Provider Notice:
Claims Processing and Payment Changes

VA Community Care Network (VA CCN)

Provider Notice: Upcoming Changes to Claims Processing and Payment

Effective March 10, 2026

Key Provider Updates

- Bill Medicare-priced services according to Medicare rules; non-Medicare providers must use the most accurate HCPCS or HCPCS/revenue code combinations available.
- Outpatient residential treatment claims must include CPT or HCPCS codes; claims without them will be denied.
- Ensure all billed services align with the Veteran's Standardized Episode of Care (SEOC); obtain RFS approval for anything outside the authorized scope.
- Include a complete service description on all claims (NTE 2300 or Boxes 19/80, as applicable).
- VA published a non-reimbursable code list

To comply with updated VA Community Care Network (VA CCN) requirements, Optum will implement enhancements to claims processing and adjudication effective March 10, 2026. These updates are designed to ensure that claims are priced accurately and aligned with the Veteran's authorized SEOC. Providers should review the following information carefully to avoid claim delays or denials.

Medicare rates will be applied to all Medicare-priced services regardless of provider type, Medicare billing status, place of service, claim type, or patient condition. Medicare-participating providers should continue billing VA CCN as they would bill Medicare. Providers who are not enrolled with Medicare must submit the most accurate HCPCS or HCPCS/revenue code combinations available and should reference CMS billing manuals for coding guidance. All providers are required to follow CMS billing and coding requirements outlined in the Medicare Claims Processing Manual, unless their VA CCN agreement states otherwise.

Outpatient claims billed by residential rehabilitation facilities must include detailed CPT or HCPCS procedure codes, even when submitted on a UB-04 with revenue codes. Residential or outpatient residential treatment claims without the required procedure codes will be denied. Providers must ensure that each claim reflects the services rendered to the Veteran.

Optum will implement updated SEOC based adjudication logic, such as procedural overview restrictions. Providers must ensure that all billed services align with the SEOC outlined in the Veteran's approved referral. Services outside the authorized SEOC must be authorized through the Request for Services (RFS) process. Prior to submitting claims, provider should review the SEOC packet, procedural overview, and applicable VA Clinical Documentation Instructions (CDIs).

Claims must include a complete service description in the appropriate claim field when billing unlisted or Not Otherwise Classified (NOC) codes. Electronic claims require the description in the NTE segment (Loop 2300), while paper claims must include it in Box 19 on the CMS-1500 or Box 80 on the UB-04. Claims submitted with unlisted CPT or HCPCS codes will be denied; however, providers may submit a reconsideration request with supporting medical documentation within ninety (90) calendar days of the denial.

Providers should review VA's list of non-reimbursable procedure codes regularly. VA may update this list up to four times per year. Providers should review claims with the denial message "THIS PROCEDURE IS DESIGNATED AS A VA NON-REIMBURSABLE CODE," to determine if a more appropriate code is available prior to resubmitting the claim.

Additional references:

- VA CCN Provider Manual
- Standard Episode of Care
- VA Clinical Determinations and Indications (CDIs)

