Department of Veterans Affairs
Health Administration Center
Spina Bifida

# Health Care Benefits Program

SPINA BIFIDA

## Spina Bifida Health Care

This handbook 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 handbook are published in the form of Handbook Changes, which are mailed to each beneficiary. It is very important that address changes be reported promptly to VA's Health Administration Center. Please read all handbook changes carefully and file them with your handbook until it is republished.

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

Check our Web site for the latest information at **www.va.gov/hac**

## Assistance

General Information:

**Phone:** 1-888-820-1756
**E-Mail:** Please go to this Web link and follow the directions for submitting e-mail via IRIS: www.va.gov/hac/contact
**Mail:** VA Health Administration Center
PO Box 469065
Denver CO 80246-9065
**Web site:** www.va.gov/hac

Preauthorization:

**Phone:** 1-888-820-1756
**E-Mail:** Please go to this Web link and follow the directions for submitting e-mail via IRIS: www.va.gov/hac/contact
**Mail:** VA Health Administration Center
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 VA's Health Administration Center, PO Box 469065, Denver, CO, 80246-9065

E-mail: Please go to this Web link and follow the directions for submitting e-mail via IRIS: **www.va.gov/hac/contact**

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

# Contents

# Spina Bifida Health Care Benefit Program

## Overview

In addition to monetary allowances, vocational training and rehabilitation, the Department of Veterans Affairs also provides VA-financed health care benefits 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).

Effective October 10, 2008, there was a change to Public Law 110-387, Section 408, which outlines the benefits available under the Spina Bifida (SB) Program. As a result of this change, medical services and supplies for spina bifida beneficiaries are no longer limited to the spina bifida condition. This program now covers comprehensive health care considered medically necessary and appropriate. The VA's Health Administration Center (HAC) in Denver, Colorado, manages the Spina Bifida Health Care 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 1-888-820-1756 to initiate the application process.

## 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 the Health Administration Center. 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.

## Contact the Health Administration Center

**Phone:** 1-888-820-1756

**E-Mail:** Please go to this Web link and follow the directions for submitting e-mail via IRIS: www.va.gov/hac/contact

**Mail:** VA Health Administration Center
PO Box 469065
Denver CO 80246-9065

**Web site:** www.va.gov/hac

# Health Benefits

Beneficiaries receive an identification card from the Health Administration Center. This card includes the beneficiary's name, Member Number (SSN), and effective date for health care benefits.

## General Coverage

This program provides comprehensive health care for covered services and supplies that are considered medically necessary and appropriate.

## 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
- Treatment for spina bifida occulta

## Preauthorization Requirements

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

- Preauthorization is **NOT** required for routine health care services and supplies.
- Preauthorization **IS** required for:
  - Attendants
  - Dental services
  - Durable medical equipment (DME) with a total rental or purchase price in excess of $2,000
  - Mental health services
  - Hospice care
  - Substance abuse treatment
  - Training of family members
  - Transplantation services
  - Travel (other than mileage for privately owned automobiles for local travel)

**Note:** When in doubt, contact the HAC.

## How to Request Preauthorization

You can obtain preauthorization from the Health Administration Center 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 SSN
- Description of service requested, including procedure(s) and diagnosis code(s)
- Estimated cost (if known)
- Medical justification for services requested
- Name, address and telephone number of the provider who will actually furnish the requested services
- Anticipated date of service
- Veteran's name

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

**VA Health Administration Center**
**PO Box 469065**
**Denver CO 80246-9065**

# 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. Coverage of ambulatory surgical procedures depends on where the surgery takes place. Ambulatory surgical procedures performed in a hospital are covered when medically necessary. Certain procedures performed in a free-standing ambulatory surgical center (not in a hospital) are covered, as long as the procedure is approved by Medicare to be performed in a free-standing ambulatory surgery center (ask your provider).

What **IS** Covered:

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

What Is **NOT** Covered:

- Surgical procedures performed in a free-standing ambulatory surgical center (outside of a hospital) that are not Medicare approved
- Ancillary services or facility fees in a free-standing ambulatory surgical center (considered inclusive in the surgical fee)

## Attendants (Preauthorization Is Required)

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

A relative or friend of a beneficiary may act as an attendant when medically necessary 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.

## Dental Services (Preauthorization Is Required)

Dental care is not a covered benefit unless necessary for the treatment of a covered medical benefit.

## What Is and Is Not Covered

### 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, and
- is used to serve a medical purpose (rather than for transportation, comfort or convenience).

Durable medical equipment 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 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. The HAC can assist you with the coordination of these purchases.

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

- Customization, accessories or supplies that are essential to provide a therapeutic benefit and to ensure proper functioning of the equipment
- 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
- 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 and Is Not Covered

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
- 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 (physician, registered nurse, home health 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:

- Companion services
- Day care (child or adult)
- Homemaker services
- Personal attendant

### Inpatient Services

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

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

- Diagnostic tests and procedures
- Patient-initiated second opinion consultation to determine the medical necessity of a service

### Inpatient Services (Continued)

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

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

- 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):

- Custodial care
- Domiciliary care
- 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

# What Is and Is Not Covered

## Mental Health Services (Preauthorization Is Required)

Mental health services are covered when medically necessary and appropriate. A proposed treatment plan is required that includes diagnosis (as listed in *Diagnostic and Statistical Manual of Mental Disorders*—DSM-IV), modalities to be used, length of sessions and estimated length of treatment (frequency and number of visits). A properly licensed or certified mental health provider must provide the services requested. In the case of an emergency mental health admission, the request for authorization should be made within 24 hours of admission. Request for authorization must be made to us within 72 hours of the time of admission.

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

- Emergency admission reported no later than 72 hours from the time of admission
- 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

## Orthotics

Orthotics are 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

# What Is and Is Not Covered

## 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 it is 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 covered medical conditions

What Is **NOT** Covered (not all inclusive):

- Drug maintenance programs where one addictive drug is substituted for another (such as methadone for heroin)
- 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 home, apartments and so on
- Camps
- Treatment for speech disturbance of a nonorganic (psychiatric or emotional) origin
- 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 furnished by an approved health care provider, on an intermittent basis, for a limited period, to someone who usually lives in a private residence, when such care helps the person continue to live in the private residence.

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

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

# What Is and Is Not Covered

## Training Family Members (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 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:

- 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 from residence to 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
- 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

# 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), Department of Defense TRICARE program, CHAMPVA, JCAHO 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 HAC; the HAC 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
- 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 physician assistants, counselors, anesthetists, 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

## 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.

# Claims

Mail claims for payment to:

**VA Health Administration Center**
**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 (UB-04, CMS-1500) to provide the required information indicated below. Beneficiaries who are filing claims for reimbursement of out-of-pocket expenses should use the HAC-supplied form, Claim for Miscellaneous Expenses (10-7959e).

## 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 (MD, Ph.D., RN, and so on)
- 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 (ICD-9 procedure codes)
- Principal diagnosis (ICD-9 diagnostic codes), established to be chief reason for the patient's hospitalization
- All secondary diagnoses (ICD-9 codes and descriptions)
- 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-9 codes and descriptions)
- Individual billed charges for each procedure, service or supply, for each date of service
- Procedure codes (CPT-4, HCPCS, ADA) 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, which is available from HAC when submitted by the beneficiary)

- Pharmacy invoice to include:
  - Date dispensed
  - Drug name
  - National Drug Code (NDC)
  - Name and address of pharmacy
  - Strength and quantity

### Travel

(Claim for Miscellaneous Expenses available from HAC—beneficiary only)

- Billing statements
- Claims for personally owned vehicle (POV) 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 HAC)
- Receipts for all travel expenses (except mileage) for POVs

## Filing Deadlines

Claims must be filed with the HAC 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 the HAC directly.

# Claims

## Other Health Insurance (OHI)

Although VA assumes full responsibility for the cost of medical services for the treatment of spina bifida beneficiaries' care, 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 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 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, and
- Any new and relevant information pertaining to the claim.

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

**VA Health Administration Center**
**Reconsideration/Appeals**
**PO Box 460948**
**Denver CO 80246-0948**

We will mail you a written statement of the result of the review if we do not change our original decision.

## Reconsideration of Claims (Continued)

If you disagree with our decision, you may request a second review. You have 90 days from the date of our first reconsideration 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, and
- Any new and relevant information pertaining to the claim.

Send your request to:

**VA Health Administration Center**
**Reconsideration/Appeals**
**PO Box 460948**
**Denver CO 80246-0948**

# Glossary



**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, Department of Defense TRICARE program, CHAMPVA, JCAHO 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.

**CHAMPVA:** Similar to TRICARE, CHAMPVA is a federal health benefits program administered by the Department of Veterans Affairs (VA), in which VA shares with eligible beneficiaries the cost of certain health care services and supplies. Administration of CHAMPVA is managed by the VA Health Administration Center in Denver, Colorado.

**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.

**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.

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

**Health Administration Center:** Located in Denver, Colorado, VA's Health Administration Center is responsible for the administration of various VA benefit programs, including the Spina Bifida Health Care Program.

## Glossary

**Health Care:** Home care, hospital 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.

**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.

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

**JCAHO:** The Joint Commission on Accreditation of Health Care Organizations is a health care industry quality assurance accrediting body.

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

**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.

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

**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 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 living in such private residence.

## Glossary

**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 for 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.

# Index

## 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 VA's Health Administration Center.

**Phone:** 1-888-820-1756

**E-Mail:** Please go to this Web link and follow the directions for submitting e-mail via IRIS: www.va.gov/hac/contact

**Fax:** 303-331-7807

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