

Community Provider Standard for Orthotic, Prosthetic, and Pedorthic Devices and Bundled Services Frequently Asked Questions – August 2026

Q1: It is our understanding that if an O&P provider does not have an existing VA contract, the reimbursement terms set forth in the Standards apply by default. Is that correct?

A: Yes

Q2: For reimbursement of the codes listed on the CMS fee schedule, which CMS fee schedule will be applied? The one for the state where the O&P services are rendered or something else? If something else, what?

A: The local Community Provider address.

Q3: Will the VA provide the reimbursement rates for items listed in Table 4 (special code pricing) up front prior to the O&P provider agreeing to provide the service to the veteran or will this pricing be received only after the PO is issued?

A: The pricing from table 4 will be provided with the itemized HCPCS listing upfront.

Q4: Is the In-Person Checkout process now optional? We understand the Standards outline the community provider is encouraged to remind the veteran to do a checkout, and that the VA encourages a veteran to return to their VA provider within 30 days. Will there be any situation where checkout is required for payment?

A: The check-out is a clinical best practice but independent of the procurement and payment process.

Q5: What is the VA doing to ensure that the confidential pricing information contained in manufacturer invoices is not shared with (a) anyone outside of the VA; and (b) anyone within VA procurement?

A: The agency maintains strict safeguards to ensure that manufacturer invoice data is handled in accordance with federal law, VA policy, and sound procurement ethics.

Q6: How did the VA determine reimbursement for Table 3 NOC Price Method?

A: VA does not release proprietary pricing methodologies or internal determinations beyond what is published.

Q7: What items are considered “Common items” in the Notes section of this pricing table?

A: This refers to items prescribed frequently without CMS codes as established in Table 4.

Q8: For items in Pricing Table 4 “VA Special Code Pricing Method Exceptions to DMEPOS pricing”: a) What is your proposed “Specially developed price method” for the items listed in this table? b) How were the items in this table identified for this special pricing? c) How does this method incorporate overhead and multiple appointments into profitability for the provider?

A: VA does not release proprietary pricing methodologies or internal determinations beyond what is published.

Q9: If a community provider does not accept the new Community Standards, will the veteran patients they serviced need to choose a new provider?

A: Please refer to the Community Provider Standard for Orthotic, Prosthetic, Pedorthic Devices and Bundled Services.

Q10: Will any existing contracts remain in existence if we do not choose to voluntarily terminate?

A: The Standard will replace Contracts and Blanket Purchase Agreements (BPA) when ordering periods or current options expire or by your choice. We encourage Community Providers to voluntarily accept orders under the Standard and agree to end contracts and BPAs early.

Q11: How is labor recognized?

A: VA authorizes the appropriate HCPC repair and labor codes to ensure that repairs to an existing prosthesis or orthosis are reimbursed in accordance with established pricing standards.

Q12: What post-delivery correction obligations exist for CPP provided care? (e.g. warranty)

A: Please refer to the Community Provider Standard for Orthotic, Prosthetic, and Pedorthic Devices and Bundled Services.

Q13: What are the expectations for loaner devices?

A: Please refer to the Community Provider Standard for Orthotic, Prosthetic, and Pedorthic Devices and Bundled Services.

Q14: What are the expectations for timeliness of clinically complex cases?

A: Please refer to the Community Provider Standard for Orthotic, Prosthetic, and Pedorthic Devices and Bundled Services.

Q15: What is the process for prescription changes during the fabrication process?

A: Prescription adjustments made during fabrication must be issued by VA to ensure the final device remains clinically appropriate and authorized. Community providers may trial components or configurations that fall within the scope of the existing VA prescription. If a Veteran wishes to explore components outside those prescribed parameters, a new VA prescription is required before proceeding. This approach maintains flexibility for device trials while ensuring all care remains authorized, safe, and aligned with VA clinical guidance. Additional Resources: [VHA Directive 1173.3\(1\) VHA OUTPATIENT AMPUTATION SPECIALTY CLINICS](#)

Q16: How can Veterans trial different components?

A: Prescription adjustments made during fabrication must be issued by VA to ensure the final device remains clinically appropriate and authorized. Community providers may trial components or configurations that fall within the scope of the existing VA prescription. If a Veteran wishes to explore components outside those prescribed parameters, a new VA prescription is required before proceeding. This approach maintains flexibility for device trials while ensuring all care remains authorized, safe, and aligned with VA clinical guidance. Additional Resources: [VHA Directive 1173.3\(1\) VHA OUTPATIENT AMPUTATION SPECIALTY CLINICS](#)

Q17: How will reimbursement evolve as new technologies come to market?

A: VA processes will adjust as new technologies emerge, consistent with established coding and coverage processes. Manufacturers are responsible for securing new Medicare codes and obtaining PDAC approval to ensure proper classification. VA will align reimbursement with these determinations, supporting access to validated innovations while maintaining clarity and fiscal discipline.

Q18: Under the new Community Provider Standard, will VA discontinue competitive contracting for O&P services and instead allow any credentialed O&P provider to furnish care? If so, how will existing contracts be phased out or amended?

A: The Standard will replace Contracts and Blanket Purchase Agreements (BPA) when ordering periods or current options expire or by your choice. We encourage Community Providers to voluntarily accept orders under the Standard and agree to end contracts and BPAs early.

Q19: Will the new standard allow community O&P providers to continue treating veterans with whom they have established clinical relationships, and how will continuity of care be prioritized under the new process?

A: Veteran preference remains an essential element of care coordination, and it will continue to play an important role in referral and authorization decisions under the new standard.

Q20: Is veteran provider preference still a significant factor in coordinating care? Will veteran provider preference continue to guide referral and authorization decisions under the new standard, and how will VA ensure that veterans retain meaningful choice in selecting their O&P provider?

A: Veteran preference remains an essential element of care coordination, and it will continue to play an important role in referral and authorization decisions under the new standard. By broadening the pool of eligible community providers, the standard enhances timely access while preserving meaningful choice.