## 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 community care staff to generate referrals and authorizations for Veterans receiving care in the community. Clinical and Department of Veterans Affairs (VA) community care staff located at VA medical centers (VAMCs), outpatient clinics, community-based outpatient clinics (CBOCs), and Veterans Integrated Service Network (VISN) 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, community providers, third-party administrators (TPAs) 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](image1)

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

3. Accessing HSRM

3.1. Getting Access to HSRM

A HealthShare Referral Manager account is needed for staff who typically process referrals, accept and reject referrals, record appointments, and share medical documentation with VA.

In order to obtain an HSRM account you will need to:

- Set up your ID.me account at [https://www.id.me](https://www.id.me).
- Navigate to the AccessVA website.
- Sign in with your ID.me credentials.
- Enable two-factor authentication.
- Verify your identity.
- Navigate to the AccessVA website.
- Log into HSRM.
4. Working in HSRM

4.1. 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. 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.

4.1.1. 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 icon or the Menu icon 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.

Figure 2: Referral List
4.1.2. Advanced Sort

The Advanced Sort feature provides multiple criteria by which users can sort any Referral List in HSRM.

To locate a referral by using the Advanced Sort feature:

1. Navigate to the Referral List by clicking either the Home icon or the Menu icon 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.

Figure 3: Referral List – Advanced Sort

3. The available options appear. 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.
4.2. Manually Change the Status of a Referral

The Referral Status shows where a referral is in its lifecycle. 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.

### 4.3. 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 within a specific period across a continuum of care are included in a SEOC. A SEOC helps reduce the need to seek individual authorization for each element of care. 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. 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**.
4. Review the **Procedural Overview** for the SEOC.

**Figure 7: SEOC Details Screen**

4.4. **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. 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.

4.4.1. **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** (below the **Patient Banner**), then select **Offline Referral Form** from the **Print** drop-down menu.

![Figure 8: Component Menu – Offline Referral Form](image)

4. The **Offline Referral Form** appears in a new browser tab and can be printed, downloaded, and saved.

![Figure 9: Offline Referral Form](image)

**Note:** If you are using Chrome as your browser, you will need to download and save the form to your computer. If you are using Internet Explorer as your browser, use the **Save and Copy** feature to save to your computer.
4.4.2. Multiple Referrals

To generate an *Offline Referral Form* for multiple referrals:

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

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](image)

3. Click the **Component Menu** icon and select **Offline Referral Form** from the **Print** drop-down menu.

![Figure 11: Component Menu – Selected Offline Referral Forms](image)

4. The **Offline Referral Form** appears in a new browser tab.
4.5. 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. There are no restrictions on the format or size of the documents uploaded.

4.5.1. 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/View Documents on the Referral Details screen to open the Documents screen. 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 Additional Referral Information section of this guide.
4.5.2. 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/View Documents 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 Document screen appears.

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 Request for Services/SAR). 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.

4.6. 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 from the Referral Details screen.

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

To record an appointment:

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.
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 Options and Record Appointment.

Figure 15: Referral Details – Record Appointment

5. Enter the appropriate information (e.g., Service Requested, Appointment for, Scheduling Method, Date/time).

Note: Mandatory fields are marked with a red asterisk.
6. 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.

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

Note: Community Provider/ Facility, State, City, Affiliation, National Provider Identifier (NPI), First Name, and Last Name fields may also be populated. Either a Specialty or NPI must be provided.
8. Select a provider for the referral by clicking on the row of the provider. The Record Appointment screen appears.

*Note: Affiliation, Appointment Type, Appointment Duration, Appointment Reason, Reason for Not Selecting CCN 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.

Figure 18: Record Appointment Screen

9. 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.

10. Select the Update button 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.

11. Click the Update button at the bottom right to save the appointment information. The Referral Details screen 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 in the **Appointment Date** field in the **Initial Community Provider/Facility Information** section on the **Referral Details** screen.

### 4.7. Cancel an Appointment or Mark an Appointment as a No Show

*To cancel an appointment:*

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

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

   ![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.
Note: The Change Status screen can also be accessed by clicking the Edit Appointment link located on the referral row and then selecting Change Status, located beneath the Appointment Status field.

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.

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.

8. The appointment status is now displayed as **Canceled**.

Figure 22: Additional Referral Information Screen

4.8. **Initiating a Request for Services**

A **Request for Services** (sometimes referred to as a **SAR**) occurs when a community provider determines that a Veteran requires additional care that is not authorized within the original SEOC or requires care within the SEOC to continue beyond the original allotted timeframe.

*To initiate a Request for Services:*

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 Requests for Services. The Action Menu is also available from the Referral Details screen in the Patient Banner.
3. The Questionnaire List: Requests for Services screen appears, listing requests previously initiated.

4. Click the **New** icon at the top right to select the Request for Services Questionnaire.

5. Complete all required fields and additional information.

6. Click the **Requestor** Signature checkbox.

7. Change the **Request** status to Sent to VA.

8. Click the **Update** button to save your changes.
4.9. Record Contact

HSRM enables users to record any contact made with the Veteran, a community provider, or other person or organization regarding the referral. Anyone with access to the referral can view this information.

To record contact about a referral:

1. Locate the referral (see the Locate a Referral section of this guide).
2. Select the referral from the Referral List.
3. Select the Action Menu icon on the Patient Banner.
4. Select Record Contact from the drop-down menu. The Record Contact screen appears.
5. Enter the relevant information regarding the contact and click the Update button at the bottom right of the screen to save changes.
4.10. View Additional Referral Information

Users can view additional information about a referral on the **Additional Referral Information** screen. This screen displays Contacts, Appointments, Referral Documents, Care Coordination Documents, Patient Letters, 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**.

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

Figure 29: Referral List - Additional Referral Information
3. The **Additional Referral Information** screen appears, showing **Contacts**, **Appointments**, **Referral Documents**, **Care Coordination Documents**, **Referral Notes**, and **Patient Letters** related to the referral. Click on each to view the corresponding information.

*Figure 30: Additional Referral Information Screen*

Note: Each of the lists can be sorted using the **Column Header** and **Advanced** sorting methods.

### 4.11. 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.

For example, 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.

**4.11.1. 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**.

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

4. Enter the appropriate information (e.g., **Task Item**, **Priority**, **Status**, **Comments**) to create the task. **Task Item**, **Priority**, **Status**, **Due Date** and **Start Date** 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.
4.11.2. View or Edit a Task

The Task List displays all task items for the facility. 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.

Figure 33: Menu - Task List

2. Locate the task on the Task List.

3. Click the task 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.

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

Figure 34: Task List Screen

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.

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**.

8. After editing the task, you can complete the task by selecting the task row to access the **Referral Details** screen.
9. When the task has been updated, you are able to mark the task as complete.

### 4.11.3. Mark a Task Complete

From the Task List, an item can 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.

#### Figure 38: Menu - Task List

2. Locate the task on the **Task List**.

3. Check the box in the **Completed** column of the task.

#### Figure 39: Task List Screen

### 4.12. 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 the **Update** button at the bottom right to save the canned text.

### 4.13. Generate Reports

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

**Table 1: 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 |
| Community Provider Referral Summary Report       | This report allows VA staff and community providers to generate a tailored list of referrals that have been sent to a community provider or facility. This provides community providers with a list of referrals received from VA during a specified period. | • VA Facility
• Community Care Staff
• Community Providers |
| Veterans Appointment Report                      | Displays all the appointments at a specified VA or community provider facility. Report fields include the appointment date, appointment status, level of care coordination, as well as referral details. | • VA Facility
• Community Care Staff
• Community Providers |
| Download Request for Services Form               | This paper RFS form can be submitted if an electronic RFS form is not being used and may be uploaded into HealthShare Referral Manager. | • VA Facility
• Community Care Staff
• Community Providers |

**To run a report:**

1. Click the **Menu** icon ☰, select **Reports**, and choose **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.

3. Navigate to the report. Reports may generate in PDF format or as Excel documents and can be saved or printed.

Note: To print the report from Chrome, click the Print icon at the top right of the report. To print from Internet Explorer, click the Print File icon at the bottom of the report.

4.14. Billing and Other Referral Information

The Billing and Other Referral Information sheet provides community providers with additional details related to the legal authority, claims submissions instructions, precertification requirements, and provision of prescriptions and durable medical equipment for the referral. The information sheet also contains links to other community provider resources, including the Community Provider Toolkit, the precertification website, the electronic data interchange (EDI) claims submission clearinghouse, and the Vendor Inquiry System (status of claims). Community providers can access this information sheet directly from the Referral Details screen. The information is also available on the Offline Referral Form. The information sheet will contain appropriate content based on the program authority. For example, a referral authorized as an
Individual Authorization, Provider Agreement, Community Care Network referral, or 1728 service-connected emergency care referral would contain content specific to that program.

To access the Billing and Other Referral Information sheet:

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

2. From the Referral Details screen, click the Component Menu icon at the far right of the Referral Details section (below the Patient Banner), then select Billing and Other Referral Information.

Figure 42: Component Menu - Billing and Other Referral Information

3. The Billing and Other Referral Information sheet appears in a new browser tab and can be printed, downloaded, and saved as a PDF file.

Figure 43: Component Menu - Billing and Other Referral Information Sheet
5. Additional Resources

Contact the HSRM Help Desk for support. Open a ticket by phone at 1-844-293-2272 (TTY: 1-512-326-6638) or email HSRMSupport@va.gov.

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

- Provider Toolkit
- VA Community Care Website
- Billing Fact Sheet for VA Community Care Programs
- Community Care Claims Process Video
- Veterans Health Administration (VHA) TRAIN – No cost, Veteran-focused training for community providers
- Vendor Inquiry System Fact Sheet
- Vendor Inquiry System
## Appendix A: Acronyms and Abbreviations

<table>
<thead>
<tr>
<th>Acronym or Abbreviation</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>CBOC</td>
<td>Community-Based Outpatient Clinic</td>
</tr>
<tr>
<td>EDI</td>
<td>Electronic Data Interchange</td>
</tr>
<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>NPI</td>
<td>National Provider Identifier</td>
</tr>
<tr>
<td>OHI</td>
<td>Other Health Insurance</td>
</tr>
<tr>
<td>SEOC</td>
<td>Standardized Episode of Care</td>
</tr>
<tr>
<td>TPA</td>
<td>Third Party Administrator</td>
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<tr>
<td>VA</td>
<td>Department of Veterans Affairs</td>
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<tr>
<td>VAMC</td>
<td>Veterans Affairs Medical Center</td>
</tr>
<tr>
<td>VHA</td>
<td>Veterans Health Administration</td>
</tr>
<tr>
<td>VISN</td>
<td>Veterans Integrated Service Network</td>
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