

**§ 17.903**

**38 CFR Ch. I (7-1-04 Edition)**

Center within 72 hours of the emergency.

(Authority: 38 U.S.C. 101(2), 1802-1803, 1811-1813, 1821)

(The Office of Management and Budget has approved the information collection requirements in this section under control number 2900-0578.)

**§ 17.903 Payment.**

(a)(1) Payment for services or benefits under §§ 17.900 through 17.905 will be determined utilizing the same payment methodologies as provided for under the Civilian Health and Medical Program of the Department of Veterans Affairs (CHAMPVA) (see § 17.270).

(2) As a condition of payment, the services must have occurred:

(i) For spina bifida, on or after October 1, 1997, and must have occurred on or after the date the child was determined eligible for benefits under § 3.814 of this title.

(ii) For covered birth defects, on or after December 1, 2001, and must have occurred on or after the date the child was determined eligible for benefits under § 3.815 of this title.

(3) Claims from approved health care providers must be filed with the Health Administration Center in writing (facsimile, mail, hand delivery, or electronically) no later than:

(i) One year after the date of service; or

(ii) In the case of inpatient care, one year after the date of discharge; or

(iii) In the case of retroactive approval for health care, 180 days following beneficiary notification of eligibility.

(4) Claims for health care provided under the provisions of §§ 17.900 through 17.905 must contain, as appropriate, the information set forth in paragraphs (a)(4)(i) through (a)(4)(v) of this section.

(i) Patient identification information:

- (A) Full name,
- (B) Address,
- (C) Date of birth, and
- (D) Social Security number.

(ii) Provider identification information (inpatient and outpatient services):

(A) Full name and address (such as hospital or physician),

(B) Remittance address,

(C) Address where services were rendered,

(D) Individual provider's professional status (M.D., Ph.D., R.N., etc.), and

(E) Provider tax identification number (TIN) or Social Security number.

(iii) Patient treatment information (long-term care or institutional services):

(A) Dates of service (specific and inclusive),

(B) Summary level itemization (by revenue code),

(C) Dates of service for all absences from a hospital or other approved institution during a period for which inpatient benefits are being claimed,

(D) Principal diagnosis established, after study, to be chiefly responsible for causing the patient's hospitalization,

(E) All secondary diagnoses,

(F) All procedures performed,

(G) Discharge status of the patient, and

(H) Institution's Medicare provider number.

(iv) Patient treatment information for all other health care providers and ancillary outpatient services such as durable medical equipment, medical requisites, and independent laboratories:

(A) Diagnosis,

(B) Procedure code for each procedure, service, or supply for each date of service, and

(C) Individual billed charge for each procedure, service, or supply for each date of service.

(v) Prescription drugs and medicines and pharmacy supplies:

(A) Name and address of pharmacy where drug was dispensed,

(B) Name of drug,

(C) National Drug Code (NDC) for drug provided,

(D) Strength,

(E) Quantity,

(F) Date dispensed,

(G) Pharmacy receipt for each drug dispensed (including billed charge), and

(H) Diagnosis for which each drug is prescribed.

(b) Health care payment will be provided in accordance with the provisions of §§ 17.900 through 17.905. However, the

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following are specifically excluded from payment:

- (1) Care as part of a grant study or research program,
- (2) Care considered experimental or investigational,
- (3) Drugs not approved by the U.S. Food and Drug Administration for commercial marketing,
- (4) Services, procedures, or supplies for which the beneficiary has no legal obligation to pay, such as services obtained at a health fair,
- (5) Services provided outside the scope of the provider's license or certification, and
- (6) Services rendered by providers suspended or sanctioned by a Federal agency.

(c) Payments made in accordance with the provisions of §§17.900 through 17.905 shall constitute payment in full. Accordingly, the health care provider or agent for the health care provider may not impose any additional charge for any services for which payment is made by VA.

(d) *Explanation of benefits (EOB)*—(1) When a claim under the provisions of §§17.900 through 17.905 is adjudicated, an EOB will be sent to the beneficiary or guardian and the provider. The EOB provides, at a minimum, the following information:

- (i) Name and address of recipient,
  - (ii) Description of services and/or supplies provided,
  - (iii) Dates of services or supplies provided,
  - (iv) Amount billed,
  - (v) Determined allowable amount,
  - (vi) To whom payment, if any, was made, and
  - (vii) Reasons for denial (if applicable).
- (2) [Reserved]

(Authority: 38 U.S.C. 101(2), 1802-1803, 1811-1813, 1821)

(The Office of Management and Budget has approved the information collection requirements in this section under control number 2900-0578.)

**§ 17.904 Review and appeal process.**

For purposes of §§17.900 through 17.905, if a health care provider, child, or representative disagrees with a determination concerning provision of health care or with a determination

concerning payment, the person or entity may request reconsideration. Such request must be submitted in writing (by facsimile, mail, or hand delivery) within one year of the date of the initial determination to the Health Administration Center (Attention: Chief, Benefit and Provider Services). The request must state why it is believed that the decision is in error and must include any new and relevant information not previously considered. Any request for reconsideration that does not identify the reason for dispute will be returned to the sender without further consideration. After reviewing the matter, including any relevant supporting documentation, a benefits advisor will issue a written determination (with a statement of findings and reasons) to the person or entity seeking reconsideration that affirms, reverses, or modifies the previous decision. If the person or entity seeking reconsideration is still dissatisfied, within 90 days of the date of the decision he or she may submit in writing (by facsimile, mail, or hand delivery) to the Health Administration Center (Attention: Director) a request for review by the Director, Health Administration Center. The Director will review the claim and any relevant supporting documentation and issue a decision in writing (with a statement of findings and reasons) that affirms, reverses, or modifies the previous decision. An appeal under this section would be considered as filed at the time it was delivered to the VA or at the time it was released for submission to the VA (for example, this could be evidenced by the postmark, if mailed).

NOTE TO §17.904: The final decision of the Director will inform the claimant of further appellate rights for an appeal to the Board of Veterans' Appeals.

(Authority: 38 U.S.C. 101(2), 1802-1803, 1811-1813, 1821)

(The Office of Management and Budget has approved the information collection requirements in this section under control number 2900-0578.)

**§ 17.905 Medical records.**

Copies of medical records generated outside VA that relate to activities for which VA is asked to provide payment or that VA determines are necessary to