Spina Bifida Health Care Benefits Program Guide

U.S. Department of Veterans Affairs

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Updated Date February 2020

Helpful Tips

Spina Bifida Health Care Benefits

This guide contains important information on spina bifida health care benefits. Please read it carefully prior to using your 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 VHA's Office of Community Care (VHA CC). Please read all guide changes carefully and file them with your guide until it is republished.

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

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

Assistance

General Information:

Phone:	1-888-820-1756
Email:	Please go to **https://iris.custhelp.com/app/ask** and follow the directions for submitting e-mail via IRIS.
Mail:	VHA Office of Community Care PO Box 469065 Denver CO 80246-9065
Website:	**www.va.gov/communitycare**

Preauthorization:

Phone:	1-888-820-1756
Email:	Please go to **https://iris.custhelp.com/app/ask** and follow the directions for submitting e-mail via IRIS.
Mail:	VHA Office of Community Care PO Box 469065 Denver CO 80246-9065
Fax:	303-331-7807

Change of address or phone number?

Stay on our mailing list…promptly report any change of address to:

VHA Office of Community Care
PO Box 469065
Denver, CO 80246-9065

Email: Please go to **https://iris.custhelp.com/app/ask** and follow the directions for submitting e-mail via IRIS.

In addition, because we do much of our business over the phone, please keep us informed of any changes to your telephone number(s).

Notice of Privacy Practices

Beneficiaries of the Spina Bifida Health Care Benefits Program and 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 beneficiaries and Veterans with information on how VHA may use and disclose personal health information. The notice also advises enrolled beneficiaries and 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 **http://www.va.gov/vhapublications/ViewPublication.asp?pub_ID=1090** or through the mail by writing the VHA Privacy Office (19F2), 810 Vermont Avenue NW, Washington, DC 20420.

Section 1: Spina Bifida Health Care Benefits Program

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Overview

In addition to monetary allowances, vocational training and rehabilitation, the Department of Veterans Affairs also reimburses for health care provided to certain Korea and Vietnam Veterans' birth children who have been diagnosed with spina bifida. For the purpose of this program, spina bifida is defined as all forms or manifestations of spina bifida (except spina bifida occulta).

The VHA Office of Community Care in Denver, Colorado, administers the Spina Bifida Health Care Benefits Program, including the authorization of 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. Call the regional office at 303-914-2900 to initiate the application process. After the Denver VA Regional Office has made its determination, including any decision related to monetary allowances, VHA CC contacts the spina bifida awardee or guardian regarding the Spina Bifida 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 to VHA CC. 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. Beneficiaries or their guardians should ask providers first whether they will accept the Spina Bifida Health Care Benefits Program as payment in full. If the providers have questions, refer them to VHA CC at 1-888-820-1756.

Contact the VHA Office of Community Care

Phone:	1-888-820-1756
Email:	Please go to **https://iris.custhelp.com/app/ask** and follow the directions for submitting e-mail via IRIS.
Mail:	VHA Office of Community Care PO Box 469065 Denver CO 80246-9065
Website:	**http://www.va.gov/communitycare/index.asp**

Section 2: Health Care Benefits

Beneficiaries receive an identification card from the VHA Office of Community Care (VHA CC). This card includes the beneficiary's name and effective date for health care benefits.

General Coverage

This program provides covered services and supplies for enrolled beneficiaries for all covered medical conditions, not simply those related to spina bifida.

General Exclusions

- 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 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. Authorization can only be approved when it is medically necessary.

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
- Homemaker services (must be health-related services)

- Outpatient mental health services in excess of 23 visits in a calendar year
- Substance abuse treatment
- Training of family members, guardians, and members of the child's household
- Transplantation services
- Travel (other than mileage at the General Services Administration rate for privately owned automobiles)

Note: When in doubt, contact VHA CC.

How to Request Preauthorization

You can obtain preauthorization from VHA CC by telephone or FAX.

By Phone: 1-888-820-1756

By Fax: 303-331-7807

To request preauthorization, include the following:

- Beneficiary's name
- Beneficiary's Social Security Number
- Description of service/treatment requested, including procedure code(s), equipment/supply code(s), diagnosis code(s) and place of service
- Estimated cost (if known)
- Physician signed letter of medical necessity and/or physician order
- Name, address and telephone number of the provider who will actually furnish the requested services
- Anticipated date of service

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

VHA Office of Community Care
PO Box 469065
Denver CO 80246-9065

Ambulatory Surgery

Ambulatory surgery is surgery performed on an outpatient or same-day basis, in an appropriately equipped and staffed facility. Surgery is usually conducted under anesthesia with no overnight stay required. Coverage of ambulatory surgical procedures depends on where the surgery takes place. Ambulatory surgical procedures performed in a hospital are covered when medically necessary and in accordance with benefit policy. Surgical procedures performed in a freestanding ambulatory surgical center (ASC) are covered, as long as the sugery is either on the TRICARE or Medicare ASC approved list (ask your provider).

What IS Covered:

- Ancillary services provided by a hospital
- Facility services for the surgical procedure(s)
- Professional services

What Is NOT Covered:

- Surgical procedures that are not on the TRICARE or Medicare ASC approved list and performed in a freestanding ASC.
- Ancillary services provided by a freestanding ASC
- Incidental procedures performed at the same time as a primary procedure
- Procedures that are medically unnecessary, experimental, or unproven

Attendants (Preauthorization Is Required)

A physician or nurse may be authorized to accompany the beneficiary to their medical appointment because of a medical condition. In this case, reimbursement for professional fees and associated travel costs will be made only when medically necessary and after the service has been preauthorized.

A relative or friend of a beneficiary may act as an attendant when medically necessary because of the beneficiary's physical or mental condition and when the relative or friend can provide the appropriate level of care. In this case, reimbursement for associated travel costs

condition and when the relative or friend can provide the appropriate level of care. In this case, reimbursement for associated travel costs will be made after 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 providers to facilitate access to health care services and coordinates the resources needed to provide the optimum level of health care.

VHA CC can provide you with assistance in receiving case management services by providing a list of case management resources, communicating program benefits, and providing claim status.

Day Health Care (Preauthorization Is Required)

What IS Covered

- 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 medical benefit.

Durable Medical Equipment (DME) (Preauthorization is required for any item purchased or rented that exceeds $2,000 in total cost)

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 medical condition
- 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, ventilators and vacuum assisted closure devices for wounds or ulcerations.

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

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

Or, in urgent need situations, preauthorization should be requested by phone, such as when a patient is being discharged from the hospital to the home and requires a hospital bed. DME items can be provided from VA sources. VHA CC can assist you with the coordination of these purchases.

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 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)
- Cost for separate maintenance agreements/contracts
- Repair and adjustment costs on rented/leased equipment (those costs should be included in the rental/lease agreements)
- Spas
- Sporting equipment
- Swimming pools
- Vehicle lifts that are nondetachable or are manufactured for a specific vehicle and cannot be removed from one vehicle and used on another
- Whirlpools

Home Care

Medical care, habilitative and rehabilitative care, preventive health services 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, such as physician, home health nurse, therapist or home health aide, when ordered by a physician and the beneficiary is homebound or the condition is such that home care is medically indicated.

What is NOT Covered

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

Homemaker Services (Preauthorization Is Required)

Homemaker services are 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 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

What is NOT Covered

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

Inpatient Services

What IS Covered (not all inclusive):

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

- Diagnostic tests and procedures
- Patient-initiated second opinion consultation to determine the medical necessity of a service
- Physician visits received in a hospital or other specialized facility for a covered diagnosis
- Physician specialist consultations requested by the attending physician (consultation performed within three days of the surgery are not reimbursed separately)
- Private room when medically necessary
- Room and board
- Semi private room
- Skilled nursing facility care that provides care 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
- 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 and appropriate. A proposed treatment plan is required for outpatient visits greater than 23 in a calendar year that includes diagnosis (as listed in the Diagnostic and Statistical Manual of Mental Disorders—DSM), modalities to be used, length of sessions and estimated length of treatment (frequency and number of visits).

What IS Covered (not all inclusive):

- Inpatient mental health services
- Outpatient mental health services up to and including 23 visits per calendar year without preauthorization (more than 23 visits require preauthorization)
- 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

Nursing Home Care

Nursing home care is covered if the nursing home is an "approved health care provider" through the Centers for Medicare & 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 devices/appliances customized to assist in movement or to provide support to a limb and are covered when medically necessary.

What IS Covered:

- Cervical orthoses
- Lower limb orthotics
- Spinal orthotics
- Upper limb orthotics
- Replacement when required because of 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 Department of Health and Human Services' Food and Drug Administration (FDA) for the treatment of the condition for which it is administered
- 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 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 medicines and/or supplies for covered medical conditions.

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

What Is NOT Covered:

- Prosthetic devices categorized by the FDA as experimental/investigational (unproven)

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

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.

What IS Covered:

- Care for up to 30 days in a calendar year, usually 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, Guardians, and Members of the Child's Household (Preauthorization is Required)

What IS Covered:

- Training for family members, guardians and members of the child's household, when required as an integral part of in-home management of covered medical conditions
- Training such as bowel and bladder care
- Training in the use of an assistive technology device

What Is NOT Covered:

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

Travel (Preauthorization Is Required for Travel Outside of the Commuting Area)

What IS Covered:

- Transportation expenses to and from approved health care providers outside the commuting area, including mileage at the General Services Administration rate for privately owned automobiles, and meals and lodging for trips greater than 12 hours (round trip)
- Ambulance services when medically necessary and life-sustaining equipment is needed or other means of transportation are contraindicated
- Transportation expenses to and from approved health care providers within the commuting area (round-trip transportation expenses cover transportation between residence and the location of treatment) for special mode vehicles and taxi services

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
- Travel allowance (meals and lodging) for less than 12 hours (round trip); travel begins when the beneficiary leaves home and ends when the beneficiary returns home; time noted on claim forms should encompass the actual times of travel
- 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 and annual meetings or conferences, where the focus is on dissemination of general information relating to a covered birth defect or related medical condition
- Rental car in lieu of taxi services or special mode vehicles.

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 & Medicaid Services (CMS), Department of Defense TRICARE program, 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 VHA CC; VHA CC does not maintain a list of providers.

Authorized Providers

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

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

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

In the case of Pastoral counselors, nurse's aides, audiologists and therapists, a referral from the primary physician is required, and the services must be supervised (overseen) by the physician.

Services from the following types of providers are **not** covered:

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

Provider Options

In addition to approved private providers, some services may also be obtained from VA health care facilities. Contact 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.

Mail claims for payment to:

VHA Office of Community Care
PO Box 469065
Denver CO 80246-9065

We recommend that you keep a copy of all claim documents that you submit.

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 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). This form is linked from the VHA CC website at: **http://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 (SSN)
- Address
- Date of birth

Provider Identification

- Full name and address of hospital or physician
- Individual provider's professional status (for example, MD, Pd.D., RN)
- Medicare provider number (inpatient institutions only)
- Physical location where services were rendered
- Provider tax identification number (TIN)—indicate whether this is the employer identification number (EIN) or Social Security number (SSN)
- Remittance address

Inpatient Treatment Information

(Universal Billing form—UB-04—Provider Only)

- All procedures performed (International Classification of Diseases (ICD) procedure code)
- Principal diagnosis (ICD diagnostic codes), established to be chief reason for the patient's hospitalization
- 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
- Patient's discharge status
- Summary level itemization of billed charges (by revenue codes)

Treatment Information and Ancillary Outpatient Services

(Standard billing forms—UB-04 or CMS-1500—Provider Only)

- Diagnosis (ICD codes)
- Individual billed charges for each procedure, service or supply for each date of service
- Procedure codes: Current Procedural Terminology (CPT®), Healthcare Procedure Coding System (HCPCS), American Dental Association (ADA), etc. and descriptions of 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 [VA Form 10-7959e], which can be found on the VHA CC website and is used when the beneficiary submits a claim.)

- Pharmacy invoice to include:
  - Date dispensed
  - Drug name

  - National Drug Code (NDC)
  - Name and address of pharmacy
  - Strength and quantity
- Other (out-of-pocket) expenses such as expenses for over-the-counter medicines and supplies (use VA Form 10-7959e)

Travel

(Claim for Miscellaneous Expenses (use VA Form 10-7959e) available from VHA CC—for beneficiary use only)

- Billing statements
- Claims for personally owned vehicle mileage to include:
  - Certification of medical appointment
  - Date of service
  - Place of service
  - Signature of provider
  - Receipts for all travel expenses (except mileage) for personally owned vehicles

Filing Deadlines

Claims must be filed with VHA CC no later than:

- One year after 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.

Note: If you pay for care and subsequently file a claim for reimbursement, our payment will be limited to the VA allowed amount. For this reason, you should have your providers bill VHA CC directly.

Other Health Insurance (OHI)

Although VA assumes full responsibility for the cost of covered medical services for the treatment of spina bifida beneficiaries, other health insurers, including Medicare and Medicaid, may assume payment responsibility for services that VA does not cover.

Explanation of Benefits (EOB)

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

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

Reconsideration/Appeal of Claims

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 reconsideration. For a reconsideration/appeal to be considered, you must:

- Submit your request in writing within one year of the date of the Explanation of Benefits (EOB), in the case of a denial of service or benefit, or within one year from the date of the letter notifying you of a denial of eligibility or service
- Identify why you believe the original decision was in error
- Include a copy of the EOB or determination letter
- Submit any new and relevant information not previously considered

You must send your request to Office of Community Care (VHA CC) within one year of the date of the initial EOB. Send your request to:

VHA CC
Reconsideration/Appeals
PO Box 460948
Denver CO 80246-0948

A written statement of the result of the review will be mailed to you. 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 second level appeal. This request must be received within 90 days of the date of the initial appeal decision. Identify why you believe the decision is in error and provide any new and relevant information pertaining to the claim that was not previously considered. The second and final determination will inform you of further appellate rights for an appeal to the Board of Veterans' Appeals. Send your request to:

VHA Office of Community Care
Reconsideration/Appeals
PO Box 460948
Denver CO 80246-0948

Allowed/Allowable Amount: The allowable amount (or allowable charge) is the maximum amount authorized for medical and other health services furnished by physicians, medical groups, professional providers, independent laboratories, suppliers of ambulance services, and suppliers of Durable Medical Equipment, Prostheses, Orthotics, and Supplies (DMEPOS), etc.

Approved Health Care Provider: A health care provider approved by the Centers for Medicare & Medicaid Services, 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 Korea or Vietnam Veteran's birth child who is in receipt of a VA regional office monetary award for spina bifida.

Child: 1. A birth child of a Korea Veteran, regardless of age or marital status, who was conceived after the date on which the Korea Veteran first served in or near the Korean demilitarized zone, during the period beginning September 1, 1967, and ending August 31, 1971.

2. A birth child of a Vietnam Veteran, regardless of age or marital status, who was conceived after the date on which the Vietnam Veteran first entered the Republic of Vietnam, during the period beginning January 9, 1962, and ending May 7, 1975.

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.

Glossary

HCFA: Health Care Financing Administration, administrators of Medicare & Medicaid, now called Centers for Medicare & Medicaid Services.

Health Care: Home care, hospital care, long-term care, nursing home care, outpatient care, preventive 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 lodging en route, and accompaniment by an attendant or attendants) and other medical services as determined necessary.

Health Care Provider: Any entity or individual who furnishes health care, including specialized spina bifida clinics.

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.

Home Care: Medical care, habilitative and rehabilitative care, preventive health services 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 are 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 preven-

tion, 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.

Korea Veteran: A Veteran who performed active duty service in or near the Korean demilitarized zone during the period beginning September 1, 1967, and ending August 31, 1971.

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

Medical Supplies: Supplies for medical treatment 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 so on.

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 (VHA CC): The VHA Office of Community Care in Denver, Colorado, is responsible for the administration of various VA benefit programs, including the Spina Bifida Health Care Benefits Program.

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

Glossary

Preventive Care: Care and treatment furnished to prevent disability or illness associated with covered medical conditions, including periodic examinations, immunizations, patient health education and other such services.

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 (January 9, 1962—May 7, 1975). Service in the Republic of Vietnam includes service in 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 a beneficiary is receiving unnecessary or inappropriate health care services are encouraged to immediately report their suspicions to VHA CC.

Phone:	1-888-820-1756
Email:	Please go to **https://iris.custhelp.com/app/ask** and follow the directions for submitting e-mail via IRIS.
Fax:	303-331-7807

Notes