

December 3, 2001

ELIGIBILITY VERIFICATION PROCESS FOR VA HEALTH CARE BENEFITS

1. PURPOSE: This Veterans Health Administration (VHA) Directive outlines Departmental policy and procedures for identifying individuals who have been determined to be ineligible for the Department of Veterans Affairs (VA) medical benefits for their nonservice-connected conditions.

2. BACKGROUND: Situations have occurred where a veteran applies for care at more than one VA medical facility and each facility enters information relative to the individual's military service as part of the Veterans Information Systems and Technology Architecture (VistA) registration process. Due to misinterpretations of proof of military service documents and administrative error, one facility may show an individual to be eligible while another shows that same individual to be ineligible. Inconsistent data between medical centers has led to conflicts between the data in VistA and the Health Eligibility Center (HEC) enrollment database. Software patches DG*5.3*249, DG*5.3*327, and DG*5.3*365 were developed and released for implementation in VistA to correct these deficiencies.

3. POLICY: In compliance with Public Law 104-262, Veterans Health Care Eligibility Reform Act of 1986, it is VHA policy that individuals who are determined to be ineligible are not to be enrolled and, if treated at a VA medical facility, are to be treated on a humanitarian emergency basis only for their non-service connected conditions.

4. ACTION: HEC is responsible for performing a second level review of all eligibility determinations made by VA health care facilities.

a. Once eligibility has been verified by HEC, HEC eligibility information will become VHA's authoritative source for health care eligibility and enrollment classification. Once eligibility information has been initially verified by HEC or an individual medical center, HEC is responsible for all future updates of the eligibility status and is designated as the verified source of the eligibility determination. Medical Center staff will not be permitted to change key data elements once eligibility has been verified. Those data elements are: Ineligible Date, TWX City, Ineligible Reason, VARO Decision, Eligibility Status, Status Entered By, Interim Response, Verification Method and Rated Disabilities. Future software modifications will allow authorized VistA users to edit the Rated Disabilities field.

b. If data provided by HEC is believed to be erroneous, medical facility staff are required to submit supporting documentation to HEC for review and correction of the verified eligibility record. VA medical facilities may request an update or revision to HEC's verified eligibility information by submitting the appropriate documentation to HEC. Three alternative methods are available to provide HEC with correct data:

(1) A VistA e-mail may be sent to the "G. Eligibility Alert@IVM" mail group. Medical facility staff may reply to the original Eligibility Alert Message via Mailman (VistA) and include the corrected data in the body of the message. Medical facility staff may also initiate a new local

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Mailman (VistA) message and send it to the mail group. If data are derived from a Hospital Inquiry (HINQ), medical facility staff should copy and paste the HINQ into the message.

(2) A Microsoft (MS) Exchange e-mail message may be sent to the "HEC Alert" mail group. Medical facility staff may initiate a MS Exchange e-mail message including the corrected data, such as a HINQ response, into the body of the message.

(3) Medical facilities staff may fax the documentation supporting the veteran's eligibility for VA health care benefits to HEC at 404-235-1355. Veteran identification information such as name, date of birth, social security number, and claim number must be clearly legible on documents faxed. Facilities should also include a fax cover sheet that identifies the facility, and the name and phone number of the individual responsible for the eligibility update request.

c. The following documents are acceptable by HEC for verification purposes:

(1) Department of Defense (DOD) DD-214, Certificate of Release or Discharge from Active Duty or equivalent.

(2) VA Form 10-7131, Exchange of Beneficiary Information and Request for Administrative and Adjudicative information.

(3) HINQ containing verified military service and/or service-connected disability information.

(4) VA Form 119, Report of Contact, documenting discussion with Veterans Benefit Administration Records Management Center or Regional Office personnel.

d. If the individual is determined to be ineligible and has no service-connected conditions, the following key fields will be set: Patient type to Non Veteran, Veteran (Yes/No) to No, Primary Eligibility to Humanitarian Emergency, Period of Service to Other Non-Veteran and the Ineligible Date and Ineligible Reason fields will be populated. These individuals will be assigned an Enrollment Status of Not Eligible, Ineligible Date, Enrollment Category of Not Enrolled, and will not be assigned an Enrollment Priority.

e. Veterans who are determined to be ineligible because they fail to meet the minimum active duty service requirements of 38 United States Code (U.S.C.), section 5303A, but who have service-connected disabilities rated zero percent combined, may nonetheless receive treatment for or in connection with a service-connected disability. These veterans will be identified in VistA as follows: Patient Type will be set to SC Veteran, Veteran (Yes/No) to Yes, Service-connected to Yes, Primary Eligibility Code to SC Less than 50 percent, the appropriate veteran Period of Service will be assigned, and Humanitarian Emergency will be added as a Secondary Eligibility (provided it does not already exist). The Ineligible Date and Ineligible Reason fields will be populated. If a previously ineligible individual is determined to be eligible, the values for the Ineligible Date and Ineligible Reason will be removed and an Eligibility Alert

Message will be sent to the VistA DGEN ELIGIBILITY ALERT mail group. This Eligibility Alert will inform the VA health care facility mail group members that the period of service should be reviewed and updated as appropriate.

f. The provisions of 38 Code of Federal Register (CFR), Section 17.102, set forth the conditions under which VA will bill an individual for care furnished on a humanitarian emergency basis. The individual, who received the care, rather than the individual's health insurance carrier, will be billed at the applicable tortuously liable rate.

g. Veterans who are in co-payment required status and do not agree to pay the co-payment are not eligible for VA medical benefits and may not be enrolled in the VA health care system. Veterans who refuse to pay applicable co-payments will be reflected in VistA as follows: Patient Type will be either NSC or SC Veteran; Veteran (Yes/No) will be Yes; Agreed to pay Deductible will be No; Primary Eligibility Code will be set to NSC or Service Connected less than 50 percent Enrollment Status will be Not Eligible; Refused to Pay Copay; Enrollment Category will be Not Enrolled; and the Enrollment End Date will be the date assigned the enrollment status of Not Eligible, Refused to Pay Copay.

h. If a veteran who previously did not agree to pay a co-payment changes his or her decision and now agrees to the co-payment, VA health care facility staff must update the VistA record by changing the Agrees to Pay Deductible field to Yes. Since veterans who do not agree to pay co-payments are not enrolled, when such veterans agree to copayments an exchange e-mail notice is sent to HEC to update the enrollment record.

5. REFERENCES

- a. Public Law 104-262, Veterans' Health Care Eligibility Reform Act of 1996.
- b. Title 38, U.S.C., Chapters 71, 72, 1710, 1722, 1722A, and 5303A.
- c. CFR 38, Sections 17.36, 17.37, 17.38, 17.102, and 19.1 thru 19.201.

6. FOLLOW-UP RESPONSIBILITY: Health Administration Service (10C3) is responsible for the content of this Directive.

7. RESCISSION: None. This Directive expires December 3, 2006.

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