Provider Manual
September 2026

VA Community Care Network (VA CCN)

Optum | United Healthcare

Contents

Overview

Welcome to the Department of Veterans Affairs (VA) Community Care Network (CCN) Provider Manual. We've collected important information about the VA CCN that will help you deliver care to Veterans in your community.

This VA CCN Provider Manual (this "Manual") applies to Covered Services you provide to Veterans as part of the VA CCN. Veteran eligibility and coverage are determined by VA.

This Manual is for any facility, ancillary provider, physician, physician organization, other health care professional, supplier or other entity engaged in the delivery of health care services under VA CCN (collectively "provider") participating in one of the Optum VA CCN partner networks or in a leased network managed by a vendor that has subcontracted with Optum or one of its affiliates for VA CCN (see the "Network Resources" section below for more information on Optum VA CCN partner networks).

As used in this Manual, "you," "your" or "provider" refers to any provider as defined above. Except where expressly indicated, the information included in this Manual is applicable to all types of providers subject to the Manual.

As used in this Manual, "us," "we" or "our" refers to Optum or UnitedHealthcare (collectively "Optum") or one of the other VA CCN-affiliated Network Partners (collectively "Network Partner(s)") with which you have contracted for VA CCN.

This Manual is a binding part of your contract with Optum or Network Partner (the "Participation Agreement") and includes requirements that you must comply with for the VA CCN, including the following categories of information, which will help you better understand VA CCN requirements, as well as how to collaborate with VA and deliver and coordinate care for the Veterans you will be serving:

- Provider resources
- Covered services
- Credentialing
- Provider responsibilities
- Eligibility and enrollment
- Referrals
- Pharmacy and Durable Medical Equipment (DME)
- Health care management
- Medical documentation
- Reimbursement and claims process
- Provider training and resources

The table of contents contains hyperlinks to specific sections. This enables providers and staff to access needed information quickly and efficiently.

Terms and acronyms in this Manual are defined the first time they appear. They are also spelled out in the Glossary and Acronyms sections at the end of this Manual.

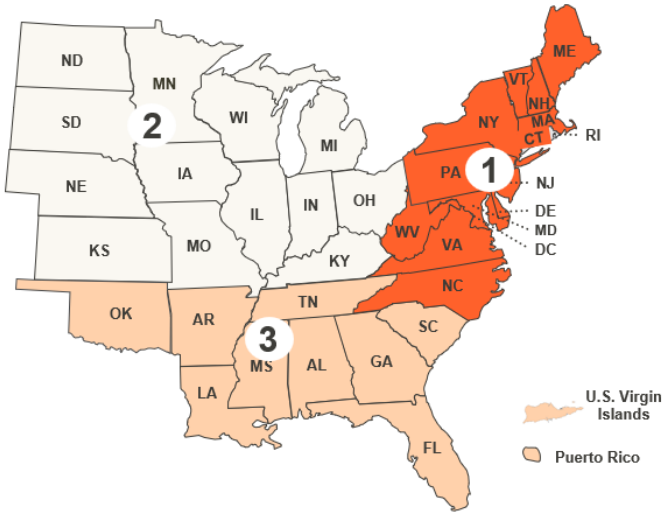
Important Note About This Manual

The Manual will be updated in January, April, July, and October. In addition, off-cycle updates may be completed as determined by Optum. Notice of VA CCN Provider Manual updates will be posted on the Optum VA Community Care Network Provider Portal. The latest version will be posted to the Optum VA Community Care Network provider portal, vacommunitycare.com/provider > Training & Guides. Please check back for updated versions. This guide was updated September 9, 2026, for physicians, health care professionals, facilities and ancillary providers currently participating in the VA CCN.

What is VA CCN?

VA recognizes that while the health care landscape is constantly changing, VA's unique population and broad geographic demands will continue to require community-based care for Veterans. VA is committed to providing eligible Veterans with the care they need when and where they need it. A significant component of having one method for Veterans to receive care from community providers is the ability for VA to purchase community services through the CCN contracts awarded to Third-Party Administrators (TPAs). Optum was awarded Region 1, Region 2, and Region 3.

Region 1	Region 2	Region 3
• Connecticut • Delaware • District of Columbia • Maine • Maryland • Massachusetts • New Hampshire • New Jersey • New York • North Carolina • Pennsylvania • Rhode Island • Vermont • Virginia • West Virginia	• Illinois • Indiana • Iowa • Kansas • Kentucky • Michigan • Minnesota • Missouri • Nebraska • North Dakota • Ohio • South Dakota • Wisconsin	• Alabama • Arkansas • Florida • Georgia • Louisiana • Mississippi • Oklahoma • Puerto Rico • South Carolina • Tennessee • U.S. Virgin Islands



Regions are based on provider locations. The provider may receive referrals for Veterans residing in a different state than the provider's location. To determine the appropriate phone number for the provider's region, click here.

VA CCN gives Veterans the opportunity to receive care from a network of community health care professionals, facilities, pharmacies, and suppliers.

Veterans have sacrificed to serve our country, and this is an opportunity to provide them with timely, accessible, and high-quality care they deserve. Providers can help Veterans access a network of community health care through their contract with Optum or another Network Partner. VA CCN only covers Veterans, not their families or dependents. VA determines a Veteran's eligibility to get care from community providers.

Network Resources

Optum's complete and comprehensive health care provider network includes, but is not limited to:

UnitedHealthcare

UnitedHealthcare provides the network for traditional medical services for VA CCN.

The UnitedHealthcare network includes:

- Primary care providers
- Specialty and sub-specialty providers
- Acute care hospitals
- Laboratories
- Specialty pharmacies
- Ambulatory surgery centers
- Long-term acute care facilities

- Federally Qualified Health Centers
- Rural Health Clinics
- Urgent care facilities
- Ancillary services, including home health, DME, hospice care, dialysis and diagnostic radiology

United Behavioral Health

United Behavioral Health (UBH) provides a network of behavioral health and substance use disorder facilities and providers who perform Complementary and Integrative Healthcare Services (CIHS) for VA CCN.

The UBH network includes:

- Psychiatric hospitals
- Inpatient and outpatient mental health and substance use disorder programs
- Psychiatrists
- Psychologists
- Social workers
- Marriage and family therapists
- Counselors

VA CCN CIHS includes biofeedback, hypnotherapy, relaxation techniques and Native American healing.

UBH serves all areas, except Puerto Rico and the U.S. Virgin Islands. Those areas are covered by a leased network.

OptumHealth Care Solutions, LLC

OptumHealth Care Solutions, LLC, (OHCS) provides a network of freestanding physical health providers and services for VA CCN, which includes:

- Physical therapy
- Occupational therapy
- Speech therapy
- Chiropractic services

The OHCS network also includes providers who provide some CIHS, including:

- Massage therapy
- Acupuncture
- Tai chi

Note: Chiropractic, Massage Therapy, and Acupuncture specialties are contracted on an individual National Provider Identifier (NPI) level only.

OHCS provides tai chi in all areas. All other specialties listed above are provided by OHCS in all areas, except Puerto Rico and the U.S. Virgin Islands. Those areas are covered by a leased network.

Optum Serve

Optum Serve (formally known as Logistics Health Inc. (LHI)) provides a network of general and specialized dental providers covering all geographic areas. This network provides outpatient dental care to all eligible Veterans.

CVS Caremark

CVS Caremark Pharmacy serves as a Pharmacy Benefits Manager (PBM) and encompassing a network of retail pharmacies covering all geographic areas for the VA CCN. The retail pharmacies provide prescription fulfillment services for urgent or emergent prescriptions from VA CCN and VA providers with an approved referral or Urgent Care Eligibility Record Number (UCERN).

UnitedHealthcare Vision

UnitedHealthcare Vision provides a network of eye care professionals covering all geographic areas. This network provides routine eye examinations. Veterans will need to fill their prescription for eyeglasses or vision devices with their local VA medical facility.

Vision Coverage Exclusions:

- The VA approved referral does not authorize eyeglasses or optical and non-optical low vision devices.
- An approved referral will not authorize cosmetic contact lenses. VA will have to review and approve any requests for medically necessary contact lenses.

VA CCN providers can submit a request for medically necessary contact lenses to the VA facility utilizing the Request for Services form located at vacommunitycare.com/provider > Forms and Resources

For more information on the vision benefit you can reference the Vision Care for Veterans document located at vacommunitycare.com/provider > Training & Guides > Benefits.

Provider Resources

Online

VA Community Care Provider Portal and Website

VA has VA CCN provider resources available at department.va.gov/vha/community-care/.

HealthShare Referral Manager (HSRM) is VA's online portal for managing referrals and authorizations.

HSRM enables electronic file sharing between VA and providers by allowing VA CCN providers to sign in to view approved referrals, submit medical documentation and Request for Service (RFS) forms.

More information on HSRM can be found in the HSRM Training and Resources section of this manual.

Providers participating in the care of high-risk medical conditions should utilize Digital Imaging and Communications in Medicine (DICOM) to communicate with the Veterans Health Administration (VHA). DICOM standard is used to communicate and share medical imaging information securely with VA.

Optum VA Community Care Network Provider Portal

Optum VA Community Care Network provider portal is available at vacommunitycare.com/provider.

The provider portal contains News, Webinars, Training & Guides, Forms & Resources, Formulary & Pharmacy Search and a COVID-19 section. Additional self-service functionality is available from the Medical & Behavioral Provider Portal icon after you sign in.

Optum's portal provides:

- Claim status and submission process
- Provider resources and education
- Real-time pharmacy dispensing information to help prevent medication errors
- Referral status
- Veteran eligibility

Online assistance is available through online chat from 8 a.m. – 6 p.m. provider's local time, Monday – Friday, excluding federal holidays, at vacommunitycare.com/provider.

Support by Phone

A dedicated Provider Services support team is available to answer inquiries from 8 a.m. – 6 p.m. provider's local time, Monday – Friday, excluding federal holidays.

- CCN Provider Services Region 1: 1-888-901-7407
- CCN Provider Services Region 2: 1-844-839-6108
- CCN Provider Services Region 3: 1-888-901-6613

To determine the appropriate phone number for the provider's region, click here.

CCN Provider Services assists with:

- Benefit questions
- Claims status and issue resolution
- Pharmacy questions
- Provider enrollment
- Referral status
- Veteran eligibility

Tip: Providers can obtain much of this information and submit transactions on the Optum VA Community Care Network provider portal. To learn more, please go to vacommunitycare.com/provider.

Covered Services

Health Care Services

Eligibility for community care is determined by VA before a Veteran can be referred to a community provider. VA will issue an approved referral to authorize a specific Standardized Episode of Care (SEOC). SEOCs will indicate a set of services and procedures that relate to a specific category of care and will include a specified number of visits, services, and duration.

The VA health benefits may include, but are not limited to:

- Abortion Counseling
- Acupuncture
- Adult day health care
- Ancillary services
- Assisted reproductive technologies (ART) and in-vitro fertilization (IVF)
- Behavioral health (to include professional counseling and substance abuse)
- Chronic dialysis treatment
- Comprehensive rehabilitative services
- Dental care
- Emergent care
- Geriatrics (non-institutional extended care services, including, but not limited to non-institutional geriatric evaluation, non-institutional adult day health care and non-institutional respite care)
- Home health care (skilled and unskilled)
- Hospice, palliative and respite care

- Hospital services
- Immunizations
- Implants – when provided as part of an authorized surgical or medical procedure
- Inpatient diagnostic and treatment services
- Ketogenic Diabetes Telehealth Services
- Long-term acute care
- Maternity and women's health
- Newborns*
- Outpatient diagnostic and treatment services (including laboratory services)
- Pharmacy
- Preventive care
- Reconstructive surgery
- Rehabilitative services and therapies
- Residential care
- Skilled nursing facility care – limitation of rehabilitation services is no more than one hundred (100) days per calendar year
- Transplant services
- Urgent care

*Newborns are covered under the Veteran's maternity- and newborn-approved referral for the date of birth plus seven (7) days. Claims for newborns must be submitted with the Veteran's Social Security number (SSN) or Integration Control number (ICN) and include the Veteran's approved referral number. All newborns delivered in the emergency department must be billed using the referral number associated with the maternity and newborn SEOC. If newborn services are performed by an out-of-network provider and there is not a maternity and newborn approved referral for the Veteran, the claims will be denied, and the out-of-network provider will need to submit claims directly to VA.

Abortion:

Abortion is excluded from VA CCN Healthcare Services, except when determined by VA to be a medical benefit. VA may issue an approved referral for abortion services for an eligible Veteran. Claims submitted for care will only be considered for reimbursement if a valid referral and applicable SEOC is listed on the claim and the CPT codes billed match those specified in the issued SEOC. Any billed CPT codes on a claim which are not listed in the applicable SEOC will result in denial of payment.

COVID-19 viral testing and vaccination of eligible Veterans is covered at one of the following locations:

- CCN in-network urgent care/retail locations, in conjunction with a clinical visit for care
- CCN in-network pharmacy
- CCN provider office, with an approved referral
- COVID-19 viral testing is eligible at a CCN in-network emergency department when the Referral for Emergent Medical Services process is followed

Request for Services

Providers must submit a Request for Service (RFS) form 10-10172 to VA, when a need is identified for additional care that falls outside the original referral and SEOC or if there is a need to extend the duration of the referral. If care is needed within forty-eight (48) hours, please contact the VA Medical Center (VAMC) on the approved referral. VA will process all requests and the provider will be notified of the decision or outcome through their preferred method of communication. The notification will also

indicate if the care will be provided within VA or in the community. The second page of the RFS form is for Home Oxygen, DME, Prosthetics, and Therapeutic Footwear Assessments requests.

The provider is required to send the completed form to VA the same day the provider determines care is needed including all supporting medical documentation for the request. Supporting documentation must include medical records and care plan(s). A separate form is required for each service requested.

This form can be uploaded into HealthShare Referral Manager (HSRM) or sent to VA through secure email or secure fax and must be completed in its entirety and include the provider signature. The signature is necessary, since the RFS form serves as the physician order. This form is available at vacommunitycare.com/provider > Forms & Resources.

All requests must include medical records and care plan to support the request. Complete the full form for the services requested, page one (1) for medical services or page two (2) for Durable Medical Equipment (DME)/Prosthetic requests.

VA will decide if the additional services are approved. If services are approved, VA will either issue an approved referral or VA will provide the services.

If the services requested are not authorized by VA, the provider may request referral reconsideration from VA. Requests for referral reconsideration must be submitted to VA within ninety (90) days from the date of denial.

COMPACT Act – Acute Suicide Crisis

VA CCN provides acute suicidal crisis care to Veterans and individuals under the COMPACT Act. Eligible individuals include VA CCN Veterans and may include former members of the Armed Forces as determined by VA. Treatment is up to thirty (30) days for inpatient care and/or ninety (90) days for outpatient care. Any extension of care would require an RFS form to be completed by the provider and sent to VA for approval.

Emergency Department or Inpatient Psychiatric Hospital/Unit

- A Veteran or individual does not need to be enrolled in the VA health care system to receive emergent suicide care at an emergency department or inpatient psychiatric hospital/unit.
- VA CCN providers must notify the Emergency Care Centralized Notification Center online or by phone as soon as possible but no later than seventy-two (72) hours to establish the Veterans eligibility for acute suicide crisis care:
  - emergencycarereporting.communitycare.va.gov
  - 1-844-72HRVHA (1-844-724-7842)

Urgent Care Facilities

- Veterans must be urgent care eligible to receive care at an urgent care facility.
- If the Veteran or individual is seeking care under COMPACT Act and is not eligible, they are responsible for the initial cost of care. They may seek reimbursement for their care from VA at: www.va.gov/resources/reimbursement-of-non-va-prescriptions-or-medical-expenses/

For further details on the Compact Act review the Compact Act AAG located on vacommunitycare.com/provider > Training & Guides > Benefits.

Service Contract Labor Standards

VA CCN providers may be subject to applicable Federal Acquisition Regulation (FAR) related to Service Contract Labor Standards (SCLS) which is listed below.

FAR 52.222-41 Service Contract Labor Standards

This FAR clauses has the same force and binding effect as if they were written in this section in its entirety. Optum is accountable for ensuring their VA CCN provider's compliance. Therefore, Optum may require periodic attestations or perform audits to ensure your compliance.

Dialysis

Providers who render covered services for dialysis treatment under our contract ("Dialysis Providers") must comply with the additional requirements outlined in this section. As a result of your participation in the VA CCN, Dialysis Providers must adhere to the applicable federal regulations, including the Federal Acquisition Regulation (FAR) and the Veterans Affairs Acquisition Regulation (VAAR) which may be accessed electronically at vacommunitycare.com/provider > Training & Guides > Provider Network Resources > Federal Acquisition Regulation (FAR) and Veterans Affairs Acquisition Regulation (VAAR). The referenced FAR and VAAR clauses applicable to Dialysis Providers, which may be amended from time to time, are incorporated into this Manual and your Participation Agreement. The applicable FAR and VAAR clauses have the same force and binding effect as if they were written in this section in its entirety.

Incorporation of Federal Acquisition Regulations (FAR) and Veteran Affairs Acquisition Regulation (VAAR)

The FAR and VAAR clauses, may be amended from time to time, are referenced and incorporated into this Manual. The applicable FAR and VAAR clauses have the same force and binding effect as if they were written in this section in its entirety.

Durable Medical Equipment, Medical Devices, Orthotic and Prosthetic Items

Providers may only provide Durable Medical Equipment (DME), medical devices, orthotics and prosthetics to eligible Veterans for an urgent or emergent condition. CCN will not pay for DME rentals beyond the initial thirty (30) calendar days. The rental period for tumor treating field wearable device for treatment of glioblastoma is up to ninety (90) days. Any rental extensions or longer-term needs for DME require submission to VA through the RFS process for approval. VA provides all non-urgent or non-emergent DME items. To locate more information on VA's expansive list of DME, medical devices, orthotics and prosthetics, access prosthetics.va.gov/psas. You may also reference Optum's DME benefit guide at vacommunitycare.com/provider > Training & Guides > Benefits.

Urgent or Emergent DME, Medical Devices, Orthotics and Prosthetics

If a provider determines that DME, medical devices, orthotics and prosthetics are needed emergently or urgently to stabilize or decrease the risk of further injury, it is covered under the visit and can be provided by the community provider.

Urgent or emergent DME, medical devices, orthotics and prosthetics may include, but are not limited to:

- Canes
- Crutches
- Home Oxygen
- Manual wheelchairs
- Slings
- Soft collars
- Splints
- Walkers

Scheduled Procedures or Discharge

Providers must coordinate with VA in advance of a scheduled procedure or patient discharge to ensure the DME, medical device, orthotics and prosthetics are approved and available to the Veteran when needed.

Purchase or Rental

Providers must ensure the most cost-effective option for urgent or emergent DME or medical devices when considering renting or purchasing. The rental period may not be more than thirty (30) calendar days. Providers should submit requests for long-term DME needs to VA for fulfillment, using the Request for Services (RFS) form.

The RFS form must include the following:

- Detailed information (brand, make, model, part number, etc.) and medical justification for each prescribed item (if a specific brand/model/product is prescribed)
- Item delivery location/address and expected delivery date
- Patient education was completed or mailed to provider to finalize education
- Medical provider's signature

Routine DME, Medical Devices, Orthotics and Prosthetics

Providers must submit all requests for routine DME, medical devices, orthotics and prosthetics to VA using an Request for Services (RFS) form. VA will provide the DME, medical devices, orthotics, and prosthetics to the Veteran. VA reserves the right to issue comparable, functionally equivalent DME, medical devices, orthotics, and prosthetics.

Hearing Aids

The provider treating the Veteran must be an audiologist licensed in the state where services are being provided.

Hearing aids cannot be purchased or provided by providers. Providers must provide the initial testing results related to the potential hearing aid needs to VA for review by completing the appropriate hearing aid order form, based on the recommended make and model. The specific audiogram requirements are outlined in the Veterans Health Administration (VHA) Audiology Toolkit provided by VA with the approved referral. If the hearing aid request is approved, VA will place an order for the Veteran's hearing aid. VA will send the hearing aid to the requesting provider who will be responsible for the Veteran's follow-up care and hearing aid fitting. For additional information regarding Vendor Resources, go to VHA Audiology - Rehabilitation and Prosthetic Services (va.gov) or visit vacommunitycare.com/provider > Training & Guides > Benefits.

Home Oxygen

Providers must submit all routine requests for home oxygen to VA for review and fulfillment using an Request for Services (RFS) form, including the definitive testing results and a detailed home oxygen prescription. Home oxygen equipment or supplies cannot be purchased or provided by providers. The need for home oxygen must always be planned sufficiently in advance of the procedure or patient discharge to avoid delay in fulfilling the prescription.

Sleep Apnea

Oral Appliance Therapy (OAT) is classified as medical treatment for a medical disorder, obstructive sleep apnea, which is provided by a licensed dentist. OAT for obstructive sleep apnea will be provided through Optum's VA CCN dental network.

Any claim for OAT DME received with a Current Dental Terminology (CDT) code will be rejected. This includes the 2022 and 2023 ADA code additions of 9947, 9948, 9949, 9953.

In accordance with the Standardized Episode of Care (SEOC), all OAT Durable Medical Equipment (DME) claims should be billed with Healthcare Common Procedure Coding System (HCPCS) and

Common Procedural Terminology (CPT) codes on a standard CMS 1500 form (HCFA), including ancillary services such as exams and X-rays. OAT claims are classified as medical, and therefore should be submitted to VA CCN's Medical Claims. Refer to the Claims Submission section for more information on how to submit a claim.

Follow-Up Care

Providers may be responsible for all necessary follow-up care should VA approved referral be issued, including Veteran's education, training, fitting, and adjustment. VA will procure and send the requested item to the provider's location, unless the provider indicates on the Request for Service (RFS) form that training and education has already been completed, in which case, the item may be sent to the Veteran directly.

Assisted Reproductive Technologies (ART) In-Vitro Fertilization (IVF)

When clinically appropriate, the VA Medical Center (VAMC) may issue approved referrals for ART/IVF services for an eligible Veteran and non-Veteran Collateral spouse. VA determines the Veteran's eligibility based on the Veteran having a service-connected (SC) condition that results in the inability to procreate without the use of fertility treatment. For ART/IVF services, the Collateral of Veteran is defined as a lawfully married spouse of the eligible Veteran. For further information you can review the Art/IVF benefit reference Guide located at vacommunitycare.com/provider > Training & Guides > Benefits.

There are seven (7) SEOCs for Fertility services that outline the care VA may authorize:

- COMMUNITY CARE-INFERTILITY (1332) Fertility-1332 Existing Ovary
- COMMUNITY CARE-INFERTILITY (1332) Fertility-1332 Existing Testicle
- COMMUNITY CARE-GAMETE HARVEST (1332) Gamete Harvest-Medical Indication
- COMMUNITY CARE-IVF VETERAN (1334) Fertility-1334 Birth Sex Male Veteran
- COMMUNITY CARE-IVF VETERAN (1334) Fertility 1334-Birth Sex Female Veteran
- COMMUNITY CARE-IVF SPOUSE (1334) Fertility-1334 Birth Sex Male Spouse
- COMMUNITY CARE-IVF SPOUSE (1334) Fertility 1334-Birth Sex Female Spouse

Covered services may include:

- Stimulation of ovulation
- Monitoring of ovulation stimulation
- Oocyte retrieval
- Laboratory studies
- Embryo assessment and transfer
- Luteal phase support
- Cryopreservation of sperm, oocytes and embryos
- Fertility counseling and treatment

See the below table for maximum IVF attempts and completed cycles.

IVF Attempt	IVF Cycle
Embryo transfer does not occur	Embryo is transferred to the uterus
It counts as an attempt if: **1.** An egg retrieval occurs and no eggs are retrieved or,	**It counts as a completed cycle if:** **1.** There is a fresh embryo transfer (regardless of the number of embryos transferred)

2. Eggs are retrieved but embryos are not transferred due to: a. No embryos are available for transfer b. Embryos are cryopreserved but not yet transferred **3.** A cryopreserved embryo is thawed/rewarmed and is not viable for transfer and thus is not transferred	**2.** There is a cryopreserved and thawed/rewarmed embryo transfer (regardless of the number of embryos transferred **3.** Each transfer counts as a completed cycle, regardless of whether or not a pregnancy and/or live birth results
VA will cover up to six (6) attempts to achieve three completed cycles over the lifetime of the Veteran	VA will cover three (3) completed cycles over the lifetime of the Veteran

Mechanically Assisted Fertilization (MAF) may be performed as part of an IVF procedure. Such procedures include Zona “drilling” (PZD) where the zona pellucida of the oocyte is mechanically interrupted to assist sperm entry and Intracytoplasmic Sperm Injection (ICSI).

Microscopic Epididymal Sperm Aspiration (MESA), Percutaneous Epididymal Sperm Aspiration (PESA), Testicular Sperm Aspiration (TESA) or Testicular Sperm Extraction (TESE) may also be used in conjunction with IVF.

VA IVF benefits do not require that a covered Veteran be able to produce their own opposite-sex autologous gametes. Covered Veterans and Collateral of Veteran may utilize donor gametes and donor embryos obtained at their own expense when receiving IVF counseling and services. The Veteran pays for the procedures or associated fees for the extraction, storage, or transportation of donor gametes. VA does cover the creation, storage, and use of resulting embryos.

IVF and infertility prescriptions may be considered urgent or emergent and can be filled at a CCN pharmacy. All other non-urgent or emergent medications must be filled at a VA pharmacy. For a detailed list of medications that are considered urgent and emergent medications refer to VA National Formulary - Pharmacy Benefits Management Services.

- VA pharmacies do not stock IVF and fertility prescriptions as standard shelf medications. The provider must coordinate with VA pharmacies on IVF, and infertility medication/prescription needs to ensure a Veteran and/or spouse receive prescriptions in a timely manner.

Urgent/emergent prescriptions written for a Veteran or spouse by a CCN in-network provider can be filled at a CCN pharmacy using the urgent/emergent formulary. Urgent/emergent prescriptions written for a Veteran or spouse by a provider who is not contracted for CCN must be filled at a VA pharmacy or paid by the Veteran out of pocket at a retail pharmacy. Veteran may submit their receipts to VA for reimbursement consideration.

Ketogenic Diabetes Telehealth Reversal Services

Ketogenic Diabetes Telehealth Reversal Services that have an approved referral will be covered through VA CCN.

These services include:

- Laboratory services including baseline and ongoing labs for the duration of treatment
- Medication management including diabetes medications, statins, and blood pressure medications
- Lifestyle modification for a ketogenic, carbohydrate-restricted diet and coaching with a ketogenic health coach

The provider will provide the following supplies:

- Ketone meter:
  - FDA approved
  - Offers alarm settings
  - Ability to download glucose and ketone readings
- Ketone test strips for the duration of the treatment

All providers are required to maintain all necessary certifications in accordance with their licensing and/or registration requirements. Licensed Independent Providers and Ketogenic Health Coaches impacted by these requirements are listed below:

- Physicians
- Nurse Practitioners
- Physician Assistants
- Certified Diabetes Care and Education Specialist
- Ketogenic Health Coach
- Registered Dietitian Nutritionist

The provider is required to submit quarterly reporting to Optum in addition to providing telehealth services.

Transplants

When clinically appropriate, VAMC may issue approved referrals for transplant services. Approved referrals will be issued to a Medicare-approved Certified Transplant Center (CTC) for transplant services who also meet Optum Quality Standards of Centers of Excellence (COE) or Transplant Access Program (TAP). CTC must hold a Centers of Excellence (COE) or Transplant Access Program (TAP) designation for Bone Marrow or the Solid Organ to be transplanted on the date of service. For further information, the Transplant Services guide is located at vacommunitycare.com/provider > Training & Guides > Benefits.

To make sure the Veteran receives timely care, VA requires the CTC to either accept or reject a comprehensive evaluation approved referral within the specific time frames listed below. VA will determine whether a referral is classified as stable or emergency for purposes of the below time frames.

- Stable referrals: Initial review and acceptance or rejection of referral must be completed by the CTC within ten (10) business days of receipt of referral
- Emergency referrals: The CTC will ensure availability of an appropriate in-network transplant physician for discussion within six (6) hours by phone
- The CTC must complete the initial face-to-face comprehensive transplant evaluation by the multidisciplinary transplant team and submit the evaluation results to the referring VAMC no later than sixty (60) days after the approved referral was received. If the CTC determines the Veteran to be a transplant candidate, the CTC must submit a Request for Services (RFS) form to VA requesting transplant services. The comprehensive transplant evaluation results and course of treatment shall be reviewed and agreed to between the CTC and the referring VAMC

Live donor transplants that have an approved VA referral will be covered through VA CCN. Live donors are defined as: collateral of a Veteran who is a clinically approved individual donor who has volunteered to donate a solid organ, part of solid organ, or bone marrow (non-registry) to an identified Veteran transplant recipient and has provided informed consent to undergo elective removal of solid organ, part of a solid organ, or bone marrow (non-registry).

When VA issues a waitlist management and transplantation referral to CTC, it includes all medically necessary services included in a Standardized Episode of Care (SEOC). Ventricular Assist Device (VAD) is not part of a transplantation referral. If a Veteran needs a VAD, the CTC must submit an RFS form. VA

will review request and, if approved, will provide the service or issue an approved referral to a CCN provider to implant device.

The CTC will list the Veteran on up to two (2) Organ Procurement and Transplantation Network (OPTN) waiting lists. If the Veteran chooses to be added to additional wait lists, the Veteran will be responsible for the costs associated with the additional wait lists. The CTC then must communicate the listing of the Veteran to the referring VAMC facility within five (5) business days of that event.

Following a transplant, the CTC may receive a post-transplant follow-up approved referral and SEOC. The CTC is responsible for all medically necessary post-transplant care included in the post-transplant SEOC.

Contractor shall require that CCN network of CTCs meet the following requirements:

- Successfully complete Contractor initial selection and evaluation process to qualify for Centers of Excellence (COE) network participation or designation as a Transplant Access Program (TAP)
- Complete the Contractor annual review process, and comply with any required interim reviews
- Comply with all OPTN obligations, including applicable provisions of the National Organ Transplantation Act (NOTA), OPTN Final Rule, OPTN Charter, OPTN Bylaws, and OPTN Policies
- Maintain good standing with Centers for Medicare & Medicaid Services (CMS) and OPTN; maintain good standing with Contractor and not designated as a "Member not in good standing" or "Probation" status

Urgent Care

Eligible Veterans may receive urgent care by a participating urgent care provider without an approved referral. Urgent care providers must be participating in the VA CCN and have Optum-provided signage that clearly identifies them as a VA CCN urgent care benefit participating location.

VA CCN urgent care providers shall advise Veterans to follow up with their Primary Care Provider (PCP). All follow-up care resulting from an urgent care visit must be coordinated by VA. VA CCN urgent care providers shall not refer Veterans to another CCN provider for continued treatment. For further information on Urgent Care visit vacommunitycare.com/provider > Training & Guides > Benefits.

Providers Required to Verify Veteran Eligibility

VA CCN urgent care providers are required to call the Urgent Care Eligibility Call Center to verify eligibility at 1-888-901-6609 prior to providing care to a Veteran. The automated Interactive Voice Response (IVR) is available twenty-four (24) hours a day, seven (7) days a week. If eligibility is not verified, it will cause a delay in the Veteran filling a prescription and may lead to the claim being denied if the Veteran is not eligible.

To verify eligibility, have the following information available:

Veteran information:

- Last 4 digits of the Veteran's SSN
- Date of birth (MM/DD/YYYY)

Urgent care facility information:

- National Provider Identifier (NPI) number
- ZIP code of the urgent care location

Upon verifying Veteran eligibility, the IVR will provide an Urgent Care Eligibility Record Number (UCERN), which will be required on the claim. Effective April 1, 2026, UCERNs are valid for the date of service (DOS) plus (1) calendar day.

If the Veteran is not eligible for the urgent care benefit, the Veteran will be required to pay out of pocket if they choose to be seen. The Veteran may contact VA to discuss urgent care eligibility status and possible reimbursement of out-of-pocket expenses.

Veterans may also verify eligibility for urgent care by calling 1-844-698-2311 or by checking the Veteran portal at vacommunitycare.com > Veterans.

Covered Services

The urgent care benefit is considered open access. Eligible Veterans may go to an in-network urgent care facility, walk-in retail health clinic, telehealth services, off-campus outpatient hospital, on-campus outpatient facility services or on-campus outpatient hospital for care without a referral from VA. The urgent care benefit covers injuries and illnesses that require immediate attention, but are not life-threatening, such as:

- Cold and flu
- COVID-19 vaccine[1]
- DME[2]
- Ear infection
- Flu vaccine
- Minor injury
- Pink eye
- Skin infection
- Strep throat

If you have urgent care benefit questions, please call the Urgent Care Eligibility Call Center at 1-888-901-6609, 7 a.m. – midnight provider's local time, seven (7) days a week.

[1]Refer to VA National Formulary for specific vaccine coverage.

[2]Note: DME Home is considered a valid urgent care place of service for DME products when issued during an UC visit.

Claims are covered when filed with a valid UCERN by an authorized urgent care provider and all other processing guidelines are met.

Preventive and dental services are excluded.

Medical Documentation Requirements for Urgent Care

VA CCN urgent care providers must fax or securely email all medical documentation to the Veteran's assigned VAMC, if known, or the closest VAMC to the Veteran's residential ZIP code within thirty (30) calendar days of the date of service. To locate the appropriate VA facility to submit your medical documentation, use the Find VA Locations locator tool at va.gov/find-locations.

For more information on the urgent care benefit, visit va.gov/communitycare > For Providers > Veteran Care > Urgent Care or vacommunitycare.com/provider > Training & Guides > Benefits > Urgent Care Benefits.

Pharmacy

Prescriber Requirements:

- Providers are prohibited from giving pharmaceutical samples to Veterans.
- Incomplete prescriptions will be returned to the prescribing provider and will have to be resubmitted to the authorizing VA facility's pharmacy.
- VA does not consider topical compounds urgent or emergent.
- Prescribers must be in the CCN Network or a VA Provider.

Note: For further information on prescribing medication for Veterans you can visit vacommunitycare.com/provider > Training & Guides > Benefits > Prescribing Medications for Veterans.

Prescribing Controlled Substances

Before prescribing controlled substances for a Veteran, Prescribers are required to:

- Query the Prescription Drug Monitoring Program (PDMP) prior to prescribing opioids (and routinely, as applicable).
- Document evidence of PDMP queries in the medical records
- Adhere to Centers for Disease Control and Prevention (CDC) Clinical Practice Guideline for Prescribing Opioids for Pain – United States, 2022 guidelines to ensure safe, evidence-based pain management for Veterans
- All medical record submissions and responses to documentation requests **must include evidence of a PDMP check** when controlled substances are prescribed or managed

For detailed guidance, please refer to the CDC's Clinical Guidance on Overdose Prevention Prescription Drug Monitoring Programs (PDMPs). This can help providers and Veterans ensure appropriate use of controlled substances.

Urgent and Emergent Prescriptions

Providers can write an urgent or emergent prescription to be filled at a VA CCN retail pharmacy for up to a fourteen (14) day supply without refills. Opioids may be filled up to a seven (7) day supply or to state limits, whichever is less. When it is determined to be medically appropriate, a second prescription for opioids may be filled at a VA CCN retail pharmacy for up to a seven (7) day supply or state limits, whichever is less (up to a fourteen (14) days' total supply). Buprenorphine may be filled for an initial fourteen (14) day supply and will allow for a second fill of up to a fourteen (14) day supply within thirty (30) calendar days (up to a twenty-eight (28) day total supply). With the exception of Urgent Care, the prescription must be associated with an approved referral.

When urgent or emergent prescriptions are clinically needed for continued or maintenance treatment beyond the initial urgent/emergent fourteen (14) day supply, providers must generate a second prescription for the additional days' supply. Providers should submit the second prescription to the referring VA facility's pharmacy by electronic prescribing or fax. To obtain the pharmacy fax number, contact the community care representative at the referring VA medical facility.

Urgent or emergent prescriptions for the same drug and strength within thirty (30) calendar days of the original fourteen (14) day prescription will not be eligible at a VA CCN retail pharmacy, with the exception of a one-time continuation of pain or antibiotic therapy. Following the dispensing of the second fourteen (14) day supply by VA CCN retail pharmacy, subsequent prescriptions for the same therapy will be required to be filled at the local VA pharmacy.

Using VA CCN Retail Pharmacies

VA CCN retail pharmacies support electronic prescribing and follow established clinical protocol for registration of new patients to determine a Veteran's allergy and previous drug history. The pharmacy must dispense prescriptions in accordance with the VA pharmacy mandatory generic substitution policy.

Prescribing Without a Referral

If there is not an approved referral on file, with the exception of Flu and Covid vaccines or claims adjudicated under an active Disaster Declaration, the Veteran will be required to pay out of pocket for the prescription. The prescribing provider must inform the Veteran of their option to contact the nearest VA to request reimbursement for any out-of-pocket expenses.

Routine and Maintenance Prescriptions

Providers with an approved referral must submit a prescription for routine and maintenance medication to the authorizing VA facility's pharmacy to fulfill by fax or electronic prescribing.

Prescribing providers need to include the following information when forwarding the Veteran's prescription to the VA facility's pharmacy:

- Veteran's full name
- Veteran's date of birth
- Veteran's Integration Control Number (ICN) or Social Security Number (SSN)
- Prescribing provider's full name
- Prescribing provider's National Provider Identifier (NPI) number
- Prescribing provider's Tax Identification Number (TIN)
- Prescribing provider's own Drug Enforcement Administration (DEA) number and expiration date (not a generic facility number)
- Prescribing provider's office address
- Prescribing provider's office phone number
- Prescribing provider's fax number (if applicable)
- Prescribing provider's discipline (e.g., physician, physician assistant, nurse practitioner, etc.)

VA may use VA-approved alternate prescribing practices when issuing medication.

When a prior authorization is required, a provider must submit the medical documentation with the prescription to VA pharmacy for review. The referring VA pharmacy will determine if the Prior Authorization Drug Request (PADR) is approved and dispense the medication as appropriate. Providers can submit a PADR using electronic prescribing or by faxing to a VA pharmacy.

Billing Intrauterine Device (IUD)'s through the CCN Pharmacy benefit

Providers have the option to order IUDs through a CCN in network pharmacy and bill the IUD to the VA CCN pharmacy benefit. Please provide the pharmacy the billing information below when ordering the IUD. The pharmacy will bill CVS/Caremark for the device.

- BIN: 004336
- PCN: ADV
- Group: RX3839
- ID #: 10-digit Veteran ID or SSN

Formularies: Finding VA's Preferred Medications

- VA has an Urgent/Emergent Formulary and a National Formulary, located at VA National Formulary – Pharmacy Benefits Management Services > VA National Formulary > Formulary Documents
- The Urgent/Emergent Formulary is also available at vacommunitycare.com/provider > Formulary & Pharmacy Search
- When prescribing for an urgent or emergent need, providers must use the Urgent/Emergent Formulary.
- For all routine maintenance prescriptions, please reference the VA National Formulary and submit the prescription directly to the VA pharmacy for fulfillment. The National Formulary is available at VA National Formulary - Pharmacy Benefits Management Services > VA National Formulary > Formulary Documents
- The VA Formulary Search tool provides formulary alternatives to non-formulary drugs in the same VA drug class. The tool is available at VA Formulary Advisor at VA National Formulary
- Additional information about VA's formularies, including VA National Formulary Frequently Asked Questions, is available at VA National Formulary - Pharmacy Benefits Management Services

If the Veteran requires a medication that is not on VA's National Formulary or the medication requires pre-authorization, contact the VAMC listed on the referral and ask for a Formulary Request Review Form. Return the completed form along with medication justification or supporting medical records to the VAMC for review.

Vaccines

COVID-19 and Seasonal Influenza (Flu)

Eligible Veterans may receive a COVID-19 and flu vaccine at a VA CCN retail pharmacy. COVID-19 and flu vaccinations do not require a referral or copayment at a VA CCN retail pharmacy that offers COVID-19 and flu vaccinations, in accordance with VA vaccination recommendations, at publichealth.va.gov > Health and Wellness > Vaccines and Immunizations and the Centers for Disease Control and Prevention (CDC) immunization protocols at cdc.gov/vaccines.

- A VA CCN retail pharmacy administering the COVID-19 and/or flu vaccine must verify the Veteran's eligibility before delivering the vaccination. Veterans are required to present a valid identification with their full name and a photograph to verify eligibility and identity. The identification may be in the form of a Veteran Health Identification Card (VHIC), federal-issued identification (e.g., passport) or state-issued identification (e.g., driver's license)
- Veterans who have a scheduled office visit with a provider may request a COVID-19 or flu vaccination at no charge during the referred visit
- Urgent care-eligible Veterans may receive a COVID-19 and/or flu vaccination at a CCN urgent care facility. Claim must be billed with an UCERN
- Providers will follow the Claim Submission guidelines when requesting reimbursement for the vaccination
- COVID-19 vaccinations will be administered in accordance with local, state or territorial vaccination plans

* Refer to VA National Formulary for specific vaccine coverage

Other Vaccinations

Pneumonia, RSV, Shingles, and tDap vaccinations are covered at CCN retail pharmacies. The Veteran must have an active referral for CCN referred care or urgent care to receive the vaccines.

VA CCN Complementary and Integrative Healthcare Services (CIHS)

VA's medical benefits package includes CIHS, based on VA's determination that they promote, preserve and restore health, and are in accordance with generally accepted standards of medical practice. Where applicable, VA will issue an approved referral with a Standardized Episode of Care (SEOC) to include CIHS. More information on SEOCs can be found in the Referral Section of this manual.

CIHS providers should submit claims using the appropriate Current Procedural Terminology (CPT®) code or Healthcare Common Procedure Coding System (HCPCS) code for the CIHS services listed below:

- Biofeedback
- Hypnotherapy
- Massage therapy
- Native American healing
- Relaxation techniques (for example, meditation or guided imagery)
- Acupuncture
- Tai chi

VA CCN Health Care Service Exceptions

The following services may be provided to Veterans directly by VA, but are not payable under your VA CCN Participation Agreement:

- Ambulance services (ambulance services must be referred directly to VA for payment consideration)
- Home deliveries and non-approved maternity care services, to include deliveries by direct entry midwives (also known as lay midwives or certified professional midwives) and medical procedures not consistent with the standard of care for maternity care services
- Medical and rehabilitative evaluation for artificial limbs and specialized devices, such as adaptive sports and recreational equipment
- Nursing home care, dependent in the Veteran's home state Per diem
- Veteran travel
- Yoga
- CIHS: acupressure, Alexander technique, animal-assisted therapy (falls under recreation therapy), aromatherapy, biofield therapies (healing touch, reiki and therapeutic touch), emotional freedom technique, rolfing, reflexology, somatic experiencing and zero-balancing

Excluded VA CCN Health Care Services

The following services are excluded from the VA CCN health benefit package:

- Pregnancy Termination Services*
- Maternity services resulting from successful assisted reproductive technology (ART)/in-vitro fertilization (IVF) services for a non-Veteran Collateral spouse
- Drugs, biologicals and medical devices not approved by the Food and Drug Administration (FDA), unless they are used under approved clinical research trials
- Gender alterations: however, medically indicated diagnostic testing or treatments related to gender alterations are covered benefits
- Hospital and outpatient care for a Veteran who is either a patient or inmate in an institution of another government agency, if that agency has a duty to give the care or services
- Membership in spas or health clubs
- Out-of-network services without a VA approved referral

* **Service may be covered when determined by VA to be included in medical benefits.**

VA Clinical Determinations, Indicators (CDIs) and Payment Guidelines

Providers are responsible for routinely reviewing and adhering to all applicable VA Clinical Determinations and Indicators (CDIs), as well as current VA payment guidelines. Providers must utilize these resources as the authoritative reference for program requirements, billing practices, and reimbursement policies to ensure compliance with VA standards. Failure to follow VA CDIs and payment guidelines may result in claim denials, payment delays, or recoupment actions.

To review the most current CDIs go to vacommunitycare.com/training-and-guides > VA CCN Provider Manual and Resources for Medica/Behavioral Providers or department.va.gov/vha/community-care/care-coordination/clinical-determinations-and-indications/.

To view the most recent Payment Guidelines go to vacommunitycare.com/training-and-guides > Claims and Medical/Behavioral Portal Guides.

Credentialing

Optum, UnitedHealthcare or its designee must credential providers and facilities according to requirements from nationally recognized accrediting organizations. Credentialing is generally not

required for health care professionals who are permitted to furnish services only under the direct supervision of another licensed independent practitioner or for hospital- or facility-based health care professionals who provide services to covered persons incidental to hospital or facility services. Providers who are currently credentialed and participating with Optum or UnitedHealthcare, as applicable, aren't required to complete a separate credentialing application for the VA CCN. For more information on Credentialing visit vacommunitycare.com/provider > Training & Guides > Provider Network Resources > Provider Credentialing.

Network	Provider type	Website or email address
UnitedHealthcare	Medical professionals, facilities and ancillary providers	UHCprovider.com/Join
UnitedHealthcare	National laboratory and national ancillary providers	naspi@uhc.com
UnitedHealthcare Home and Community Based Services	Adult day care Homemaker/Personal Care Private duty nursing (non-Medicare Certified Home Health)	hcbsprovidernetwork@uhc.com
UnitedHealthcare Vision	Routine vision services	spectera.com > Join Our Network
United Behavioral Health	Mental health and substance abuse	providerexpress.com > Our Network
Optum Serve Health Services	Dental providers	providers.optumserve.com > Join Our Network
Optum Complex Care Management	Skilled nursing facilities (SNFs)	UHCprovider.com/Join
OptumHealth Care Solutions	Acupuncture, chiropractic, massage therapy, occupational therapy, physical therapy, speech pathology, tai chi	myoptumhealthphysicalhealth.com > Interested in becoming a Provider?

Professional credentialing, Licensing and Accreditation

All providers and practitioners in the VA CCN must be credentialed by the appropriate accrediting organization.

The credentialing process involves obtaining primary-source verification of the provider's education, board certification, license, professional background, malpractice history and other pertinent data.

New providers, who are not currently credentialed and participating with one of our Network Partners, will have to complete a standardized, applicable, nationally accredited credentialing process to participate in the VA CCN.

If a provider specialty is not credentialed under an accredited credentialing process, the provider must operate within the scope of the provider's professional license and maintain and provide, upon request, the following documentation:

- Proof of identity with a government-issued photo and I-9 documentation

- An active, unrestricted license from the state where the service is provided, if applicable (unskilled home health excluded)
- Criminal background disclosure
- Current National Provider Identifier (NPI) number, if applicable (unskilled home health excluded)
- Drug Enforcement Administration (DEA) number if controlled substances are prescribed
- Education and training, if applicable (unskilled home health excluded)
  - Professional references
  - Proof of professional liability insurance in an amount in accordance with the laws of the state in which the care is provided
  - Tax Identification Number (TIN)
  - Work history

The provider must notify Optum or the appropriate Network Partner within five (5) days of the occurrence of an action, lapse, or limit impacting the provider license, registration, or certification, as applicable. This notification must be in writing. If a provider does not comply with the five (5) day notice requirement to the appropriate Optum or Network Partner, the provider may be removed from the VA CCN.

An action encompasses any disciplinary activity including, but not limited to, a provider's licensure, registration, or certification being placed in any status that limits, restricts, or otherwise indicates disciplinary notices of the intent to take disciplinary actions against a provider's license, registration, or certification, revocation of a provider's license, certification, or registration, and/or suspension of a provider's license, certification, or registration.

If any state, in which a provider currently or has previously held a license, registration, or certification, takes any disciplinary action which results in the termination, removal, preclusion, revocation, loss, suspension, restriction, probation, rescission, or any other adverse action relating to such license, registration or certification, the provider will be immediately removed from the VA CCN. Also, if a provider voluntarily surrenders a license in connection with disciplinary action, the provider will be removed immediately from the VA CCN. If a provider is excluded from participating in any government programs, including but not limited to, Medicare, Medicaid, and any federal programs, such exclusion will make the provider ineligible to participate in the VA CCN.

All services, facilities and providers must adhere to all applicable federal and state regulatory requirements. Optum will monitor the U.S. Department of Health and Human Services (HHS) Office of Inspector General (OIG) exclusionary list. If you're on the exclusionary list, you won't be eligible to participate in the CCN. See oig.hhs.gov/exclusions for more information about the exclusionary list. If you don't maintain your credentialing status, your Provider Agreement could also be terminated.

In accordance with requirements outlined in the OIG's Compliance Guidance, all services, facilities and providers, as applicable, must have a compliance program in place that includes:

- Conducting internal monitoring and auditing
- Implementing compliance and practice standards
- Designating a Compliance Officer or contact
- Conducting appropriate training and education
- Responding appropriately to detected offenses and developing corrective action
- Developing open lines of communication
- Enforcing disciplinary standards through well-publicized guidelines

Professional Liability Insurance Requirement

Providers must maintain, during the term of their Provider Agreement, professional liability insurance issued by a responsible insurance carrier of not less than (per specialty per occurrence):

- $1,000,000 per occurrence
- $3,000,000 aggregate

In lieu of purchasing the required insurance coverage, a provider may self-insure its medical malpractice and/or professional liability, as well as its commercial general liability coverage.

Unskilled or non-clinical providers (e.g., tai chi instructors, massage therapists, etc.) are only required to maintain insurance coverage consistent with the types and limits commonly necessary for their scope of practice, as determined by Optum and VA.

Providers must notify Optum of any change in professional liability insurance carrier. New professional liability policies must meet the coverage limits and other coverage requirements.

Facility Accreditation

All inpatient facilities must maintain one of the following accreditations:

- Joint Commission accreditation
- American Osteopathic Association – AOA
- Commission on Accreditation of Rehabilitation Facilities – CARF

Rehabilitation facilities that maintain a Joint Commission accreditation are not required to maintain an additional CARF accreditation.

Facilities are required to immediately notify the appropriate Network Partner of any changes in their facility accreditation status.

CIHS Credentialing

When a Complementary and Integrative Healthcare Services (CIHS) provider's practice area provides for certification or licensure, the provider must possess and maintain that certification or licensure.

Like all providers, CIHS providers must comply with all applicable federal and state laws, statutes and regulatory requirements.

Provider Responsibilities

Marketing and Advertising Requirements

In accordance with all VA CCN contractual and Optum requirements, all advertisements, solicitations, promotions, any information or guidance regarding the VA CCN program, and the marketing of a provider's participation in VA CCN must be approved by Optum prior to posting and dissemination. Providers must submit a written request to market, promote, provide information or guidance regarding the VA CCN program, and/or advertise participation in VA CCN to Optum no less than thirty (30) days prior to the date the provider seeks to advertise, market, provide, or promote this information. The written request must clearly show the exact language, layout, font, pictures, artwork, and all other relevant information in the advertisement, solicitation, promotion, information, guidance, or marketing materials and the proposed date of its utilization. Providers are responsible for ensuring all information in their marketing, promotion, solicitation, guidance, and advertisements is accurate, verifiable, and complies with all applicable local, state, and federal laws. Providers assume any and all liability associated with its marketing, promotion, solicitation, and advertisements.

Providers are strictly prohibited from displaying, using, distributing, marketing, and/or advertising in any form, including written or electronically, the trademarks, names, or logos of the Department of Veteran Affairs (VA), VA CCN, and/or Optum. Providers may not advertise, state, or market any actual or implied affiliation or preferential status with VA. Providers are permitted to generally state their participation in

VA CCN. Providers are responsible for ensuring any marketing, advertisements, promotions, or solicitations conform to this guidance.

For more information review the Marketing & Advertising Requirements on vacommunitycare.com/training-and-guides.

Updating Demographic Information

It's important for providers to report any outdated or incorrect demographic information as soon as possible. This allows us to provide accurate information to Veterans and referring providers through the VA provider directory and will ensure that claims are appropriately paid, and payments are made correctly.

Providers are encouraged to view va.gov/find-locations/ to verify their information. Any corrections should be immediately reported to the Network Partner maintaining your record. You can also visit vacommunitycare.com/provider > Training & Guides > Provider Network Resources for a quick guide on Provider Demographic Updates.

Table 1: Provider Demographic Updates

Network	Provider Type	Submit Updates
UnitedHealthcare	Medical professionals Facilities Ancillary providers	UHCprovider.com/mypracticeprofile Providers that do not have access to My Practice Profile, and Facility and Ancillary providers who are unable to edit information in My Practice Profile, may visit UHCprovider.com to view available resources.
UnitedHealthcare	Delegated providers	Report provider demographic information to your delegated entity owner to submit updated rosters through their established delegated process.
UnitedHealthcare Providers	National laboratory National ancillary providers	UHCprovider.com/mypracticeprofile Providers that do not have access to My Practice Profile, and Facility and Ancillary providers who are unable to edit information in My Practice Profile, may visit UHCprovider.com to view available resources.
UnitedHealthcare Vision	Vision providers	spectera.com Sign in with user ID and password. Click on the Entity Management tab. Complete changes and submit. Provider can also submit changes through Attestation process.
United Behavioral Health	Mental health Substance abuse	providerexpress.com

Network	Provider Type	Submit Updates
Optum Serve (formally known as Logistics Health, Inc. (LHI))	Dental providers	All updates must be submitted using the provider portal https://providers.optumserve.com/login
Optum Complex Care Management (Optum CCM)	Skilled nursing facilities (SNF)	For SNFs follow the process defined by your Optum Regional Contract team.
OptumHealth Care Solutions, LLC (OHCS)	Acupuncture Chiropractic Massage therapy Occupational therapy Physical therapy Speech pathology Tai chi	myoptumhealthphysicalhealth.com Fax updates to 1-888-626-1701 Mail updates to: Optum Provider Data Mgmt. MN103-0700 P.O. Box 1459 Minneapolis, MN 55440-1459

Non-Discrimination

Providers must provide all services for any person determined eligible by VA, regardless of the race, color, religion, sex, or national origin of the person for whom such services are ordered.

Veteran Appointments

Providers must honor all appointments with Veterans for covered services with an approved referral.

If a provider cancels a Veteran's appointment, the appointment must be rescheduled in a timely manner, based on the medical necessity of the Veteran and the required VA CCN appointment availability standards, from the time of initial appointment request:

- Within twenty-four (24) hours for emergent health care need
- Within forty-eight (48) hours for urgent health care need
- Within thirty (30) calendar days for routine care need

Providers may not charge Veterans for missing a scheduled appointment.

In the event a provider is no longer participating in CCN, provider shall coordinate with VA and/or Optum in the transition of Veteran care to ensure continuity of health services.

Provider Satisfaction Surveys

Participating in the Provider Satisfaction Survey is important because the results allow both VA and Optum to understand areas where the network experience can be enhanced for all stakeholders.

The survey was developed by VA and is required to be made available to providers with one or more claims submitted within a quarter. Individual responses are confidential when reported to VA.

To complete the survey, go to vacommunitycare.com/provider > Forms & Resources > Provider Satisfaction Survey. Select the Provider Satisfaction Survey hyperlink and follow the prompts to complete each question. Once finished, select Submit.

Questions related to the survey can be directed to CCN Provider Services for your region.

Dental Provider Requirements

VA CCN dental providers must comply with the most current version of the Code on Dental Procedures and Nomenclature published in the American Dental Association's (ADA) Current Dental Terminology (CDT) manual. There is a separate provider manual for dental providers located at vacommunitycare.com/provider > Training & Guides > Dental Providers Resources > VA CCN Provider Manual for Dental Providers. Dental functionality is available from vacommunitycare.com/provider > Dental Provider Portal.

Out-of-Network Providers

Typically, out-of-network providers must submit health care claims directly to VA and follow the VA claim submission process. Supporting medical documentation must be submitted with the claim. You can find information on VA's process at department.va.gov/vha/community-care/care-coordination/. The only applicable out-of-network providers who may be eligible for reimbursement by Optum are those that have an approved referral. For these instances where out-of-network providers are eligible for reimbursement by Optum for VA-approved care as defined in the Standardized Episode of Care (SEOC), the reimbursement amounts paid by Optum to out-of-network providers may be less than the reimbursement amounts paid to in-network providers. All care provided to a Veteran must be included on a CCN-approved referral. To ensure timely claims processing, in-network providers shall forward the approved referral, including referral number, to the out-of-network provider when the in-network provider or facility refers to another provider for approved services on the referral. To ensure timely claims processing, the out-of-network provider should include the referral number on the claim.

Fraud, Waste and Abuse Reporting

Fraud is the intentional misrepresentation of information to gain undeserved payment for a claim. Fraud is generally defined as knowingly and willfully executing, or attempting to execute, a scheme or artifice to defraud any health care benefit program or to obtain (by means of false or fraudulent pretenses, representations or promises) any of the money or property owned by, or under the custody or control of, any health care benefit.

One example could be when a provider or staff member knowingly bills for services not provided or bills more costly services than provided, including billing for brand name drugs when generics are dispensed.

Waste is the spending of federal health care dollars on services that are unnecessary. Abuse is a questionable practice that is inconsistent with accepted medical or business practices. Instances of waste or abuse may be unintentional, resulting from a variety of causes, including limited knowledge about best practices or delays in implementing new processes that would improve efficiencies.

As a provider, if you identify potential fraud, waste, or abuse, report it to Optum immediately so we can investigate and respond.

To report suspected fraud or abuse, please contact Optum using one of the following methods:

Online:

Complete the Fraud, Waste and Abuse Reporting form available at vacommunitycare.com/provider > Forms & Resources.

Phone:

Optum Fraud, Waste, and Abuse Hotline: 1-844-883-3461

In cases of fraud, waste, or abuse, Optum will make every reasonable attempt to recover improper payments for services delivered to Veterans or to anyone not eligible to receive a benefit as part of the VA CCN.

Security / Privacy Incident / Notice of Security / Privacy Breach

Provider must provide Optum written notice of any known or suspected security/privacy incidents, or any unauthorized disclosure of sensitive data related to the providers VA CCN Contract. Provider's written notice to us shall provide all relevant information surrounding the incident and identify the information involved, including but not limited to, the date and time of the security/privacy incident, personal information and number of Enrolled Eligible Veterans affected by the security/privacy incident, actions taken by the Provider to mitigate any additional security/privacy incidents. Provider must provide Optum written notice within five days (5) of the security/privacy incident event.

Eligibility and Enrollment

Confirming Eligibility

VA determines Veteran eligibility for community care. A Veteran must be eligible for community care to be referred to a provider participating in VA CCN. Veterans are required to present a valid identification with full name and a photograph to verify their identity before receiving care. The identification may be in the form of a Veteran Health Identification Card (VHIC), U.S. government-issued passport or a state driver's license. Veterans will not have a VA CCN health insurance identification card. An approved referral sent to the provider, or the referral letter VA has sent the Veteran is proof of eligibility. Providers can confirm a Veteran's enrollment status online at vacommunitycare.com/provider > Medical & Behavioral Provider Portal or by calling CCN Provider Services for your region.

Primary Care Provider (PCP) Designation

Each Veteran will have a PCP. If the Veteran's PCP is a VA CCN provider, VA will issue an approved referral to the PCP indicating the length of time it is valid. VA may communicate a Veteran's PCP assignment information on an approved referral. This ensures that providers can share pertinent medical documentation with the assigned PCP.

Referrals

All services, except those provided at a participating urgent care facility, require an approved referral from VA before claims can be processed. Approved referrals from VA will authorize a specific SEOC that will include a specified number of visits and/or services related to a plan of care. The referral packet may include the referral with a SEOC, consult order with chief complaint, patient history and clinical findings related to the chief complaint. The consult order states what the VA provider is requesting from the community provider. Because VA does not want to delay treatment of a Veteran, in addition to the consult order, the provider is approved for all medically necessary services for the quantities listed on the SEOC. Services the provider feels are medically necessary, and are included within the SEOC, may be completed without an additional approved referral. The referral includes the procedural overview which will indicate any services that are not covered under the current referral. A new Request for Services (RFS) form must be sent to VA for approval for these services to be covered. If a new referral is not received, the claim will be denied. The VA SEOC billing code list of preapproved billing codes associated to the services within each SEOC are located at department.va.gov/vha/community-care/care-coordination/precertification-requirements/ or vacommunitycare.com/provider > Forms & Resources > Fee Schedules and VA SEOC Billing Codes > VA SEOC Billing Code List.

The approved referral will state the issue and expiration date. The expiration date may change based on the date of first appointment to allow for the complete time frame from first appointment to the expiration date. When recalculated, a new referral will not be issued. However, the provider will be able to see the update in HealthShare Referral Manager (HSRM) or vacommunitycare.com/provider > Medical & Behavioral Provider Portal.

Providers may be contacted by VA to request acceptance of a referral and schedule an appointment. Once the referral is assigned to the provider, the referral will be available in HSRM. VA will send the approved referral based on the provider's preferred method of communication.

When approved referrals result in the need for urgent or emergent pharmacy prescriptions, or urgent or emergent prescriptions for Durable Medical Equipment (DME), medical devices, orthotics and prosthetics, these supplies and services are also authorized as part of the SEOC.

VA will send approved referral information, including the referral number and any attachments, to the provider through HSRM, secure email, or secure fax.

When VA is referring to a CCN laboratory with a lab and pathology SEOC, the standing lab order will be part of the referral packet.

When VA issues an approved referral and SEOC to a Home Health Care Agency, a Veteran does not need to meet Medicare home-bound criteria and face-to-face requirements. Home Community Base Services (HCBS) providers are to check the referral to ensure that the services required can be serviced by your agency.

- All SEOCs that indicate Bundled are only for Medicare certified agencies
- Refer to the consult order to determine the authorized number of hours or visits approved.
- Hours include ALL services rendered
- Reference to the Personal Care Services and Skilled Home Health Reference Guides for further details

When VA authorizes a specific number of services per week, Optum calculates approved visits based on a Sunday through Saturday week.

You can also visit vacommunitycare.com/provider > Training & Guides > Benefits for additional information on Hospice and Skilled Home Health.

If you are providing services to a Veteran under an approved referral and determine that the Veteran is experiencing an emergent symptom or condition, provide emergency treatment to the Veteran or assist the Veteran in seeking emergency treatment and notify the nearest VAMC immediately.

Referrals for emergent services will follow a different process. See the section below on referrals for emergent medical services for more information about requesting an approved retroactive referral in those cases.

To verify the status of a referral, access HSRM, vacommunitycare.com/provider > Medical & Behavioral Provider or call CCN Provider Services for your region.

When it is necessary for a CCN provider to refer care to another provider for services on the approved referral and SEOC, the referring provider must do the following:

- Call CCN Provider Services for your region to confirm they are referring to an in-network CCN provider
- The referring provider must forward the approved referral, including the referral number, to the referred provider
- The referring provider must send billing information to the referred provider, including the necessity for the referral number to be listed on the claim

When the Veteran has an approved referral, out-of-network claims may be considered for reimbursement by Optum. Where out-of-network providers are eligible for reimbursement by Optum for VA-approved care, as defined in the SEOC, the reimbursement amounts paid by Optum to out-of-network providers may be less than the reimbursement amounts paid to in-network providers. Refer to the Out-of-Network Providers section for more information.

Providers are **not permitted** to bill Veterans for services listed on the approved referral and SEOC.

Any additional services not listed on the SEOC or extension of a treatment period will require making a referral request to VA using the RFS form, with the exception of laboratory or radiology services. Laboratory and radiology services are covered, as long as there is an approved referral on file for the date of service(s) and condition. If a new referral is not received from VA, the claim will be denied.

It is the responsibility of providers to ensure there is an approved referral before providing care or services to a Veteran, including when a Veteran self-schedules the appointment. This means the provider may need to request a new referral from VA if the Veteran's scheduled appointment falls outside the approved referral's dates of service. This applies to all visits, whether it is the Veteran's initial visit or a follow-up appointment.

For any approved referral, where VA is marked as the primary payer, claims should be submitted to Optum and payment to the provider shall be considered payment in full. Other Health Insurance (OHI) should never be billed when a Veteran has an Approved Referral. If a Veteran has other health insurance, please see department.va.gov/vha/community-care/care-coordination/precertification-requirements/ for additional information.

If a service is denied for failure to obtain a referral, exceeding the referral scope, or failure to submit a timely clean claim, the provider shall hold the Veteran harmless for those services and may not invoice Veterans for any services denied for failure of a provider to obtain an approved referral.

For an example of a referral packet, see Appendix A – Sample VA Referral Packet in this Manual.

Referral for Emergent Medical Services

Veterans are allowed to seek emergent medical care in a VA CCN emergency department without a referral. The provider must notify the Emergency Care Centralized Notification Center online or by phone within seventy-two (72) hours of the Veteran presenting to the emergency department:

- emergencycarereporting.communitycare.va.gov

  Note: If unable to access the link in Internet Explorer, use Google Chrome or Microsoft Edge
- 1-844-72HRVHA (1-844-724-7842)

If a Veteran presents to a Behavioral Health (BH) provider not classified as an emergency facility, such as General Acute Care, Emergency Room, or Psychiatric Hospital without a valid referral, the BH provider must contact the Veteran's VA Medical Center (VAMC) to obtain a referral.

For newborn referral requirements please see newborn section above.

The person notifying VA should be prepared to supply case-specific details necessary for care coordination and eligibility determinations including an email address to receive VA's authorization determination. A list of Veteran and treating facility required information is available at department.va.gov/vha/community-care/types-of-veteran-care/?target=Emergency-care.

VA will determine if the Veteran is eligible to receive community care and, if eligible, issue a retroactive approved referral to the provider. The approved referral number is required on the claim. If the referral number is not listed, the claim will be denied.

In the event that VA determines that the Veteran is ineligible to receive a retroactive referral, the provider may follow their standard billing procedures (other health insurance (OHI) or Self-Pay). Provider may **not** bill OHI or the Veteran in the event that the retroactive referral is denied due to failure to contact the Emergency Care Centralized Notification Center within the required seventy-two (72)-hour timeframe.

VA will assign a notification identification number during emergency notification submission. To ensure the safety of Veteran's Protected Health Information (PHI) and Personal Identifiable Information (PII), VA will communicate an authorization decision using encrypted email and the notification identification number provided during submission.

When it is determined that a Veteran needs additional services following the emergency department visit, the Veteran must contact VA to determine if a referral will be issued to either a VA or CCN provider.

Once a Veteran has been stabilized, if additional services including inpatient stay, has been determined to be necessary, notification to VA is key to improving care. VA will determine if the Veteran should be transferred to a VA facility. If the Veteran refuses to be transferred to a VA or other federal facility after their emergency condition is stabilized, the Veteran may be liable for the cost of care beyond the point of stabilization. A VA Form 10-8001, Refusal of Transfer to VA Health Care Facility, is used when a Veteran refuses to transfer to a VA Health Care Facility. The Refusal of Transfer form must be sent directly to VA, utilizing the Facility Contact Number for Care Coordination to locate the appropriate VA point of contact.

After receiving an approved referral, the provider should follow the Claim Submission Process. The claim must be submitted to Optum within the VA CCN timely filing guidelines of one hundred-eighty (180) calendar days from the date of service for outpatient care or date of discharge for inpatient care. Claims submitted outside of those timely filing requirements will be denied. The referral number is required on the claim.

If services are provided in conjunction with an approved referral at a CCN emergency department by an out-of-network provider, refer to the Out-of-Network section.

If CCN provider did not notify VA within seventy-two (72) hours of admission or the emergency department is out-of-network, claims and medical documentation must be submitted to VA for payment consideration. Additional information on emergency care is on VA's community care website at department.va.gov/vha/community-care/types-of-veteran-care/?target=Emergency-care.

If a Veteran is receiving approved services and the treating facility determines the Veteran needs a higher level re than the facility is capable of providing, the facility must notify VA through secure email, secure fax, telephone or Electronic Data Interchange (EDI) (when available). The request should include:

- Facility name and location
- Admitting provider's NPI number
- Admitting diagnosis
- Date of admission
- Any services already delivered (if available)
- Appropriate attachments

Training on how to submit a request for referral is available at vacommunitycare.com/provider > Training & Guides.

Health Care Management

Critical Findings

Critical findings are findings or results that require immediate evaluation by a provider, such that failure to take immediate appropriate action might result in significant morbidity to, serious adverse consequences, to or death of the Veteran.

When a provider makes a critical finding, the provider must communicate the finding, verbally or in writing, to the Veteran, referring provider and VA within either two (2) business days of the discovery or the time frame required to provide any necessary follow-up treatment to the Veteran, whichever is sooner.

Clinical Quality

Optum's Clinical Quality (CQ) program helps ensure high-quality, safe access to health care and services by using established quality monitoring and improvement principles.

Optum uses the CQ program to:

- Monitor clinical performance against evidence-based clinical guidelines and service standards
- Monitor and assess the quality and appropriateness of services given to Veterans
- Achieve continuous improvement of Veteran health care and services
- Enhance patient safety and maintain the confidentiality of Veteran medical information
- Investigate and resolve identified quality of care issues within the scope of care and authorized services rendered

Providers are required to participate in the CQ process in accordance with their Provider Agreement and VA requirements.

Activities that are related to the CQ process may include, but not limited to:

- Participation in the investigation of potential quality issues (PQIs), patient safety concerns, or emerging trends in clinical quality rendered.
- Review of findings of clinical quality studies as published in the Provider newsletters, as well as any subsequent educational offerings or practice considerations.
- Compliance with peer review, patient safety, and clinical quality programs and procedures established by Optum or VA, including but not limited to:
  - Retrospective reviews
  - Allowing Optum and its designees to have access to provider's medical records within a reasonable time frame and providing complete medical records upon request
    - Routine requests: provider must submit medical records within thirty (30) calendar days from request date
    - Expedited requests: provider must submit medical records within twenty-one (21) calendar days from request date.
  - Responding to all peer review communications and requests, including, but not limited to all assigned corrective actions within specified time frames
- Prompt and diligent response to medical record requests as a part of any of the above activities.
  - The provider must submit medical records and clinical information to Optum upon request. Failure of provider to comply may impede the patient safety investigation process of PQI's, trends, and/or quality studies and may impact provider's network status.
  - The number of pages will vary based on the episode(s) of care and documentation of care provided.
  - The volume of requests depends on the number of PQIs, trends and/or selection for clinical quality study sample.

Optum is not authorized to reimburse providers for the costs for retrieving, copying, postage and/or handling of documents related to clinical quality activities.

Providers may appeal the Peer Review Committee's determination of a confirmed quality issue(s), severity level, and assigned corrective actions. The provider has sixty (60) days from the date the initial Peer Review Committee determination letter to submit an appeal. All appeal requests must be in writing identifying the reason for the specific dispute, include the initial Peer Review Committee's determination letter and any additional support information to be considered. All appeal

determinations are final. **Appeal findings could be favorable, less favorable, or the same based on the issues identified and severity levels assigned.**

Failure to comply with any of the above requirements including, but not limited to, lack of response to peer review communication(s) and requests for submission of medical records, documents, and/or data may impact a provider's network status.

High Performing Providers and Centers of Excellence

Provider performance will be analyzed and monitored against specific quality and performance measures agreed upon by Optum and VA. Individual and Group Practice Providers who meet or exceed the threshold for quality and performance measures are designated as High Performing Providers, and Institutional Providers are designated as Centers of Excellence. Performance will be reviewed and monitored for quality and performance measures, which may change based on Optum's agreement with VA.

Behavioral, Dental, Vision and Complimentary and Integrative Health (CIH) providers are not included in High Performing Provider monitoring.

Designation is not an endorsement or guarantee of a provider's ability to provide health care services and is not viewable to Veterans or Providers through Optum. The provider designation is only viewable in VA's internal provider directory utilized when scheduling a Veteran appointment with a CCN provider.

Performance will be reviewed, utilizing internally and externally available data. When CQ identifies a trend or pattern where an institution is not meeting one or more measure(s), CQ may send the institution a letter detailing improvement opportunities and refer the institution to references on vacommunitycare.com/provider > Forms & Resources > Centers of Excellence: Resources for Quality Improvement for information on how to increase specific performance measure(s).

VA CCN Providers that are not evaluated:

If a VA CCN provider is not designated a High Performing Provider or Centers of Excellence, this does not mean the provider/institution does not provide quality care. Some providers/institutional providers will not be evaluated, for example:

- Too few cases/patients to report
- Hospitals that are excluded due to different quality reporting programs
- Applies to medical providers only, excludes behavioral, dental, vision, complimentary and integrative health providers

Potential Quality Issue (PQI) Review

For VA CCN, Optum assesses all medical records, claims, referrals, and other relevant documentation during the PQI investigation process. All care provided under the VA CCN contract, including medical, surgical, behavioral health, dental, pharmacy and all CIHS, are within the scope for PQI investigations. PQIs can include quality of care concerns, including CMS HACs/HAIs, AHRQ Patient Safety Indicators (PSIs), National Quality Forum (NQF) Serious Reportable Events (SREs). The Joint Commission (TJC) Sentinel Events (SE), or any other quality of care concern surfaced from VA. In all or any of the following categories:

- Surgical events
- Product or device events
- Patient protection events
- Care management events
- Environmental events
- Radiologic events

- Criminal events
- Documentation events
- Dental events

PQIs do not include quality of service concerns.

Providers may be contacted about a potential quality issue by an Optum VA CCN representative.

If you become aware of a PQI while providing care to a Veteran, please complete and submit the PQI referral form, which is available at vacommunitycare.com/provider > Forms & Resources > Forms.

CQ Confidentiality

Providers are responsible for helping to ensure the privacy and security protection of information, in accordance with applicable federal, state, and local laws and provisions applicable to sensitive and personally identifiable health care information.

All Clinical Quality information shall be treated as confidential and in accordance with applicable federal, state, and local laws and regulations.

- Everything related to CQ activities are considered privileged and confidential information
- Optum limits Protected Health Information (PHI) to the necessary minimum

Medical Documentation

All Providers are responsible for creating, maintaining, and submitting a Veteran's medical documentation to VA according to established requirements. This includes ensuring all documentation is submitted in accordance with any applicable federal, state and local laws and regulations. Providers can reference our Medical Documentation Requirements in English and Spanish. Located at vacommunitycare.com/provider > Training & Guides > Medical Documentation and Referrals.

Access to Records

You are required to:

- Send VA copies of the Veteran's medical or administrative records related to care
- Give access to records to VA or Optum for all dates of service that occurred when you were a contracted provider

Submitting Medical Documentation to VA

All providers, regardless of specialty, must submit medical documentation directly to VA and to the referring provider using one of the following:

Preferred Methods:

- HealthShare Referral Manager (HSRM) at department.va.gov/vha/community-care/ > Care Coordination > Care Coordination Tools > HealthShare Referral Manager (not available for Urgent Care)
- Veterans Health Information Exchange (VHIE) allows providers to electronically exchange information with VA, once becoming a VHIE partner. To learn more about VHIE, click here.

Other Methods:

- Secure, encrypted email (Azure RMS) at department.va.gov/vha/community-care/ > Care Coordination > Care Coordination Tools > Azure Rights Management Services
- Secure fax located on the approved referral, or Veteran's local VA Medical Center (VAMC) for Urgent Care

Note: VA strongly encourages all providers to use HSRM or VHIE to submit medical documentation. Submitting medical documentation via secure, encrypted email (Azure RMS) or secure fax may result in processing delays, which can impact Veteran care, and require additional follow-up to the provider to

meet documentation compliance standards. Providers are encouraged to utilize HSRM or VHIE for all document submission to ensure timely and accurate record processing.

All medical documentation must include:

- **Approved referral number must be included**
  - The referral number should be placed in the top right corner of the cover page, as this is the preferred location for proper documentation processing
- Provider authentication (including a written signature, written initials or electronic signature and provider phone number)
- The Veteran's unique identifier
  - Integration Control Number (ICN) – primary beneficiary ID; or
  - Social Security Number (SSN) – secondary beneficiary ID; or
  - Electronic Data Interchange Patient Identifier (EDIPI); or
  - Patient Control number (PCN)
- Veteran's full name (including suffix)
- Veteran's date of birth

Provider is not required to have a Veteran's signature to share medical documents.

Part 2 Substance Use Disorder (SUD) providers are required to obtain a Veteran's signature in order to share any Veteran medical documents and/or records.

Home and Community Based Services Documentation

For each date of service provided to the Veteran, documentation should include all of the following:

- Date of service
- Full name and address of the Veteran receiving care
- Documentation of time in and time out of the Veteran's home recorded by the aide
- Description of the tasks performed (bathing, dressing, housekeeping chores, etc.)
- Full name and signature of the aide rendering care in the home
- Veteran or Veteran representative's signature and date, validating the visit time and tasks performed
- All documentation should be legible and support the hours in the Veteran's home

Submission Time Frames

Medical documentation must be submitted to VA and the referring provider when applicable, according to the following time frames:

- Outpatient care
  - Within thirty (30) calendar days of the Veteran's initial appointment
  - Within thirty (30) calendar days of completing care included on an approved referral
- Inpatient care
  - Within thirty (30) calendar days of discharge to include, at a minimum, the discharge summary
- When VA requests medical documentation, it will include the submission deadline.
- For urgent requests from VA, documentation is required within twenty-four (24) hours of receiving the request.

Additional Provider Responsibilities

Provider will ensure your Provider Professionals, and your staff are able to: perform assigned duties and responsibilities; communicate observations verbally and in writing; accept and use supervision; respect privacy and confidentiality; adapt to a variety of situations; and respect and accept different values, nationalities, races, religions, cultures, and standards of living.

Provider agrees to maintain written personnel files for all staff and Provider Professionals with documentation on the results of interviews, resumes, any references, background checks, performance reports, annual evaluations, and any other pertinent personnel information. Provider will ensure that Provider, Provider Professionals, and staff report, record, and maintain accurate time for hours dedicated to the performance of services and tasks under this agreement. Provider is required to have policies and procedures for timekeeping and timesheet processing. Altering, falsifying, or tampering with any time records for hours dedicated to the performance of services and tasks under this agreement is prohibited.

Provider will have written policies and procedures and processes in place for handling allegations of loss, theft, and/or damage of Enrolled Eligible Veterans' property. Provider will have policies that prohibit the handling of the Enrolled Eligible Veterans' valuables (e.g. jewelry, heirlooms, etc.) and money that includes, but is not limited to: using mobile payment apps to send or receive funds from Enrolled Eligible Veterans (e.g. Cash App, Zelle, Venmo, Apple Pay, Google Pay, PayPal, etc.) the reconciling checkbooks, writing checks, using bank cards/Automated Teller Machines (ATMs), or providing banking services.

Provider will have policies, procedures, and plans in place for handling allegations and incidents of violence such as physical assault and physical abuse of Enrolled Eligible Veterans. Also, Provider will have policies, procedures, and processes in place to handle allegations and incidents of unwelcome and inappropriate touching, sexual harassment, and sexual assault up to and including rape, of Enrolled Eligible Veterans.

Provider will have policies, procedures, and plans in place for dealing with emergencies in the Enrolled Eligible Veterans' homes, including accessing emergency medical services and contacting your appropriate staff. Provider will promptly report to United the following actions: loss, theft, and/or damage of Enrolled Eligible Veterans' property, injury to Enrolled Eligible Veteran, allegations or incidents of physical assault and physical abuse of Enrolled Eligible Veterans, allegations or incidents unwelcome and inappropriate touching, sexual harassment, and sexual assault, and any Enrolled Eligible Veterans' complaints.

Failure to Comply

If a VA CCN provider does not comply with submission requirements, VA will notify Optum.

A representative from Optum will notify the provider of failure to comply. Providers have thirty (30) calendar days to respond to VA with corrected medical documentation.

Optum Medical Documentation Requirements

In addition to submitting medical documentation to VA, Providers will be required to:

- Submit complete* or partial medical records, as requested, to Optum directly or through its designee, immediately on receipt of request, no later than twenty-one (21) calendar days for expedited requests or thirty (30) calendar days for routine requests.
- Comply with any applicable state, federal and local laws, and regulations as it relates to submission of medical documentation.

Lack of participation or response may result in recommendation of removal from the VA CCN Provider Network.

- Optum is not authorized to reimburse providers for the costs for retrieving, copying, postage and/or handling of medical records in connection with processes for CCN.

*Complete medical record shall include, but is not limited to, history and physical, discharge summary, progress notes, emergency records, operative notes, consultations, medication administration record (MAR), evidence of PDMP queries, nursing notes and flowsheets (vital signs, daily care, patient safety, lines/drains/tubes, etc.), orders, laboratory and pathology reports, radiology reports and consent forms.

All services must be authenticated by the responsible provider with a dated signature confirming review and approval. Each entry must include a legible signature identifying the practitioner by name; credentials are strongly recommended.

Acceptable signature methods include:

- **Handwritten:** Must be legible or supported by a printed name, signature log, or attestation.
- **Electronic:** Must include date (and time when applicable) and clear attestation language with the provider's name and credentials.
- **Digital:** Must be securely generated and protected to ensure sole use by the provider.

All signatures must comply with applicable regulatory requirements and ensure record integrity and accountability.

Patient Safety Concerns

Optum has a strong commitment to ensuring the safety of Veterans receiving care within Optum VA CCN. Providers must acknowledge the importance of maintaining patient safety and ensure all appropriate measures are taken to ensure Veterans' safety. Optum may receive notification of patient safety concerns from VA, a Veteran, or a provider regarding the actions of another provider.

Providers are required to cooperate with all patient safety investigations in accordance with VA requirements. Providers must comply with the following:

- Providers will report to Optum any actions, adverse events, and/or issues regarding a patient safety concern of a Veteran receiving care within VA CCN. This report must be submitted to Optum within two (2) business days of the provider's knowledge of the patient safety concern. Providers must report this information to Optum in writing.
- Providers will respond to all requests for information and documentation relative to the investigation of grievances and patient safety concerns within two (2) business days from receipt of outreach or communication from Optum.*
- Providers must respond to all Optum's requests for information and documentation in writing.
- Providers will implement enhanced policies, procedures, training, and processes to ensure patient safety risks are identified and addressed appropriately, and Optum is timely notified of patient safety issues. Such policies, procedures, training, and processes will be outlined in written form and made available to Optum if requested.

Failure to comply with any of the above requirements including, but not limited to, lack of response to patient safety investigation communication(s) and requests for documents may impact a provider's network status. During the patient safety investigations, providers may be placed on hold and may not receive new referrals.

To report a suspected patient safety concern, please contact CCN Provider Services for your region. A dedicated Provider Services support team is available to assist providers for regions one, two and three from 8 a.m. to 6 p.m. local time, Monday - Friday, excluding federal holidays.

Region 1: 1-888-901-7407

Region 2: 1-844-839-6108

Region 3: 1-888-901-6613

Or submit online: https://vacommunitycare.com/pqi.

*Please note that Optum is not authorized to reimburse providers for the costs of retrieving, copying, postage and/or handling, or the copies of documentation in connection with patient safety investigations for VA CCN.

Reimbursement and Claims Process

Registration and billing staff must be aware of the appropriate Third-Party Administrator (TPA) to bill and be paid quickly. Please share these details with your staff.

On the VA CCN referral, look for the following **Affiliations** and **Networks** specific to the VA CCN region indicating Optum is the TPA.

Affiliation:	**Network**:
• CCN1	• CC Network 1
• CCN2	• CC Network 2
• CCN3	• CC Network 3

When you see the above **Affiliations** and **Networks** on an approved referral, the Veteran should be registered in your practice management system as VA CCN, and the claim should be submitted to Optum (or Optum Serve for dental claims) using Electronic Data Interchange (EDI), secure fax, mail, or the provider portal.

For an example, see Appendix A – Sample VA Referral Packet in this Manual.

Reimbursement

Providers will be reimbursed in accordance with the payment provisions and requirements in their respective Provider Agreements and any applicable payment appendices. For Covered Services rendered by providers to Eligible Veterans, the contract rates will be the lesser of:

1. Provider's Eligible Charges (as defined in the Provider Agreement and any applicable payment appendices), or
2. The applicable contract rates are determined in accordance with the Provider Agreement and any applicable payment appendices. All coding and billing guidelines issued by CMS will be followed by the provider in submitting claims, unless otherwise specified in the Provider Agreement and any applicable payment appendices
3. Contracted rates for Covered Services that are included in the Centers for Medicare & Medicaid Services (CMS) program also include Medicare Administrative Contractor (MAC) Local Pricing schedules

Services reimbursed under CMS MS-DRG payment methodology, episodic payments, and payment appendices where reimbursement is based on a negotiated percentage of the facility-specific Medicare rate letter, such as Critical Access Hospitals and Rural Health Clinics, are not subject to lesser of logic, unless otherwise stated by CMS, for example under CMS Fee Schedule methodologies. Services reimbursed under CMS APC methodology, where applicable or other outpatient services reimbursed under CMS Fee Schedule methodologies, may be subject to lessor of logic as determined by CMS.

Long-term care hospitals (LTCH), also known as long-term acute care facilities, will not be subject to the LTCH Prospective Payment System (PPS) rules that, under Medicare, could result in reimbursement reductions. For all services that LTCHs provide, the payment will be 100% of Medicare rates.

Provider's administering medications in the provider's office with an approved referral are required to purchase the medication and submit the claim for payment consideration.

Medical providers contracted for VA CCN as part of a UnitedHealthcare Participation Agreement, who receive an approved medical referral identified by a medical SEOC to include dental services, must file medical CPT or HCPCS codes to Optum and dental Current Dental Terminology (CDT) codes to Optum Serve. Reimbursement for dental services as part of a medical referral will be in accordance with your UnitedHealthcare payment appendix.

Medical providers contracted for VA CCN, as part of a UnitedHealthcare Participation Agreement, who receive an approved dental referral signified by Category of Care: dental and a dental SEOC, must file

medical CPT or HCPCS codes to Optum and dental CDT codes to Optum Serve. Payment for dental services as part of a dental referral will be in accordance with the fixed rates for the applicable CCN region listed on the dental fee schedule. Links to Centers for Medicare & Medicaid Services (CMS) and VA Fee Schedules are available at vacommunitycare.com/provider > Forms & Resources.

VA Fee Schedule is updated annually by VA and additional updates may be implemented at VA discretion. Optum will have up to thirty (30) calendar days from the VA publish date to implement the new/updated VA Fee Schedule in our claim system. VA may classify rate revisions as retroactive. When that occurs, Optum will use the date of service to determine applicable rate and reprocess affected claims at the new published rate. Calendar Year 2026 VA Fee Schedule shall reimburse services based on the CMS locality of the servicing provider for care provided or the CMS locality for the Veteran for home health or other services provided in a home setting.

Providers with a VA CCN general acute care hospital payment appendix or VA CCN critical access hospital payment appendix that did not permit reimbursement for a Ventricular Assist Device (VAD) or Chimeric Antigen Receptor T-Cell Therapy (CAR-T) are now eligible for reimbursement. When VA has approved a referral and SEOC that includes a VAD or CAR-T procedure for a particular Veteran, reimbursement rates will be payable in accordance with the reimbursement methodology in your payment appendix and terms of your agreement.

For applicable academic medical centers, Indirect Medical Education (IME) is eligible for reimbursement even when a hospital's current VA CCN payment appendix reflects IME as an exclusion.

Spinal decompression, S9090, is not eligible for reimbursement.

T2003 is eligible for reimbursement for non-emergent medical transportation provided by the Adult Day Health Care Services Provider (ADHC) with an approved referral and Adult Day Health Care Services SEOC.

When VA authorizes a specific number of services per week, Optum calculates approved visits based on a Sunday through Saturday week.

Medicare rates are 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 bill 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. Please 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.

Providers must ensure that all billed services align with the Procedural Overview- Standardized Episode of Care (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 providing services and submitting claims, providers 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 (4) 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.

VA Fee Schedule for Authorized Community Care - Community Care

Claims Processing and Filing

Electronic submissions are preferred for sending claims to Optum using Electronic Data Interchange (EDI) from a vendor, clearinghouse, or billing service.

Providers must submit claims on nationally recognized claims forms, including:

- CMS-1500
  - Veteran's Social Security Number (SSN) or Integration Control Number (ICN) in box 1a
  - Referral number or UCERN in box 23
    - Only one referral number per claim form
- UB04 or CMS-1450
  - Veteran's SSN or ICN in box 60
  - Referral number or UCERN in box 63A
    - Only one referral number per claim form
- American Dental Association (ADA) claim form (dental codes only)
  - Veteran's SSN or ICN in box 15
  - Referral number in box 2
    - Only one referral number per claim form

NOTE: Medical providers billing dental procedures must submit a dental claim to Optum Serve on an ADA claim form with the appropriate Current Dental Terminology (CDT) code(s).

Timely Filing

Claims must be submitted within one hundred-eighty (180) calendar days from the date of service for outpatient care or the date of discharge for inpatient care.

- When a claim is submitted to VA or another VA Third-Party Administrator (TPA) acting on behalf of VA in error, the provider is required to submit to Optum within one hundred-eighty (180) calendar days from the denial and must include proof of initial timely filing.
  - Proof should include an Explanation of Payment (EOP) from VA or a Provider Remittance Advice (PRA) from VA or another VA TPA acting on behalf of VA
- A 277 EDI rejection notice from Optum, VA or another VA TPA when a date of submission confirms the claim was submitted timely
- If the claim was submitted to any other payer, the claim must be submitted to Optum within one hundred-eighty (180) calendar days of the date of service or discharge
- In cases where Optum receives the referral past the date of service or discharge, Optum can use one hundred-eighty (180) calendar days from the date Optum received the referral as the timely filing deadline

Claims Submission

Electronic:

Payer ID: VACCN

Note: VA CCN electronic claims should be routed to Optum 360 directly or through a clearinghouse or vendor.

Use the provider portal to submit online:

- **Medical/Behavioral**: Go to vacommunitycare.com/provider > Medical & Behavioral Provider Portal
- **Dental**: Go to vacommunitycare.com/provider > Dental Provider Portal

Paper:

If electronic capability isn't available, providers can submit claims by mail.

- Medical
  - Mailing:
    VA CCN Optum
    P.O. Box 202117
    Florence, SC 29502
- Dental
  - Mailing:
    Optum Serve, Inc.
    Attn: VA CCN Claims
    3237 Airport Rd
    La Crosse, WI 54603
  - Secure Fax:
    1-608-793-2143 (Please specify VA CCN on the fax.)

Claims Processing Timelines

Optum is committed to processing 98% of all clean claims within thirty (30) calendar days of receipt of the clean claim.
A "clean claim" is a claim that contains all the required data elements necessary to be accepted by the clearinghouse and/or the payer's adjudication system. Claims that do not meet the definition of a clean claim will be returned to the provider with an explanation of deficiencies within thirty (30) calendar days of being received.

You may use the provider portal at vacommunitycare.com/provider > Medical & Behavioral Provider Portal to verify claims status. All claims submitted will be acknowledged either with a payment, a provider remittance advice or returned with a specific request for additional information.

Other Health Insurance and Veteran Billing

Providers may not bill Other Health Insurance (OHI) or the Veteran when a Veteran has an approved referral. All claims for any approved referral where the Department of Veterans Affairs (VA) is indicated as the primary payer, must be submitted to Optum. Payment issued by Optum is considered payment in full for the authorized services. If a Veteran has other health insurance, please see department.va.gov/vha/community-care/care-coordination/precertification-requirements/ for additional information.

Billing of Veterans for services listed on the approved referral and Standardized Episode of Care (SEOC) is not permitted. **Veterans are to be held harmless and may not be billed for any reason, including failure to submit claims for reimbursement, failure to submit claims timely, or for claim denials.** Veterans are not subject to deductibles, copays, pre-service billing, balance billing, and are not responsible for denied claims and may not be charged for missed appointments.

Providers are prohibited from billing OHI or the Veteran if a retroactive referral is denied due to failure to contact the Emergency Care Centralized Notification Center within the required seventy-two (72) hour timeframe. Standard billing procedures, including billing OHI or Self-Pay, are only permitted when VA determines that the Veteran is ineligible for a retroactive referral.

Optum may contact providers at any time if incorrect billing is identified, including OHI, and/or duplicate payment. In such cases, the provider will be required to promptly refund the OHI and/or duplicate payment and report the date of refund to Optum. **Failure to comply will result in corrective action, up to and including termination from the network.**

When a CCN provider refers care to another in-network CCN provider for services on the approved referral, the referring provider must ensure the referral, including the referral number and the billing

information, is sent to the rendering provider. These requirements apply to all referred services, including laboratory, radiology, and ancillary services.

All providers are subject to the billing requirements in the VA CCN Provider Manual**. Failure to comply with VA CCN billing practices, including OHI and Veteran billing, may result in corrective action plan, up to and including termination from the network.**

Claim Denials

- Veterans shall be held harmless and may not be billed for any reason including, but not limited to, when claims are not submitted for reimbursement, when claims are not submitted timely or when services are denied for any of the reasons identified below. Claims submitted that are missing one or more of the following elements will be denied:
  - The Veteran's Social Security Number (SSN) or Integration Control Number (ICN)
  - An approved referral number (only one referral number can be submitted on a claim)
  - A valid National Provider Identifier (NPI) number

- Additional reasons that a claim may be denied include, but are not limited to, the following examples:
  - Claims for care that are not within the scope of the approved referral
  - Duplicate claims
  - Claims for services that are not part of the Veteran's medical benefits package
  - Claims submitted on unapproved claim forms. (Resubmitted claims on approved claim forms must be submitted within the timely filing deadline of one hundred-eighty (180) calendar days from the date of service or date of discharge)
  - Emergency claims submitted by an in-network emergency department when an approved referral does not exist, due to the in-network emergency department not contacting VA within seventy-two (72) hours of the Veteran self-presenting to the emergency department to request a retroactive referral
  - Claims that are not submitted within one hundred-eighty (180) calendar days from the date of service or date of discharge (i.e., claims that are submitted past the timely filing deadline)
  - Administrative charges related to completing and submitting the applicable claim form
  - The provider fails to submit a claim according to the claim's adjudication rules
  - The provider delivers health care services outside of the validity period specified in the approved referral

- Out-of-network providers providing emergency services need to submit health care claims directly to VA and follow VA claims submission procedures.
- Claims for ancillary services will be processed in accordance with CMS NCCI, MUE and related edits.
- Veterans shall be held harmless and may not be billed when claims are denied.
- Providers may not charge Veterans for missed appointments.

Veteran's Signature on File

When a Veteran has signed a release of information statement, providers should indicate "Signature on File" on the claim submission. A new signature is required every year. Claims submitted for diagnostic tests, test interpretations or other similar services do not require the Veteran's signature. When submitting these claims, you must indicate "patient not present" on the claim submission.

Optum randomly reviews claims to confirm that signature-on-file requirements are being followed.

Provider's Signature on File

Optum will follow its normal business operations to verify signature of providers on claim submissions.

In lieu of a provider's actual signature, the following are acceptable alternatives:

- A facsimile signature or signature of a representative is accepted only if Optum or the Network Partner has on file a notarized authorization from the provider to use a facsimile signature or Power of Attorney (POA) for another person to sign on the provider's behalf
- The facsimile signature may be produced by a signature stamp or a block letter stamp, or it may be computer-generated if the claim form is computer-generated
- If a POA is on file, the authorized representative may sign using the provider's name, followed by the representative's initials, or using the representative's own signature followed by POA, or similar indication of the type of authorization granted by the provider
- The provider is required to update their signature authorization on file annually
- Optum may return a claim with a request for the signature authorization when there is no authorization on file, or it is out-of-date
- Failure to comply with these requirements will result in claim denial

Remittance Advice

VA CCN will transmit a provider remittance advice using Electronic Data Interchange (EDI) 835. For providers who don't use EDI, an 835 transaction will be created, printed, and mailed.

Claim Inquiries / Replacement Claims

All medical claim inquiries, including allowable reviews must be submitted by mail or fax within twelve (12) months after the claim was initially processed. A replacement claim should be submitted to Optum when the original claim included information that has been determined to be inaccurate or lacking information. A corrected claim may be submitted through the provider's clearing house, XPressClaim, or U.S. mail. Further detailed information can be found in the Medical Service Model and Claims Guide located at vacommunitycare.com/provider > Training & Guides > Claims and Medical/Behavioral Portal Guides.

- Mail:
  VA Community Care Network
  Claims
  P.O. Box 202118
  Florence, SC 29502

Claim Reconsiderations

Under VA CCN, a reconsideration is a formal process by which a provider may request that Optum reviews a claim denied, partially or in whole.

- When a claim is denied partially or in whole, a reconsideration request must be filed within ninety (90) calendar days from the date of denial
- For further details on the reconsideration process please review the Medical Service Model and claims guide at vacommunitycare.com/provider > Training & Guides > Claims and Medical/Behavioral Portal guides

Reconsideration requests must be in writing and must include the claim number, date of service, Veteran name, and reason for the request, along with an explanation/justification for reconsideration. Providers can locate the reconsideration form on vacommnitycare.com/provider > Form & Resources.

Providers can request reconsiderations of multiple claims in a single letter or use the Reconsideration form available at vacommunitycare.com/provider > Forms & Resources.

Send reconsideration requests to the address or fax number listed on the remittance advice. If unable to locate the address, please submit the reconsideration request by mail, secure fax, or secure email.

- Mail:
  - VA Community Care Network
    Appeals and Grievance
    Team MS-21
    3237 Airport Road
    La Crosse, WI 54603
- Secure Fax: 1-877-666-6597
- Secure Email:
  - Region 1: faxAG1@optumserve.com
  - Region 2: faxAG2@optumserve.com
  - Region 3: faxAG3@optumserve.com

Subrogation

You must notify the nearest VAMC in all circumstances of any VA CCN health care services related to or associated with any claim involving subrogation against:

- Workers' compensation carrier
- An auto liability insurance carrier
- Third-party tortfeasor (e.g., medical malpractice)
- Any other situation where a third party is responsible for the cost of VA CCN health care services. Optum will work with VA and notify you if any recoupment processes will be initiated

For further details on the recoupment process refer to the Standard Recoupment Process located on vacommunitycare.com/provider > Training & Guides.

Veteran Appeals

In the event Optum denies a claim and the Veteran has a financial liability for that denied claim (such as emergency care without an approved referral), Optum will provide a notice of the denial to the Veteran with a description of their right to appeal to VA.

A copy of the Veteran's Explanation of Benefits (EOB) will be available to the Veteran through vacommunitycare.com > Veterans.

Claims Audits

Optum may recover from provider any amounts owed to Optum, pursuant to VA CCN requirements, including payments that were made beyond or outside what is provided under the Provider Participation Agreement.

Provider will receive a recoupment letter with the reason for the recovery, including claims detail and the amount due. The provider will be required to submit the refund within the time frame specified in the provider's agreement. If the refund is not received, future claims will be offset with the amount owed. If your reconsideration request is overturned and the offset has already completed, Optum will reimburse the amounts previously recouped.

For further details please see the Standard Recoupment Process.

Claims identified and substantiated as fraud or abuse will be denied or subject to recovery from the provider by Optum. See Fraud, Waste and Abuse for more information.

Claim/Referral Audit and Compliance

As a provider, you must respond to inquiries from Optum regarding Veterans who have scheduled appointments, but there is no associated claims activity. This may occur if a Veteran missed or cancelled an appointment and does not reschedule.

Provider Training and Resources

VA CCN providers will find information, resources, and helpful links at vacommunitycare.com/provider > Training & Guides.

Training

Provider training will include, but is not limited to:

- VA CCN Provider Manual
- Benefits reference guides
- Claims reference guides
- Medical documentation reference guide
- Referral reference guide
- Educational videos

Community Provider Resources

VA has additional tools and resources available for providers working with Veterans. This includes easy-to-access information about how to screen for military experience, understanding military culture and referring to VA, as well as tools for working with a variety of behavioral health concerns. Providers have access to VA's Exercises for Providers, available at https://www.mentalhealth.va.gov/healthcare-providers/index.asp, created especially for health care professionals as part of VA and Department of Defense's Integrated Mental Health Strategy.

Optum also offers a Provider Toolkit to assist provider offices and office staff with essential tools and guidelines. The goal of this toolkit is to collaborate and streamline critical information that will further assist your practice and office in caring for Veterans. The Behavioral Toolkit for Providers – Military and Veterans is available at providerexpress.com.

HealthShare Referral Manager (HSRM) Training and Resources

There are several opportunities for providers to learn more about HSRM. Please check the VHA TRAIN website for available training course dates and register in advance.

To download HSRM informational resources prior to the training, please navigate to the Office of Community Care (OCC) webpage at department.va.gov/vha/community-care/care-coordination/care-coordination-tools/.

- Community Provider HealthShare Referral Manager Training Course

  This course will include an overview of HSRM, an in-depth walkthrough of the system and additional time allotted for questions/demos
- Community Provider HealthShare Referral Manager Registration Course

  The HSRM registration sessions will provide an in-depth walkthrough of the process to obtain access to HSRM.
- HSRM web-based, self-study training is available on VHA TRAIN twenty-four (24) hours a day, seven (7) days a week. Search courses via Course Catalog: ***"community provider lifecycle for HealthShare Referral Manager."*** Select lessons one (1) through eleven (11)

Additional Resources

- For support and more information, contact hsrmsupport@va.gov
- For Community Care Points of Contact for HSRM, go to department.va.gov/vha/community-care/hsrm-contacts-list/

VA Trainings and Resources

VA has developed courses designed to help providers better understand how to care for Veterans. These courses cover key topics such as Opioid Safety Initiative, military culture, suicide awareness and prevention, military sexual trauma, posttraumatic stress disorder, and traumatic brain injury.

All these courses are available through the VHA TRAIN website and can also be accessed via the links provided below. Most of these courses offer Continuing Medical Education (CME) credit for licensed providers.

To access the courses, providers must create a free VHA TRAIN account, which can be completed in just a few minutes.

To support users, VHA offers several guides, including:

- How to set up and manage your TRAIN profile
- How to navigate learning activities in TRAIN
- How to identify, access, and track continuing education (CE) courses and credits

These guides are available on the VHA TRAIN Tutorials page.

VA Required Trainings

Providers must complete applicable VA required trainings and review VA required resources to successfully manage Veteran care.

- Opioid Safety Initiative
  - See Provider Manual Addendum A
- **Opioid Safety Initiative** - Course ID 1086479

VA Recommended Trainings

Providers are highly encouraged to complete all applicable VA recommended trainings and review VA resources to successfully manage Veteran care.

- **Community Care Provider-A Perspective for Veteran Care Training** – Course ID 1136832
- **Community Care Provider: A Perspective for Veteran Care Provider Test-Out** – Course ID 1085497
- **Lethal Means Safety Counseling (LMSC) Training** – Course ID 1075258
- **Skills Training for Evaluation and Management of Suicide Training** – Course ID 1090912
- **MISSION Act 133: Traumatic Brain Injury (TBI) Training** – Course ID 1136830
- **MISSION Act Section 133: PTSD Course** – Course ID 109490
- **MISSION Act 133: A Core Training on Military Sexual Trauma (MST) for Community Medical Professionals** – Course ID 1089409
- **MISSION Act 133: Core Training for Military Sexual Trauma (MST) for Community Mental Health Providers** – Course ID 1090456

Acronyms

Table 3: Acronyms

Acronym	Meaning
ART	Assisted Reproductive Technologies
BH	Behavioral Health
CAR-T	Chimeric Antigen Receptor T-Cell Therapy
CARF	Commission on Accreditation of Rehabilitation Facilities
CCN	Community Care Network
CDT	Current Dental Terminology
CIHS	Complementary and Integrative Healthcare Services
CMS	The Centers for Medicare & Medicaid Services
CPT	Current Procedural Terminology
CQMP	Clinical Quality Monitoring Plan
CTC	Certified Transplant Center
CVS	CVS Caremark
DME	Durable Medical Equipment
DOS	Dates of Service
EDI	Electronic Data Interchange
EDIPI	Electronic Data Interchange Patient Identifier
EHR	Electronic Health Record
EOB	Explanation of Benefits
FDA	Food and Drug Administration
FQHC	Federally Qualified Health Center
HCAHPS	Hospital Consumer Assessment of Healthcare Providers and Systems Survey
HCBS	Home Community Based Services
HCPCS	Healthcare Common Procedure Coding System
HEDIS®	Healthcare Effectiveness Data and Information Set
HHS	U.S. Department of Health and Human Services
HIE	Health Information Exchange
HSRM	HealthShare Referral Manager
ICD	International Classification of Diseases
ICN	Integration Control Number
ICSI	Intracytoplasmic Sperm Injection
IME	Indirect Medical Education
IVF	In Vitro Fertilization
LHI	Logistics Health Incorporated
MAF	Mechanically Assisted Fertilization
MESA	Microscopic Epididymal Sperm Aspiration
MRI	Magnetic Resonance Imaging
MSDRG	Medicare Severity Diagnosis-Related Group
NOTA	National Organ Transplantation Act
NPI	National Provider Identifier
OAT	Oral Appliance Therapy
OHI	Other Health Insurance
OIG	Office of Inspector General
OPTN	Organ Procurement and Transplantation Network
PBM	Pharmacy Benefits Manager

Acronym	Meaning
PCP	Primary Care Provider
PCPI	Physician Consortium for Performance Improvement
PESA	Percutaneous Epididymal Sperm Aspiration
PHI	Protected Health Information
PII	Personal Identifiable Information
PQI	Potential Quality Issue
PZD	Partial Zona Dissection
RFS	Request for Services
RHC	Rural Health Clinic
SEOC	Standardized Episode of Care
SNF	Skilled Nursing Facility

Acronym	Meaning
SSN	Social Security Number
TESA	Testicular Sperm Aspiration
TESE	Testicular Sperm Extraction
UBH	United Behavioral Health
VA	U.S. Department of Veterans Affairs
VA CCN	VA Community Care Network
VAD	Ventricular Assist Device
VAMC	VA Medical Center
VBA	Veterans Benefits Administration
VHA	Veterans Health Administration
VHIC	Veteran Health Identification Card

Glossary

Table 4: Glossary

Term	Meaning
Approved referral	An approved referral from VA will support a specific plan of care, as it relates to a specified number of visits and/or services related to a standardized episode of care for a specified Veteran, as long as the services are provided by a provider.
Certified Diabetes Care and Education Specialist	A health professional who possesses comprehensive knowledge of and experience in diabetes prevention, prediabetes, and diabetes management.
Certified Transplant Center (CTC)	Medicare-approved hospital or medical facility that provides transplantation of an organ, or combination thereof: heart, lung, liver, kidney, pancreas; or bone marrow; or stem cell.
Claim	An invoice for health care, dental or pharmacy services.
Clean claim	A claim that contains all the required data elements necessary to be accepted by the clearinghouse and the payer’s adjudication system.
Collateral of Veteran	The Collateral of Veteran is a lawful married spouse of the eligible Veteran for reasons relating to the Veteran's clinical care (e.g., organ, or bone marrow donor, and spouses covered under ART-IVF).

Term	Meaning
Complementary and Integrative Healthcare Services (CIHS)	CIHS includes practices that promote, preserve, and restore health, such as biofeedback, hypnotherapy, massage therapy, Native American healing, relaxation techniques (such as meditation and guided imagery) acupuncture, and tai chi.
Confirmed Quality Issue (CQI)	Quality of care issue reviewed and affirmed by the Peer Review Committee.
Corrective Actions (CAP)	Requirements established by the Peer Review Committee for the provider or facility to complete to address confirmed quality issues with the goal of preventing recurrence of those confirmed quality issues.
Covered services	Health care services and supplies that are covered under the VA CCN, as described in 38 CFR 17.38 and for which the provider has received an approved referral.
Critical Access Hospital	A designation given to eligible rural hospitals by the Centers for Medicare & Medicaid Services (CMS).
Critical finding	Those findings or results that require immediate evaluation by a health care provider, such that failure to take immediate appropriate action might result in death, significant morbidity, or serious adverse consequences to the Veteran.
Durable Medical Equipment (DME)	Equipment that can withstand repeated use, is primarily and customarily used to serve a medical purpose, generally is not useful to a person in the absence of an illness or injury and is appropriate for use in the home.
EDI 278 Request	Requests for referrals for additional visits, DME, emergent services or services outside of initial referral. At this time, VA does not accept 278 transactions for VA CCN.
EDI 835 Remittance Advice (RA)	An electronic explanation of payments and other decision-making information.
Electronic Data Interchange (EDI)	The electronic exchange of information between two or more organizations.
Eligible charge	Defined in the Provider Agreement and any applicable payment appendices.
Eligible Veteran	Any Veteran who VA determines is eligible to receive community care.
Emergent care	Medical care required within twenty-four (24) hours or less essential to evaluate and stabilize conditions of an emergent need that, if not provided, may result in unacceptable morbidity/pain if there is significant delay in the evaluation or treatment.

Term	Meaning
Emergent health care need	Conditions of one's health that may result in the loss of life, limb, vision or result in unacceptable morbidity/pain when there is significant delay in evaluation or treatment.
Enrolled Veteran	Any Veteran who is enrolled in VA's patient enrollment system and is eligible to receive health care benefits.
Episodic payments	A payment method that covers all the care a patient receives in the course of treatment for a specific illness, condition or medical event.
General care	All other care and services offered under VA Health Benefit Package other than primary care and Complementary and Integrative Healthcare Services (CIHS).
Hold Status	Temporary status assigned to a provider that does not allow future referrals to be assigned while under review by Optum. The timeline for a hold status is situational.
Infertility	Infertility is a disease, condition, or status characterized by any of the following: • The inability to achieve a successful pregnancy as established by a patient's medical, sexual, and reproductive history, age, physical findings, diagnostic testing, or any combination of those factors; or • The need for medical intervention, including, but not limited to, the use of donor gametes or donor embryos in order to achieve a successful pregnancy, either as an individual or with a partner
Ketogenic Diet	A low carbohydrate diet that produces the metabolic state of nutritional ketosis (0.5 - 3.0 mM ketones (beta-hydroxy butyrate), and < 7 mM, with alerts and patient contact occurring at >3mM to review patient's status of medication management, insulin dosage, carbohydrate intake), typically achieved with less than 5% of calories from carbohydrates.
Ketogenic Health Coach	A health professional who helps patients gain the knowledge, skills, tools and confidence to become active participants in their care so that the patient can reach their self-identified health goals.
Ketogenic Monitor	A device used to measure blood serum levels to determine the amount of ketones in the body. It works the same way as a blood glucose meter.
Licensed Independent Provider	Any provider that provides care for a Veteran whether contracted directly to the contractor or is a member of a group or hospital.
Medical device	An instrument, apparatus, implement, machine, contrivance or other similar or related article, including a component part or accessory, which is intended for use in the cure, mitigation or treatment of disease or compensates for a person's loss of mobility or other bodily functional abilities and function as a direct and active component of the person's treatment and rehabilitation.
Non-service-connected care	Medical care and services provided for a Veteran for an illness or injury that was not incurred in or aggravated by military service as determined by VA.

Term	Meaning
Patient Safety Concern	An act or omission of a Provider giving rise to **harm or danger**. • **Physical/emotional harm/danger** includes, but is not limited to, acts of abuse (physical, sexual, emotional), assault (physical, sexual), theft, and/or other inappropriate or unethical behavior • **Medical harm/danger** includes, but is not limited care management deviations in following evidenced-based standards of care, which can lead to sentinel events, serious reportable events, facility acquired infections/conditions, etc.
Peer Review	The process of qualified providers with the requisite training, experience and expertise who review care provided by a provider or facility to determine if there are deviations from the standard of care.
Pharmacy benefit manager	A third-party administrator for prescription drug programs.
Primary care	Health care at a basic, rather than specialized, level.
Potential Quality Issue (PQI)	A potential quality issue is a clinical or system variance warranting further review and investigation to determine the presence of an identified quality of care issue.
Provider	Physician, practitioner or ancillary facilities participating in VA CCN.
Provider Agreement	An executed agreement, between Optum or Network Partner with the provider for VA CCN.
Referral request	A request and approval process that authorizes the Veteran to obtain specified care within a specified time frame from additional resources in the community. Upon approval, a referral number is generated. The referral number must always be included on claims submitted by VA CCN providers for payment.
Registered Dietitian Nutritionist	Food and nutrition experts who can translate the science of nutrition into practical solutions for healthy living.
Remittance advice	An explanation of payments and other decision-making information.
Rural Health Clinics	A clinic in a rural area that has primary care and outpatient services.
Service-connected care	Medical care and services provided for a Veteran for a service-connected condition is an illness or injury decided by the Veterans Benefits Administration (VBA) as having been incurred or aggravated in line of duty in the active military, naval or air service.
Severity Level (SL)	A defined scale to measure a departure from the standard of care.
Special authority	Individuals eligible for VA benefits due to designation given by VA.
Standardized Episode of Care (SEOC)	A set of clinically related health care services for a specific unique illness or medical condition (diagnosis and/or procedure) provided by an authorized provider during a defined, authorized period of time.

Term	Meaning
Urgent health care need	Non-life-threatening conditions that require care in a timely manner (such as within twenty-four (24) hours) to avoid having them worsen.
Urgent care	Provision of immediate medical service offering outpatient care for the treatment of acute and chronic illness or injury.
VA Community Care Network	A network of community-based providers and services designed to coordinate with VA in providing timely, accessible and high-quality health care to Veterans.
VA facility	A VA facility is a VA hospital or VA medical center.
VA hospital	A VA hospital is any VA-owned, staffed and operated facility providing acute inpatient and/or rehabilitation services.
VA Medical Center (VAMC)	A VA medical center is a VA point of service that provides at least two categories of care (inpatient, outpatient, residential or institutional extended care).

Appendix A – Sample VA REFERRAL PACKET

VA | U.S. Department of Veterans Affairs

VA Form 10-7080 - Approved Referral For Medical Care

Veteran Name: PATIENT ONE
Veteran ICN: 1234567890V123456
Veteran EDIPI: 123456
Veteran Date of Birth: 1900-01-01
Veteran Address: 000 Any ST
Any City, PA 19144
Veteran Phone Number: (555) 555-5555

Referral Number:VA0000000000
Priority: Routine
Referral Issue Date: 2023-02-17
Expiration Date: 2023-08-16
First Appointment Date: 2023-06-19

Referring VA Facility: Philadelphia VA Medical Center
VA Telephone Number: 215-555-1111 *ext* 6310
VA Fax Number: 555-555-5555

Initial Community Care Provider/Facility: HOSPITAL OF UNIVERSITY OF PA
Initial Provider Location: HOSPITAL OF UNIVERSITY OF PA-000 ANY ST, ANY CITY, PA, 18104-282N00 000X
Provider Name (if known): Trustees of the University Pennsylvania
Community Provider NPI: 0000000000

Any claim related to this episode of care **MUST INCLUDE THE APPROVED REFERRAL NUMBER** on the EDI transaction as the Referral Number or Prior Authorization number.

Please see below for Additional VA Referring Facility Information and Billing Information

Pertinent Clinical Information

Chief Complaint: brown scaly patch of skin

Patient History / Clinical Findings / Diagnosis (Comorbidities): atopic dermatitis

Provisional Diagnosis: C44 Basal cell carcinoma of the skin, unspecified

Services Authorized

Service Requested: Dermatology Comprehensive SEOC 1.0.10

Category of Care: DERMATOLOGY

Procedural Overview – Standardized Episode of Care (SEOC)

No.	Service/Procedure	No. Visits Authorized
1.	Initial outpatient evaluation (including full body exam), treatment and follow-up visits for the referred condition on the consult order	3
2.	Diagnostic imaging relevant to the referred condition on the consult order	1
3.	Labs and pathology relevant to the referred condition on the consult order	1
4.	Procedures relevant to the referred condition on the consult order including but not limited to: cryotherapy, biopsy (including excisional, shave, punch biopsies, etc.), excision, excimer laser, photodynamic therapy, UVB therapy, debridement, medically necessary hair removal.	1

Note: Please note this SEOC does not cover cosmetic procedures that are not considered medically necessary or correct a functional disability as they are excluded from the Medical Benefits Package.

Note: This SEOC does not cover MOHS. A separate referral specifically for MOHS with the MOHS SEOC is required

Note: Superficial Radiation Therapy (SRT) is not covered in this episode of care. SRT is only to be performed and approved by a radiation oncologist and not a dermatologist. SRT must be requested through an RFS and approved with the radiation therapy episode of care.

Note: Additional consultations needed relevant to the patient complaint/condition require VA review and approval including a referral to another specialty for secondary/complex closure

Note: This SEOC does not cover the removal of skin tags, seborrheic keratosis and other benign skin lesions unless they are bleeding, painful, or changing.

SEOC Disclaimer

• Requests for additional physical therapy services must include a detailed plan linked to time limited attainment of objective functional outcomes with documented justification relating to outcome questionnaires listed above. • Additional consultation needed relevant to the patient complaint/condition require VA review and approval. • DME, prosthetics and orthotics will be reviewed by the VA for provision. • All routine medications must be immediately faxed/providedto VA pharmacy to be dispensed timely by VA pharmacy. Non-formulary drug approval process may be required. • Urgent/emergent prescriptions can be provided for a 14-day supply only. • The Veteran will be required to pay out of pocket for any urgent/emergent medications and can submit a reimbursement request to their local VA facility.

REFER ALL QUESTIONS RELATED TO THIS APPROVAL TO THE ISSUING VA OFFICE

Referring VA Facility: Philadelphia VA Medical Center
Station Number: 642
Ordering Officer: OFFICER ONE
Telephone Number: 555-555-5555 *ext* 6610
Address: 000 Any ST Any City PA 16104
Referring Provider: PROVIDER ONE
Referring Provider NPI: 0000000000
Unique Consult No: 642_0000000
Program Authority: Authorized/Pre-authorized VA Referral (not otherwise specified)- 1703
Affiliation: CCN1
Network: CC Network 1

Submitting Claims

ANY CLAIMS RELATED TO THIS EPISODE OF CARE MUST BE SUBMITTED TO OPTUM, UNITEDHEALTHCARE AND

Billing and Other Referral Information

Methods to submit claims:

Electronic data interchange (EDI):

Payer Status: VA - Primary Payer

More information on how to submit claims can be found by visiting
va.gov/COMMUNITYCARE/revenue-ops/Veteran-Care-Claims.asp

Any claim related to this episode of care **MUST INCLUDE THE APPROVED REFERRAL NUMBER** on the EDI transaction as the Referral Number or Prior Authorization number.

Precertification

The Standardized Episode of Care (SEOC) referral you have accepted does not include services that require Third Party

Payer (TPP) precertification. It is imperative that you notify VA if you have scheduled any of these specific services for a Veteran that has Other Health Insurance (OHI), so that VA can notify the TPP. VHA is required by law to bill the TPP. VHA is required by law to bill the TPP for care that is not for a Service Connection or Special Authority eligibility.

Notification details and specific care requiring TPP precertification for this SEOC can be found at va.gov/COMMUNITYCARE/providers/PRCT-reqirements.asp

Pharmacy

CVS Caremark is the retail pharmacy network for Veterans' immediately needed or Urgent/Emergent prescriptions.

Immediate-need prescriptions:

Must follow the VA Urgent/Emergent Formulary which can be found at pbm.va.gov/nationalformulary.asp

Prescription can only go up to a 14-day supply. No refills for the immediate need medication may be authorized.

Only a seven-day supply for opioids, or up to the opioid-prescribing limit allowed by the state – whichever is less – may be authorized.

Immediate-need prescriptions extending past 14 days:

The provider will need to send second prescription (beyond 14 days0 to the referring VA medical facility's pharmacy for prescription fulfillment services.

Routine/maintenance prescriptions:

Must be sent to the referring VA medical facility's pharmacy

If you do not have the ability to electronically submit prescriptions to pharmacies, please contact the Community Care representative at the referring VA medical facility for their pharmacy fax number. Please refer to va.gov/COMMUNITYCARE/providers/Service-Requirements.asp for additional instructions related to p

Veterans Health Administration

VHA Medical Documentation

Document Created: 06/10/2020 11:18

The documents accompanying this transmission contain confidential health information that is legally privileged. This information is intended only for the use of the individual or entity providing care to this Veteran. The authorized recipient of this information is prohibited from disclosing this information to any other party unless required to do so by law or regulation and is required to destroy the information after its stated need has been fulfilled and in accordance with agency destruction and retention requirements. If you are not the intended recipient, you are hereby notified that any disclosure, copying or distribution is strictly prohibited as this information is protected by Federal Privacy law (e.g., HIPAA Privacy Rule). If you have received this information in error, please notify the sender immediately and arrange for the return or destruction of these documents.

PHILADELPHIA VAMC, 3900 Woodland Avenue, Philadelphia, Pennsylvania 19104-4551

VA Referrals phone: 999.999.9999 EXT 6060 **Fax: 999.999.9999**

Point of Contact (POC): Provider One

Phone: Fax:

Patient Name: PATIENT ONE
0000 Any Street
Any City, FLORIDA 00000

DOB: 01/01/1900
Phone (residential): (123)123-4567
Phone (mobile): (123)123-4567

Referral Type: Community Care Network

Next of Kin Contact Information

TWO, PATIENT

Address (Next Of Kin)
0001 Any Street
Any Town, NEW JERSEY 00000

Phone: (111) 111-1111

CONSULTS

Current PC Provider: TWO, PROVIDER
Current PC Team: PHL PACT GOLD 07
Current Pat. Status: Outpatient
UCID: 123 XXXXXX
Primary Eligibility: SC LESS THAN 50% (VERIFIED)
Patient Type: SC VETERAN
OEF/OIF: NO
Service Connection/Rated Disabilities
SC Percent: 10%
Rated Disabilities: TINNITUS (10%)
TRAUMATIC BRAIN DISEASE (0%)
FACIAL SCARS (0%)
IMPAIRED HEARING (0%)
Order Information
To Service: VASCULAR SURGERY OUTPT

From Service: PHL PACT GOLD TEAM NP 7
Requesting Provider: TWO, PROVIDER

Service is to be rendered on an OUTPATIENT basis
Place: Consultant's choice
Urgency: Routine
Clinically Ind. Date: Mar 02, 2020
Orderable Item: VASCULAR SURGERY OUTPT
Consult: Consult Request
Provisional Diagnosis: Occlusion and Stenosis of unspecified Carotid artery (ICD-10-CM I65.29)
Reason For Request:
Routine Consult
Consult ordered as: Face-to-Face Clinic Visit
(Consult Will Be Denied Unless Medically Optimized)

Ordering Provider and Contact Number: 4911

Does the patient require van transportation? No

Carotid Disease
If the patient is having active carotid TIA/stroke symptoms, then send the patient to the nearest Emergency Department rather than placing a Vascular Surgery consult.
For patients to be seen in vascular surgery clinic for carotid disease, they must have a carotid duplex study less than or equal to 60 days old.

Carotid Disease: Recent Negative Symptoms (No carotid symptoms):
If duplex scan >50% ICA stenosis -> consult Vascular Surgery.
Need duplex results:

Inter-facility Information
This is not an inter-facility consult request.

Status: ACTIVE
Last Action: STATUS CHANGE

Facility Activity	Date/Time/Zone	Responsible Person	Entered By
CPRS RELEASED ORDER	03/02/20 16:14	TWO, PROVIDER	TWO, PROVIDER
ADDED COMMENT	03/02/20 22:55	THREE, PROVIDER	THREE, PROVIDER

SR – Schedule/reschedule routine appointment.
ME – May discontinue if Veteran fails to respond to the mandated scheduling effort

RECEIVED	03/03/20 13:22	FOUR, PROVIDER	FOUR, PROVIDER
SCHEDULED	03/09/20 15:14	FOUR, PROVIDER	ONE, SURGEON

PHL VASCULAR SURGERY I/V MD Consult Appt. on 04/14/20 @ 09:30 #COO# PID 03/02/2020 SPOKE TO PATIENT APPT SCHEDULED.

STATUS CHANGE	04/14/20 11:30	FOUR, PROVIDER	TWO, SURGEON

PHL VASCULAR SURGERY I/V MD Appt. on 4/14/20 @9:30 was cancelled by the Clinic.
Remarks: COVID19

Note: TIME ZONE is local if not indicated

No local TIU results or Medicine results available for this consult

PROBLEM LIST

Sensitive Diagnoses

No sensitive diagnoses were provided.

Other Diagnoses

Problem	Code
<< DEFIBRILLATOR>>	R69.
CAD – Coronary artery disease	R69.
Carcinoma in situ of colon	D01.0
Hypertensive heart disease with heart failure	I11.0

APPOINTMENTS

Appointment Date and Time	Location
09/10/2020 10:00:00	PHL PACT TELE GOLD TEAM NP 7
06/19/2020 10:00:00	COM CARE-VASCULAR LAB

MEDICATIONS

100 most recent outpatient medications released by VA to Veteran in the last six months

Medication Name and Dose	Quantity	Refill Number	Issue and Fill Date	Status
CETIRIZINE HCL 10MG TAB	Qty:30	Fill: 3 of 11	Orig: 2020-01-29	ACTIVE
TAKE ONE TABLET BY MOUTH DAILY FOR ALLERGY SYMPTOMS			Last: 2020-05-06	
FLUTICASONE PROP 50MCG 120D NASAL INHL	Qty:1	Fill: 1 of 11	Orig: 2020-01-29	ACTIVE

NON-VA MEDICATIONS

Local Drug Name and Dose	Medication Route	Schedule
CARVEDILOL 25 MG TAB	MOUTH	TWICE A DAY
LOSARTAN 100MG TAB	MOUTH	ONCE DAILY

ALLERGIES

No documented allergies

ORDERS

VASCULAR SURGERY OUTPT Con Consultant's Choice
Activity:
03/02/2020 16:13 New Order entered by FOUR, PROVIDER (NURSE
UCID: 642_3953421 Order Text:
VASCULAR SURGERY OUTPT Cons
Consultant's Choice Nature of Order:
ELECTRONICALLY ENTERED
Signature: SERVICE CORRECTION TO SIGNED ORDER

Current Data:
Treating Specialty:
Ordering Location: PHL PACT GOLD TEAM NP 7
Start Date/Time: 03/02/2020 16:14
Stop Date/Time:
Current Status: ACTIVE
Orders that are active or have been accepted by the service for processing (e.g., dietetic orders are active upon being ordered, pharmacy orders are active when the order is verified, lab orders are active when the sample has been collected, radiology orders are active upon registration).
Order #56369066

Order:
Consult to Service/Specialty: VASCULAR SURGERY OUTPT
Reason for request:

Routine Consult
Consult ordered as: Face-to-Face Clinic Visit
(Consult Will Be Denied Unless Medically Optimized)
Ordering Provider Name and Contact Number: 4911
Does the patient require van transportation? No
Carotid Disease
If the patient is having active carotid TIA/stroke symptoms, then send the patient to the nearest Emergency Department rather than placing a Vascular Surgery consult. For patients to be seen in vascular surgery clinic for carotid disease, they must have a carotid duplex study less than or equal to 60 days old. Carotid Disease: Recent Negative Symptoms (no carotid symptoms): if duplex scan >50% ICA stenosis > consult Vascular Surgery. Need duplex results:

Category: OUTPATIENT
Urgency: ROUTINE
Clinically Indicated Date: Mar 02, 2020
Place of Consultation: Consultant's Choice
Provisional Diagnosis: Occlusion and Stenosis of Unspecified Carotid Artery (ICD-10-CM I65.29)
Consult No: 3953421

PROGRESS NOTES

LOCAL TITLE: VASCULAR SURGERY TELEPHONE NOTE
STANDARD TITLE: VASCULAR SURGERY TELEPHONE ENCOUNTER NOTE

NOTE DATE OF NOTE: APR 13, 2020@10:50
ENTRY DATE: APR 13, 2020@10:50:42
AUTHOR: FIVE, PROVIDER EXP COSIGNER:
URGENCY: STATUS: COMPLETED

87yo male h/o CAD, HTN and chronic recurrent bilateral otalgia who is being evaluated for bilateral moderate degree cardiac stenosis. He has had a history of cerebellar stroke in the past, which was found incidentally on a CT. He has no known history of acute cerebrovascular event in recent months, nor TIA or amaurosis. He is otherwise functioning well and has not smoked since 1970s.

VASCULAR HISTORY
None
Past Medical History
1. Ischemic congestive cardiomyopathy due to 05/10/16
SIX, PROVIDER
coronary artery disease
EF < 10% on 11/2015, has AICD
2. CAD – Coronary artery disease 05/10/16
SIX, PROVIDER
s/p drug eluting stent to RCA and Mid LAD, 10/2014

On examination could be performed due to telephone encounter

VASCULAR IMAGING
1/2020
Right side: Common Carotid artery – No disease. Carotid Bulb – Mild to moderate plaque. Internal Carotid artery – Moderate to severe, partly calcified plaque resulting in a 50 to 69% Internal Carotid artery stenosis based on the velocity flow measurements. External Carotid artery – Moderate plaque

Plan discussed at length the etiology pathophysiology and prognosis of this disease. Educated him about treatment modalities, which included conservative therapy consisting of antiplatelet and hypercholesterolemic medications. He has maintained smoking cessation since 1970s and continues to be in relatively good state of health. We will see him for a face-to-face visit in six months with repeat carotid duplex exams.

/es/ PHYSICIAN ONE, MD

TELEPHONE NOTE – CLINIC DISRUPTION DUE TO CORONAVIRUS/COVID-19
Call placed to patient/family.
Able to reach patient/family.
Confirmed that patient is scheduled for clinic appointment on April 14, 2020
Indication: carotid stenosis
Any acute concerns at this time voiced by patient/family:
none

Informed patient/family that because of coronavirus concerns, the VA has offered a number of scheduling options to reduce risk to our patients, including:
- Keeping appointment as scheduled in clinic
- Cancelling currently scheduled appointment and rescheduling for a future date
- Performing telephone interview on the date/time of their scheduled appointment, with the understanding this would not include physical examination – performing a video interview on the date/time of their scheduled appointment, via VA Video Connect, with the understanding this would not include physical examination (this is only an option for providers with VVC access)

Informed patient/family that due to coronavirus concerns, all persons entering the VA are being screened for infectious symptoms. Please accommodate accordingly with the understanding there may be delays in entering the building because of this.

If coming to clinic, answer the following:

1. Any fever, cough, or flu-like symptoms? No
2. Any travel to COVID-affected areas in the last 14 days? No
3. Have you been in close contact with someone (including health care workers) who has been CONFIRMED to have coronavirus? No

LABS

Lab	Result	Abnormal	Specimen Date	Reference Range	Units
CO2	26		2019-01-13	22 - 31	mEq/L
CREATININE	0.8		2019-01-13	0.6 - 1.5	mg/dl
GLUCOSE	86		2019-01-13	70 - 115	mg/dl
POTASSIUM	3.9		2019-01-13	3.30 - 5.10	mEq/L
SODIUM	135		2019-01-13	135 - 147	mEq/L

Addendum A

Opioid Safety Initiative (OSI)

Department of Veterans Affairs Office of Integrated Veteran Care (IVC)

Objective

The intent of the VA Office of Integrated Veteran Care is to educate and ensure a greater awareness and adherence to safe opioid prescribing practices consistent with evidence-based guidelines as part of the Opioid Safety Initiative (OSI) requirements set forth by the Mission Act of 2018 (section 131) to include non-VA purchased care providers. Our objective is to build a collaborative effort between VA and non-VA purchased care providers promoting improved patient outcomes and decreased incidence of serious and potentially catastrophic adverse effects related to opioid prescribing.

The Opioid Safety Initiative (OSI)

The Opioid Safety Initiative (OSI) was deployed in 2013 with the aim of ensuring the use of opioids in a safe, effective, and judicious manner. VA employed four strategies to address the crisis: education, pain management, risk mitigation, and addiction treatment. The OSI uses population health tools in the form of metrics available in pharmacy/medical claims data and electronic health records to identify patients who may be high-risk for adverse outcomes related to use of opioids and providers whose prescribing practices may not reflect the best evidence. Early outcome data showed a substantial reduction in high-dose opioid prescribing and concurrent benzodiazepine-opioid prescribing from pre-OSI data compared to post-OSI implementation.

Clinical Practice Guidelines

The 2022 VA/DoD Clinical Practice Guideline (CPG) for the Use of Opioids in the Management of Chronic Pain reflect the broader cultural transformation in the way pain is viewed and treated. The opioid crisis necessitates a cautious approach to opioid prescribing while embracing multimodal care and whole health principles for long-term success and management of chronic pain. These guidelines align well with the 2022 CDC CPG for Prescribing Opioids for Pain and the best interest of providers engaging in Veteran care.

Summary of Evidence-based Recommendations (Please see full CPG at link below for the full 20 recommendations):

- Recommend against initiation of opioid therapy for the management of chronic noncancer pain.
- Recommend against long-term opioid therapy, particularly for younger age groups, as age is inversely associated with the risk of opioid use disorder and overdose.
- Recommend against concurrent use of benzodiazepines and opioids for chronic pain.
- If prescribing opioids, we recommend using the lowest dose and shortest duration of opioids as indicated by patient-specific risks and benefits.
- If considering an increase in opioid dosage, we recommend reevaluation of patient-specific risks and benefits and monitoring for adverse events.

Note: Nonpharmacologic and non-opioid pharmacologic treatment options are preferred for chronic pain. Education should be provided, and available therapies should be implemented and optimized including:

- Self-management to promote foundational health and wellness.
- Non-opioid pharmacologic management.
- Non-pharmacologic pain treatments.
  - Behavioral therapies (e.g., cognitive behavioral therapy).
  - Physical/movement-based therapies (e.g., physical therapy).
  - Manipulative therapies (e.g., chiropractic care).
  - Complementary and integrative health treatments (e.g., acupuncture).

- Interventional pain care (e.g., joint injection, radiofrequency ablation).
- Realistic expectations and limitations of medical treatment.

If the provider determines in their clinical judgement that opioid therapy may be appropriate, we recommend the following consideration checklist prior to opioid prescribing:

- Risks do not outweigh potential benefits.
- Patient has a condition that is:
  - Causing severe chronic pain.
  - Interfering with function and quality of life.
  - Failing to adequately respond to indicated non-pharmacologic and non-opioid pharmacologic therapy.
- Clear and measurable functional goals are established.
- Patient is willing and able to access adequate follow-up for prescribed opioids.
- PDMP and Urine drug testing (UDT) are concordant with expectations (no aberrant behavior).
- Patient is fully informed and consents to treatment with opioids.

Documentation of rationale and risk assessment should be included in the medical record.

Please consider reviewing the clinical practice guideline provider summary and abbreviated pocket card available in links below.

https://www.healthquality.va.gov/guidelines/Pain/cot/VADoDOpioidsCPG.pdf

Quality of Care Reviews

Quality of care reviews are performed quarterly with the intent to maintain the same standard of care requirements around opioid safety for both VA and non-VA purchased care providers which may be stricter than state/local regulations. Section 131 of the Mission Act requires evaluating compliance of contracted providers with safe opioid prescribing practices. The legislation outlines that, “if VA determines that a community provider is not complying with the Opioid Safety Initiative, VA is authorized to refuse authorization of care by such provider and direct their removal from the community care network.” VA values its non-VA purchased care partners and is committed to making this process completely transparent. The OSI dashboard is used to perform data-based risk reports evaluating the following metrics around opioid prescribing:

- Opioid and benzodiazepine combinations
- Morphine equivalent daily dose (MEDD) ≥ 90
- New long-term opioid therapy (LTOT)

From these metrics, a list of providers is generated for review by VA facility staff with the aim to review the highest risk providers and risk to Veteran patients. If additional clinical review is determined to be appropriate, then clinical staff with pain expertise will review medical records to determine appropriateness of care, which could include, but not be limited to, filing a potential quality issue (PQI) with the Third-Party Administrator. Among others, these four critical elements are standard opioid risk mitigation strategies used to define the minimum standard of quality for opioid prescribing:

1. Signed consent for long-term opioid therapy (per guidance in VHA Directive 1005Informed Consent for Long-Term Opioid Therapy for Pain)
https://www.va.gov/PAINMANAGEMENT/Opioid_Safety/OSI_docs/10791Safe_and_Responsible_Use_508.pdf#

2. Urine drug testing (per guidance in VA/DoD Clinical Practice Guidelines-Management of Opioid Therapy for Chronic Pain).

3. Prescription drug monitoring program (PDMP) report or evidence/documentation of PDMP query (at initiation and per guidance in VHA Directive 1306-Querying State Prescription Drug Monitoring Programs, unless the provider’s state licensing requirements are more stringent).

4. Prescription for naloxone or evidence of offering a prescription for naloxone (or as determined by state law).

Clinical reviewers are directed to review available documentation for indication and rationale for initiating and continuing opioid prescribing in available clinical documentation.

Requirements for the Non-VA Community Provider:

- With respect to contractual requirements:
  - Submit all prescribed non-urgent/non-emergent medications to VA for dispensing as part of the health care treatment authorized by VA (VHA National Formulary Handbook).
  - Send medical records to VA within thirty (30) days of initial pain consultation or episode of care.
- Review and sign the receipt of the Opioid Safety Initiative (OSI) and evidence-based guidelines included within this module.

Resource Section:

Opioid Safety Overview
https://jamanetwork.com/journals/jamainternalmedicine/article-abstract/2608540

Pain & OSI Educational Materials
IB 10-999 Pain – Provider- Pain Quick Reference Guide (va.gov)

VA/DoD CPG The Use of Opioids in the Management of Chronic Pain Provider Summary
https://www.healthquality.va.gov/guidelines/Pain/cot/VADoDOpioidsCPGProviderSummary.pdf

Opioid Therapy Pocket Card
https://www.healthquality.va.gov/guidelines/Pain/cot/VADoDOpioidsCPGPocketCard.pdf

Safe and Responsible Use of Opioids for Chronic Pain – A Patient Information Guide
https://www.va.gov/PAINMANAGEMENT/Opioid_Safety/OSI_docs/10-791Safe_and_Responsible_Use_508.pdf#

VA Opioid Overdose Education & Naloxone Distribution (OEND)
https://www.pbm.va.gov/PBM/AcademicDetailingService/Documents/508/IB101539OEND_OverdosePreventionwithNaloxone_508Ready.pdf

Optum