

The Spina Bifida Health Care Benefits Program and Payment Methodology

What is the Spina Bifida Health Care Benefits Program?

The Spina Bifida (SB) Health Care Benefits Program is administered by the Department of Veterans Affairs (VA) for certain Korea, Vietnam, and Thailand Veterans' biological children diagnosed with spina bifida (except spina bifida occulta). The Veterans Health Administration Office of Community Care (VHA OCC) manages the program, including the authorization of benefits and the subsequent processing and payment of claims. The SB Health Care Benefits Program provides reimbursement for a comprehensive suite of medically necessary health care services and supplies.

Who is eligible for this program?

If you are the biological child of a Vietnam-era Veteran who served in Korea, Vietnam, or Thailand and you are diagnosed with spina bifida (except spina bifida occulta), to receive health care benefits through this program you first must be granted a military service-connected monetary award for spina bifida through the Veterans Benefits Administration (VBA). Application for the VBA monetary award may be sent to the Denver VA Regional Office by email to bdeffects.vbaden@va.gov or by fax to 844-531-7818. Once a monetary award has been made by VBA, VBA notifies VHA OCC to enroll you in the SB Health Care Benefits Program. VHA OCC will contact you when your enrollment is complete.

Is preauthorization required for services?

Most services do not require preauthorization. Preauthorization is required for the following (can only be approved if medically necessary):

- Day health care provided as outpatient care
- Dental services
- Durable medical equipment (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, such as bowel and bladder assistance, of family members, guardians and members of the patient's household
- Organ transplants
- Travel (other than mileage at the General Services Administration rate for privately owned automobiles for local travel), to include attendant services

When is preauthorization required for travel?

Travel to a physician in your local commuting area (50 miles or less from your home) does not require preauthorization. If your local attending physician recommends examination or treatment by a specialist who is not your local area (someone who is in another part of the state or country), you will need to obtain preauthorization for the travel.

The request for preauthorization should include your attending physician's recommendation for evaluation, an explanation of why the service cannot be performed by a specialist in the local area, and the name and address of the physician to whom you are being referred.

Are there times when travel will not be covered?

Travel will not be covered in the following circumstances:

- When a provider in your local area could provide the same services sought from a provider outside of the local area
- When an ambulance is not medically necessary or required and is used in lieu of regular transportation, such as a privately owned vehicle or taxi



- When the travel is for reasons other than to obtain medical treatment or services (e.g., travel to attend meetings or conferences)

How do I request preauthorization?

If the preauthorization relates to a medical service or supply, your health care provider should submit the request. Requests may be made by fax to 303-331-7807.

Spina Bifida Health Care Benefits Program Payment Methodology Summary

BENEFIT	SPINA BIFIDA HEALTH CARE BENEFITS PROGRAM PAYS
Ambulatory Surgery: Facility Services	Lesser of the billed charge or a prospective payment system (PPS) reimbursement. The PPS amount is similar to the DoD TRICARE or Medicare rate.
Ambulatory Surgery: Professional Services	Lesser of the billed charge or 100 percent of the VA-determined maximum allowable charge, which is similar to the DoD TRICARE or Medicare rate.
Durable Medical Equipment (DME)	Lesser of the billed charge or the VA-determined allowable amount.
Home Health Services	Lesser of the billed charge or the VA-determined allowable amount.
Hospice	The Hospice reimbursement is based on Medicare's per diem rates for the four levels of care; routine home care, continuous home care, inpatient respite care and general inpatient care.
Inpatient Services: Professional Services	Professional services (physician fees and anesthesia) are paid the lesser of the billed amount or the VA-determined maximum allowable amount.
Inpatient Services: DRG-Based Payment System	An inpatient service occurs when the admission to a hospital is for 24 hours or more, or when the admission was intended to last for more than 24 hours. The Diagnosis Related Group (DRG) payment system is used to calculate payments for episodes of care. The DRG payment system is priced as of the date of discharge using the rules, weights and rates in effect on the date of discharge. The DRG payment rates are based on an average cost of local care and the allowable amount may be up to the billed amount. DRG payment rates are similar to DoD TRICARE and Medicare rates.
Inpatient Services: Non-DRG-based	These include Christian Science Sanitoriums, foreign hospitals, long-term hospitals, rehabilitation hospitals and sole community hospitals (not an all-inclusive list). Payment is equal to billed charges.
Residential treatment center (RTC)	Payment is based on the lesser of the DoD TRICARE mental health per diem rate or the billed charge.
Mental Health: High Volume/Low Volume	Payment is based on the TRICARE's inpatient mental health per diem rates.
Outpatient Services (i.e., doctors' visits, lab/radiology, skilled nursing visits, ambulance)	Lesser of the billed amount or 100 percent of the VA-determined maximum allowable amount (similar to DoD TRICARE and Medicare rates).
Pharmacy Services	Lesser of the billed amount or 100 percent of the average wholesale price plus a \$3 dispensing fee.
Skilled Nursing Facilities	Reimbursement is based on the Medicare's Skilled Nursing Facility Prospective Payment System (SNF PPS) rates.



What does the Spina Bifida Health Care Benefit Program pay?

There are no co-pays or deductibles for beneficiaries. The SB Health Care Benefits Program pays 100 percent of the VA-allowable amount or billed charges. The chart above shows a summary of the payment methodologies used to reimburse different covered medical services under the program.

What is an allowable amount?

The term allowable amount (or allowable charge) is the maximum amount the SB Health Care Benefits Program will authorize for reimbursement to a hospital, institutional provider, pharmacy, physician or other individual professional provider or an authorized provider for covered medical services.

Does the provider have to accept the SB Health Care Benefits Program-allowable rate?

Yes. Under 38 C.F.R. § 17.903(c), providers must accept the SB Health Care Benefits Program-allowable rate and cannot bill the patient for any remaining balance.

Cancelling Enrollment

If you choose to cancel your enrollment in the SB Health Care Benefits Program, you may send a letter requesting cancellation. You will receive a letter in response notifying you of the effective date of disenrollment. You may send your letter to:

Spina Bifida Health Care Benefits Program Office
PO Box 469065
Denver CO 80246-9065

If you choose to cancel your enrollment in the SB Health Care Benefits Program, you may reapply at any time; however, acceptance for future health care benefits will be based on eligibility factors at the time of application.

How much does the SB Health Care Benefits Program pay for services and how quickly are claims paid?

There is no co-pay or deductible for beneficiaries. Spina bifida is a primary coverage. Additional insurance, including Medicare, are not required. VA pays 100 percent of the allowable charge.

Normally, 90 percent of claims for services are processed within 30 days of receipt.

How do I get more information?

Mail: VHA Office of Community Care

Spina Bifida Health Care Benefits Program
P.O. Box 469065
Denver, CO 80246-9065

Phone: 888-820-1756, Monday-Friday

8:05 a.m. to 6:45 p.m., Eastern Time

Fax: 303-331-7807

Email: Submit to SB.HAC@va.gov

Website: www.va.gov/COMMUNITYCARE/programs/dependents/spinabifida/index.asp