

## CHAMPVA POLICY MANUAL

CHAPTER: 3  
SECTION: 1.2  
TITLE: CLAIMS PROCESSING - FOREIGN

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AUTHORITY: 38 CFR 17.270(a) and 17.273-278

RELATED AUTHORITY: 32 CFR 199.7 GC-97-06

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### I. EFFECTIVE DATES

A. Prior to January 1, 1994, claims were required to be received no later than December 31<sup>st</sup> following the year in which the services/supplies were provided.

B. For services on or after January 1, 1994, claims must be received within one year from the date of service or one year from the date of discharge from an inpatient facility.

### II. DEFINITIONS

United States. For purposes of this policy and payment of inpatient and outpatient services, the term "United States" includes the 50 States, the District of Columbia, American Samoa, Guam, Puerto Rico, and the Virgin Islands. [PPI 98-1, January 22, 1998]

### III. POLICY

A. General. The objective of CHAMPVA claims processing procedures is to ensure that all claims are processed in a timely and consistent manner and that government funds are expended only for those services or supplies authorized by regulation. All claims reviewed must include sufficient information to determine:

1. eligibility of the beneficiary,
2. the service/supply is a CHAMPVA benefit,
3. the service/supply is medically necessary, and
4. the beneficiary is legally obligated to pay for the service or supply.

B. Itemization. Requirements for itemization are liberally interpreted for foreign claims and foreign claims will not be rejected for lack of itemization.

C. Claim content. Claims must contain the following minimal information:

1. A valid, payable diagnosis,
2. Provider name and address,
3. Service/supply/drug/DME ordered, performed or prescribed, and
4. Charges for each item.

D. Preauthorization. The beneficiary and/or provider must ensure advance approval is received from CHAMPVA for the following treatment/services.

1. Dental care (see [Chapter 2, Section 5.1](#), *Adjunctive Dental Care*).
2. Durable medical equipment (DME) (see [Chapter 2, Section 17.1](#), *Durable Medical Equipment and Supplies*).
3. Non-emergent mental health/substance abuse treatment including admission of emotionally disturbed children and adolescents to residential treatment centers (see [Chapter 2, Section 18.17.2](#), *Preauthorization for Residential Treatment Center Care*).
4. Admissions to a partial hospitalization program, including alcohol rehabilitation (see Chapter 2, Section 18.18, *Psychiatric Partial Hospitalization Programs-Preauthorization and Day Limits*).

5. Organ transplants (see [CHAMPVA PM Section 31](#), *Transplants*).

E. Retroactive authorizations. When either a claim for CHAMPVA eligibility or claim for benefits has been denied, such denial may be overturned with the submittal of additional information or evidence in support of the claim. When a retroactive authorization has been made, claims must be received:

1. 180 days following notification to the beneficiary of an approved retroactive authorization date.
2. 180 days following beneficiary notification of the approval of a covered service that had previously been denied.

F. Other health insurance (OHI). CHAMPVA is always the secondary payer of benefits when there is other health insurance. If OHI is involved, an explanation of benefits (EOB) from the OHI must accompany the submission (see [Chapter 3, Section 4.1](#), *Other Health Insurance (OHI)*).

G. Allowable amount. Claims are paid at 75% of the billed charge unless the catastrophic cap has been met.

H. Payment of benefits. Payment will be made to the beneficiary or provider based on the evidence submitted. In either case, there must be clear evidence submitted as to whether payment has or has not already been made by the beneficiary to the provider.

I. Payment under \$1.00. If the CHAMPVA benefit payment is under \$1.00, payment will not be issued although the catastrophic cap and deductible will be credited.

J. Claim disposition. Upon completion of claim processing, an EOB will be sent to the beneficiary and the provider if benefits were assigned. For claims resulting in a payment, a check, or electronic funds transfer (EFT) will be issued by the U.S. Treasury.

1. An EOB will be issued to the beneficiary whether or not an actual payment is involved.

2. Procedure codes for claims involving abortion, AIDS, alcoholism, drug abuse, psychosexual dysfunction or venereal disease will not be included on beneficiary EOBs.

K. Reopened claims. A claim may be reopened based on new information or a finding of administrative error. A reopened claim may result in increased or decreased allowable charges.

1. The new or relevant information will be appended to the original claim.

2. The reopened claim will be computed using the payment methodology applicable on the date of service.

3. If there was an underpayment, the claim will be reprocessed for additional payment through regular procedures.

4. If there was an overpayment, a recoupment action will be issued by the Debt Collection Unit (DCU).

L. Fraud. Falsifying information, e.g., providing an incorrect residence address, modifying claim forms, billing for services not provided, etc. is considered fraud.

#### IV. POLICY CONSIDERATIONS

A. Development of missing information will be kept to a minimum.

B. Policy Considerations A - F in [Chapter 3, Section 1.1](#), *Claims Processing-General*, are applicable to foreign claims.

C. If the billing is submitted in a foreign language, it will first be sent to the HAC foreign-language contractor for translation.

D. If the billing is in foreign currency, the billed amount will be converted to the US currency equivalent based on conversion rates:

1. in effect on the date of service, and
2. published in the *Wall Street Journal* [GC-97-06].

## V. EXCEPTIONS

A. Exceptions to timely filing requirements for medical claims may be granted when:

1. There is medical documentation of beneficiary incompetence and the beneficiary did not have a legal guardian.

2. There is evidence of an administrative error (that is, misrepresentation, mistake, or other accountable action), by an employee of the Health Administration Center (HAC), that prevented the timely filing the medical claim. Necessary evidence must include:

a. a written statement describing how the error caused failure to file within the usual time limit, and

b. a copy of an agency letter or written notice reflecting the error.

3. The claimant submitted the claim to the primary health insurer and the primary insurer delayed adjudication past the CHAMPVA deadline. In this case, the following must be established:

a. The claim was originally sent to the primary health insurer prior to the CHAMPVA claim-filing deadline or, the claim was filed with CHAMPVA prior to the deadline and returned or denied pending processing by the primary health insurer.

b. The claimant must submit with the claim a statement indicating the original date of submission to the primary health insurer, the date of adjudication, any relevant correspondence, and an explanation of benefits (EOB).

B. American Samoa, Guam, Puerto Rico, and Virgin Islands claims are subject to the same provisions applicable to services provided in the United States.

C. The Director, Health Administration Center may waive the claims filing deadline in other circumstances in which the Director determines that a waiver is appropriate and necessary to ensure adequate access to health care services for CHAMPVA beneficiaries.

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**\*END OF POLICY\***