### Revision History

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1. Introduction

1.1. Project and Solution Overview

HealthShare Referral Manager (HSRM) is an enterprise-wide system in support of community care used by facility community care staff to generate referrals and authorizations for Veterans receiving care in the community. Department of Veterans Affairs (VA) community care staff located at VA medical centers, community-based outpatient clinics, and Veterans Integrated Service Network offices use this solution to enhance Veteran access to care. HSRM is an integral component of the community care information technology (IT) architecture that allows Veterans to receive care from community providers.

HSRM allows VA to transition from what is currently a largely manual process to a more streamlined process that generates standardized referrals and authorizations according to clinical and business rules. HSRM supports clinical and administrative processes expected to:

- Seamlessly provide eligible Veterans with prompt referrals to a community provider of their choice
- Provide community providers with referrals and authorizations consistent with industry standards
- Decrease the administrative burden on VA clinical and facility community care staff members by establishing clinical and business pathways that reflect best practices, consistent outcomes, and reduced turnaround times, along with a solution that automates those pathways
- Facilitate communication between facility community care staff and community providers via a unified platform that enables the secure exchange of medical information

HSRM allows VA and community providers to better manage community care referrals and authorizations, resulting in simpler processing for VA and community providers as well as enhanced patient experience for Veterans.

1.2. User Guide Overview

Community providers play a key role in delivering high-quality care to Veterans in their communities. HSRM enables community providers to receive and process referrals from VA and share information faster and more accurately than ever before. Community providers, VA, and Veterans all benefit from this new system. This user guide provides details about the community provider’s role in processing referrals in HSRM and how to maximize system functionality.
2. HSRM Lifecycle

A referral’s lifecycle begins when the referral is received in HSRM, and it ends when the episode of care (EOC) is complete and all medical documentation has been received. There are six steps in the lifecycle. Community providers complete steps 3, 4, and 5, as shown in the referral lifecycle diagram.

*Figure 1: HSRM Referral Lifecycle*

<table>
<thead>
<tr>
<th>Step</th>
<th>Title</th>
<th>Description</th>
<th>Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>3</td>
<td>Accept a Referral</td>
<td>A community provider accepts or rejects the referral. A TPA or the facility community care staff member complete this on behalf of the community provider/facility.</td>
<td>Accepted or Rejected</td>
</tr>
<tr>
<td></td>
<td>Reject a Referral</td>
<td></td>
<td>(Manual Change)</td>
</tr>
<tr>
<td>4</td>
<td>Record an Appointment from</td>
<td>The community provider schedules the Veteran's appointment in an external system and records the appointment in HSRM. A TPA or the facility community care staff member complete this on behalf of the community provider.</td>
<td>First Appointment Made</td>
</tr>
<tr>
<td></td>
<td>the Referral List</td>
<td></td>
<td>(Automatic Change)</td>
</tr>
</tbody>
</table>

*The status of the referral automatically changes in HealthShare Referral Manager once the step is completed.*

Table 1 provides a description of each step of the referral lifecycle process that a community provider performs in HSRM.

Table 1: Referral Lifecycle Steps
### Step Table

<table>
<thead>
<tr>
<th>Step #</th>
<th>Title</th>
<th>Description</th>
<th>Status</th>
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</thead>
<tbody>
<tr>
<td></td>
<td>Follow Up on an Appointment</td>
<td>Once the first appointment is completed, the community provider enters information regarding the appointment (including treatment notes) and uploads medical documentation in HSRM. A TPA or the facility community care staff member complete this on behalf of the community provider.</td>
<td>Initial Care Given (Manual Change)</td>
</tr>
</tbody>
</table>

### 3. Working in HSRM

#### 3.1. Locate a Referral

HSRM allows community providers to locate referrals more quickly and manage them according to their priority. When logging into the system, the **Referral List** screen – which is also the home screen – appears (see Figure 2). The **Referral List** screen features what is in effect a user to-do list; it shows all of the referrals from VA in a central location and allows referrals to be sorted.

All lists in HSRM can be sorted by column heading. The default view lists referrals by highest priority and date added, making it easy to see which referrals need immediate attention. The **Referral List** may also be sorted by the user.

#### 3.1.1. Column Header Sort

Sorting the **Referral List** allows users to view the information in any column in ascending or descending order.

*To locate a referral by sorting column headers:*

1. Navigate to the **Referral List** by clicking either the **Home** button 🏡 or the **Menu** button ☐ at the top left of the screen, then selecting **Referral List** on the menu.

2. Click on a column heading to sort data in ascending order by that category. Click it a second time to sort in descending order. Click it a third time to sort by the default, **Priority Order**, and **Date Added**.

   ⚠️ Note: The blue hyperlink at the top right will update based on the sort.

3. Click on the row of the relevant referral to access the **Referral Details** screen.
3.1.2. Advanced Sort

The Advanced Sort feature provides multiple criteria by which users can sort any Referral List in HSRM (see Figure 3).

To locate a referral by using the Advanced Sort feature:

1. Navigate to the Referral List by clicking either the Home button or the Menu button at the top left of the screen, then selecting Referral List on the menu.
2. Click the blue hyperlink at the top right corner of the Referral List to activate Advanced Sort.

3. The available options appear (see Figure 4). Both primary and secondary sort criteria can be selected. Click the Ascending or Descending icon associated with the specific criterion for the sort. In the case shown below, Last Name and Date of Birth have been selected in ascending order. The referrals are now sorted according to the sort criteria. Click on the row of the relevant referral to view the Referral Details screen.
3.2. Manually Change the Status of a Referral

The Referral Status shows where a referral is in its lifecycle (see Figure 5). As shown in Figure 1, the possible statuses are: Approved, Sent, Accepted, Rejected, First Appointment Made, Initial Care Given, and EOC Complete. Community providers should only use Accepted, Rejected, First Appointment Made, and Initial Care Given.

To manually update the status of a referral:

1. Locate the referral (see the Locate a Referral section of this guide).
2. Navigate to the Referral Details screen by clicking on the referral row.
3. Navigate to the Referral Processing Information section on the Referral Details screen. Click the Magnifying Glass icon and select the new status. Community providers can change the referral status to Accepted, Rejected, First Appointment Made (status automatically changes to First Appointment Made when an initial appointment is recorded), or Initial Care Given, depending on where the referral is in its lifecycle.

Note: If the Rejected status is selected, the Referral Reason field will be mandatory.
4. Enter any relevant comments regarding the referral in the **Comments** field of the **Referral Processing Information** section.

5. Click the **Update** button at the bottom right of the screen to save changes and return to the previous screen. Click the **Apply** button to save changes and stay on the same screen.

3.3. **Access Standardized Episode of Care Information**

A standardized episode of care (SEOC) is a bundle of services that has been authorized under a single referral. All clinically related services for one patient for a discrete diagnostic condition, disease, or medical condition within a specific period of time across a continuum of care are included in a SEOC. A SEOC reduces the frequency in which community providers need to submit a Secondary Authorization Request (SAR) or Request for Services (RFS). It includes all physician, inpatient, and outpatient care as well as labs and diagnostics. Within HSRM, the user can view a list of services associated with the SEOC (see Figure 6). This is the procedural overview of services.

To view SEOC details:

1. Locate the referral (see the Locate a Referral section of this guide).
2. Click on the row of the referral to navigate to the **Referral Details** screen.
3. Navigate to the **Service Requested** section on the **Referral Details** screen and click on the **SEOC Details** link.

>Note: VA is required by law to obtain precertification and bill third-party payers for care that is not related to a Veteran’s service or
special authority for Veterans who have other health insurance (OHI). Precertification information and instructions can be found under the **SEOC Details** link and in the **Offline Referral Form**.

**Figure 6: Referral Details – SEOC Details**

4. Review the **Procedural Overview** for the SEOC.

**Figure 7: SEOC Details Screen**

3.4. **Print the Offline Referral Form**

Printing the **Offline Referral Form** enables the community provider to retain a hard copy of the referral for their files (see Figure 8). The **Offline Referral Form** contains referral details, additional referral information, billing and precertification information, patient details, and SEOC information. Community providers can print offline referral forms for individual or multiple referrals.
3.4.1. Individual Referral

To print the Offline Referral Form for an individual referral:

1. Locate the referral (see the Locate a Referral section of this guide).
2. Click on the row of the referral to navigate to the Referral Details screen.
3. Click the Component Menu icon at the far right of the Referral Details section to open the Component Menu (below the Patient Banner), then select Offline Referral Form from the Print drop-down menu.

Figure 8: Component Menu – Offline Referral Form

4. The Offline Referral Form appears in a new browser tab and can be printed, downloaded, and saved (see Figure 9).

Figure 9: Offline Referral Form

3.4.2. Multiple Referrals

To generate an Offline Referral Form for multiple referrals:
1. Navigate to the **Referral List** by clicking either the **Home** button 🏡 or the **Menu** button 📖 at the top left of the screen, then selecting **Referral List** on the menu (see Figure 10).

2. Click the **Toggle Multiple Selections** checkbox 🛡️ at the top right to enable the selection of multiple referrals, then click the checkboxes next to the appropriate referrals.

**Figure 10: Referral List – Multiple Referrals**

![Referral List – Multiple Referrals](image)

3. Click the **Component Menu** icon 📚 then select **Offline Referral Form** from the **Print** drop-down menu (see Figure 11).

**Figure 11: Component Menu – Offline Referral Form**

![Component Menu – Offline Referral Form](image)

4. The **Offline Referral Form** appears in a new browser tab (see Figure 12).
3.5. Manage Documents

HSRM allows VA and community providers to easily upload and download medical documents such as medical records and images. Prior to providing care to a Veteran, community providers can download and review documents that VA shares regarding the Veteran/patient. Following care, community providers upload relevant patient care documentation for VA’s review. This eliminates faxing and emailing documentation and greatly enhances the accuracy of patient documentation.

3.5.1. View and Download Documents

To view and download documents:

1. Locate the referral (see the Locate a Referral section of this guide).
2. Navigate to the Referral Details screen by clicking on the referral row.
3. Click Add Documents to Referral on the Referral Details screen to open the Documents screen (see Figure 13). Here all documents that have been added to the referral can be viewed.

Note: Documents may also be viewed and downloaded by accessing Documents from the Additional Referral Information screen. These instructions are included in the View Additional Referral Information section of this guide.

3.5.2. Add Documents

To add documents to a referral:

1. Locate the referral (see the Locate a Referral section of this guide).
2. Navigate to the **Referral Details** screen by clicking on the referral row.

3. Click **Add Documents to Referral** on the **Referral Details** screen to open the **Documents** screen.

**Figure 13: Referral Details – Add Documents to a Referral**

4. Click the **New** button at the bottom right of the **Documents** screen. The **Add Documents** screen appears (see Figure 14).

5. Enter data in the corresponding fields on the **Add Document** screen.

   ![Note: The Date Created, Time Created, and User Created fields are populated automatically and are read-only.]

**Figure 14: Add Documents Screen**

6. Click the **Upload button** and select the file from the computer’s hard drive.

7. To identify which type of document it is, click the **Magnifying Glass** icon in the **Document Type** field and choose the appropriate type (either **Medical Documents** or **SAR/RFS**). This will trigger an automatic task for VA to review the document.
8. Click the **Update** button at the bottom right of the screen to save and go back to the **Documents** screen.

9. Select **Referral Details** from the **Breadcrumb Trail** drop-down list at the top left of the screen to go back to the **Referral Details** screen or continue to add documents in the same manner.

### 3.6. Record an Appointment

Recording appointments in HSRM makes this information available to VA without having to phone, email, or fax, thus reducing the administrative burden for both VA and community providers. An appointment can be recorded in the system in two ways: from the **Referral List** and from the **Referral Details** screen.

*Note: You will also need to book the appointment in your own external system.*

#### 3.6.1. Referral List Method

*To record an appointment from the **Referral List**:

1. Locate the referral (see the Locate a Referral section of this guide).

2. Click the **Record Appointment** icon on the desired referral row (see Figure 15).

3. Enter the appropriate information (e.g., **Service Requested**, **Appointment for**, **Scheduling Method**, **Date/Time**).

*Note: Mandatory fields are marked with a red asterisk.*

**Figure 15: Record Appointment Screen**
4. If the name of the specific facility caregiver is unknown or the appointment is with a facility caregiver other than the initial community provider, click the **Provider Search and Additional Details** link. The **Provider Search** screen appears (see Figure 16).

**Figure 16: Provider Search Screen**

5. Populate the **Specialty** field on the **Provider Search** screen and click the **Find** button at the bottom right.  

   ![Provider Search Screen](image)

   **Note:** **Community Provider/Facility, State, City, Affiliation, NPI, First Name, and Last Name** fields may also be populated.

6. Select a provider for the referral by clicking on the row of the provider. The **Record Appointment** screen appears (see Figure 17).

   ![Record Appointment Screen](image)

   **Note:** **Appointment Duration, Appointment Reason, Reason for Selecting Provider, and Notes** fields are optional. However, entering information in these fields is a best practice, as it ensures that VA and the community provider have access to all relevant appointment information in a central location.
7. The **Provider Name** field populates.

   ![Note: For subsequent appointments, the name of the previous caregiver will appear in that field and will need to be changed if the new caregiver is different.]

8. Select **Update** on the **Record Appointment** screen to save changes. The status of the referral will automatically change to **First Appointment Made**.

   ![Note: If an appointment is recorded for a provider other than the initial community provider, that second provider will not see the referral on their referral list but will instead receive a task on his/her facility’s **Task List** that will allow them to work with the referral.]

9. Click the **Update** button at the bottom right to save the appointment information. The **Referral List** appears.

   ![Note: The first appointment made in the SEOC will be on the **Referral List** for the duration of the referral, regardless of subsequent appointments that are scheduled and occur. The date of the first appointment made also displays the **Appointment Date** field in the **Initial Community Provider/Facility Information** section on the **Referral Details** screen.]

### 3.6.2. Referral Details Method

To record an appointment from the **Referral Details** screen:

1. Locate the referral (see the Locate a Referral section of this guide).
2. Click on the referral to navigate to the **Referral Details** screen (see Figure 18).
3. Click the **Component Menu** icon located at the far right of the screen in the **Referral Details** section to open the **Component Menu**.

4. Select **Record Appointment**.

**Figure 18: Referral Details – Record Appointment**

5. Refer to the Referral List Method section of this guide to complete recording the appointment.

### 3.7. Cancel an Appointment

*To cancel an appointment:*

1. Locate the referral (see the Locate a Referral section of this guide).

2. Select the **Action Menu** icon to the right of the corresponding referral row and select **Additional Referral Information** (see Figure 19).

   ![Note: The Action Menu icon is also available from the Referral Details screen in the Patient Banner.](image)

**Figure 19: Action Menu – Additional Referral Information**

3. Locate the appointment from the **Appointments** section and click the **Status** link. The **Appointment Change Status** screen appears (see Figure 20).
4. The Change Status To field automatically populates as Canceled. If selecting a different status, click the Magnifying Glass icon in the Change Status To field and select a status from the drop-down list (see Figure 21).

   Note: If No Show is selected, the Reason for No Show field must be populated.

5. Click the Magnifying Glass icon in the Reason for Cancellation field and select the appropriate reason for cancellation from the available options.

6. Enter any additional information regarding the appointment cancellation.

   Note: The Free Text for Cancellation field can be used for additional details regarding the appointment (e.g., spoke to Veteran’s family member to cancel the appointment.)
7. Click the **Update** button at the bottom right of the screen to save changes.

### 3.8. View Additional Referral Information

Users can view additional information about a referral on the **Additional Referral Information** screen. This screen displays **Contacts**, **Appointments**, **Documents**, **Patient Letters** (to be enabled in a future release) and **Referral Notes**.

*To view additional referral information:*

1. Locate the referral (see the Locate a Referral section of this guide).
2. Select the **Action Menu** icon to the right of the corresponding referral row and select **Additional Referral Information** (see Figure 22).

*Note: The Action Menu icon is also available from the Referral Details screen in the Patient Banner.*

---

**Figure 21: Appointment Change Status Screen**

**Figure 22: Patient Banner – Additional Referral Information**
3. The Additional Referral Information screen appears, showing Contacts, Appointments, Documents, Referral Notes, and Patient Letters (to be enabled in a future release) related to the referral (see Figure 23).

Figure 23: Additional Referral Information Screen

3.9. Working with Tasks

A task in HSRM represents a discrete action that must be completed for a Veteran’s referral. Tasks minimize administrative burdens and streamline communications. They enable VA and community providers to share information without having to pick up the phone. Automatic tasks serve as reminders for submitting medical documents and precertification information, minimizing potential delays in payment.

A community provider will receive an auto-generated task from VA to submit medical documentation 7 days after the referral status is changed to Initial Care Given. Alternatively, the community provider can create a manual task to communicate with VA; for example, to request VA to contact the Veteran or to provide additional referral documents.

3.9.1. Create a Task

To manually create a task:

1. Locate the referral (see the Locate a Referral section of this guide).
2. Select the Action Menu icon to the right of the corresponding referral row, then select Add Task (see Figure 24).

Note: The Action Menu icon is also available from the Referral Details screen in the Patient Banner.
3. The **Task Edit** screen appears (see Figure 25). The **Patient Banner** is located at the top of the screen to show demographic information for the patient the referral is associated with.

4. Enter the appropriate information (e.g., **Task Item**, **Priority**, **Status**, **Comments**) to create the task. **Task Item**, **Priority**, and **Status** fields are mandatory (as denoted by the red asterisk) and can be edited.

5. Click the **Magnifying Glass** icon within each field to view and select available options.

6. Click the **Update** button at the bottom right to save the task information.

### 3.9.2. View or Edit a Task

The **Task List** displays all task items for the facility (see Figure 26). From the **Task List**, an item can be reviewed and edited.

*To view or edit a task:*

1. Click the **Menu** icon at the top left and select **Task List** from the drop-down options.
2. Locate the task on the **Task List**.

3. Click the text title in the **Task** column to navigate to the **Task Edit** screen (data in the **Task** and **Last Name** columns are displayed as hyperlinks). The **Task Edit** screen appears (see Figure 27).

   Note: Overdue tasks have a red indicator in the **Due Date** column.

4. Review the task, including any comments.

5. Edit the **Priority** and **Status** fields as needed. To do this, click the **Magnifying Glass** icon within each field and select the appropriate option (see Figure 28).

6. Edit the **Comments** field.
7. Click the **Update** button at the bottom right to save the task information and go back to the **Task List**.

### 3.9.3. **Mark a Task Complete**

From the **Task List**, an item can also be marked as complete.

*To mark a task as complete:*

1. Click the **Menu** icon at the top left of any screen and select the **Task List** option (see Figure 29).

![Menu – Task List](image)

2. Locate the task on the **Task List** (see Figure 30).
3. Check the box in the **Completed** column of the task.
3.10. Canned Text

Canned text automatically populates text fields with predefined text items. Clicking the **Canned Text** icon will display existing items in the canned text library. Users can create their own canned text to populate any text field that contains the **Canned Text** icon.

*To create canned text:*

1. Locate the referral (see the Locate a Referral section of this guide).
2. Navigate to the **Referral Processing Information** section. In the **Comments** box, enter the text you wish to save, highlight it, and click the **Plus** icon. This will take you to the **Canned Text** screen.
3. On the **Canned Text** screen, enter a code you wish to assign to the text. Click **Update** at the bottom right to save the canned text.

3.11. Generate Reports

HSRM can generate reports that display the types of services that are being referred to a specific community provider/facility as well as the current status of the referrals sent during the selected period.

**Table 2: HSRM Report Types**

<table>
<thead>
<tr>
<th>Report Type</th>
<th>Description</th>
<th>Users Allowed to Run Report</th>
</tr>
</thead>
</table>
| HSRM Reports Reference Guide | This report provides VA staff and community providers with the definitions and uses of all reports that they have access to. | • VA Facility Community Care Staff  
• Community Providers |
<table>
<thead>
<tr>
<th>Report Type</th>
<th>Description</th>
<th>Users Allowed to Run Report</th>
</tr>
</thead>
</table>
| Community Provider Referral       | This report allows VA staff and community providers to generate a tailored  | • VA Facility  
| Summary Report                    | list of referrals that have been sent to a community provider or facility   | Community Care Staff  
|                                   | (see Figure 31). This provides community providers with a list of referrals | • Community Providers  
|                                   | received from VA during a specified period of time.                         |                                                                  |

**To run a report:**

1. Click the **Menu** button, select **Reports**, and choose **Community Provider Referral Summary Report**.

**Figure 31: Menu – Community Provider Referral Summary Report**

2. Select the criteria needed to run the desired report from the fields available and click the **Preview** icon to run the report (see Figure 32).

**Figure 32: Community Provider Referral Summary Report Parameters**

3. Navigate to the report. It can be saved or printed.

Note: The **HSRM Reports Reference Guide** option, located in **Reports**, provides directions and detailed information about the report.
4. Additional Resources

Contact the HSRM Help Desk for direct support with HSRM. Open a ticket by phone at 1-844-293-2272 or email HSRMSupport@va.gov.

Additionally, the following websites provide quick and easy access to commonly needed materials:

- [Community Care Provider Resources Toolkit](#)
- [VA Community Care Website](#)
- [Billing Fact Sheet for VA Community Care Programs](#)
- [Additional Information on Claims Payment](#)
- [Emergency Care Claims and Payments](#) (scroll down to the Emergency Care Claims and Payments section)
- [Community Care Claims Process Video](#) (pending update by June 2019)
- [VHA TRAIN – No cost, Veteran-focused training for community providers](#)
- [Checking Claims Status](#) (scroll down to the Checking Claims Status section)
- [Vendor Inquiry System Fact Sheet](#)
- [Vendor Inquiry System](#)
### Appendix A: Acronyms and Abbreviations

#### Table 3: Acronyms and Abbreviations

<table>
<thead>
<tr>
<th>Acronym or Abbreviation</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>EOC</td>
<td>Episode of Care</td>
</tr>
<tr>
<td>HSRM</td>
<td>HealthShare Referral Manager</td>
</tr>
<tr>
<td>IT</td>
<td>Information Technology</td>
</tr>
<tr>
<td>RFS</td>
<td>Request for Additional Services</td>
</tr>
<tr>
<td>SAR</td>
<td>Secondary Authorization Request</td>
</tr>
<tr>
<td>SEOC</td>
<td>Standardized Episode of Care</td>
</tr>
<tr>
<td>VA</td>
<td>U.S. Department of Veterans Affairs</td>
</tr>
</tbody>
</table>