

What is the CWVV Health Care Benefits Program?

The CWVV program is a federal benefits program administered by the Department of Veterans Affairs (VA) for children of women Vietnam Veterans born with certain birth defects (other than Spina Bifida, which is covered under VA's Spina Bifida Health Care Benefits Program). The CWVV program is a fee-for-service program that provides reimbursement for medical care related to conditions associated with certain birth defects as determined by the Veterans Benefit Administration (VBA).

Are there out-of-pocket costs (deductibles, coinsurance, etc.) for beneficiaries?

Since VA is the exclusive payer for covered medical services, CWVV beneficiaries will have no out-of-pocket cost.

What is an allowable amount?

The allowable amount (or allowable charge) is the maximum amount VA will authorize for payment to a hospital, institutional provider, physician or other individual professional, or authorized provider for covered medical services.

Does the provider have to accept the CWVV program allowable rate?

Yes. The VA-determined allowable amount for covered services constitutes payment in full. A provider may not bill the beneficiary for the difference between the billed amount and the VA-determined allowed amount (balance billing).

What does the CWVV program pay for services?

The CWVV-determined allowable amount for services, treatment and supplies is based on the same payment methodologies as the Civilian Health and Medical Program of the Department of Veterans Affairs (CHAMPVA) program.

CWVV program payment for services and equipment

Ambulatory surgery: The facility charges for surgical procedures performed in an ambulatory surgical center (includes both freestanding facilities and hospitals) are reimbursed using prospectively determined rates and are adjusted for local costs. The allowable amount for any ambulatory surgery service will not exceed the billed charge.

Dental: Coverage of dental services require prior authorization. The allowable amount for dental services is the

lesser of the CWVV Maximum Allowable Charge (CMAC), the prevailing charge, or the billed charge.

Durable medical equipment (DME)/DME, prosthetics, orthotics and supplies (DMEPOS): The CWVV-determined allowable amount for DME is the lesser of the CMAC, DMEPOS fee schedule, the prevailing charge, or the billed charge.

Home health services: The allowable amount is the lesser of the CMAC, the prevailing charge, or the billed charge.

Hospice services: Reimbursement for approved hospice services is determined using the national Medicare hospice rates for the following four levels of care: routine home care, continuous home care, inpatient respite care, and general inpatient care.

Inpatient services: An inpatient service occurs when the admission to a hospital is over 23 hours (including observation).

The CWVV Diagnosis Related Groups (DRG)-based payment system is used to calculate the cost for most inpatient services furnished by hospitals subject to this system. Payment is made on the basis of prospectively determined rates and applied on a per discharge basis using DRGs.

The DRG rate does not apply to all inpatient facilities such as cancer hospitals, Christian Science sanatoriums, foreign hospitals, long-term hospitals, Maryland hospitals, non-Medicare participating hospitals, skilled nursing facilities, rehabilitation hospitals, sole community hospitals that have a special exemption from Medicare, and non-VA federal health care facilities (Military Treatment Facilities and Indian Health Services).

When the DRG rate does not apply, CWVV pays the billed amount for covered services and supplies.

Mental health services: The allowable amount for inpatient care in psychiatric hospitals and psychiatric units within hospitals that are exempt from the DRG-based payment system is based on the mental health per diem rate. The per diem rate is a reimbursement methodology that calculates cost based on the daily rate times the length of stay.

CWVV uses two sets of mental health per diems. One set of per diems applies to providers that have a high number

of mental health discharges (25 or more per fiscal year). The other set applies to providers with a lower number of mental health discharges (less than 25 per fiscal year).

- **High Volume** (to include residential treatment centers): The allowable amount is the lesser of the hospital specific daily rate or the billed charge. CWVV pays 75% of the allowable amount.
- **Low Volume**: The allowable amount is the lesser of the adjusted regional per diem rate or the billed amount. CWVV pays 75% of the allowed amount.

Outpatient services: The allowable amount for outpatient services is the lesser of the CWVV established maximum allowable amount or the actual billed charge.

Pharmacy services: CWVV pays the full cost of covered prescriptions for medications obtained through the Meds by Mail program or through CITI participation.

The CWVV allowable amount for medications obtained from a local pharmacy is the average wholesale price plus a dispensing fee.

Professional services: The CWVV-determined allowable amount for these services is the lesser of the CMAC, the prevailing charge, or the billed charge. CWVV pays 75% of the allowable amount.

Skilled nursing facility (SNF): A SNF is a special kind of facility that primarily furnishes skilled nursing and rehabilitation services. The allowable amount for SNF services is based on the lesser of the Medicare Resource Utilization Group (RUG) rate or the billed charge.

How do I get more information?

- **Mail:** Chief Business Office Purchased Care
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PO Box 469065, Denver CO 80246-9065
- **Phone:** 1-888-820-1756, Monday-Friday from 8:05 a.m. to 6:45 p.m., Eastern Standard Time
- **Email:** Follow the directions for submitting email via our Inquiry Routing & Information System (IRIS) at <https://iris.custhelp.com/app/ask>
- **Website:** <http://www.va.gov/purchasedcare/>