period.

VAMC Coordinators are required to review and approve all planned purchases to make sure they do not duplicate any services offered by the VAMC. In addition, there may be instances where the Veteran will need to save for larger than the allowable limit outlined in the paragraph above. For example, if the Veteran is saving for a large purchase, they may be at risk of having no emergency back-up savings. In these rare cases, the VAMC Coordinator can approve savings in excess of the case-mix rate minus $100.

In tracking the Veteran's emergency back-up and planned savings fund balance, a Veteran can have a negative balance in this fund. This could occur if a Veteran makes a purchase for a good or service which results in the monthly spending exceeding the monthly case-mix rate. In situations where the Veteran's emergency back-up and planned savings fund is in a negative balance, the Veteran should have a plan to ensure that they do not go over their authorized budgeted amount for the period of the authorization for VD-HCBS. The example below will provide you with additional guidance for tracking total spending and the emergency back-up and planned savings fund.

How This Works!

A Veteran enrolled in VD-HCBS with a case-mix rate "C" that lives in Abilene, Texas has a monthly case-mix rate of $1,777. The Veteran is authorized to receive services from January 1, 2015 through December 30, 2015. The monthly administrative fee for this Veteran is $406.

- In January 2015, 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 2015 is: $1,606.
- After January, the balance of the emergency back-up and planned savings fund is $171 ($1,777 - $1606).
- In February, the VAMC approves the purchase of a new microwave for $400. The Veteran also spends $1,250 as outlined in their approved spending plan.
    - The monthly invoice for February 2015 is $2,056. This includes $400 for the purchase, $1,250 in spending and $406 monthly admin fee.
    - The new balance of the emergency back-up and planned savings fund is -$108.
        - In two months, the Veteran has spent $3,662 ($2,056+$1,606)
        - Based on their monthly case-mix rate ($1,777), two months of spending would equal $3,554
        - The monthly case-mix rate multiplied by the amount of time minus total spending to date will give you the balance of the emergency back-up and planned savings fund.
- The Veteran's total authorized budget for the authorization period is $21,324 ($1,777 * 12). After February, the Veteran has $17,662 ($21,324 - $3,662) remaining to spend for VD-HCBS from March 1 – December 30. The Veteran's spending plan should document how the Veteran will use their funds within their authorized budget for the remaining authorization period.

Per recent VA guidance, VD-HCBS Providers can only bill for actual services purchased by the Veteran and for the monthly administrative fee. This means that monthly VD-HCBS invoices will not include funds that the Veteran saved for their emergency back-up and planned savings fund. It is imperative that the VD-HCBS Provider keep an accurate account of funds available for emergency back-up and planning savings for when the Veteran does use this fund. They will bill the VAMC when the Veteran makes purchases for goods and services when the Veteran uses this fund. In addition, VAMCs will track the available balance of emergency back-up and planned savings so that invoices that include purchases

from the emergency back-up and rainy day fund, and in excess of the monthly case-mix rate, are not rejected by VA's finance and billing office.

Institutional Placements for Veterans Enrolled in VD-HCBS

VA recognizes that Veterans enrolled in VD-HCBS may utilize inpatient (nursing home and hospital) services. Guidance for invoicing for months in which the Veteran is placed in an inpatient setting is provided in this section. The VD-HCBS Provider should discuss policies and communicate with the VAMC VD-HCBS Coordinator during a situation when the Veteran is admitted to an inpatient setting.

VA will reimburse the full administrative fee for the month in which the Veteran is admitted to an inpatient setting. When the Veteran is in an inpatient setting for 15 days or less, the Veteran's monthly spending amount will not be prorated. A change in the Veteran's budget can be authorized and approved by the VAMC if there is a situation in which a change in case-mix is required. For an inpatient placement which continues beyond 15 days, the Veteran will be placed in an inactive status, at which time all payments to the provider will cease until the Veteran's status is reactivated by the VAMC. The Veteran will be discharged from the VD-HCBS Program when it is determined that it is no longer clinically appropriate.

While VA will 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 need pre-approval.

Completing the UB-04 Form using Excel or Purchased Software

There are a number of software packages available to assisting in completing the UB-04, which generally cost $100-$200. To evaluate these packages it is important to understand what they can and cannot do. All off them should be able to walk a biller through the process of completing the UB-04. They also should be able to save the completed bill so the biller only has to complete the new billing dates and amounts each time. If the package does not have these functions, it probably will not be helpful to a biller.

How well the program will print a bill also matters. Since paper bills are scanned by the VAMC for processing at the payment center, printed bills must be clear and be within standard margins. An important reason bills are rejected is that the scanned copy is not readable by the payment center.

Finally, be skeptical of claims that the software will "electronically bill." The VA electronic billing system is through an intermediary, Change Healthcare, previously known as Emdeon, which has its own requirements. While it may be possible to upload from a software package directly to Change

Healthcare, this functionality should be tested and confirmed before a biller can be sure that a software package can assist in electronic billing.

In summary, one of the UB-04 software packages may be helpful for billing the VA, and having one may be essential for sites that have over 30 Veterans. Careful shopping is required, however, to make sure the package meets the needs of the VD-HCBS site. Asking for a trial period or a money-back period may be required to determine whether a specific package will work for a specific site.

In addition to using software to complete the UB-04, several sites have formatted an excel spreadsheet to match the UB-04 form. A version of the excel formatted UB-04 is found on the ACL NWD website at: https://nwd.acl.gov/vd-hcbs.html. It is important to test the excel version of the UB-04 to make sure it is accepted by the VAMC.

Submitting UB-04 Form to VAMC

ACL and VA recommend that every VD-HCBS Program (both the VAMC and VD-HCBS Provider) discuss and establish local procedures for when invoices are submitted, how they are submitted, and the parties that receive VD-HCBS invoices and subsequent monthly documentation. Currently, VD-HCBS Providers are submitting VD-HCBS invoices and documentation to: (1) the VD-HCBS Coordinator at the VAMC; (2) the billing, finance or Non-VA Care office[5] that is responsible for processing invoices; or, (3) both the VD-HCBS Coordinator and the billing, finance or Non-VA Care office. VA and ACL do recommend that the VD-HCBS Coordinator receive monthly invoices and spending reports if the UB-04 is sent directly to the VA Office responsible for processing payments. This type of arrangement will allow the VD-HCBS Coordinator to answer any questions once the invoice is received by the VAMC, potentially reducing the likelihood of rejected invoices.

Submitting Corrected Bills in VD-HCBS

There are rare instances where timesheets and receipts are submitted to the FMS entity after the VD-HCBS Provider submits VD-HCBS invoices to VAMCs. It's encouraged that you work with the FMS to ensure timesheets are submitted timely in order to not delay the ability to invoice VAMCs for VD-HCBS. In addition, sites will need to consider and wait an adequate amount of time after the month to submit monthly VD-HCBS invoices to ensure that the need to submit corrected bills do not happen frequently. However, when this occurs, the VD-HCBS Provider should alert the VD-HCBS Coordinator at the VAMC that the VD-HCBS Provider will need to submit a corrected invoice for a particular month and Veteran. Local procedures will need to be discussed on how to submit corrected invoices between the VD-HCBS Provider and VAMC based on local policy and requirements.

[5] There is no standard name for the VAMC Office responsible for processing payments for Non-VA Care services.

It is recommended that any corrected invoices reflect new total spending amounts for the month in which spending occurred, rather than supplemental invoices that only account for the new charges. For example, if the VD-HCBS Provider submitted a monthly VD-HCBS invoice for $2,000 and had $100 of previously unaccounted invoices, the VD-HCBS Provider should submit a revised invoice for $2,100 to accurately reflects total spending in that month.

In the UB-04 form used for VD-HCBS invoices, Field 4 “Type of Bill” can capture adjustments and replacements for corrected and revised bills.

- If the VAMC has already reimbursed the VD-HCBS Provider for an invoice and a new invoice needs to be submitted, code “346” in Field 4 of the UB-04 will signify that an adjustment of a prior claim is being submitted. The UB-04 Form should be filled out to reflect total spending in the month, however, the total charges should only reflect the amount due (e.g. total VD-HCBS invoice - amount already reimbursed).
- If the VAMC has not yet reimbursed the VD-HCBS Provider and a new invoice needs to be submitted, code “347” will signify that a replacement of prior claim is being submitted.

For corrected bills to be paid and reimbursed in a timely manner, the VD-HCBS Provider and VAMC need to discuss and approve procedures for corrected bills. Additionally, prior to submitting corrected bills under approved procedures, the VD-HCBS Provider needs to notify the VAMC Coordinator and/or billing office, if appropriate, that a corrected bill will need to be submitted.

Appendix A: Step-by-Step Guide for Completing UB-04 Form

The UB-04 Form (also known as the CMS 1450 Form) is used as the monthly invoice form for VD-HCBS. The UB-04 Form contains 81 sections; not of all which are required when submitting invoices to the VA for VD-HCBS reimbursement. In order to assist VD-HCBS Providers complete the UB-04 Form, below is a list of fields from the UB-04 form with their corresponding title, whether or not the field must be completed for VD-HCBS, a brief definition, and input values.[6]

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		N		
#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 VD-HCBS, this should be: • 3 = Home Health -The second digit signals the type of clinic. For VD-HCBS, this should 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

[6] This list is based on current guidance provided by VA and the experience of VD-HCBS Providers with using this form to date. As a result, VAMCs may not follow every direction provided here depending on their local billing practices.

				referenced diagnostic services. -The third digit signals the frequency of claim. For VD-HCBS, this could be: • 2 = Interim – First Claim • 3 = Interim – Continuing Claims • 4 = Interim – Last Claim • 5 = Late Charge Only • 6 = Adjustment of Prior Claim • 7 = Replacement of Prior Claim
#05	Federal Tax Number	Y	Every provider is required to have a federal tax number in order to receive payment	Example format: • NN-NNNNNNN
#06	Statement Covers Period (From-Through)	Y	Statement period date based on when care was provided	Example format: • MM/DD/YY
#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 VD-HCBS 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 VD-HCBS, 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 VD-HCBS, 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 VD-HCBS. Generally speaking, the following code should be used unless otherwise specified by the VAMC: • 3109 If code '3109' is not accepted, the following code can be used: • 0571
#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 VD-HCBS, only two codes are used.	The following two codes should be used only for VD-HCBS: • 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 in which 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 VD-HCBS"	Example Format: • MM/DD/YY
#46	Units of Service	Y	Number of Units. This field should be completed for each row where a daily rate is billed to VA	For VD-HCBS, the unit of service for each row will be "1"
#47	Total Charges	Y	Daily Rate for VD-HCBS. Further defined in the section "Calculating the Daily Rate for VD-HCBS"	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 VD-	NPI is a unique 10-digit identifier.

			HCBS State TA Lead or ACL Project Officer.	
#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		
#63		N		
#64		N		
#65		N		
#66	Diagnostic and Procedure Code Qualifier	Y	ICD 9 is a standard tool for mapping health conditions which can be up to six characters long. ICD-9 is maintained by the World Health Organization.	ICD-9 Code will be provided by the VAMC at time of referral.
#68-75		N		
#76[7]	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		

[7] Several VAMCs have required 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 B: Sample UB-04 Form and Accompanying Monthly Spending Report Documentation

This appendix will provide an example of a completed UB-04 Form and accompanying monthly spending report.

Randy King is a 90 year old World War II Veteran with progressive Alzheimer's disease living in New Haven, Connecticut along with his elderly wife. In early February 2015, Mr. King was identified as a potential VD-HCBS enrollee due to his increasing for assistance with ADLs/IADLs after a primary care appointment at the VAMC. Mr. King and his wife were excited for the opportunity to self-direct their own care, to include hiring his children and grandchildren to assist with his care. 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 $3,013.

The VD-HCBS Coordinator at the West Haven VAMC referred Mr. King, along with his case-mix level, medical history, contact and demographic information, and, primary ICD-9 code to the South Central Community Choices ADRC's Person-Centered Counselor to complete a person-centered assessment for VD-HCBS. The ADRC PCC assisted Mr. King with developing a spending plan for VD-HCBS that included hiring his daughter, Sandy Sue, and three grandchildren (Brandan, Betty and Sarah) as well as regularly attend Adult Day Care, LLC near his home. Additionally, Mr. King will use his VD-HCBS budget to purchase a grab-bar for his bathroom, laundry services, yard care (snow removal). Mr. King was officially enrolled in the program on November 1, 2015.

The monthly spending report and UB-04 below are an example of Mr. King's VD-HCBS spending in November 2015, the first month in which Mr. King begin utilizing his VD-HCBS monthly budget.[8] 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 $2,122. With a monthly administrative fee of $667, South Central Community Choices' VD-HCBS invoice for Mr. King based on April 2015 services will be $2,789. Mr. King received "hands-on" personal care, day care or respite services on 26 unique days in November 2015 based on the FMS reports that were received. As a result, the daily VD-HCBS rate for Mr. King in April 2015 is $107.27 ($2,789 / 26).

[8] Printing the Veteran Spending Plan and UB-04 will require legal-sized paper. The blank spending plan report and UB-04 links provided above can be printed on normal letter paper

	A	B	C	D	E	F	G
1	Monthly Veteran Spending Report: (November/2015)						
2	**Veteran Name**	Randy King	**Aging/Disability Services Contact**			Tina Turner	
3	**Veteran SSN**	xxxxxxxxx					
4	**Start Date of Using Monthly Spending Plan**	11/1/2015	**VAMC Contact**			Beth Hamson	
6	**Monthly Budget Amount**	$ 3,013.00					
7	**Monthly Admin Rate**	$ 667.00	**VD-HCBS Annualized Budget**			**$36,156.00**	
8	**Total Days in Month**	30	**Budget Available to Veteran in First Month (Pro-Rated)**			**$3,013.00**	
10							
11	**Personal Care/Day Care/Respite Service**	**Employee**	**Rate to Employee (per hour or day**	**Employer Taxes and Workers' Comp**	**Total Units (Hours or Days)**	**Day of Service**	**Total**
12	Personal Care	Sandy Sue	$20.00	$6.00	18	01, 02, 03, 10, 20, 24	$468.00
13	Day Care	Day Care, Inc.	$60.00	$0.00	9	02, 10, 11, 12, 14, 22, 28, 29, 30	$540.00
14	Respite	Brandan King	$12.00	$3.00	18	05, 06 ,07, 18, 19, 27	$270.00
15	Personal Care	Betty King	$15.00	$3.00	33	02, 04, 06, 08, 09, 12, 15, 18, 21, 23, 25	$594.00
26				***Total Employee Services***			**$1,872.00**
27	**Purchased Non-Employee Good/Service**	**Vendor**		**Unit Cost**	**Units**	**Total**	
28	Good	Grab Bar		$150.00	1	$150.00	
31	Service	Lawn Service		$100.00	1	$100.00	
32							
33				***Total Non-Employee Goods/Services***		**$250.00**	
34							
35					**Total Veteran Spending This Month**	**$2,122.00**	
36					**Monthly Admin & Oversight**	**$667.00**	
37					**Monthly Actual Expenses**	**$2,789.00**	
38							
39					**Number of Unqiue Days in Month Where Personal Care, Day Care and Respite Care was Provided by Paid VD-HCBS Provider**	**26**	
40					**Actual Unique Days in the Month Where Care was Provided (e.g. Days to Invoice For)**	**1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 14, 15, 18, 19, 20, 21, 22, 23, 24, 25, 27, 28,**	
41					**Daily VD-HCBS Rate for This Month**	**$107.27**	
42							
43	**Emergency Back-Up/Planned Savings Allocated This Month**	$224.00		**Up/Planned Savings Balance End of Month (New Balance)**		$224.00	
44	**Annual VD-HCBS Budget Remaining**					**$33,143.00**	

Randy King's VD-HCBS Invoice for November 2015 (3 pages)[9]

South Central Community Choices		3a. PAT CNTL #	4. Type of Bill
1 Long Wharf Dr		b. Med Rec #	343
New Haven, CT 06511		5. FED TAX NO.	6. STATEMENT COVERS PERIOD FROM / THROUGH
(888) 756-4321		03-5555555	11/1/15 / 11/30/15

8. PATIENT NAME	a. Randy	9. PATIENT ADDRESS	a. 624 Hope Street				
b. King		b. New Haven		c. RI	d. 06501	e. US	

10. BIRTHDATE	11. SEX	ADMISSION DATE	HR	TYPE	16. DHR	17. STAT	CONDITION CODES 18–28	29. ACDT STATE	30
10/29/1944	M	3/1/2015		6		30			

31 OCCURANCE CODE	DATE	32 OCCURANCE CODE	DATE	33 OCCURANCE CODE	DATE	34 OCCURANCE CODE	DATE	35 CODE	OCCURANCE SPAN FROM	THROUGH	36 CODE	OCCURANCE SPAN FROM	THROUGH	37

38		39 VALUE CODES CODE	AMOUNT	40 VALUE CODES CODE	AMOUNT	41 VALUE CODES CODE	AMOUNT
	a						
	b						
	c						
	d						

42 REV CD	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV. DATE	46 UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49
3109	Other Adult Care	T1020	11/1/15	1	107.27		
3109	Other Adult Care	T1020	11/2/15	1	107.27		
3109	Other Adult Care	T1020	11/3/15	1	107.27		
3109	Other Adult Care	T1020	11/4/15	1	107.27		
3109	Other Adult Care	T1020	11/5/15	1	107.27		
3109	Other Adult Care	T1020	11/6/15	1	107.27		
3109	Other Adult Care	T1020	11/7/15	1	107.27		
3109	Other Adult Care	T1020	11/8/15	1	107.27		
3109	Other Adult Care	T1020	11/9/15	1	107.27		
3109	Other Adult Care	T1020	11/10/15	1	107.27		
3109	Other Adult Care	T1020	11/11/15	1	107.27		
3109	Other Adult Care	T1020	11/12/15	1	107.27		
3109	Other Adult Care	T1020	11/14/15	1	107.27		

[9] Please note that due to rounding, the total amount on the UB-04 form maynot match to the Veterans' spending report. This should be noted in the invoice to the VAMC. Also, VD-HCBS Providers sites can change the total authorized amount to be reimbursed if necessary.

3109	Other Adult Care		T1020	11/15/15	1	107.27		
3109	Other Adult Care		T1020	11/18/15	1	107.27		
3109	Other Adult Care		T1020	11/19/15	1	107.27		
3109	Other Adult Care		T1020	11/20/15	1	107.27		
3109	Other Adult Care		T1020	11/21/15	1	107.27		
3109	Other Adult Care		T1020	11/22/15	1	107.27		
3109	Other Adult Care		T1020	11/23/15	1	107.27		
3109	Other Adult Care		T1020	11/24/15	1	107.27		
	Page 1 Total					2252.67		
	PAGE	2	OF	2	CREATION DATE	12/10/15	TOTALS	2789.00

50 PAYER NAME	51 HEALTH PLAN ID	52 REL INFO	53 ASG BEN.	54 PRIOR PAYMENTS	55 EST. AMOUNT DUE	56 NPI	XXXXXXXXXX
						57 OTHER PRV ID	

58 INSURED'S NAME	59 P.REL	60 INSURED'S UNIQUE ID	61 GROUP NAME	62 INSURANCE GROUP NO.
King, Randy		XXX-XX-XXXX		

63 TREATMENT AUTHORIZATION CODES	64 DOCUMENT CONTROL NUMBER	65 EMPOYEE NAME

66 DX	712.0									68

New Haven, CT 06511				5. FED TAX NO.	6. STATEMENT COVERS PERIOD FROM	THROUGH	7
(888) 756-4321				03-5555555	11/1/15	11/30/15	

8. PATIENT NAME	a.	Randy	9. PATIENT ADDRESS	a.	624 Hope Street					
b.	King		b.	New Haven		c.	RI	d.	06501	e.	US

10. BIRTHDATE	11. SEX	ADMISSION DATE	HR	TYPE	16. DHR	17. STAT	CONDITION CODES 18	28. ACDT STATE	30
10/29/1944	M	3/1/2015		6		30			

31 CODE	OCCURANCE DATE	32 CODE	OCCURANCE DATE	33 CODE	OCCURANCE DATE	34 CODE	OCCURANCE DATE	35 CODE	OCCURANCE SPAN FROM	THROUGH	36 CODE	OCCURANCE SPAN FROM	THROUGH	37

38		39 VALUE CODES CODE	AMOUNT	40 VALUE CODES CODE	AMOUNT	41 VALUE CODES CODE	AMOUNT
	a						
	b						
	c						
	d						

42 REV CD	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV. DATE	46 UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49
3109	Other Adult Care	T1020	11/25/15	1	107.27		
3109	Other Adult Care	T1020	11/27/15	1	107.27		
3109	Other Adult Care	T1020	11/28/15	1	107.27		
3109	Other Adult Care	T1020	11/29/15	1	107.27		
3109	Other Adult Care	T1020	11/30/15	1	107.27		

	Page 2 Total					536.35		
	PAGE 2 OF 2		CREATION DATE 12/10/15	TOTALS		2789.00		

50 PAYER NAME	51 HEALTH PLAN ID	52 REL INFO	53 ASG BEN.	54 PRIOR PAYMENTS	55 EST. AMOUNT DUE	56 NPI	XXXXXXXXXX
						57 OTHER PRV ID	

58 INSURED'S NAME	59 P.REL	60 INSURED'S UNIQUE ID	61 GROUP NAME	62 INSURANCE GROUP NO.
King, Randy		XXX-XX-XXXX		

63 TREATMENT AUTHORIZATION CODES	64 DOCUMENT CONTROL NUMBER	65 EMPOYEE NAME

DX	712.0									69