



Veteran Directed Care Billing and Medical Claims Guide

September 2026



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I. Introduction

The Veteran Directed Care (VDC) Billing and Medical Claims Guide, hereinafter referred to as the “Guide,” outlines billing and medical claims procedures to assist with and ensure timely and accurate reimbursement for VDC medical claims. The Guide supplements [guidance from the U.S. Department of Veterans Affairs \(VA\)](#) that standardizes VA billing requirements, payment processes, and the use of the VDC Budget Calculator, as well as associated case mix rates, assessment rates, emergency back-up care and planned purchases, and the submission of VDC medical claims to VA. The Guide provides detailed information on billing and medical claims procedures for both VA Medical Centers (VAMCs) and VDC providers developing or operating VDC programs.^{1,2}

The Guide includes:

- VA resources to assist with managing VA referrals and tracking VDC medical claims including:
 - The HealthShare Referral Manager (HSRM), a VA online portal for community providers to manage VA referrals; and
 - The Electronic Claims Adjudication Management System (eCAMS) Provider Portal (ePP), an online VA portal for tracking the status of VDC medical claims;
- Budgeted amounts for VDC authorizations;
- Additional items to include in a Veteran’s spending plan;
- Clarification on emergency back-up care and planned purchases;
- Monthly Service Report submission guidelines; and
- Strategies for submitting VDC medical claims electronically using Electronic Data Interchange (EDI) 837 and switching from paper VDC medical claims using UB-04 (also known as the CMS 1450) Claim Form to electronic VDC medical claims.

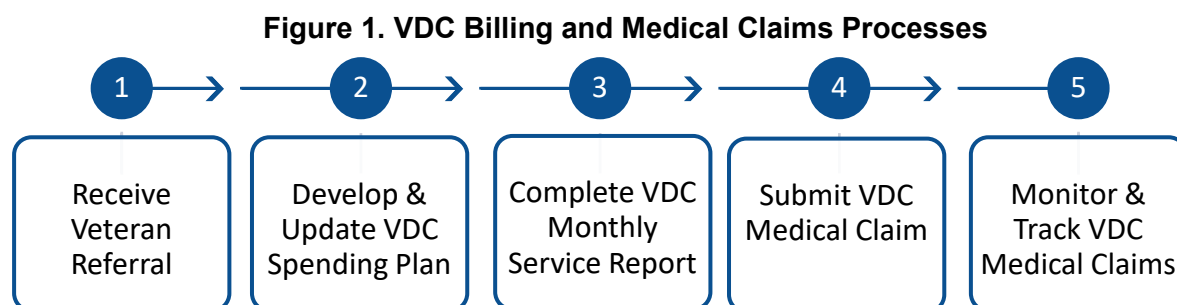
For additional information on definitions of terms and acronyms used throughout the Guide, see [Appendix A](#).

¹ VDC providers include aging and disability resource centers (ADRCs), area agencies on aging (AAAs), centers for independent living (CILs), or state units on aging (SUAs) that have a signed Veteran Care Agreement (VCA) with a VAMC.

² The Senator Elizabeth Dole 21st Century Veterans Healthcare and Benefits Improvement Act expands on the MISSION Act to enable Indian tribes or tribal organizations receiving assistance under Title VI of the Older Americans Act of 1965 and any other entity deemed appropriate by the Secretary to serve as VDC providers.

II. Overview

There are five steps in the VDC billing and medical claims process (**Figure 1**):



Step 1: VDC providers *receive a Veteran referral* from a VAMC. The Veteran offline referral form (VA Form 10-7080) includes a VA authorization number (required on all VDC medical claims) and the Veteran’s demographic and health information and, in some circumstances, the Veteran’s caregiver.

Step 2: DC providers complete a person-centered counseling assessment and facilitate a process that supports the Veteran to *develop a spending plan* that must be approved by the VAMC and updated annually at a minimum, or as needed during the Veteran’s enrollment in VDC.

Step 3: After the VAMC approves the spending plan, VDC providers *complete a Monthly Service Report* that lists goods and services purchased during the month, the monthly administrative fee, and the days in the month when care was provided.

Step 4: VDC providers *submit the VDC invoice electronically to the VA for payment* and *Monthly Service Report* to the VAMC for reference. VA strongly encourages the electronic submission of medical claims to improve the accuracy and timeliness of payment.

Step 5: VDC providers *monitor and track VDC medical claims* to verify timely payment and follow-up promptly with any outstanding medical claims greater than 45 days.

III. VDC Provider Enrollment Process

Prior to receiving VDC Veteran referrals, VDC providers must complete the following steps to enroll as a provider in the VA system.

1. Obtain a National Provider Identifier (NPI)
 - a. VDC providers need an NPI number to bill VAMCs for VDC services. VDC providers can obtain an NPI by [Applying for an NPI](#) through the National Plan and Provider Enumeration System.
2. Sign a Veterans Care Agreement (VCA)
 - a. VAMCs and VDC providers are required to sign a VCA ([VA form 10-10171](#)) to send and receive Veteran referrals. VDC providers partnering with more than one

VAMC are only required to sign one VCA. The signed VCA is valid for three years. Additional information about VCAs is included in the [VDC Operations Manual Template](#).

3. Complete vendorization process
 - a. Prior to submitting a VDC invoice, VDC providers must be vendorized by VA's Financial Services Center (FSC). VDC providers must first register for the [System for Award Management](#) (SAM.GOV). To complete the vendor process, VDC providers need to complete [form VA 10-091](#) and ensure all information provided matches information provided on SAM.GOV. The second page of the form includes instructions and a fax number to submit the completed form.
4. Share NPI and VCA numbers with the U.S. Administration for Community Living (ACL)
 - a. Upon receipt of an NPI and VCA number, email veterandirected@acl.hhs.gov to provide ACL with the information. ACL collects VDC providers' NPI and VCA numbers to share with VA to ensure VDC providers are registered correctly in VA's billing system.

IV. VAMC Referrals and VDC Authorizations

VAMCs refer Veterans to VDC providers for enrollment into the VDC program. At the time of referral, the VAMC sends a VA authorization and accompanying information about the Veteran and caregiver to the VDC provider. This section provides information on the VDC Veteran referral process which includes authorizations for VDC, HSRM, and the VA Personal Care Services (PCS) Case Mix Tool (CMT) and Case Mix Budget Calculator.

VAMC Authorizations

At the time of referral, the VAMC sends the VDC provider a Veteran authorization, Offline Referral Form (VA Form 10-7080), that includes the authorization number, the authorization period, amount of the full and partial assessment fees, the Veteran's authorized budget for the authorization period, and the average monthly budget. Additional information on full and partial assessment fees is available in the [VDC Assessment Fee section](#).

Veteran authorizations cover specific time periods, which are noted in the authorization and vary by VAMC. Most VAMCs send Veteran authorizations for twelve months, although the actual period may vary based on local practices. Additionally, VAMCs send other information pertaining to the Veteran and caregiver, including contact information, demographics, diagnostic code (using the International Classification of Diseases, 10th Revision (ICD -10) classification), and other pertinent health information.

If the Veteran's case mix score is not determined at the time of referral, the VAMC will send a Veteran authorization with only the full and partial assessment fee (see the [Case Mix Rates Components](#) section for more information on case mix levels). In this situation, the VAMC will provide the Veteran's authorized budget for the authorization period, the

[REFDOC](#)

The Referral Documentation Tool (REFDOC) is a web-based tool used by many VAMCs that allows VA staff to extract a Veteran's health information from VA databases and compile it into a PDF package that can be easily and securely exchanged with community providers. If you are not receiving REFDOCs from the VAMC, you may discuss with them if REFDOC is available for their VDC program.

Veteran's average monthly budget, and the monthly administrative fee to the VDC provider once the case mix score is determined.

The VAMC and VDC provider track the expiration date of the authorization and ensure the re-authorization is sent and received for a Veteran who stays enrolled in VDC beyond the initial authorization period. At least 30 days before the end of the authorization, the VDC provider verifies with the VAMC that a new authorization is anticipated. **VA is not required to pay for any care provided without authorization covering the date of service.**

Authorization Annotation

As of June 2019, VA requires an authorization number on all 837 EDI and paper claim submissions using the UB-04 Form for preauthorized services. For electronic claim submissions using the EDI 837, the Referral Number is Loop = 2300, Segment = REF*9F, Position = REF02 or Prior Authorization, Loop = 2300, Segment = REF*G1, Position = REF02. If submitting a paper claim, VDC providers **must** list the authorization number on Field #63 of the UB-04 claim form, titled "Treatment Authorization Codes."

HSRM

[HSRM](#) is a secure online portal for managing referrals and authorizations and is available to all VA community providers at no cost (HSRM users access HSRM through the Community Care Referral and Authorization website). HSRM facilitates the exchange of health care information and provides a platform for VAMCs to send referrals to VDC providers and issue authorizations.

[HSRM](#)

HSRM allows for up-to-date status tracking for every referral and reduces time spent using slower means of communication such as fax, phone, or email before serving a Veteran. HSRM also reduces turnaround time for authorizations and reimbursement.

Through HSRM, VAMCs can share important information about the Veteran, including their authorization and authorization number, case mix level, authorized budget amount, and standardized episode of care (SEOC).³ VDC providers can reference the most current version of

³ A SEOC is a VA health policy made up of a pre-approved bundle of services and procedures that relate to a specific category of care or sub-specialty. It is comprised of a clinical and coding profile to drive consistency in the community care approval, care delivery, and reimbursement processes. A VDC SEOC must be attached to each VDC consult to complete the authorization process. For more information on SEOCs, please see VA's [care coordination webpage](#).

the [HSRM Community Provider User Guide](#), available on the [Office of Community Care \(OCC\) Website](#), for additional information. VDC providers should coordinate with their partnering VAMC to establish procedures regarding the use of HSRM for Veteran referrals.

HSRM Referral Page

HealthShare Referral Manager QA R23_US0X_ADHOC3_B103													Training Community Provider
Referral List													
> Referrals													
Referring Facility	Last Name	First Name	Date of Birth	SSN	Service	Priority	Optional Task(s)	Date Added	Referral Number	Category of Care	Status	Community Provider / Facility	Appt Date
Canandaigua VA Medical Center	ONE	Veteran	01/01/1900	000000000	Hematology SEOC 1.0.2 PRCT	Routine		02/07/2019	VA0000000718	HEMATOLOGY	First Appointment Made	ACUTE & WELLNESS CHIROPRACTIC CLINIC	03/13/2019
Canandaigua VA Medical Center	ONE	Veteran	01/01/1900	000000000	Newborn Care SEOC 1.0.2 PRCT	Routine		02/07/2019	VA0000000712	NEWBORN CARE	Sent	ACUTE & WELLNESS CHIROPRACTIC CLINIC	...
Canandaigua VA Medical Center	ONE	Veteran	01/01/1900	000000000	Lab and Pathology SEOC 1.0.2 PRCT	Routine		02/07/2019	VA0000000719	LAB AND PATHOLOGY	Sent	ACUTE & WELLNESS CHIROPRACTIC CLINIC	...
Canandaigua VA Medical Center	ONE	Veteran	01/01/1900	000000000	Emergency/Urgent Care SEOC 1.0.2 PRCT	Routine		03/07/2019	VA0000000804	ER VISIT/URGENT CARE	Sent	ACUTE & WELLNESS CHIROPRACTIC CLINIC	...
Canandaigua VA Medical Center	ONE	Veteran	01/01/1900	000000000	Allergy and Immunology SEOC 1.0.3 PRCT	Routine		05/31/2019	VA0000000171	ALLERGY AND IMMUNOLOGY	Sent	ACUTE & WELLNESS CHIROPRACTIC CLINIC	...
Canandaigua VA Medical Center	THREE	Veteran	01/01/1900	666010003	Cardiology - Cath/PCI SEOC 1.0.4	Routine		05/31/2019	VA0000000173	CARDIOLOGY TESTS, PROCEDURES, STUDIES	Sent	ACUTE & WELLNESS CHIROPRACTIC CLINIC	...

HSRM is available at all VAMCs, and community providers can register for the HSRM Community Provider training or Community Provider Registration Information Session through the [Veterans Health Administration \(VHA\) TRAIN website](#). For more information about HSRM, visit the [OCC Website](#).

PCS CMT

VAMCs use the PCS CMT to determine the amount of personal care services that will best support Veterans who wish to remain at home, maximize their independence, and avoid costly nursing home placements. Completion of this tool leads to a case mix score, which, when input along with other information into the Case Mix Budget Calculator, yields a case mix rate that provides information about the Veteran's VDC budget and VDC provider fees. The [Case Mix Rates Components](#) section includes more information on case mix rates.

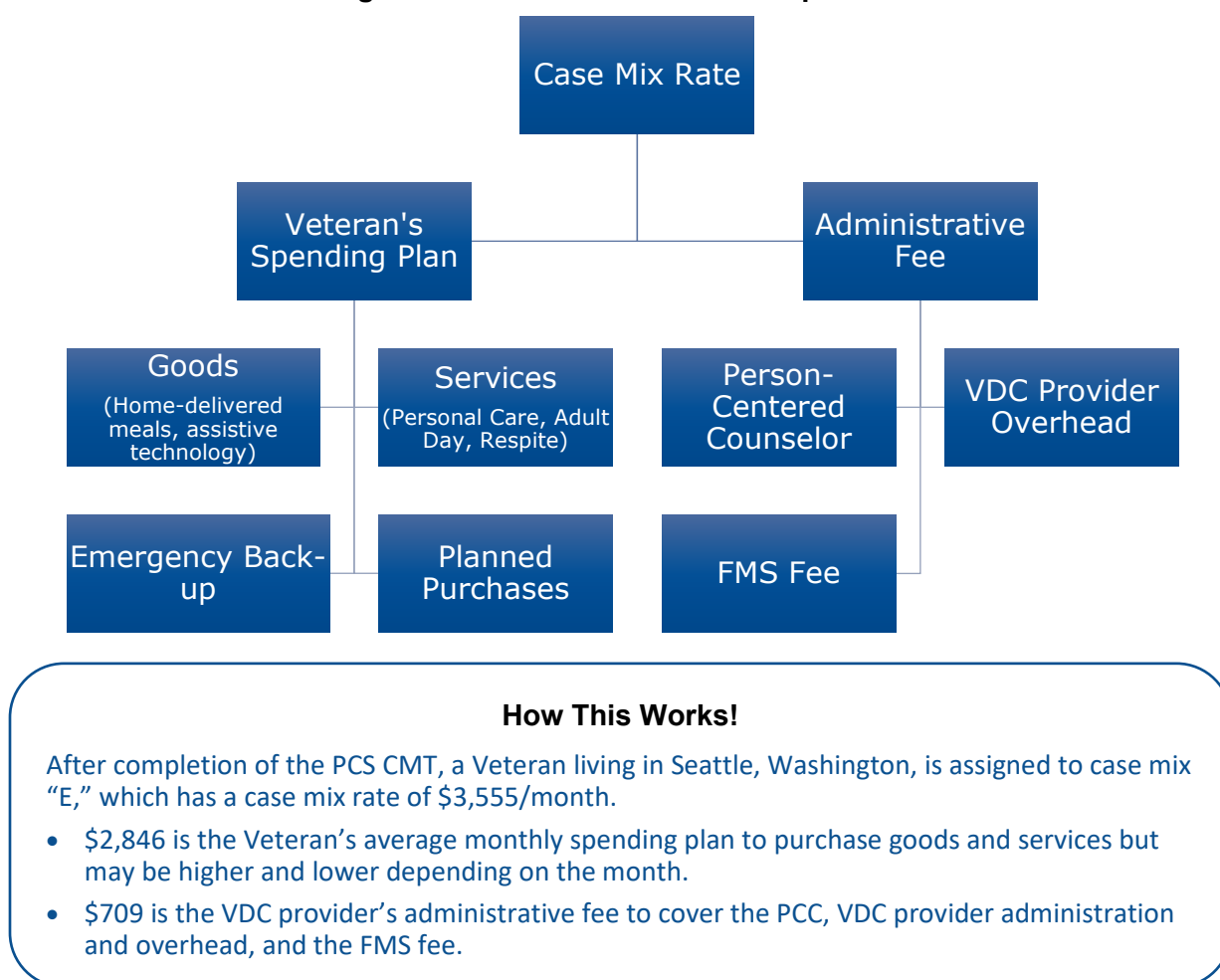
The CMT includes four components used to determine a Veteran's case mix score: Activities of Daily Living (ADLs), Special Nursing Needs, Behavioral Characteristics, and Neuromuscular Diagnosis. The VDC provider's person-centered counselor (PCC) facilitates an in-depth assessment of actual service needs and preferences with the Veteran after the case mix score is determined. Completed independently of the CMT, this assessment is also known as a person-centered counseling assessment. More information about the person-centered counseling assessment is in [Section V](#).

VAMCs are responsible for completing the CMT before enrolling a Veteran in the VDC program. Throughout the course of the referral period, VDC providers should collaborate with the Veteran's referring VAMC to determine if any changes in the Veteran's clinical or functional status have occurred that may impact the Veteran's case mix score.

Case Mix Rate Components

After the CMT is completed, the Veteran is assigned a case mix score. The case mix score, along with the Veteran's county and state of residence, and the SEOC start and end dates, are entered into the Case Mix Budget Calculator to yield the Veteran's annual budget, estimated monthly budget, and the VDC provider's administrative fees. **Figure 2** shows the components of the Veteran's estimated monthly budget and monthly administrative fee. VA case mix rates are published by VA Central Office and are available online at the [ACL No Wrong Door \(NWD\) Website](#). The VHA developed the VDC Case Mix Budget Calculator to locate VDC case mix rates by state, county, and case mix score and releases an updated calculator for each fiscal year. [Appendix B](#) describes additional information on the VDC Case Mix Budget Calculator.

Figure 2. VDC Case Mix Rate Components



V. VDC Spending Plan Submissions and Approvals

After receiving a Veteran referral and authorization, the VDC provider's PCC conducts a person-centered counseling assessment with the Veteran, supports the Veteran in developing a spending plan for VAMC approval, and completes an invoice for either the full or partial assessment fee.

Person-Centered Counseling Assessment

After the PCS CMT is completed and the Veteran is assigned a case mix score, the VDC provider's PCC completes a person-centered counseling assessment with the Veteran.⁴ The purpose of the in-person assessment is to:

- Help the Veteran identify their goals, strengths, and care preferences;
- Conduct a comprehensive review of resources and informal supports; and
- Provide the Veteran with information and support to make an informed choice of available services and goods in the development of a spending plan.

More information on the person-centered counseling assessment is included in the [VDC Operations Manual Template](#).

VDC Spending Plan

After completing the person-centered counseling assessment, the PCC either helps the Veteran (a) develop a spending plan that the VAMC will review, edit, and approve; or (b) learn that the Veteran does not want to self-direct their care and notify the VAMC VDC Coordinator so they can discuss other options that may meet the Veteran's needs and preferences.⁵

If the Veteran enrolls in VDC and a spending plan is developed, the spending plan will include:

- Information about the employee(s) the Veteran plans to hire, how much the employee(s) will be paid, and an estimate of the number of hours worked per month;
- An estimate of other personal care services and/or goods that the Veteran plans to purchase monthly;
- Information about back-up or emergency employees, if a primary employee or caregiver is unable to provide care;
- An estimate of any one-time goods or services by dollar amount and estimated date of purchase;
- Estimated average monthly spending by employee, good, and service;
- Estimated average monthly invoice, including the monthly administrative fee; and
- Estimated total Veteran spending during the period of the authorization, including all Veteran spending including one-time goods or services, and monthly administrative fees.

Supporting Documentation

If a Veteran hires two employees, the supporting documentation could explain how one employee will support improving the Veteran's engagement in the community by driving and supporting activities outside of the home and the other employee will support the Veteran with daily bathing and dressing needs.

⁴ It is the responsibility of the VAMC to complete the VHA Purchased HCBS Case Mix & Budget Tool and determine the Veteran's VDC budget using the Case Mix Budget Calculator.

⁵ See Section IV's subsection, [VDC Assessment Fee](#), which describes the process for submitting medical claims to the VAMC if the Veteran does not meet eligibility requirements for VDC enrollment.

VDC programs can use the [VDC Spending Plan Template](#) to build the Veteran's spending plan. Supporting documentation from the person-centered counseling assessment must also be submitted with the spending plan so that the VAMC understands how the Veteran intends to use their budget to meet their goals.

VDC Workers and Authorized Representatives

The majority of VDC workers' hourly rates range from \$15.00 – \$21.00/hour (excluding employer tax costs) but may be exceeded if necessary to meet the Veterans' personal care services needs. Veterans as employers have the right to determine and establish hourly rates within the funds available in their spending plan. The hourly rate will directly impact the hours of service allotted for the VDC worker as calculated in the Veteran's VDC budget.

Any Veteran who is uncomfortable or unable to independently manage the VDC employer responsibilities must select an authorized representative to manage the budget on their behalf. An authorized representative may be their legal guardian, family member, friend, or any other person identified by the individual to manage the program on their behalf and in their best interest. Authorized representatives cannot be paid VDC workers of the Veteran.

State and local policy requirements regarding background checks may vary, but the VDC program requires Veterans to complete a background check on all VDC workers and authorized representatives. VDC providers should follow state and local requirements for background checks. A worker cannot be hired if one of the following disqualifying events are identified during a background check:

- Felony for fraud;
- Abuse; and/or
- Exploitation of a person of any age.

Additional disqualifying events for hiring a worker and the length of time they are in place vary by state. Potential VDC employees and authorized representatives should not be onboarded and put in place until a disposition has been made on all charges on the background report. This approach is nondiscriminatory and keeps Veteran safety at the forefront. It also drives next steps in the hiring process (i.e., hire the employee, hire with a mitigation plan in place, or deny employment). Costs for background checks can be paid from the Veteran's budget. Costs for background checks do not require pre-approval from the VAMC but should be included in the Veteran's spending plan and can be invoiced after the VDC spending plan is approved by the VAMC.

VDC Authorized Budget, Planned Purchases, and Emergency Back-up Care

VAMCs issue authorizations for the full and partial assessment fees, the time period the Veteran is authorized to receive care (i.e., the authorization period), the Veteran's authorized budget for the authorization period, and the average monthly budget. The box below provides an example of how a Veteran's budget is calculated.

How This Works!

The Veteran's VA-approved budget for the authorization period is calculated based on the applicable average monthly case mix rate multiplied by the length of the authorization. A Veteran living in Seattle, Washington, (King County) is assigned to case mix "E," which has a case mix rate of \$4,081.

- If the Veteran were granted a six-month authorization period, their authorized VDC budget would be \$24,486 for six months (\$4,081 x 6 months).
- If the Veteran were granted a twelve-month authorization period, their VDC budget would be \$48,972 for twelve months (\$4,081 x 12 months).

All changes to a Veteran's spending plan — including adjustments to recurring costs, unexpected expenses, or one-time purchases — must be submitted to the VAMC VDC Program Coordinator and approved before any spending occurs. Approved plans take effect on the date signed by the Program Coordinator or their designee. VDC providers are encouraged to work with Program Coordinators to establish a process for addressing urgent plan changes to prevent delays in care.

Veterans are encouraged to stay within their monthly budget; however, they have access to and may use their global budget at any time during the authorization period, even if this results in spending above their monthly average. Overspending on a monthly basis is allowed as long as all changes are reflected in an updated spending plan, receive Program Coordinator approval, and do not exceed the Veteran's total authorized budget. This approach removes the previous requirement to document planned savings.

It is the responsibility of the Veteran, with support from the VDC provider, to develop a VDC spending plan that is below the authorized amount, and to track and monitor VDC spending and make any necessary changes to the VDC spending plan to ensure spending does not exceed the authorized budget. The Veteran's authorized budget is designed to meet the Veteran's needs for the entire authorization period. The VDC provider must support the Veteran to develop a spending plan that avoids overspending. If overspending repeatedly occurs, the VDC provider will develop a plan with the Veteran to align their spending with the approved spending plan. Please see the Remediation Training and Termination Policy call out box for additional information. **VAMCs are not required to reimburse for any VDC spending that exceeds the Veteran's authorized budget.**

Remediation Training and Termination Policy

The remediation training and termination policy aims to support Veterans who consistently spend over their average monthly budget and are at risk of exceeding their authorized budget prior to the end of their authorization period. The VDC provider is responsible for applying the policy by developing a plan with the Veteran to align spending with the average monthly amount and continue to review spending with the Veteran monthly. The VDC provider must alert the VAMC VDC Coordinator of continuous Veteran overspending. If overspending continues to occur despite remediation training, the VAMC VDC Coordinator may work with the Veteran to determine if a different VHA program will better meet their needs.

VDC Assessment Fee

Once the VAMC approves the Veteran's spending plan, the VDC provider may enter a claim for the full assessment fee. The assessment fee reimburses the VDC provider and Fiscal Management Service (FMS) for supporting the Veteran with the person-centered assessment, VDC enrollment, in-home visit, spending plan development, and assistance with identifying, hiring, and training employees of the Veteran.

If the Veteran does not enroll in VDC, the VDC provider submits an invoice for the partial assessment fee. The partial assessment fee includes the rate to reimburse the VDC provider for the person-centered assessment conducted with the Veteran.

State and Locality Mandated Paid Leave Policies' Impact on VDC Authorized Budgets

Veterans, as employers, may be obligated to pay mandatory leave for their employees depending on state or local laws on paid leave. As of January 1, 2024, VA allows VDC providers to submit authorized budget amendments to the VAMC to increase the Veteran's authorized budget due to a government mandate related to mandatory paid leave.

The VDC provider must notify the VAMC VDC Coordinator of the Veteran's authorized budget amendment on mandatory paid leave payments by submitting a quarterly or as-needed report as an attachment to the Veteran's spending plan (**Figure 3**). The VDC provider must submit the report for each Veteran who paid leave to a worker in the quarter and include the following information.

- | | |
|--|--|
| <ul style="list-style-type: none">■ Veteran name, date of birth, address■ Type of leave reported & paid■ Worker information<ul style="list-style-type: none">● Name of worker eligible for paid leave;● Date(s) leave was taken and paid;● Number of hours of paid leave;● Hourly wage; and● Total paid leave paid | <ul style="list-style-type: none">■ Emergency backup worker information<ul style="list-style-type: none">● Name of emergency backup (EBU) worker;● Date(s) EBU worker worked;● Number of hours worked to cover primary worker;● Hourly wage; and● Total EBU wages paid■ The total paid leave expenses paid for in the quarter for the Veteran |
|--|--|

VDC providers must coordinate with their FMS to prepare the form according to mandatory paid leave laws using data from Veteran's workers' payroll information.

Upon receipt of the report, the VAMC VDC Coordinator must update the Veteran's authorized budget in the Veteran's profile within the HSRM platform. The amendment provides the Veteran

with funding to cover the cost of paid leave without reducing the funds available in their budget for goods and services included in their spending plan. Amendments will increase the funds available to the Veteran by the total cost of the mandatory paid leave.

Figure 3. Paid Leave Budget Amendment Report

Veteran Key Information			
Veteran Name		Date of Birth	
Veteran Address			
Type of Leave Reported & Paid			
Type of Leave Paid (Select ONE)	☐ GENERAL ☐ SICK LEAVE ☐ FAMILY MEDICAL		
Worker Information			
Name of Worker Eligible for Paid Leave			
Date(s) Leave was Taken and Paid			
Number of Hours of Leave Paid			
x Hourly Wage (\$_/hr)	x \$ _____ / hr		
= Total Paid Leave Paid	= \$ _____		
Emergency Backup Worker Information			
Name of Emergency Backup (EBU) Worker			
Date(s) EBU Worker Worked			
Number of Hours Worked to Cover Primary Worker			
x Hourly Wage (\$_/hr)	X \$ _____ / hr		
= Total EBU Wages Paid	= \$ _____		
Total Paid Leave Expenses Paid as Needed for the Veteran			
= Total Paid Leave + Total EBU Wages	= \$ _____		

VI. VDC Monthly Service Reports

VDC providers are required to develop Monthly Service Reports to track Veteran VDC spending. Monthly Service Reports are crucial for monitoring Veteran spending against their authorized budget and approved spending plan. This section outlines the key components of developing Monthly Service Reports in accordance with VA procedures.

Monthly Documentation of Spending

Monthly Service Reports document actual spending. **VDC providers are required to send VAMC VDC Coordinators a Monthly Service Report within 30 days.** VDC providers should discuss with their VAMC the preferred method for sending this information. Options include uploading Monthly Service Reports to HSRM, sending via secure email, fax, or secure mail. VDC providers are encouraged to discuss documentation requirements with the VAMC VDC Coordinator or their VAMC finance office to ensure appropriate accounting of monthly spending consistent with VAMC operations.

At a minimum, Monthly Service Reports must include:

- The Veteran's monthly case mix rate;
- The monthly administrative rate;
- A breakout of goods and services purchased in the month by employee, good, and service; and
- The total amount of medical claims, which includes Veteran spending as well as the monthly administrative fee.

The Monthly Service Report can also be used to calculate the daily rate used to build the invoice (see [Section VII](#)).

Monthly Service Reports are submitted to the referring VAMC for two purposes:

1. VAMCs are required to verify that all spending incurred by the Veteran is included in the approved spending plan. VAMCs will not pay for any services or goods that are not included in the spending plan.
2. VAMCs are required to verify that reimbursement to the VDC provider for a Veteran does not exceed the Veteran's authorized budget. Tracking total spending during the

VDC Monthly Service Reports vs. VDC Spending Plans

VDC Monthly Service Reports are different from VDC spending plans, described in [Section V](#). VDC spending plans are for Veterans, authorized representatives, and PCCs to describe the plan for Veterans' monthly spending for the VAMC VDC Coordinator's review and approval. This report should be user-friendly and include basic information needed to plan for Veteran spending. VDC spending plans must be approved by VAMC VDC Coordinators. Monthly Service Reports are formal documents submitted to the VAMC VDC Coordinator monthly for each Veteran served that month. FMS' develop and use this report to prepare monthly claims. Templates for each of these tools can be found on the [ACL NWD website](#).

authorization is crucial for monitoring spending and ensuring that total spending does not exceed the total authorized budget.

An example [Monthly Service Report](#) is available to support VDC providers in collecting the information needed to develop monthly medical claims. A sample monthly template is in [Appendix C](#) and on the [ACL NWD website](#).

Calculating Daily Rate

VDC providers are required to have monthly VDC medical claims computed as a daily rate based on the number of days when direct care was provided to the Veteran in their home. When completing the EDI 837 or UB-04, the VDC provider only bills the daily rate for days when direct care was provided to the Veteran.

The number of days when direct care was provided to the Veteran is defined as days when the Veteran paid for a personal care worker (e.g., worker hired and employed by the Veteran) to assist with ADLs or instrumental ADLs (IADLs).

Direct Care

- Examples of **direct care** provided in the Veteran's home include assistance with bathing, dressing, eating (including food prep), and transportation to and from the Veteran's home for health care or social activities.
- Examples of **care that would not count as direct care** include the purchase of goods (e.g., delivery and installation of a ramp or grab bars), home technology purchases needed to fulfill VDC employer responsibilities, and other purchases where a personal care worker is not required to visit a Veteran's home.

How This Works!

A Veteran enrolled in VDC with a case mix rate "C" that lives in Taylor County, Texas has a monthly case mix rate of \$2,753. The monthly administrative fee for this Veteran is \$809. In March 2026, the Veteran made purchases for goods and services that total \$1,100.

- Based on the monthly administrative fee and Veteran purchases, the monthly invoice for VDC is: \$1,909.
- The Veteran received direct care in their home for personal care services 21 of the 31 days in March. The daily rate for VDC will be: $\$1,909 / 21 = \underline{\$90.90}$

VDC Medical Claims Based on Actual Spending and Tracking of Total Spending

VDC providers only bill for actual services and goods purchased by the Veteran and for the monthly administrative fee. The example below provides additional guidance for tracking actual spending, total spending in the authorization, and remaining budget.

How This Works!

A Veteran enrolled in VDC with a case mix rate “C” that lives in Taylor County, Texas has a monthly case mix rate of \$2,753. The Veteran is authorized to receive services from January 1, 2026, through December 31, 2026. The monthly administrative fee for this Veteran is \$809.

- In January 2026, the Veteran made purchases for goods and services that total \$1,200. Based on the monthly administrative fee and Veteran purchases, the monthly invoice for January 2026 is \$2,009 (\$1,200+\$809).
- In February, the VAMC approves the purchase of a new microwave for \$400. The Veteran also spends \$1,821 as outlined in their approved spending plan. The monthly invoice for February 2026 is \$3,030. This includes \$400 for the purchase, \$1,821 in spending, and the \$809 monthly admin fee.
- The Veteran’s total authorized budget for the authorization period is \$33,036 (\$2,753x12). After February, the Veteran has \$29,615 (\$33,036-\$3,421) remaining to spend from March 1 through December 31.

VDC Monthly Administrative Rates

Veterans can enroll in VDC and start receiving services any day of the month. Veterans may also be discharged on any day of the month. The administrative fee is paid in full regardless of the number of days in the month that the Veteran uses their budget. However, if a Veteran does not receive any personal care services in a given month, the VDC provider will not bill an administrative fee for that month.

If a Veteran’s authorized budget amount changes mid-month, the VDC provider should pro-rate the monthly administrative fee accordingly. For example, if a Veteran’s authorized budget changes on January 15 but their monthly budget started on January 1, the administrative fee should be pro-rated for 14 days of the previous authorization’s administrative fee plus 17 days of the new monthly administrative fee.

Hospital and Nursing Home Admissions for Veterans Enrolled in VDC

While enrolled in VDC, some Veterans may need inpatient hospital and/or nursing home care. When a Veteran is admitted to an inpatient setting, VA reimburses the full administrative fee for the month when the Veteran was admitted and any month the Veteran receives personal care services. The Veteran’s budget is not pro-rated as a result of an inpatient admission. A change in the Veteran’s case mix can be authorized and approved by the VAMC if the Veteran’s needs change. For an inpatient stay that continues beyond 15 days, the Veteran must be placed in an inactive status starting the month after the 15th day of the inpatient stay, at which time all payments to the VDC provider must cease until the Veteran’s status is reactivated by the VAMC.

The VA may discharge the Veteran from the VDC program if the VAMC VDC Coordinator determines that VDC is no longer clinically appropriate.

While VA does not reimburse any services that occur during the Veteran’s inpatient stay, there may be circumstances that require the Veteran to receive personal care services during the first day

(i.e., admission) or last day (i.e., discharge) of the Veteran's inpatient stay. If this is required, VA is allowed to reimburse for VDC services provided but will require approval from the VAMC.

VII. VDC Medical Claims

VDC providers invoice the VAMCs monthly. VDC providers submitting medical claims electronically use the EDI 837.⁶ VDC providers using the UB-04 claim form to submit paper VDC medical claims should consider strategies for converting to electronic medical claims, and contact veterandirected@acl.hhs.gov for assistance.

Medical claims include only actual spending in a month and are based on a daily rate determined by the number of days the Veteran received personal care services. This section outlines requirements for developing medical claims, including procedures for electronic claims submission, and submitting revised or corrected medical claims.

Electronic Claims

VDC providers are strongly encouraged to submit VDC claims electronically. Electronic claims submission reduces processing times and likelihood of rejections. [Appendix E](#) provides guidance for converting from a paper claim to an electronic claim submission process.

Vendor Process

Prior to submitting a VDC invoice, VDC providers must be vendorized by VA's Financial Services Center/FSC. VDC providers must first register for the System for Award Management. To complete the vendor process, VDC providers need to complete the [form VA 10-091](#). The second page of the form includes instructions and a fax number to submit the completed form. VDC providers can call VA's Financial Services Center (FSC) at (877) 353-9791 with questions.

Completing a VDC Invoice and Providing Supporting Documentation

VDC medical claims are required to be completed using the EDI 837 or UB-04 claim form (also known as the CMS 1450). Please visit [VA's OCC website](#) for more information on filing an electronic claim for Veteran care. A step-by-step guide for completing the UB-04 claim form is included in [Appendix D](#), although VDC providers are encouraged to review the guidance in [Appendix E](#) and switch to medical claims electronic submission.⁷ In addition to the EDI 837 or UB-04 claim form, Monthly Service Reports are submitted to the VAMC VDC Coordinator or VAMC OCC.⁸ VA and ACL recommend that the VAMC and VDC provider discuss and

⁶ The EDI 837 is the electronic transaction format established to comply with HIPPA requirements for the electronic submission of health care claims. Please visit [VA's OCC website](#) for more information on filing a claim for Veteran care.

⁷ As of June 2019, VA requires an authorization number on all 837 Electronic Data Interchange (EDI) and paper claim submissions for preauthorized services. For EDI 837, Referral Number is Loop = 2300, Segment = REF*9F, Position = REF02 or Prior Authorization, Loop = 2300, Segment = REF*G1, Position = REF02. VDC providers must list the authorization number on Field #63 of the UB-04 claim form, titled "Treatment Authorization Codes."

⁸ VDC providers can discuss with their VAMCs whether Monthly Service Reports will be sent with the UB-04 to either the VAMC VDC Coordinator, the VAMC OCC, or both.

establish local procedures for sharing monthly documentation, including medical claims and Monthly Service Reports.

VDC providers should coordinate with their VAMC to determine if Monthly Service Reports as supporting documentation for VDC medical claims are to be submitted to either: (1) the VAMC VDC Coordinator; (2) the billing, finance, or OCC's Payment Operations and Management (POM);⁹ or (3) both the VAMC VDC Coordinator and the billing, finance, or OCC's POM. This communication strategy allows the VAMC to answer any questions once the invoice is submitted by the VDC provider.

VDC Invoice Submission

VA accepts and encourages electronic submission of health care claims in accordance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA). VA contracts with Change Healthcare, formerly Emdeon, to provide clearinghouse services for

Electronic submission software packages can streamline the development of VDC invoices by allowing VDC providers to save the completed bill, so the biller only has to complete the new billing dates and amounts each time.

electronic medical care claims.

VDC providers can purchase software packages to assist in completing and electronically submitting the EDI 837, which generally cost \$100-\$200 per month. Several VDC providers have purchased software packages from Change Healthcare and Office Ally to submit their medical claims electronically. Before purchasing software, VDC providers must confirm that the software is compatible with Change Healthcare for electronic billing uploads.

EDI Claims Submission

To register or submit an EDI claim to your local VA health care facility, visit the [Change Healthcare Payer Lists website](#) or call 1-800-845-6592. While registering, you will need the Non-VA Medical Care Program Payer ID which includes 12115 for submission of medical claims authorized by a Veteran Care Agreement. For more information on how to submit invoices electronically, visit [OCC's Provider Claims Overview page](#).

VDC providers are encouraged to submit VDC medical claims electronically as it will reduce processing times and the likelihood of rejections. If you are submitting a paper invoice, please review [Appendix E](#) and [VA's Office of Community Care's guidance](#) regarding the paper invoice submission process for Veteran community care claims for up-to-date information on submitting paper medical claims.

Corrected Bills

There are rare instances when timesheets and receipts are submitted to the FMS after the VDC provider submits medical claims to VAMCs or when a billing error occurs. VDC providers may need to resubmit claims for reasons such as late medical claims or timesheets. VDC providers will work with the FMS to ensure timesheets are submitted in a timely manner to avoid delays in submitting medical claims to VAMCs. In addition, VDC providers should wait an adequate

⁹ There is no standard name for the VAMC Office responsible for processing payments for non-VA Care services.

amount of time to submit monthly medical claims to ensure that the need to submit corrected bills does not happen frequently. When this occurs, the VDC provider must alert the VAMC VDC Coordinator that a corrected invoice will be submitted.

The VDC provider and the VAMC must discuss and approve procedures to correct bills to ensure that corrected bills are reimbursed in a timely manner. Additionally, the VDC provider must notify the VAMC VDC Coordinator and/or billing office that a corrected bill needs to be submitted before submitting a corrected bill.

Refund Policy

There are certain instances when a VDC provider will need to return funds to a VAMC. This happens most commonly when withheld taxes for a Veteran as an employer are returned after tax filing. VAMCs must issue a bill of collection (BOC) in order to receive returned payments from a VDC provider. Since the process may differ by VAMC and Veteran Integrated Service Network (VISN), the VAMC VDC Coordinator should work internally with their local and/or VISN OCC POM staff to determine the process for issuing a BOC and receiving refund checks from VDC providers.

VIII. Monitoring of VDC Accounts Receivable

VDC providers are responsible for tracking and monitoring VDC medical claims that have been submitted to VAMCs. VA has systems, such as the eCAMS ePP to track the status of claims received by the VA. This section provides more information on eCAMS ePP as well as policies for follow-up on outstanding medical claims greater than 45 days.

eCAMS ePP

VA's eCAMS ePP is an online system available for community care providers to track the status of claims received by the VA. eCAMS ePP allows users to access the status of claims submitted, as well as adjudication information, remittance reports, and explanation of payment documents. Access eCAMS [ePP](#) to register and view trainings for use of the portal. VDC providers can also refer to the VA's [step-by-step guide](#) for using eCAMS ePP, including how to gain access to the portal and use the portal to track claims status.

ePP Support

The following contacts are available through the VA for additional information and guidance regarding ePP:

- Customer Service Phone Number: 1-855-299-0231
- Email Support: eCamsHDSupport@va.gov

Timeliness for VDC Invoice Submission and Requirement

VDC providers are required to submit medical claims within 180 days as outlined in Section J of the VCA.¹⁰ VDC providers are *encouraged* to submit VDC medical claims no later than 30 days

¹⁰ Please review Section J of the Veteran Care Agreement ([VA Form 10-10171](#)) for more information regarding requirements for billing and submitting medical claims.

after the end of the month. The faster the invoice is submitted, the sooner the VDC provider is likely to be paid for the services provided. VDC providers must submit VDC medical claims monthly and minimize instances where multiple months of VDC medical claims are simultaneously submitted to the VAMC.

IX. VA Billing Resources

Billing and Medical Claims Issues

VDC providers who experience billing issues or have questions about VA billing procedures are encouraged to review the following information about the billing and medical claims submission process including the VDC Medical Claims Submission Timeline (see **Figure 4**):

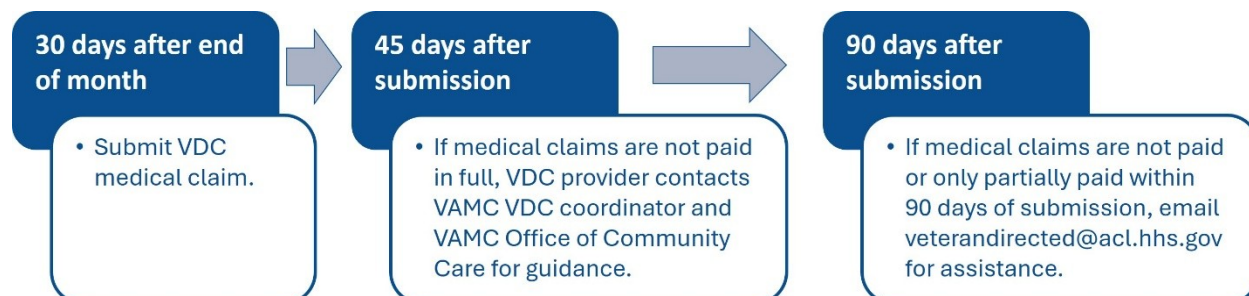
1. Check the [eCAMS ePP](#), VA’s online system for tracking the status of claims received by the VA. This includes information on previous, current, and future payments.
2. Access [VA’s community care website](#), which links to billing resources that include:
 - a. [Submitting Claims for Veteran Care](#)
 - b. [Claims and Payment Information](#)
 - c. [Corrections and Voids](#)

VA Disputes and Appeals Process

VDC providers who do not agree with a payment decision should refer to the [Community Care Provider Disputes and Appeals](#) page, which outlines the steps that VDC providers may take to submit a dispute or appeal. As VCA holders, VDC providers should make their initial appeal to the Regional Payment Operations at one of the addresses below. Following adjudication, any further appeals must be made using the “Higher-Level Review” process found on the page referenced above.

VISNs 1-8	VISNs 9-16	VISNs 17-33
Eastern Region VA Consolidated Payment Center ATTN 11FB P.O. Box 5005 Bay Pines, FL 33744	Central Region VA Consolidated Payment Center P.O. Box 320394 Flowood, MS 39232	Western Region VA Consolidated Payment Center P.O. Box 1004 Ft. Harrison, MT 59636

Figure 4. VDC Medical Claim Submission Timeline



Appendix A. VDC Billing and Medical Claims Guide Glossary

The glossary provides definitions for terms and acronyms used throughout the VDC Billing and Medical Claims Guide.

Term	Acronym	Definition
Activity of Daily Living	ADL	Basic fundamental self-care tasks, such as bathing; dressing; eating; grooming; transferring and ambulation; toileting and continence; and bed mobility, that people perform daily.
Aging and Disability Resource Center	ADRC	These centers help older adults, people with disabilities, and their families find and access long-term services and supports and provide unbiased, reliable information and counseling to people with all levels of income.
Area Agency on Aging	AAA	A public or private nonprofit agency designated by a state to address the needs and concerns of all older persons at the regional and local levels.
Center for Independent Living	CIL	These centers are designed and operated by people with disabilities and provide independent living services for people with disabilities.
Centers for Medicare and Medicaid Services	CMS	A federal agency providing health coverage to people through Medicare, Medicaid, the Children's Health Insurance Program, and the Health Insurance Marketplace.
Electronic Claims Adjudication Management System Provider Portal	eCAMS ePP	VA's online system available for tracking the status of claims received by the VA.
Electronic Data Interchange	EDI	Electronic exchange of information between businesses.
Financial Services Center	FSC	The VA's Office of Finance center for financial management, professional, and administrative services.
Fiscal Management Service	FMS	Service that provides Veterans with the support necessary to manage their flexible spending plan and employer tasks including assisting Veterans with documentation and paperwork for hiring employees, paying employees, providing monthly reports to the VDC provider, and managing other goods/services in accordance with local, state, and federal regulations.
Fiscal Year	FY	One-year account period used for budgeting purposes. The government fiscal year runs from October 1st through September 30th.
Home and Community-Based Services	HCBS	Services and supports that enable people who are aging and people with disabilities to live at home or in their communities.
Medicaid Home and Community-Based Services	Medicaid HCBS	Services provided for Medicaid beneficiaries of various population groups, including people with intellectual or developmental disabilities, physical disabilities, and/or mental illness, to receive services in their own home or community.
HealthShare Referral Manager	HSRM	A secure online portal for managing referrals and authorizations and is available to all VA community providers at no cost.
Health Insurance Portability and Accountability Act of 1996	HIPAA	A federal law requiring national privacy standards that protect sensitive patient health information from being disclosed without consent.
Information Technology	IT	Use of technology to transfer information.

Term	Acronym	Definition
Instrumental Activity of Daily Living	IADL	Complex daily tasks required for a person to live independently in a home or community, such as housework, managing money, taking medication, preparing and cleaning up after meals, shopping, transportation, etc.
Long-Term Services and Supports	LTSS	Care provided in the home, in community-based settings, or in facilities, such as nursing homes for older adults and people with disabilities who need support because of age; physical, cognitive, developmental, or chronic health conditions; or other functional limitations that restrict their abilities to care for themselves.
No Wrong Door	NWD	A collaborative effort of ACL, CMS, and the VHA that builds upon the ADRC program and CMS' Balancing Incentive Program. No Wrong Door requirements support state efforts to streamline access to LTSS options for older adults and individuals with disabilities.
Office of Community Care	OCC	The Veterans Health Administration Office of Community Care administers multiple community care programs that enable eligible Veterans and beneficiaries to receive health care services from providers outside of a VA medical facility. OCC also manages all national billing and collection activities for medical care and services provided by VA medical centers.
Person-Centered Counselor	PCC	An individual hired by a VDC provider who serves as an advocate and coach to the Veteran, caregiver(s), and/or authorized representative. The PCC is an extension of the VAMC, supporting the Veteran and monitoring their health and well-being. The PCC is a paid professional who is trained in self-direction, including budget development, person-centered practices, and Veterans' health and support needs.
Standard Episode of Care	SEOC	A VA health policy made up of a pre-approved bundle of services and procedures that relate to a specific category of care or subspecialty. It is comprised of a clinical and coding profile to drive consistency in the community care approval, care delivery, and reimbursement processes.
State Unit on Aging	SUA	These state-level agencies develop and administer plans to provide assistance for older adults, families, and in many states also adults with physical disabilities.
U.S Department of Veterans Affairs	VA	An agency of the federal government that provides benefits, health care, and cemetery services to military Veterans.
Veterans Affairs Medical Center	VAMC	A health care facility operated by the Veterans Health Administration serving Veterans and their families.
Veteran Care Agreement	VCA	An agreement signed by eligible non-VA providers and VAMCs to cover Veteran community care not covered by VA's contracted community care network.
Veterans Health Administration	VHA	An integrated health care system in the United States, consisting of 1,255 health care facilities serving over nine million Veterans enrolled in the VA health care program.
Veteran Directed Care	VDC	The VHA and the Administration on Aging, now part of ACL, developed the VDC program in 2008 to offer Veterans and their caregivers greater access, choice, and control over the LTSS that help Veterans live at home and remain a part of their community. Veterans enrolled in VDC decide for themselves what mix of goods and services best meet their needs. This includes the ability to hire, schedule and supervise their workers.

Appendix B. VDC Case Mix Budget Calculator

The VHA released the Fiscal Year (FY) 2027 VDC Budget Calculator effective for new referrals starting October 1, 2026.

- These rates are effective for Standard Episodes of Care (SEOCs) established starting October 1, 2026, for medical center level budgeting purposes, but SEOCs are not bound by fiscal years.
- This version of the VDC Budget Calculator should be used for newly referred Veterans and for Veterans who are renewing their referrals each year.
- The term “Average Monthly Veteran Budget” does not include the “Monthly Administrative Fee,” as detailed in the glossary found in **Table 2** of the “Calculator” tab.
- In the tab titled “Calculator,” the “Average Monthly Veteran Budget” is listed on row nine and the “Monthly Administrative Fee” is listed in row 10. **Table 2** on this tab provides further instruction and definitions.
- The calculator includes instructions for how to use the tool and determine VDC rates and fees.
- If your VDC program has questions about reimbursement rates, you may contact the local VAMC VDC Coordinator or local VCA point of contact in the OCC.

State	New York
County or City	New York County
Case Mix Level	D
Start Date of SEOC^ (MM/DD/YYYY)	10/1/2015
End Date of SEOC (MM/DD/YYYY)	9/30/2016
Number of Months in SEOC	12.0
Prorated First Month Veteran Budget	\$2,688
Average Monthly Veteran Budget	\$2,688
Monthly Administrative Fee	\$758
Average Monthly VA Obligation	\$3,446
Total Veteran Budget for SEOC	\$32,341
Full Assessment Fee	\$1,068
Partial Assessment Fee	\$534
Total VA Obligation for SEOC (if includes Full Assessment Fee)	\$42,507
Total VA Obligation for SEOC (if DOES NOT include Full Assessment Fee)	\$41,439

Appendix C. Sample UB-04 Claim Form and Accompanying Monthly Services Report Documentation

This appendix provides an example of a completed UB-04 claim form and accompanying monthly services report.

Randy King is a 90-year-old World War II Veteran with progressive Alzheimer's disease who lives with his wife in New Haven County in New Haven, Connecticut. In early December 2020, Mr. King was identified as a potential VDC enrollee due to his increasing need for assistance with ADLs/IADLs after a primary care appointment at the VAMC. Mr. King and his wife were excited for the opportunity to self-direct his care, including hiring their children and grandchildren to provide assistance with ADLs/IADLs. After the West Haven VAMC completed the Purchased HCBS Case Mix & Budget Tool, Mr. King was assigned to Case Mix "D" with a monthly rate of \$3,000.

The VDC Coordinator at the West Haven VAMC referred Mr. King, along with his case mix level, medical history, contact and demographic information, and primary ICD-10 code to the PCC at South Central Community Choices ADRC to complete a person-centered assessment for VDC. The PCC assisted Mr. King with developing a spending plan for VDC that included hiring his daughter, Sandy Sue, for personal care services. Additionally, Mr. King will use his VDC budget for lawn services, meals, and medication.

Mr. King was officially enrolled in the program on January 1, 2021. The monthly services report and UB-04 below are an example of Mr. King's VDC spending in January 2021, the first month when Mr. King begins utilizing his VDC monthly budget. Based on timesheets and medical claims submitted by Mr. King to the FMS and provided to South Central Community Choices, he spent a total of \$561. With a monthly administrative fee of \$500, South Central Community Choices' VDC invoice for Mr. King based on January 2021 services will be \$1,061. Mr. King received hands-on personal care, day care, or respite services on 16 unique days in January 2021 based on the FMS reports that were received. As a result, the daily VDC rate for Mr. King in January 2021 is \$66.31 (\$1,061/16).

Randy King's VDC Invoice for January 2021 (2 pages)¹¹

South Central Community Choices		3a. PAT CNTL #		1234567		4. Type of Bill	
1 Long Wharf Dr		b. Med Rec #				343	
New Haven, CT 06511		5. FED TAX NO.		03-5555555		6. STATEMENT COVERS PERIOD	
(888) 756-4321				11/1/2020		11/30/2020	
8. PATIENT NAME		a. Randy		9. PATIENT ADDRESS		a. 624 Hope Street	
b. King		b. New Haven		c. RI		d. 06501	
10. BIRTHDATE		11. SEX		12. DATE		13. TIME	
10/29/1944		M		3/1/2020		6	
14. DHR		15. STAT		16. DHR		17. STAT	
30		30		30		30	
18. CODE		19. CODE		20. CODE		21. CODE	
22. CODE		23. CODE		24. CODE		25. CODE	
26. CODE		27. CODE		28. CODE		29. CODE	
30. CODE		31. CODE		32. CODE		33. CODE	
34. CODE		35. CODE		36. CODE		37. CODE	
38. CODE		39. CODE		40. CODE		41. CODE	
42. REV CD		43. DESCRIPTION		44. HCPCS / RATE / HIPPS CODE		45. SERV. DATE	
3109		Other Adult Care		T1020		11/1/20	
3109		Other Adult Care		T1020		11/2/20	
3109		Other Adult Care		T1020		11/3/20	
3109		Other Adult Care		T1020		11/4/20	
3109		Other Adult Care		T1020		11/5/20	
3109		Other Adult Care		T1020		11/6/20	
3109		Other Adult Care		T1020		11/7/20	
3109		Other Adult Care		T1020		11/8/20	
3109		Other Adult Care		T1020		11/9/20	
3109		Other Adult Care		T1020		11/10/20	
3109		Other Adult Care		T1020		11/11/20	
3109		Other Adult Care		T1020		11/12/20	
3109		Other Adult Care		T1020		11/14/20	
3109		Other Adult Care		T1020		11/20/20	
3109		Other Adult Care		T1020		11/18/20	
3109		Other Adult Care		T1020		11/19/20	
3109		Other Adult Care		T1020		11/20/20	
3109		Other Adult Care		T1020		11/21/20	
3109		Other Adult Care		T1020		11/22/20	
3109		Other Adult Care		T1020		11/23/20	
3109		Other Adult Care		T1020		11/24/20	
Page 1 Total						2387.49	
PAGE		2		OF		2	
CREATION DATE		12/10/2020		TOTALS		2955.94	
50 PAYER NAME		51 HEALTH PLAN ID		52 REL INFO		53 ASO BEN	
54 PRIOR PAYMENTS		55 EST. AMOUNT DUE		56 NPI		XXXXXXX	
57 OTHER PRV ID		58 INSURED'S NAME		59 P. REL.		60 INSURED'S UNIQUE ID	
		King, Randy				XXX-XX-XXXX	
61 GROUP NAME		62 INSURANCE GROUP NO.		63 TREATMENT AUTHORIZATION CODES		64 DOCUMENT CONTROL NUMBER	
				1234567			
65 EMPLOYEE NAME		66 DX		67		68	
		712.0					
69 ADMIT DX		70 PATIENT REASON		71 HIPPS CODE		72 ECI	
73 CODE		74 CODE		75 CODE		76 ATTENDING NPI	
77 OPERATING		78 OTHER		79 OTHER		80 REMARKS	
81 KIC		82 KIC		83 KIC		84 KIC	
85 KIC		86 KIC		87 KIC		88 KIC	
89 KIC		90 KIC		91 KIC		92 KIC	
93 KIC		94 KIC		95 KIC		96 KIC	
97 KIC		98 KIC		99 KIC		100 KIC	

¹¹ Please note that due to rounding, the total amount on the UB-04 form may not match to the Veterans' spending report. This must be noted in the invoice to the VAMC. Also, VDC providers can change the total authorized amount to be reimbursed if necessary.

[illegible]

Appendix D. Step-by-Step Guide for Completing Paper Medical Claims Using the UB-04 Claim Form

The UB-04 claim form (also known as the CMS 1450 form) is the monthly paper invoice form for VDC. The UB-04 claim form contains 81 sections, not all of which are required when submitting medical claims to the VA for VDC reimbursement. Below is a list of fields from the UB-04 claim form with their corresponding title, whether or not the field must be completed for VDC, a brief definition, and input values.¹² For electronic submissions, please visit [VA's Community Care website for information on filing an electronic claim using the EDI 837](#).

Field Number	Title	Required (Y/N)	Brief Definition	Input Values
#01	Provider Information	Y	Information specific to the Provider of Care	Line 1: [Provider Name] Line 2: [Provider Street Address] Line 3: [Provider City, State, Zip] Line 4: [Provider Telephone, Fax]
#02	-	N	-	-
#03a	Patient Control Number	Y	Number assigned to Veteran	Any number assigned by VDC provider
#04	Type of Bill	Y	This three-digit code represents the type of facility, type of clinic and frequency of claim submitted	- The first digit signals the type of facility. For VDC, this must be: 3 = Home Health - The second digit signals the type of clinic. For VDC, this must be: 4 = Other (part B) - includes HHA medical and other health services not under a plan of treatment, hospital, and skilled nursing facility for diagnostic clinical laboratory services for "nonpatients," and referenced diagnostic services. - The third digit signals the frequency of claim. For VDC, this could be: 2 = Assessment – First Claim 3 = Interim – Continuing Claims 4 = Interim – Last Claim 7 = Replacement of Prior Claim 8 = VOID/Cancel
#05	Federal Tax Number	Y	Every provider is required to have a federal tax number to receive payment	Example format: NN-NNNNNNN
#06	Statement Covers Period (From-Through)	Y	Statement period date based on when care was provided.	Example format: MM/DD/YY
#07	-	N	-	-

¹² This list is based on current guidance provided by VA and the experience of VDC providers with using this form to date. As a result, VAMCs may not follow every direction provided here depending on their local billing practices.

Field Number	Title	Required (Y/N)	Brief Definition	Input Values
#08	Patient's Name	Y	Name of Patient (Veteran)	Name (Text)
#09	Patient's Address	Y	Address of Patient (Veteran)	Address (Text)
#10	Patient's Birth Date	Y	Birthdate of Patient (Veteran)	Example Format: MM/DD/CCYY
#11	Patient's Sex	Y	Sex of Patient	M for male; F for female
#12	Admission Date	Y	Date of Admission. This would be the day that the Veteran initiated services in the VDC program (e.g., purchased first good or service)	Example Format: MM/DD/YY
#13	-	N	-	-
#14	-	N	-	-
#15	Point of Origin for Admission or Visit	Y	Used to identify the type of facility where the admission was initiated.	For VDC, input 6. 6: The patient was referred to this facility for services by (a physician of) another health care facility not defined elsewhere in this code list where he or she was an inpatient or outpatient
#16	-	N	-	-
#17	Patient Status Through Billing Period	Y	Status of patient for period of billing	For VDC, potential inputs are: 02: discharge/transferred to a short-term general hospital for inpatient care 06: left against medical advice or discontinued care 20: expired 30: still patient or expected to return for outpatient services
#18-28	-	N	-	-
#29	-	N	-	-
#30	-	N	-	-
#31-34	-	N	-	-
#35-36	-	N	-	-
#37	-	N	-	-
#38	-	N	-	-
#39-41	-	N	-	-
#42	Revenue Code	Y	Signifies the appropriate revenue code to identify specific accommodation and/or ancillary charges.	Multiple types of revenue are applicable for VDC. Generally, the following code must be used unless otherwise specified by the VAMC: 3109 If code 3109 is not accepted, the following code can be used: 0571

Field Number	Title	Required (Y/N)	Brief Definition	Input Values
#43	Revenue Description	Y	Text to match with corresponding revenue code (field #42)	For code 3109, enter Other Adult Care. For code 0571, enter Aide/Home Health/Visit.
#44	HCPCS/Rate/ HIPPS Code	Y	Type of care provided to Veteran. For VDC, only two codes are used.	The following two codes must be used only for VDC: T2024 – Service Assessment/Plan of Care Development (This is a one-time code – for initial assessment fee) T1020 – Other Adult Care (Used for monthly claims)
#45	Service Date	Y	Date when a single day of care is provided. A single day of care to be included in the UB-04 is defined in the section Calculating the Daily Rate for VDC .	Example Format: MM/DD/YY
#46	Units of Service	Y	Number of Units. This field must be completed for each row where a daily rate is billed to VA.	For VDC, the unit of service for each row will be 1.
#47	Total Charges	Y	Daily Rate for VDC. Further defined in the section Calculating the Daily Rate for VDC .	Example Format: \$DDD.CC
#48	Non-Covered Charges	Y	Will be left blank	Leave blank
#49	-	N	-	-
#50-55	-	N	-	-
#56	NPI	Y	The National Provider Index (NPI) is listed by the Individual Provider or Agency. NPI is a unique 10-digit identification number used for Medicare services and other payers. If you have questions regarding NPI, please reach out to the VDC Inbox (veterandirected@acl.hhs.gov).	NPI is a unique 10-digit identifier.
#57	-	N	-	-
#58a-c	Insured's Name	Y	Veteran's Name	Name of Veteran
#59a-c	-	N	-	-
#60a-c	Insured's Unique ID	Y	Veterans social security number (SSN) or other unique identifier.	Most likely SSN of Veteran unless otherwise instructed by VAMC.
#61a-c	-	N	-	-
#62a-c	-	N	-	-

Field Number	Title	Required (Y/N)	Brief Definition	Input Values
#63	Treatment Authorization Codes	Y	Veteran Care Agreement authorization	The Veteran's authorization number as listed on the authorization.
#64	-	N	-	-
#65	-	N	-	-
#66	Diagnostic and Procedure Code Qualifier	Y	ICD-10 is a standard tool for mapping health conditions which can be up to six characters long. ICD-10 is maintained by the World Health Organization.	ICD-10 Code will be provided by the VAMC at time of referral.
#68-75	-	N	-	-
#76 ¹³	Attending Provider Name and Identifiers (including NPI)	Y	Required when claim contains any services other than nonscheduled transportation services.	NPI is a unique 10-digit identifier.
#77-79	-	N	-	-

¹³ Several VAMCs require that NPIs be entered into fields #56 and #76. Your VAMC may request that this information be placed in only one, or both, fields.

Appendix E. Switching from Paper to Electronic VDC Medical Claims

VA strongly encourages electronic submission of VDC medical claims. Electronic claims submission reduces processing times and likelihood of rejections. Below are considerations for moving to VDC electronic claims submission for VDC providers who are currently submitting paper medical claims using the UB-04 claim form (also known as the CMS 1450 form).

Action	Consideration
Consider whether your organization or your FMS subcontractor has the capability and/or expertise to submit electronic VDC medical claims	If your organization does not have experience submitting medical claims electronically or does not desire to gain the capability, your FMS provider may be able to assist with the electronic submission of VDC medical claims. VDC providers are encouraged to reach out to other VDC providers to discuss their experience and processes for submitting medical claims electronically. The VDC provider's name, address, and banking information should always be used for submitting VDC medical claims. The VDC provider should always review VDC medical claims for accuracy prior to submitting the invoice to VA. If you want your FMS provider to submit VDC medical claims on your behalf, you may need to adjust subcontracts, agreements, or other documents used with the FMS Provider.
Explore software options to submit VDC medical claims electronically	VA contracts with Change Healthcare, formerly Emdeon, to provide clearinghouse services for electronic medical care claims (EDI 837 and 275 claims). VDC providers can use Change Healthcare, or another clearinghouse software of choice, to submit VDC medical claims. The use of software clearinghouses is an additional cost absorbed in the monthly administrative reimbursement paid by the VA and cannot be invoiced as part of the Veteran's spending. VDC providers must confirm that the software is compatible with Change Healthcare for electronic billing uploads.
Learn about and follow VA requirements for completing the EDI 837	VA's OCC website includes information for providers to learn how to file claims electronically. Guidance includes using VA's national payer ID and authorization annotation.
Track VDC medical claims	Follow the processes outlined in Section VIII. Monitoring of VDC Accounts Receivable to track the timeliness and accuracy of payment and reimbursement from VA for VDC. If you experience any issues with timeliness and accuracy of payment, it is critical that you follow up with the VA immediately to resolve any issues. Section VIII. Monitoring of VDC Accounts Receivable includes appropriate timelines for following up with VA and with ACL if you are not able to resolve issues with reimbursement.

Appendix F. Common Billing Issues and Recommendations for Reaching a Resolution

VDC providers should refer to the [Preventing Paper Claims Rejections](#) VA resource to understand common billing issues and rejections they may encounter during the billing and medical claims process.

Some billing issues may require further support to reach a resolution. The following guidance provides recommended steps to take to reach a resolution.

1. Access VA's community care website, which links to billing resources that include:
 - a. How to File a Claim for Veteran Care
 - b. Claims and Payment Information
 - c. Corrections and Voids
2. Check the eCAMS ePP:
 - a. ePP is VA's online system for tracking the status of claims received by the VA. This includes information on previous, current, and future payments.
 - b. The ePP home page can be accessed at the [eCAMS ePP login page](#).
 - c. For more information on ePP, please refer to [Section VIII. Monitoring of VDC Accounts Receivable](#).
3. Follow up with the VDC Coordinator at your partnering VAMC for guidance on the desired approach for denied claims (i.e., address existing issues until they are resolved locally or wait for completion of the late and partial payment resolution process).

Email veterandirected@acl.hhs.gov for technical assistance.