

Department of Veterans Affairs

§ 17.902

to an individual who resides primarily in a private residence when such care will help the individual continue residing in such private residence.

Spina bifida means all forms and manifestations of spina bifida except spina bifida occulta (this includes complications or medical conditions that are associated with spina bifida according to the scientific literature).

Vietnam veteran for purposes of spina bifida means the same as defined at §3.814(c)(1) or §3.815(c)(1) of this title and for purposes of covered birth defects means the same as defined at §3.815(c)(1) of this title.

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

§ 17.901 Provision of health care.

(a) *Spina bifida*. VA will provide a Vietnam veteran's child who has been determined under §3.814 or §3.815 of this title to suffer from spina bifida with such health care as the Secretary determines is needed by the child for spina bifida. VA may inform spina bifida patients, parents, or guardians that health care may be available at not-for-profit charitable entities.

(b) *Covered birth defects*. VA will provide a woman Vietnam veteran's child who has been determined under §3.815 of this title to suffer from spina bifida or other covered birth defects with such health care as the Secretary determines is needed by the child for the covered birth defects. However, if VA has determined for a particular covered birth defect that §3.815(a)(2) of this title applies (concerning affirmative evidence of cause other than the mother's service during the Vietnam era), no benefits or assistance will be provided under this section with respect to that particular birth defect.

(c) *Providers of care*. Health care provided under this section will be provided directly by VA, by contract with an approved health care provider, or by other arrangement with an approved health care provider.

(d) *Submission of information*. For purposes of §§17.900 through 17.905:

(1) The telephone number of the Health Administration Center is (888) 820-1756;

(2) The facsimile number of the Health Administration Center is (303) 331-7807;

(3) The hand-delivery address of the Health Administration Center is 300 S. Jackson Street, Denver, CO 80209; and

(4) The mailing address of the Health Administration Center—

(i) For spina bifida is P.O. Box 65025, Denver, CO 80206-9025; and

(ii) For covered birth defects is P.O. Box 469027, Denver, CO 80246-0027.

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

NOTE TO §17.901: This is not intended to be a comprehensive insurance plan and does not cover health care unrelated to spina bifida or unrelated to covered birth defects. VA is the exclusive payer for services paid under §§17.900 through 17.905 regardless of any third party insurer, Medicare, Medicaid, health plan, or any other plan or program providing health care coverage. Any third-party insurer, Medicare, Medicaid, health plan, or any other plan or program providing health care coverage would be responsible according to its provisions for payment for health care not relating to spina bifida or covered birth defects.

§ 17.902 Preauthorization.

(a) Preauthorization from a benefits advisor of the Health Administration Center is required for the following services or benefits under §§17.900 through 17.905: rental or purchase of durable medical equipment with a total rental or purchase price in excess of \$300, respectively; transplantation services; mental health services; training; substance abuse treatment; dental services; and travel (other than mileage at the General Services Administration rate for privately owned automobiles). Authorization will only be given in those cases where there is a demonstrated medical need related to the spina bifida or covered birth defects. Requests for provision of health care requiring preauthorization shall be made to the Health Administration Center and may be made by telephone, facsimile, mail, or hand delivery. The application must contain the following:

- (1) Name of child,
- (2) Child's Social Security number,
- (3) Name of veteran,
- (4) Veteran's Social Security number,
- (5) Type of service requested,
- (6) Medical justification,

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(7) Estimated cost, and
(8) Name, address, and telephone number of provider.

(b) Notwithstanding the provisions of paragraph (a) of this section, preauthorization is not required for a condition for which failure to receive immediate treatment poses a serious threat to life or health. Such emergency care should be reported by telephone to the Health Administration 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,