Department of Veterans Affairs

Memorandum

Date: September 15, 2003 VAOPGCPREC 5-2003

From: General Counsel (022)

Subj: Informal Claim for Increase Based on Hospital Admission – 38 C.F.R. § 3.157(b)(1)
XXXXXXX XXXXXX X

To: Chairman, Board of Veterans' Appeals (01)

QUESTION PRESENTED:

May the language of 38 C.F.R. § 3.157(b)(1) that provides that the date of admission to a Department of Veterans Affairs (VA) or uniformed services hospital will be accepted as the date of receipt of a claim for an increased disability rating be construed as including the date of admission to a private hospital pursuant to the prior authorization of a contractor that administers the Department of Defense's (DoD) TRICARE program?

COMMENTS:

1. In 1991, while serving on active duty, the veteran sustained a right-eye injury. In February 1993, a VA Regional Office granted service connection for blindness of the right eye secondary to a retinal detachment and assigned a 30-percent evaluation effective March 11, 1992. In November 1998, the veteran's private physician contacted TriWest Healthcare Alliance (TriWest) and received authorization for an inpatient enucleation of the veteran's damaged eye at the Covenant Medical Center (CMC), a private medical facility. TriWest is a management services organization that, by contract, is responsible for administering DoD's TRICARE program in the TRICARE Central Region consisting of 16 states. TRICARE is DoD's comprehensive managed health care program, which provides health care services for active duty military personnel, military retirees, and their dependents. On November 24, 1998, the veteran contacted a TriWest nurse to confirm the authorization. The nurse confirmed TriWest authorization for the procedure. Later that day, the veteran had the eye enucleation performed at the CMC without prior VA authorization.

2. On January 5, 2000, VA received the veteran's claim for an increased rating for the right-eye disability. A February 2000 VA examination noted that the veteran had an enucleation of the right eye in 1998 and had an eye prosthesis fitted in 1999. In a March 2000 rating, VA assigned a 40-percent evaluation for

the disability effective January 5, 2000. The veteran disagreed with VA's decision to base the effective date of the increased rating on the date of the claim for an increased rating. The question has arisen whether, under 38 C.F.R. § 3.157(b)(1), the date of the veteran's admission to the private medical facility under the authorization of the DoD contract health-care administrator may be the basis for an earlier effective date.

3. Section 5110(a) of title 38, United States Code, provides:

> Unless specifically provided otherwise in this chapter, the effective date of an award based on an original claim, a claim reopened after final adjudication, or a claim for increase, of compensation, dependency and indemnity compensation, or pension, shall be fixed in accordance with the facts found, but shall not be earlier than the date of receipt of application therefor.

With respect to claims for increased compensation, section 5110(b)(2) provides: "[t]he effective date of an award of increased compensation shall be the earliest date as of which it is ascertainable that an increase in disability had occurred, if application is received within one year from such date." VA's implementing regulation essentially tracks the statutory language; a claim for an increased compensation rating is effective on the "[e]arliest date as of which it is factually ascertainable that an increase in disability had occurred if claim is received within 1 year from such date otherwise, date of receipt of claim." 38 C.F.R. § 3.400(o)(2).

4. Sections 5110(a) and 5110(b)(2) limit VA's authority to establish effective dates earlier than the date it receives a claim for an increased disability rating. VA has determined by regulation, however, that the "date of admission to a VA or uniformed services hospital will be accepted as the date of receipt of a claim" for an increased rating. 38 C.F.R. § 3.157(b)(1). That regulation goes on to state that "[t]he date of admission to a non-VA hospital where a veteran was maintained at VA expense will be accepted as the date of receipt of a claim, if VA maintenance was previously authorized." Id. These rules apply only when the hospitalization relates to a disability for which service connection has already been established or for disabilities that are the subject of claims made within one year of hospital admission. Id.

5. In VAOPGCPREC 35-91 (O.G.C. Prec. 35-91), we held that, for purposes of determining entitlement to VA benefits, care at a private facility at VA expense is equivalent to care at a VA facility. Thus, as noted in that opinion, care at a contract nursing home under VA auspices constituted care by VA within the meaning of applicable statutes allowing readmission to a VA hospital without regard to the patient's current eligibility for hospitalization. See also VAOPGCPREC 2-95 (O.G.C. Prec. 2-95) (care provided at a private hospital under contract with VA considered care furnished by United States). However,

this office has not previously issued an opinion on the specific question of whether, under section 3.157(b)(1), VA may establish an effective date for increased benefits on the basis of the date of admission to a private hospital at DoD expense under the TRICARE program.

6. Section 3.157(b)(1) does not address whether care at a private facility at DoD expense is the equivalent of care at a uniformed services facility for effective date purposes. Although section 3.157(b)(1) does contain a provision referring to admission to a non-VA facility at VA expense and no equivalent provision concerning admission to a non-DoD facility at DoD expense, we do not consider this on its face to be determinative evidence of an intent to exclude the latter from consideration. We therefore look to the history of the provision for evidence of its meaning and construe it in the context of relevant legislation.

7. In 1959, VA promulgated a predecessor to current section 3.157(b)(1), which provided that the "date of admission to a VA hospital or date of admission to a non-VA hospital if previously authorized will be accepted [as the date of receipt of a claim for increased benefits]." 38 C.F.R. § 1157(b)(1) (1959). In 1966, VA revised the regulation to provide that the "date of admission to a VA or uniformed services hospital will be accepted as the date of receipt of a claim [for increased benefits]." 38 C.F.R. § 1157(b)(1) (1966) (emphasis added). In a September 1966 transmittal sheet explaining the revision, the Deputy Administrator of Veterans Affairs stated that reports of admission to uniformed services hospitals were to be treated the same as VA hospital reports for purposes of establishing effective dates for increased benefits. He noted that, among other things, the amendment was intended to benefit military retirees and was "adopted following an understanding reached with the [DoD] and the Public Health Service" concerning notice of hospital admissions and diagnosis. The memorandum defined "uniformed services hospital" as including United States Army, Navy, Air Force, and Public Health Service hospitals. The revision moved to a separate sentence the reference to acceptance of the date of admission to a non-VA hospital as the date of receipt of an informal claim for increased benefits and added specific reference to hospitalization "at VA expense." No comparable provision relating to admissions at DoD expense was included, presumably due to the fact that, as explained below, up to that time DoD was not authorized to provide contract health care for military retirees. Except for certain revisions not relevant to this opinion, current section 3.157(b)(1) is identical to the rule as revised in 1966.

8. The 1966 revision of section 3.157(b)(1) preceded Congress's revamping of the military health care system with respect to retired service members. In 1956, Congress had enacted legislation establishing a health care plan for dependents of active duty service members, which authorized DoD to enter into contracts for the purpose of providing care at civilian medical facilities. See Dependents' Medical Care Act, ch. 374, §§ 201-204, 70 Stat. 250, 252-53 (1956). Congress, however, made retirees ineligible for the new plan, noting that a future

analysis of cost data might permit extension of the plan to retirees. See Dependents' Medical Care Act, § 301(b), 80 Stat. at 253; H.R. Conf. Rep. No. 84-2195 (1956), reprinted in 1956 U.S.C.C.A.N. 2712, 2714. Congress revisited the issue of contract health care in 1966 when it enacted legislation that authorized military retirees to receive contract health care in civilian facilities. See Pub. L. No. 89-614, § 2(7), 80 Stat. 862, 865 (1966). The Senate Committee on Armed Services noted that existing law provided no financial assistance to military retirees who use civilian facilities and that military medical facilities met only 57 percent of retirees' hospital needs. S. Rep. No. 89-1434 (1966), reprinted in 1966 U.S.C.C.A.N. 3082, 3093. Congress intended that the legislation would provide "a new hospitalization and outpatient program in civilian sources for retired military members, their spouses and children, and the spouses and children of deceased retired members and of deceased active duty members." Id. at 3083. DoD subsequently implemented the 1956 and 1966 legislation through the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS). See 32 C.F.R. pt. 199.

9. Congress has legislated extensively in the area of military health care since the 1956 and 1966 enactment of legislation authorizing contract health care for certain beneficiaries of the military health care system. See, e.g., Pub. L. No. 97-174, 96 Stat. 70 (1982) (encouraging greater sharing of resources between DoD and VA in an effort to reduce Federal health care costs); Pub. L. No. 99-661, § 701, 100 Stat. 3816, 3894 (1986) (expanding the use of civilian health care providers); Pub. L. No. 101-189, § 722, 103 Stat. 1352, 1477 (1989) (authorizing DoD to use CHAMPUS funds to reimburse VA for medical care provided to CHAMPUS beneficiaries); Pub. L. 102-585, §§ 201-206, 106 Stat. 4943, 4949-50 (1992) (expanding DoD and VA health care sharing arrangements); Pub. L. No. 103-160, § 731, 107 Stat. 1547, 1696 (1993) (directing DoD to implement a health benefit program based on health maintenance organization plans offered in the private sector). These enactments reflected Congress' appreciation of the interrelationship of the VA, DoD, and private health care systems in treating former military personnel.

10. Pursuant to the 1993 enactment of Public Law No. 103-160, § 731, 107 Stat. at 1696, DoD established its TRICARE program for the purpose of "implementing a comprehensive managed health care program for the delivery and financing of health care services in the Military Health System." 32 C.F.R. § 199.17(a). Congress has defined "TRICARE program" as meaning the "managed health care program that is established by [DoD] under the authority of [chapter 55 of title 10, United States Code], principally [10 U.S.C. § 1097], and includes the competitive selection of contractors to financially underwrite the delivery of health care services under [CHAMPUS]." 10 U.S.C. § 1072(7). Under TRICARE, DoD health care beneficiaries are classified in four enrollment categories: (1) active duty members, who are automatically enrolled in the "TRICARE Prime" option; (2) "TRICARE Prime" enrollees; (3) "TRICARE Standard" enrollees, who are CHAMPUS eligible beneficiaries that choose not to

enroll in the "Prime" option; and (4) non-CHAMPUS beneficiaries eligible for treatment in military facilities. 32 C.F.R. § 199.17(a)(6)(i). TRICARE provides three options for receiving DoD health care. "TRICARE Prime" involves the use of military treatment facilities and designated civilian provider networks at a substantially reduced rate for CHAMPUS-eligible beneficiaries. See 32 C.F.R. § 199.17(a)(6)(ii)(A). Beneficiaries agree to follow managed care rules and procedures modeled after civilian health maintenance organization plans. Id. "TRICARE Standard" is the basic CHAMPUS program, under which beneficiaries may use civilian health care providers and may receive care in military facilities on a space-available basis. 32 C.F.R. § 199.17(a)(6)(ii)(C). The third option, "TRICARE Extra," allows "Standard" enrollees to use a preferred provider network, which includes military and civilian facilities, at a reduced cost to the beneficiary. 32 C.F.R. § 199.17(a)(6)(ii)(B). CHAMPUS eligible retired service members are generally eligible for enrollment in the "Prime" option. 32 C.F.R. § 199.17(c)(3).

11. In addition to the above-cited legislation, which cumulatively created a unified military health care system utilizing military, VA, and civilian facilities, Congress has addressed the issue of whether military health care benefits may be afforded to veterans with service-connected disabilities. In 1975, the General Counsel of DoD interpreted the 1966 enactment of section 2 of Public Law No. 89-614 as precluding CHAMPUS reimbursement for care that was otherwise available from the Veterans' Administration. See H.R. Rep. No. 96-469 (1979), reprinted in 1979 U.S.C.C.A.N. 2625, 2626. DoD implemented this interpretation in its 1977 revision of the CHAMPUS regulations. Id. Congress responded by enacting legislation providing that "no person eligible for health benefits under [10 U.S.C. § 1086] may be denied benefits under [that] section with respect to care or treatment for any service-connected disability which is compensable under chapter 11 of title 38 solely on the basis that such person is entitled to care or treatment for such disability in Veterans' Administration facilities." See Pub. L. No. 96-173, 93 Stat. 1287 (1979) (codified as amended in 10 U.S.C. § 1086(g)). The House Committee on Armed Services explained the purpose of dual eligibility for retirees as follows:

> Limiting access of military retirees to CHAMPUS will force these individuals to seek covered medical treatment for care related to their service-connected disabilities from the Veterans' Administration or a military medical facility, while all other care may be provided by their local physician under CHAMPUS. Such fragmented care is most often difficult for retirees because of the distance involved in travelling to Federal facilities. In many cases, as indicated by the Office of the Secretary of Defense, such a restriction could interrupt physician-patient continuity.

H.R. Rep. No. 96-469, at 2, reprinted in 1979 U.S.C.C.A.N. at 2626-27. Congress reinforced this concept of dual eligibility in recent legislation, which provided: "The Secretary of Defense may not take any action that would require, or have the effect of requiring, a member or former member of the armed forces who is entitled to retired or retainer pay to enroll to receive health care from the Federal Government only through the Department of Defense." Pub. L. No. 107-107, § 731(a), 115 Stat. 1012, 1169 (2001) (codified at 10 U.S.C. § 1086b). This provision prohibited DoD from "implementing a policy of forced choice enrollment by military retirees who are eligible for care in the health care facilities and programs of both [DoD] and [VA]." H.R. Conf. Rep. 107-333, at 683 (2001), reprinted in 2001 U.S.C.C.A.N. 1021, 1105. Again, Congress' actions reflected its understanding of the interrelationship of the DoD, VA, and private health care systems.

12. The opinion request raises the question of whether the phrase "uniformed services hospital" in section 3.157(b)(1) may be construed as including private facilities that provide health care under TRICARE. We believe the above discussion provides ample authority to conclude that care provided by DoD through TRICARE at a private facility is equivalent to DoD care in a "uniformed services hospital." VA's 1966 revision of the predecessor to section 3.157(b)(1) was clearly intended to extend the liberalized informal claim procedures relating to hospital admissions to individuals with dual health care eligibility under DoD and VA programs. As the legislation noted above makes clear, military health care is no longer restricted to military facilities, as it generally was at the time of VA's 1966 revision of section 3.157(b)(1). Moreover, with respect to retired service members, Congress has unequivocally authorized that group of beneficiaries to receive care for service-connected disabilities in private facilities under the TRICARE program. Under a narrow construction of section 3.157(b)(1), a retired disabled veteran would be required to seek care in a VA facility, a military facility, or a private facility at VA expense in order to benefit from the liberal date-of-claim provision governing claims for an increased rating, while all other care that the veteran receives might be provided by DoD at a private facility under its TRICARE program. As we noted above, Congress has sought to avoid that kind of fragmented health care for retired disabled veterans. Thus, we believe it would be inconsistent with Congress intent concerning the provision of Federal health care benefits to former military personnel to construe the relevant part of section 3.157(b)(1) as applying only to reports of admission to military medical facilities. Rather, the regulation should be construed as encompassing hospital admission to a private health care facility at DoD expense under the TRICARE program.

HELD:

The provision of 38 C.F.R. § 3.157(b)(1) stating that the date of admission to a "uniformed services hospital will be accepted as the date of receipt of a claim" for

increased benefits is applicable to veterans hospitalized in private facilities at DoD expense under DoD's TRICARE program.

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Attachment: C-files (2)