

# **Children of Women Vietnam Veterans Health Care Benefits Guide**



U.S. Department  
of Veterans Affairs

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# Helpful Tips

## Children of Women Vietnam Veterans (CWVV)

This guide contains important information on the CWVV Health Care Benefits Program. Please read it carefully prior to using your CWVV benefits.

Changes that take place between printings of this guide are published in the form of guide changes, which are mailed to each beneficiary. It is very important that address changes be reported promptly to Office of Community Care (OCC) in Denver, Colorado. Please read all guide changes carefully and file them with your guide until it is republished.

There is no scheduled republishing date for this guide. The next edition will be published based on the volume and extent of changes.

Check our website at <http://www.va.gov/communitycare/index.asp> for the latest information.

## Assistance

General Information and Preauthorization:

Phone: 1-888-820-1756

E-mail: Go to [https://www.va.gov/COMMUNITYCARE/about\\_us/contacts.asp](https://www.va.gov/COMMUNITYCARE/about_us/contacts.asp) and follow the instructions for submitting e-mail via IRIS.

Mail: Office of Community Care  
CWVV Health Care Benefits Program  
P.O. Box 469065  
Denver, CO 80246-9065 USA

Website: <http://www.va.gov/communitycare/index.asp>

Fax: 1-303-331-7807

## **Change of address or phone number?**

Stay on our mailing list. Promptly report any change of address or phone number to:

Office of Community Care  
CWWV Health Care Benefits Program  
P.O. Box 469065  
Denver, CO 80246-9065 USA

E-mail: Go to [https://www.va.gov/COMMUNITYCARE/about\\_us/contacts.asp](https://www.va.gov/COMMUNITYCARE/about_us/contacts.asp) and follow the instructions for submitting e-mail via IRIS.

## **Notice of Privacy Practices**

Veterans who are enrolled for VA health care benefits are afforded various privacy rights under federal law and regulations, including the right to a Notice of Privacy Practices. The Veterans Health Administration (VHA) issued the VA Notice of Privacy Practices, IB 10-163, in April 2009. The VA Notice of Privacy Practices provides enrolled Veterans with information on how VHA may use and disclose personal health information. The Notice also advises enrolled Veterans of their rights to know when and to whom their health information may have been disclosed, request access to or receive a copy of their health information on file with VHA, request an amendment to correct inaccurate information on file and file a privacy complaint. The VA Notice of Privacy Practices may be obtained through the Internet at <https://www.va.gov/privacy-policy/> or through the mail by writing the VHA Privacy Office (19F2), 810 Vermont Avenue NW, Washington, DC 20420.

# Section 1: CWV Health Care Benefits Programs

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## Overview

In addition to monetary allowances, vocational training and rehabilitation, the Department of Veterans Affairs also provides VA-financed health care benefits to women Vietnam Veterans' birth children who the Veterans Benefits Administration has determined to have a covered birth defect.

This program is not a comprehensive health care plan and only covers those services necessary for the treatment of a covered birth defect and associated medical conditions. It does not cover care that is unrelated to a covered birth defect.

Office of Community Care (OCC) in Denver, Colorado, manages the CWV Health Care Benefits Program, including the authorization of medical benefits and the subsequent processing and payment of claims. Contact us if you have questions.

## Application Process

Health care benefits are based on eligibility determinations made by the Denver VA Regional Office. You must first contact the Denver VA Regional Office to initiate the application process by calling 1-303-914-2900. After the Denver VA Regional Office has made its determination, including any decision related to monetary allowances, OCC contacts the CWV awardee or guardian regarding the CWV Health Care Benefits Program.

## Costs

There are no beneficiary co-payments or deductibles. VA is the exclusive payer for services provided to beneficiaries under this program, and billing should be sent directly OCC. The determined allowable amount for payment is considered payment in full, and the provider may not bill the beneficiary for the difference between the billed amount and the VA-determined allowed amount.

# Section 1: CWV Health Care Benefits Programs

## Contact OCC

Phone: 1-888-820-1756

Contact: Go to [https://www.va.gov/COMMUNITYCARE/about\\_us/contacts.asp](https://www.va.gov/COMMUNITYCARE/about_us/contacts.asp) and follow the instructions for submitting e-mail via IRIS.

Mail: Office of Community Care  
CWV Health Care Benefits Program  
P.O. Box 469065  
Denver, CO 80246-9065

Website: <http://www.va.gov/communitycare/index.asp>

# Section 2: Health Benefits

CWV beneficiaries receive an identification card from OCC. This card includes the beneficiary's name and effective date for health care benefits.

## General Coverage

This program provides health care coverage only for services and supplies that are necessary for the covered birth defect and associated medical conditions.

## General Exclusions

- Care unrelated to a covered birth defect
- Care as part of a grant, study or research program
- Care considered experimental or investigational
- Care that is not medically necessary or appropriate
- Drugs not approved by the Food and Drug Administration (FDA) for commercial marketing
- Services provided outside the scope of the provider's license or certification
- Services rendered by providers suspended or sanctioned by a federal agency
- Services, procedures or supplies for which the beneficiary has no legal obligation to pay, such as services obtained at a health fair

## Preauthorization Requirements

Although most health care services and supplies do not require approval in advance (preauthorization), some do.

- Preauthorization **IS** required for:
  - Attendants
  - Day health care provided as outpatient care
  - Dental services
  - Durable medical equipment (DME) with a total rental or purchase price in excess of \$2,000



## Section 2: Health Benefits

- Homemaker services (must be related to the covered birth defect or associated medical condition(s))
- Mental health services
- Substance abuse treatment
- Training of family members
- Transplantation services
- Travel (other than mileage for privately owned automobiles for local travel)
- Preauthorization is **NOT** required for routine health care services and supplies that are clearly related to the treatment of the covered birth defect and associated medical conditions.

**Note:** When in doubt, contact OCC.

### How to Request Preauthorization

You can obtain preauthorization from OCC by telephone or fax.

**By Phone: 1-888-820-1756. By Fax: 1-303-331-7807**

To request preauthorization, please provide the following:

- Beneficiary's name
- Beneficiary's Social Security number
- Description of service requested, including procedure and diagnosis codes
- Estimated cost (if known)
- Medical justification for services requested
- Name, address and telephone number of the provider who will actually furnish the requested services
- The anticipated date of service

If the service is not urgent, you can mail your preauthorization requests to:

Office of Community Care  
CWW Health Care Benefits Program  
P.O. Box 469065  
Denver, CO 80246-9065 USA

# Section 3: What Is and Is Not Covered

## Ambulatory Surgery

Ambulatory surgery is performed on an outpatient, walk-in or same-day basis in an appropriately equipped and staffed facility. Surgery is usually conducted under general anesthesia, with no overnight stay required. CWV coverage of ambulatory surgical procedures depends on where the surgery takes place. Ambulatory surgical procedures performed in a hospital are covered when medically necessary for the covered birth defect and associated conditions. Certain procedures performed in a freestanding ambulatory surgical center (not in a hospital) are covered as long as the procedure is approved by Medicare to be performed in a freestanding ambulatory surgical center. (Ask your provider.)

What **IS** covered:

- Surgical procedures
- Facility service
- Professional fees, such as physician services
- Ancillary services (e.g., X-rays, lab tests, etc.) in an approved hospital

What is **NOT** covered

- Surgical procedures performed in a freestanding ambulatory surgical center (outside of a hospital) that are not Medicare approved
- Ancillary services or facility fees in a freestanding ambulatory surgical center (considered to be included in the surgical fee)

## Attendants (Preauthorization is required)

A physician or nurse may be authorized to accompany the beneficiary when medically necessary, owing to the beneficiary's physical or mental condition as related to the covered birth defect. In this case, CWV will provide reimbursement for professional fees and associated travel costs when the service has been preauthorized.

# Section 3: What Is and Is Not Covered

A relative or friend of a beneficiary may act as an attendant, provided it is medically necessary because of the beneficiary's physical or mental condition as related to a covered birth defect and the relative or friend can provide the appropriate level of care. In this case, reimbursement for associated travel costs will be made when the service has been preauthorized. Fees for the nonprofessional attendant's time are not reimbursable.

## Case Management

Case management is a collaborative process that assists in the planning and coordination of medically necessary and appropriate health care services. The case manager works with you and your provider to facilitate access to health care services and coordinates the resources needed to provide the optimum level of health care.

OCC can provide you with assistance in receiving case management services by providing benefit liaison support functions such as: completing the beneficiary's intake checklist information, providing a list of community contacts for case management resources, assisting in the case management provider selection process, coordinating with the case management provider to establish the beneficiary/case manager relationship, communicating program benefits, providing payment information, creating awareness, and educating case managers of VA benefits.

## Day Health Care

A therapeutic program prescribed by an approved health care provider that provides necessary medical services, rehabilitation, therapeutic activities, socialization, nutrition, and transportation services in a congregate setting.

What is **Not** covered:

- Services that are not health-related

## Dental Services (Preauthorization is required)

Dental care is not a covered benefit unless necessary for the treatment of a covered birth defect or an associated medical condition.

# Section 3: What Is and Is Not Covered

## **Durable Medical Equipment (Preauthorization is required for any item bought or rented that exceeds \$2,000 in total cost)**

Durable Medical Equipment (DME) is equipment that is ordered by a physician for the specific use of the beneficiary and:

- Can withstand repeated use
- Improves the function of a malformed, diseased or injured body part or prevents further deterioration of the medical condition
- Is medically necessary for the treatment of a covered birth defect or related medical condition(s)
- Is appropriate for use in the home
- Is used to serve a medical purpose (rather than for transportation, comfort or convenience)

DME includes items such as wheelchairs, hospital beds and ventilators.

Requests for preauthorization must have the doctor's DME order (prescription or certificate of medical necessity) that includes:

- The name, address, and tax identification number (TIN) of the provider
- Diagnosis for which the DME is requested
- The anticipated duration of need for the item
- The make, model number, cost and indication of whether the item must be customized
- A statement that describes the medical necessity

In the case of an emergency, immediate rental from a local supply center will be authorized for DME necessary for the covered birth defect until the equipment can be provided through the VA. In urgent-need situations, such as a patient being discharged from the hospital to the home and requiring a hospital bed, preauthorization should be requested by phone. DME items can be provided by VA sources. OCC can assist in the coordination of these purchases.

# Section 3: What Is and Is Not Covered

What **IS** covered (not all inclusive):

- DME that is prescribed by a physician for the treatment of a covered illness or injury, provides the necessary level of performance and is consistent with the FDA-approved labeling for use
- Customization, accessories or supplies that are essential to provide a therapeutic benefit and to ensure proper functioning of the equipment
- Duplicate item of DME when it is essential to provide a fail-safe, in-home, life-support system
- Maintenance by a manufacturer's authorized technician
- Repair and adjustment
- Replacement needed as a result of normal wear or a change in the medical condition
- Temporary rental when the purchased DME is being repaired
- Vehicle wheelchair lift (detachable)

What is **NOT** covered (not all inclusive):

- DME for which the patient has no obligation to pay
- Exercise equipment
- Hot tubs
- Household and recliner chairs
- Luxury or deluxe equipment (Only the cost of basic equipment that meets the medical needs of the patient is covered.)
- Maintenance agreements/contracts
- Modifications to home or vehicle
- Ramps
- Repair and adjustment costs on rented/leased equipment (Those costs should be included in the rental/lease agreements.)
- Spas
- Sporting equipment
- Swimming pools

# Section 3: What Is and Is Not Covered

- Vehicle lifts that are nondetachable or are manufactured for a specific vehicle that cannot be removed from one vehicle and used on another
- Whirlpools

## Home Care

Medical care, habilitative and rehabilitative care and health-related services furnished to an individual in the individual's home or other place of residence.

What **IS** covered:

- Treatment by an approved health care provider (physician, registered nurse, licensed practical nurse, licensed vocational nurse, therapist or home health aide) when the beneficiary is homebound or the condition is such that home care is medically indicated by a physician

What is **NOT** covered:

- Services that are not health-related
- Services that are not for the covered birth defect or associated medical condition(s)
- Services outside the home or place of residence

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## Homemaker Services

Homemaker services is a component of health-related services encompassing certain activities that help to maintain a safe, healthy environment for an individual in the home or other place of residence. Such services contribute to the prevention, delay, or reduction of risk or harm or hospital, nursing home, or other institutional care.

What **IS** covered:

Homemaker services to include assistance with personal care; home management; completion of simple household tasks; nutrition, including menu planning and meal preparation; consumer education; and hygiene education. Homemaker services may include assistance with Instrumental Activities of Daily Living, such as: Light housekeeping; laundering; meal preparation; necessary services to maintain a safe and sanitary environment in the areas of the home used by the individual;

# Section 3: What Is and Is Not Covered

and services essential to the comfort and cleanliness of the individual and ensuring individual safety. Homemaker services must be provided according to the individual's written plan of care and must be prescribed by an approved health care provider.

What is **NOT** covered:

- Services that are not health-related
- Services outside the home or place of residence

## Inpatient Services

An inpatient episode of care (more than 24 hours) is covered when medically necessary for the covered birth defect.

What **IS** covered (not all inclusive):

- Diagnostic tests and procedures
- Patient-initiated, second-opinion consultation to determine the medical necessity of a service
- Physician care/visits received in a hospital or other specialized facility for a covered diagnosis
- Physician specialist consultations requested by the attending physician (Consultations performed within three days of the surgery are not reimbursed separately.)
- Private room when medically necessary
- Room and board
- Semiprivate room
- Skilled nursing facility care that is prescribed by, or performed under, the general direction of a physician
- Surgical assistant, if required by the complexity of the surgical procedure being performed (must submit supporting medical documentation)
- Surgical services

What is **NOT** covered (not all inclusive):

- Halfway houses
- Personal comfort items, such as telephones and televisions

# Section 3: What Is and Is Not Covered

- Retirement or rest homes
- Services/supplies that could have been (and are) performed routinely on an outpatient basis
- Staff consultations required by the policies of a hospital or other institute
- Telephone consultation

## **Mental Health Services (Preauthorization is required for outpatient services in excess of 23 visits per calendar year)**

Mental health services are covered when medically necessary for treatment of the covered birth defect.

A proposed treatment plan is required that includes diagnosis (as listed in the *Diagnostic and Statistical Manual of Mental Disorders-DSM*), modalities to be used, length of sessions, estimated length of treatment (frequency and number of visits) and the relationship of the need for treatment to the covered birth defect. A properly licensed or certified mental health provider must provide the services requested.

What **IS** covered (not all inclusive):

- Inpatient mental health services
- Outpatient mental health services up to and including 23 visits per calendar year
- Service by a mental health provider who is appropriately licensed or certified

What is **NOT** covered (not all inclusive):

- Outpatient psychotherapy provided while a beneficiary is participating in an inpatient program
- Services not related to a covered birth defect or related medical condition(s)



# Section 3: What Is and Is Not Covered

## Nursing Home Care

Nursing home care is covered if the nursing home is an “approved health care provider” through the Centers for Medicare and Medicaid Services (CMS), Department of Defense TRICARE program, The Joint Commission, or currently approved for providing health care under a license or certificate issued by a governmental entity with jurisdiction.

What **IS** covered:

- Admission to a nursing home
- Nursing home care provided by an approved health care provider
- Other covered services, to include medications and medically necessary durable medical equipment while a resident in a nursing home

## Orthotics

Orthotics are appliances customized to assist in movement or to provide support to a limb, which are medically necessary for the covered birth defect.

What **IS** covered:

- Cervical orthotics
- Lower limb orthotics
- Spinal orthotics
- Upper limb orthotics
- Replacement when required due to growth or a change in condition

## Pharmacy Services, Supplies and Over-the-Counter Items

What **IS** covered (not all inclusive):

- Drugs and medications, administered by a physician or obtained by prescription
- Drugs approved by the FDA for the treatment of the condition for which it is administered

# Section 3: What Is and Is Not Covered

- Drugs prescribed by an authorized provider and dispensed in accordance with state law and licensing requirements
- Drugs that are medically necessary and appropriate for the treatment of the covered condition(s) for which they are administered
- Expendable supply items, such as catheters, colostomy or ileostomy sets and supplies, plastic or rubber gloves, skin preparations and powders for orthotic and prosthetic appliance wearers, urinals, leg or canister type urinary drainage supplies and incontinence supplies
- Over-the-counter medications prescribed for the treatment of a covered birth defect or associated medical condition(s)

What is **NOT** covered (not all inclusive):

- Drugs not approved by the FDA for commercial marketing
- Drugs prescribed or furnished by a member of the patient's immediate family
- Experimental/investigational (unproven) drugs
- Group C drugs for terminally ill cancer patients (These medications are available free from the National Cancer Institute through its registered physicians.)
- Items such as bed linens, specialty garments and clothing
- Placebo injections and drugs

## Prosthetic Services/Devices

What **IS** covered:

- Replacement of prosthesis when required due to growth or a change in the patient's condition
- Replacement of prosthesis when medically necessary
- Surgical implants that have FDA approval

What is **NOT** covered:

- Prosthetic devices categorized by the FDA as experimental/investigational (unproven)
- Prosthetic devices unrelated to the covered birth defect

# Section 3: What Is and Is Not Covered

## Rehabilitative Services

What **IS** covered (not all inclusive):

- Diagnostic or assessment tests and exams
- Inpatient cognitive rehabilitation for a maximum of 65 calendar days
- Occupational therapy
- Osteopathic and chiropractic manipulative therapy
- Parenteral and enteral nutrition therapies
- Physical therapy
- Restoration of lost neuromuscular functions
- Speech pathology services

What is **NOT** covered (not all inclusive):

- Assisted living, including group homes, apartments and similar assisted living accommodations
- Camps
- Treatment for speech disturbance of a nonorganic (psychiatric or emotional) origin
- Services provided by athletic trainers, Occupational Therapy Assistants, and Physical Therapy Assistants
- Myofunctional or tongue thrust therapy
- Vocational rehabilitation and training (This benefit is covered through the VA Vocational Rehabilitation and Employment Service. For information, please call 1-800-827-1000.)

## Respite Care

Respite care is care, including day health care, furnished by an approved health care provider on an intermittent basis for a limited period to an individual who resides primarily in a private residence when such care will help the individual continue residing in such private residence.

# Section 3: What Is and Is Not Covered

What **IS** covered:

- Care for up to 30 days in a calendar year for periods not to exceed 14 calendar days
- Care provided by an approved health care provider
- Care provided in a hospital, skilled nursing facility, intermediate care facility, nursing home or private residence
- Day health care provided as outpatient care

What is **NOT** covered:

- Care provided by a relative, friend or other person who is not licensed or certified within the state to provide medical services

## **Training Family Members (Preauthorization and certificate of completion are required)**

What **IS** covered:

- Training for family members, guardians and members of the child's household when required to provide in-home management of a covered birth defect or related medical condition(s)
- Training in the use of an assistive technology device
- Training such as bowel and bladder care

What is **NOT** covered:

- Training provided at general meetings, annual meetings, conferences and other such seminars
- Fees (wages) submitted by family members or other nonprofessional caregivers for service provided, with the exception of bowel and bladder care provided by a trained family member

# Section 3: What Is and Is Not Covered

## Travel (Preauthorization is required for travel outside of the commuting area)

What **IS** covered:

- Ambulance services, when medically necessary and life-sustaining equipment is needed, or other means of transportation are contraindicated
- Transportation expenses for special mode vehicles to and from approved health care providers within the commuting area (Round-trip transportation expenses include transportation to and from the residence and the location of treatment.)

What is **NOT** covered:

- Ambulance service, when transport or transfer of a patient is primarily for the purpose of having the patient nearer to home, family, friends or personal physician
- Ambulance service, when used in lieu of taxi service, for example, to take the patient to the hospital for treatment/therapy, when the use of an ambulance is not medically necessary or when the patient's condition would have permitted use of regular private transportation whether or not the private transportation was actually available
- Meals and lodging for trips of fewer than 12 hours (round-trip)
- Travel by parents or other family members to visit the beneficiary
- Travel outside the commuting area, when services are available within the commuting area
- Travel to attend general meetings, annual meetings, conferences and other such seminars, where the focus is on dissemination of general information relating to a covered birth defect or related medical condition(s)
- Rental care in lieu of taxi services or special mode vehicles

# Section 4: Selecting Health Care Providers

## Provider Guidelines

Beneficiaries may select the provider of their choice, as long as the provider is an approved health care provider. The provider must be approved by the Centers for Medicare and Medicaid Services (CMS), the Department of Defense TRICARE program, or The Joint Commission, or may be a health care provider approved for providing services pursuant to a state license or certificate. A provider is not required to contract with the OCC, so the OCC does not maintain a list of providers.

## Authorized Providers

Medical services and supplies are covered when received from the following professional providers (not all inclusive).

- Anesthetist
- Audiologist
- Certified Clinical Social Worker
- Certified Marriage and Family Therapist
- Certified Midwife
- Certified Nurse Anesthetist
- Certified Nurse Practitioner
- Certified Physician Assistant
- Certified Psychiatric Nurse Specialist
- Chiropractor
- Clinical Psychologist
- Dentist (when services are preauthorized and a covered benefit)
- Licensed Practical Nurse
- Licensed Vocational Nurse
- Medical Doctor (MD)
- Occupational Therapist
- Optometrist
- Osteopath
- Pastoral Counselor

# Section 4: Selecting Health Care Providers

- Physical Therapist
- Physician (MD)
- Podiatrist
- Psychiatrist
- Physiologist
- Registered Nurse

Services from the following types of providers are NOT covered:

- Acupuncturist
- Naturopath
- Physical Therapy Assistant and Occupational Therapy Assistant

Pastoral counselors, nurse's aides, audiologists, therapists, and similar providers must be referred by the primary physician, and the services they provide must be supervised by the physician.

## **Provider Options**

In addition to approved private providers, some services may also be obtained from VA health care facilities. Contact the VA in your area to see if they have space available to provide treatment. It's up to the local VA health care facility to decide if they can provide the care you need.

# Section 5: Claims

Mail claims for payment to:

Office of Community Care  
CWW Health Care Benefits Program  
P.O. Box 469065  
Denver, CO 80246-9065

We recommend that you have your provider bill OCC directly and that you keep a copy of all claim documents submitted. The determined allowable amount for payment is considered payment in full, and the provider may not bill the beneficiary for the difference between the billed amount and the VA-determined allowed amount.

## Forms

Providers should use a standard billing form Uniform Bill-04 (UB-04), or Centers for Medicare and Medicaid Services-1500 (CMS 1500) to provide the required information, as indicated below. Beneficiaries who are filing claims for reimbursement of out-of-pocket expenses should use the VHA CC-supplied form, Claim for Miscellaneous Expenses (VA Form 10-7959e). That form can be obtained from the OCC website at <https://www.va.gov/COMMUNITYCARE/pubs/forms.asp>.

### Required Documentation

All claims must contain:

#### ***Patient Identification***

- Full name (as it appears on identification card)
- Social Security number
- Address
- Date of birth

#### ***Provider Identification***

- Full name and address, with zip code, of hospital or physician
- Individual provider's professional status (MD, PhD, RN, etc.)
- Medicare provider number (inpatient institutions only)
- Physical location where services were rendered
- Provider tax identification number—indicate whether this is an employer identification number or Social Security number
- Remittance address



## **Inpatient Treatment Information** (UB-04 or CMS 1500—provider only).

- All procedures performed (ICD codes)
- Principal diagnosis (ICD code) established as the reason for admission
- All secondary diagnoses (ICD codes)
- Dates and services (specific and inclusive)
- Dates for all absences from a hospital or other approved institution during the period for which inpatient benefits are being claimed
- Discharge status of the patient
- Summary level itemization of billed charges (by revenue codes)

## **Treatment Information and Ancillary Outpatient Services** (UB-04 or CMS 1500—provider only)

- Diagnosis (ICD codes)
- Individual billed charges for each procedure, service or supply, for each date of service
- Current procedure codes (CPT-4, HCPCS, ADA) and descriptions for each procedure, service or supply, for each date of service
- Specific dates of service

## **Prescription Drugs and Medicines** (standard billing forms when submitted by provider/or Claim for Miscellaneous Expenses available from OCC when submitted by the beneficiary)

- Pharmacy receipt to include:
  - date dispensed
  - drug name
  - National Drug Code (NDC)
  - name and address of pharmacy
  - strength and quantity
- On each receipt, write the associated diagnosis legibly

# Section 5: Claims

**Travel** (Claim for Miscellaneous Expenses available from OCC—beneficiary only)

- Billing statements
- Claims for personally owned vehicle mileage to include:
  - certification of medical appointment
  - date of service
  - place of service
  - signature of provider
- Other (out-of-pocket) expenses—such as expenses for over-the-counter medicines and supplies (Standard billing form—Claim for Miscellaneous Expenses is available from OCC.)
- Receipts for all travel expenses (except mileage) for personally owned vehicles

## Filing Deadlines

Claims must be filed with OCC no later than:

- One year from the date of service; or
- In the case of inpatient care, one year after the date of discharge; or
- In the case of a VA regional office award for retroactive eligibility, 180 days following beneficiary notification of the award

## Other Health Insurance

Although VA assumes full responsibility for the cost of medical services related to the treatment of a covered birth defect and associated conditions, other health insurers, including Medicare and Medicaid, might assume payment responsibility for services unrelated to the VA-covered conditions.

## Explanation of Benefits

When we finish processing a claim, we will mail you an explanation of benefits (EOB)—even if the claim was filed by the provider. The EOB is a summary of the action taken on the claim and contains the following information:

- Amount billed
- Beneficiary name
- Dates of service or supplies provided
- Description of services and/or supplies provided
- Reasons for denial (if applicable)
- To whom payment, if any, was made
- VA-allowed amount

## Reconsideration of Claims/Appeals

If you, your representative (who must be designated in writing by the beneficiary or legal guardian) or your health care provider disagree with a claim determination, you can request a reconsideration. Include the following in your written request:

- A copy of the EOB in question
- The specific issue that is being disputed
- Why you think the VA determination is in error
- Any new and relevant information pertaining to the claim

You must send your request to OCC within one year of the date of the initial EOB. Send your request to:

Office of Community Care  
Reconsideration/Appeals  
P.O. Box 460948  
Denver, CO 80246-0948

We will mail you a written statement of the result of the review. If the original decision is reversed or modified, the claim will be reprocessed and you will receive a new EOB. If the denial is upheld, you may request a formal appeal.

# Section 5: Claims

You have 90 days from the date of our second denial to make your appeal in writing. Include the following with your request:

- A copy of the EOB in question
- The specific issue that is being disputed
- Why you think the VA determination is in error
- Any new and relevant information pertaining to the claim that was not previously considered

Send your request to:

Office of Community Care  
Reconsideration/Appeals  
P.O. Box 460948  
Denver, CO 80246-0948

**Allowed/allowable amount:** The allowable amount (or allowable charge) is the maximum amount authorized for payment to a hospital, institutional provider, physician or other individual medical professional, or an authorized provider for covered medical services.

**Approved health care provider:** A health care provider approved by the Centers for Medicare and Medicaid services (CMS), the Department of Defense TRICARE program, The Joint Commission, or any health care provider approved for providing services pursuant to a state license or certificate. An entity or individual shall be deemed to be an approved health care provider only when acting within the scope of the approval, license or certificate.

**Beneficiary:** A woman Vietnam Veteran's birth child who has been determined by a VA regional office to have a covered birth defect.

**Child:** A birth child of a woman Vietnam Veteran, regardless of age or marital status, conceived after the date on which the Veteran first served in the Republic of Vietnam during the Vietnam era (February 28, 1961– May 7, 1975).

**CMS:** Centers for Medicare and Medicaid Services, administrators of Medicare; formerly the Health Care Financing Administration.

**Day health care:** A therapeutic program prescribed by an approved health care provider that provides necessary medical services, rehabilitation, therapeutic activities, socialization, nutrition, and transportation services in a congregate setting. Day health care may be provided as a component of outpatient care or respite care.

**Explanation of benefits (EOB):** A statement issued by a health benefits plan/program, summarizing the action taken on a claim.

**Habilitative and rehabilitative care:** Professional counseling, guidance services and treatment programs (other than vocational training) necessary to develop, maintain or restore, to the maximum extent practicable, the functioning of a disabled person.

**Health care:** Home care, hospital care, nursing home care, outpatient care, habilitative and rehabilitative care, case management and respite care. Includes the training of appropriate members of a child's family or household in the care of the child; the provision of pharmaceuticals, supplies, equipment and devices; direct transportation costs to and from approved health care providers (including any necessary meals and

# Glossary

lodging en route and accompaniment by an attendant or attendants) and other medical services as determined necessary.

**Health-related services:** Homemaker or home health aide services furnished in the individual's home or other place of residence to the extent that those services provide assistance with Activities of Daily Living and Instrumental Activities of Daily Living that have therapeutic value.

**Health care provider:** Any entity or individual who furnishes health care, including specialized clinics.

**Home care:** Medical care, habilitative and rehabilitative care and health-related services furnished to an individual in the individual's home or other place of residence.

**Home health aide services:** A component of health-related services providing personal care and related support services to an individual in the home or other place of residence. Home health aide services (HHAS) may include assistance with Activities of Daily Living such as: Bathing; toileting; eating; dressing; aid in ambulating or transfers; active and passive exercises; assistance with medical equipment; and routine health monitoring. HHAS must be provided according to the individual's written plan of care and must be prescribed by an approved health care provider.

**Homemaker services:** Homemaker services is a component of health-related services encompassing certain activities that help to maintain a safe, healthy environment for an individual in the home or other place of residence. Such services contribute to the prevention, delay, or reduction of risk of harm or hospital, nursing home, or other institutional care. Homemaker services include assistance with personal care; home management; completion of simple household tasks; nutrition, including menu planning and meal preparation; consumer education; and hygiene education. Homemaker services may include assistance with Instrumental Activities of Daily Living such as: Light housekeeping; laundering; meal preparation; necessary services to maintain a safe and sanitary environment in the areas of the home used by the individual; and services essential to the comfort and cleanliness of the individual and ensuring individual safety. Homemaker services must be provided according to the individual's written plan of care and must be prescribed by an approved health care provider.

**Hospital care:** Care and treatment furnished to an individual who has been admitted to a hospital as a patient.

**The Joint Commission:** The Joint Commission is a health care industry quality assurance accrediting body.

**Long-term care:** Home care, nursing home care, and respite care.

**Medical supplies:** Supplies for medical treatment and/or home care determined to be expendable stock items. Expendable stock items might include catheters, colostomy or ileostomy sets and supplies, plastic or rubber gloves, skin preparation and powders for orthotic and prosthetic appliance wearers, urinals, incontinence supplies, dressing materials and the like.

**Nursing home care:** Care and treatment furnished to an individual who has been admitted to a nursing home as a resident.

**Office of Community Care (OCC):** Located in Denver, Colorado, Office of Community Care is responsible for the administration of various VA benefit programs, including the CWV Health Care Program.

**Outpatient care:** Care and treatment, including preventive health care services, furnished to an individual outside hospital or nursing home settings.

**Respite care:** Care, including day health care, furnished by an approved health care provider on an intermittent basis, for a limited period, to an individual who resides primarily in a private residence, when such care will help the individual continue residing in such private residence.

**TRICARE:** Formerly known as CHAMPUS. A federal health benefits program administered by the Department of Defense (DoD) for military retirees as well as families of active duty, retired and deceased service members. DoD shares with eligible beneficiaries the cost of certain health care services and supplies.

**VA regional office:** Regional centers under VA's Veterans Benefits Administration, the VA branch responsible for the administration of VA benefits other than health care. Among other responsibilities, VA regional offices process applications for benefits and determine monetary benefit awards.

**Vietnam Veteran:** A Veteran who performed active military, naval or air service in the Republic of Vietnam, during the Vietnam era (February 28, 1961–May 7, 1975). Service in the Republic of Vietnam includes the waters offshore and service in other locations, if the conditions of service involved duty or visitation in the Republic of Vietnam.

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# Fraud and Abuse

Individuals who have reason to believe that the Department of Veterans Affairs is being billed for services that were not rendered or that a beneficiary is receiving unnecessary or inappropriate health care services are encouraged to immediately report their suspicions to Office of Community Care.

Mail: Purchased Care of the Health Administration Center  
ATTN: Purchased Care Program Integrity  
P.O. Box 461307  
Denver, CO 80246-5307

E-mail: [OCCProgramintegrity@va.gov](mailto:OCCProgramintegrity@va.gov)



