

The Department of Veterans Affairs As a Funding Source for Assistive Technology

**Diana M. Straube, Staff Attorney
James R. Sheldon, Jr., Supervising Attorney
National Assistive Technology Advocacy Project
Neighborhood Legal Services, Inc.
237 Main Street, Suite 400
Buffalo, New York 14203
716-847-0650, 0227 (fax), 1322 (tdd)
jsheldon@nls.org ; dstraube@nls.org
www.nls.org**

April 2008

Introduction

There were 26.4 million veterans reported in the 2000 United States federal census. While only a percentage of veterans are enrolled in the VA, enrollment has jumped in recent years, from approximately 3.6 million in 1999, to 6.2 million in 2002. Of that number, 1.4 million have no other private or public health insurance. Further, it is estimated that 41.2 percent of those enrolled in 2002 reported restrictions or limitations in performing activities of daily living (bathing, eating, getting dressed, using the toilet) or instrumental activities of daily living (shopping, managing money, preparing meals, using the telephone). This is an increase from those reporting limitations in 1999, which was 27.8 percent.

The VA oversees programs provide a wide range of benefits for qualifying veterans. These include, for example, cash benefits, educational assistance, health care, home loans, life insurance and vocational rehabilitation. Health care services include a wide range of assistive technology (AT) and AT-related services.

Like many funding sources, the VA has eligibility criteria that limits who qualifies for its range of benefits and the underlying VA program has many complicated requirements that one must satisfy before you even get to the issue of eligibility for AT. Because of the complexity of the topic, this is not intended to be a comprehensive discussion regarding either the VA's eligibility criteria or VA standards for obtaining AT. We will, however, describe some significant provisions governing AT and provide illustrations of how eligibility for AT will be determined. If the reader wants to determine

a specific veteran's eligibility for AT, you need to look to the person's individual circumstances. In many cases, the Prosthetic Representative who works for the VA Medical Center will help ensure that the person gets all the AT to which he or she is entitled. In other cases, you may want to dig more deeply in the law and regulations or consult with a Veterans' Service Organization or other advocacy agency.

I. What Is the VA?

- A. The Department of Veterans Affairs is a cabinet level government department responsible for administering a system of health care and benefits for veterans, their families and dependents.
- B. It was established in 1989, to replace the Veterans Administration, an independent agency that dates back to 1930.
- C. The VA operates more than 1400 hospitals, community clinics, nursing homes, domiciliaries and various other facilities, where eligible veterans receive care and services. This contrasts sharply with the Medicaid model, in which the Medicaid agency reviews medical records submitted by ordering and treating medical professionals but is not directly involved in providing healthcare services.

II. Who Qualifies for VA Services?

- A. Eligibility for most VA benefits is based on active military service under other than dishonorable conditions. Active service generally means service as a member of the Army, Navy, Air Force, Marine Corps, Coast Guard, or as a commissioned officer of the Public Health Service, the Environmental Services Administration or the National Oceanic and Atmospheric Administration. 38 U.S.C. § 101(2); 38 C.F.R. § 3.12.
- B. With a few exceptions (set forth in 38 C.F.R. § 17.37), veterans must be enrolled in the VA healthcare system in order to receive VA care and services. 38 C.F.R. § 17.36(a)(1)
- C. A veteran may apply to be enrolled at any time. 38 C.F.R. § 17,36(d)(1).
- D. Upon enrollment, veterans are assigned to a priority category. Those categories, in order of priority, are:
 - 1. Veterans with a singular or combined rating of 50 percent or greater based on one or more service-connected disabilities or unemployability.

2. Veterans with a singular or combined rating of 30 percent or 40 percent based on one or more service-connected disabilities.
3. Veterans who are former prisoners of war; veterans awarded the Purple Heart; veterans with a singular or combined rating of 10 percent or 20 percent based on one or more service-connected disabilities; veterans who were discharged or released from active military service for a disability incurred or aggravated in the line of duty; veterans who receive disability compensation under 38 U.S.C. 1151; veterans whose entitlement to disability compensation is suspended pursuant to 38 U.S.C. 1151, but only to the extent that such veterans' continuing eligibility for that care is provided for in the judgment or settlement described in 38 U.S.C. 1151; veterans whose entitlement to disability compensation is suspended because of the receipt of military retired pay; and veterans receiving compensation at the 10 percent rating level based on multiple noncompensable service-connected disabilities that clearly interfere with normal employability.
4. Veterans who receive an increased pension based on their need for regular aid and attendance or by reason of being permanently housebound and other veterans who are determined to be catastrophically disabled by the Chief of Staff (or equivalent clinical official) at the VA facility where they were examined.
5. Veterans not covered by paragraphs (b)(1) through (b)(4) of this section who are determined to be unable to defray the expenses of necessary care under 38 U.S.C. 1722(a).
6. Veterans of the Mexican border period or of World War I; veterans solely seeking care for a disorder associated with exposure to a toxic substance or radiation, for a disorder associated with service in the Southwest Asia theater of operations during the Gulf War, or for any illness associated with service in combat in a war after the Gulf War or during a period of hostility after November 11, 1998, as provided and limited in 38 U.S.C. 1710(e); and veterans with zero percent service-connected disabilities who are nevertheless compensated, including veterans receiving compensation for inactive tuberculosis.
7. Veterans who agree to pay to the United States the applicable copayment determined under 38 U.S.C. 1710(f) and 1710(g) if their income for the previous year constitutes "low income" under the geographical income limits established by the U.S. Department of Housing and Urban Development for the fiscal year that ended on

September 30 of the previous calendar year.

8. Veterans not included in priority category 4 or 7, who are eligible for care only if they agree to pay to the United States the applicable copayment determined under 38 U.S.C. 1710(f) and 1710(g). This category is further prioritized. 38 C.F.R. § 17.36(b).
- E. An enrolled veteran is eligible for care provided in the “Medical Benefits Package.” 38 C.F.R. § 17.36 (3).
- F. The veteran’s category is extremely important because it determines eligibility for both general and specific benefits and services. A wider range of services are available to those in higher priority categories, with category 1 being the highest.
1. For example, a person with a singular or combined rating of 50 percent or greater service-connected disabilities will have access to more benefits and services than a veteran whose enrollment is based on inability to defray the costs of medical care.
- G. A veteran may have to pursue and appeal on the following issues:
1. the rating given the veteran upon enrollment,
 2. establishing disability or the severity of disability (graded up to 100 percent),
 3. showing that the disability was service-connected,
 4. showing that the disability is not the result of the veteran's willful misconduct.
 5. proving that they are unable to defray the costs of medical care.

III. AT as a Medical Service for Qualified Veterans

- A. The VA provides a “medical benefits package” that includes durable medical equipment and prosthetic and orthotic devices. Considered basic care, these devices are provided to an enrolled veteran receiving any care and service if appropriate healthcare professionals determine that the care is needed to promote, preserve, or restore the health of the veteran and it is in accord with generally accepted standards of medical practice. 38 C.F.R. § 17.38(b).

- B. The “Medical Benefits Package” includes, among other things, the following basic care and preventive care:
1. Outpatient medical, surgical and mental health care
 2. Inpatient hospital, medical, surgical and mental health care
 3. Comprehensive rehabilitative services other than vocational services provided under chapter 31 of 38 U.S.C.
 4. Consultation, professional counseling, training, and mental health services for the members of the immediate family or legal guardian of the veteran or the individual in whose household the veteran has indicated an intention to live, if needed to treat
 - a. The service-connected disability of a veteran, or
 - b. The nonservice-connected disability of a veteran where these services were first given during the veteran’s hospitalization and continuing them is essential to permit the veteran’s release from inpatient care
 5. Durable medical equipment
 6. Prosthetics
 7. Orthotic devices
 8. Eyeglasses and hearing aids if the veteran meets criteria under 38 C.F.R. § 17.149.
 9. Payment of travel and travel expenses if otherwise eligible
 10. Prevention of musculoskeletal deformity or other gradually developing disabilities of a metabolic or degenerative nature
- C. The “Medical Benefits Package” does not include, among other things:
1. Medical devices not approved by the Food and Drug Administration unless:
 - a. The treating facility is conducting formal clinical trials under and Investigational Device Exemption, or
 - b. The devices are prescribed under a compassionate use

exemption

2. Membership in spas and health clubs
- D. The regulations define needed “care” as that which is needed to promote, preserve or restore the health of the individual and is in accord with generally accepted standards of medical practice. 38 C.F.R. § 17.38(b).
1. Promote health means care that will:
 - a. enhance the quality of life or daily functional level of veteran;
 - b. identify a predisposition for development of a condition or early onset of disease which can be partly or totally ameliorated by monitoring or early diagnosis and treatment;
or
 - c. prevent future disease.
 2. Preserve health means care that will:
 - a. maintain the current quality of life or daily functional level of a veteran;
 - b. prevent the progression of disease; or
 - c. extend life span.
 3. Restoring health means care that will:
 - a. restore the quality of life or daily functional level that has been lost due to illness or injury.

IV. Specific Items of Available AT

- A. Durable medical equipment and prosthetic and similar appliances, in general:

1. The term “durable medical equipment” appears to have no definition in federal regulations involving Veterans Benefits.

Note: In the regulations governing the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS), durable medical equipment is defined as equipment that:

- (1) can withstand repeated use;
- (2) Is primarily and customarily used to serve a medical purpose;
- and
- (3) Generally is not useful to an individual in the absence of illness or injury. 32 C.F.R. § 199.2(b).

2. "Prosthetic and similar appliances" have been defined to include: artificial limbs, braces, orthopedic shoes, hearing aids, wheelchairs, medical accessories, similar appliances including invalid lifts and therapeutic and rehabilitative devices, and special clothing made necessary by the wearing of such appliances.
3. Where feasible and medically necessary, the VA will purchase, make or repair the item in question for eligible veterans as part of outpatient care or when the veteran is receiving hospital, domiciliary or nursing home care in a VA facility. 38 C.F.R. § 17.150.

B. Invalid Lifts. A veteran who is receiving special monthly compensation or an increased pension based on the need for aid and attendance may be eligible for an invalid lift or any type of therapeutic or rehabilitative device, if the veteran has loss, or loss of use, of both lower extremities and at least partial loss of one upper extremity, has been medically determined incapable of moving himself or herself from a bed to a wheelchair or from a wheelchair to a bed without the aid of an attendant, and an invalid lift would be a feasible means of accomplishing those maneuvers and is medically necessary. 38 U.S.C. § 1717(a)(3)(b), 38 C.F.R. § 17.151.

1. Invalid lifts may include van lifts, residential elevators, and electric hospital beds.
2. Board of Veterans' Appeals, Docket No. 92-09 702, BVA 93-00220.
 - a. The Board of Veterans' Appeals has ruled that a residential elevator could meet this invalid lift criteria:
 - b. The veteran had a permanent and total disability rating and received special monthly compensation. He requested a Minivator Residential Elevator so that he could access the second floor in his new home.
 - c. The Board held that a residential elevator may fit more than one legal ground for payment and the VA Medical Center (VAMC) must make a determination considering ALL potential legal grounds for VA payment.

- d. The matter was remanded back to the VAMC to determine whether the elevator might qualify as a prosthetic or an invalid lift.
- C. Devices for assisting in overcoming a handicap of deafness. Any veteran who is profoundly deaf (rated 80 percent or more disabled for hearing impairment) and is entitled to compensation on account of a hearing impairment may be furnished devices for assisting in overcoming the handicap of deafness, including telecaptioning television decoders. 38 U.S.C. § 1717(a)(3)(c), 38 C.F.R. § 17.152.
- D. Guide dogs and equipment for the blind.
 - 1. Blind veterans entitled to compensation for a service-connected disability may be furnished a trained guide dog and expenses related to travel, lodging and meals where the veteran receives training to use the dog.
 - 2. They may also be furnished with mechanical and/or electronic communication equipment necessary to overcome blindness, such as adaptive computers, and computer-assisted devices such as reading machines and electronic travel aids, talking books, tapes and braille literature. 38 U.S.C. § 1714, 38 C.F.R. § 17.154.
- E. Automobile adaptive equipment.
 - 1. Automobiles and adaptive equipment may be provided to eligible veterans receiving compensation for a number of enumerated service-connected disabilities if the disability is the result of an injury incurred or disease contracted in or aggravated by active service. 38 U.S.C. §§ 3901, 3902.
 - 2. Adaptive equipment includes but is not limited to power steering, power brakes, power window lifts, power seats, special equipment necessary to assist a person into and out of the automobile or other conveyance, and air conditioning when necessary for the health and safety of the veteran, even if the automobile will not be operated by the veteran, and any modification of the size of the interior space if needed because of physical condition of such person in order for such person to enter and operate the vehicle. 38 U.S.C. §§ 3901(2), 3902, 38 C.F.R. § 17.156.
 - 3. Docket No. 03-18 663A, Citation Nr. 0522921. The Board of Veterans' Appeals has held that a veteran who was unable to

transfer from his wheelchair to the driver's side seat safely was entitled to have his truck lowered to the maximum extent possible under safety guidelines for the vehicle.

- F. Training in the use of appliances: Veterans who are provided prosthetic and similar appliances are also entitled to training in the use of the prosthetic or appliance. 38 U.S.C. § 1714(a), 38 C.F.R. § 17.153.
- G. Acquisition of housing with special features or adaptations to current residence, such as ramps and wheelchair accessible showers, may allow a qualifying veteran to live in a family home or remain independent.
 - 1. Veterans who are entitled to compensation for a permanent and total service-connected disability and who meet other medical criteria, are eligible for financial assistance in acquiring suitable housing with special or movable features, including land, made necessary by the nature of the disability. 38 U.S.C. § 2101(a).
 - 2. No more than three such grants may be given to an eligible veteran and the maximum aggregate amount available under this provision is \$50,000.
- H. Veterans entitled to compensation for a permanent and total service-connected disability who do not meet the medical criteria under section 2101(a) may be eligible for adaptations to their residences if owned by the veteran or a family member and the veteran can reasonably be expected to continue residing there. 38 U.S.C. § 2101(b). Once again, no more than three grants may be given to an eligible veteran and the maximum aggregated amount available is \$10,000.
- I. Home Improvements and Structural Alterations (HISA)
 - 1. Those veterans who do not qualify for housing with special features or adaptations to housing as described in the preceding paragraphs may qualify for HISA as a home health service.
 - 2. HISA may be furnished only as necessary to assure the continuation of treatment for the veteran's disability or to provide access to the home or to essential lavatory and sanitary facilities. It can be used for example, to widen doorways, lower kitchen counter tops and build ramps. This benefit is subject to the following limitations:
 - a. Payment of up to \$4,100 is available for a veteran with a service-connected disability or a non-service connected

disability rated at 50 percent or more;

- b. Payment of up to \$1,200 is available to other veterans eligible for outpatient care;
 - c. Once the veteran has used the maximum amount, he or she is not eligible for another HISA grant. 38 U.S.C. § 1717(2).
- J. Clothing allowance: A veteran with a service-connected disability, or a disability compensable as if it were service-connected, is eligible for a \$662 annual clothing allowance when the veteran uses certain devices, including wheelchairs, that wear and tear clothing. 38 U.S.C. § 1162 , 38 C.F.R. § 3.810.

v. AT and Vocational Rehabilitation

- A. The VA provides a wide range of services to enable veterans with service-connected disabilities to attain maximum independence in daily living and overcome an employment handicap. A veteran who is involved in a rehabilitation plan may receive, among other things:
- 1. prosthetic appliances
 - 2. eyeglasses
 - 3. other corrective or assistive devices
 - 4. services to the veteran's family as necessary for effective rehabilitation
 - 5. services necessary to enable a veteran to achieve maximum independence in daily living
 - 6. language training
 - 7. speech and voice correction
 - 8. training in ambulation
 - 9. training in one-handed typing
 - 10. orientation, adjustment, mobility, reader, interpreter, and related services

11. telecommunications, sensory and other technical aids and devices. 38 U.S.C. § 3104.
- B. Generally, a veteran is eligible for these services for a period of 12 years after the date of the veteran's discharge from active service. There are several instances in which the 12 year period does not begin to run immediately upon discharge, including any of the following instances:
1. The veteran was prevented from participating in a vocational rehabilitation program because of a medical condition which made it infeasible for the veteran to participate.
 2. The veteran had not established the existence of a service-connected disability at the time of discharge.
 3. The veteran had not met the requirement of a discharge from service under conditions other than honorable until a later date.
 4. The VA has made a determination that the veteran is in need of services to overcome a serious employment handicap. 38 U.S.C. § 3103.

VI. The Right to Appeal a VA Decision

- A. Filing claims
1. All claims are filed in one of 58 VA regional offices or other VA field level offices.
 2. Claims must be submitted on forms approved by the VA and are available from the VA upon request. 38 U.S.C. § 5102.
 3. The VA is obligated to assist the claimant in developing the facts relevant to his or her claim and to render a decision which grants every benefit that can be supported in law while protecting the interests of the government.
 4. The VA is required to consider all the lay and medical evidence in the record, and when the positive and negative evidence is balanced, give the benefit of the doubt to the claimant. 38 U.S.C. § 5107(b).
 5. The claimant is entitled to written notice of the decision made on the claim. 38 CFR § 3.103(a).

- B. Veterans and other claimants have a right to appeal decisions made by a regional office of Medical Center.
1. A claimant has one year from the date the VA decision was mailed to file an appeal.
 2. The claimant commences the appeal process by filing a written Notice of Disagreement with the regional office.
 3. A Notice of Disagreement is considered timely if postmarked within one year of the mailing of the VA decision. 38 U.S.C. § 7105(b)(1).
 4. If no Notice of Disagreement is filed within the year, the regional office decision will be considered final. 38 U.S.C. § 7105(c).
 5. Following receipt of the Notice of Disagreement, the VA will furnish the claimant a Statement of the Case, which must include a summary of the evidence relevant to the contested issues, citation to relevant laws and regulations, and a decision on each issue with a summary of the reasons for each decision. 38 U.S.C. § 7105(d)(1).
 6. The veteran must file a Substantive Appeal before the Board of Veterans Appeals (BVA) within 60 days of the date the Statement of the Case is mailed.
 7. This time may be extended upon a show of good cause.
 8. The formal appeal must set forth specific allegations of error of law or fact made in the decision and must clearly identify the benefits sought. 38 U.S.C. § 7105(d)(3), (5).
 9. A claimant may request a hearing before the BVA, to be held at its principal location or at a VA facility located within the area served by a regional office. 38 U.S.C. § 7107(d)(1).
 10. The BVA does not have jurisdiction to review a medical determination. 38 C.F.R. § 20.101(b), 38 U.S.C. § 511 (See Board of Veterans' Appeals, Docket No. 93-25 678, Citation Nr. 9601144, involving a wheelchair stairway glide)..
 11. Decisions of the Board of Veterans' Appeals can be found through a search function available on the VA website at www.index.va.gov/search/va/bva.html.

- C. The claimant may request a review of the regional office decision by an individual who was not involved in the original decision.
1. Upon receipt of the Notice of Decision, the VA will notify the claimant in writing of his or her right to this review.
 2. The claimant then has 60 days from the date of the mailing of the regional office notice in which to request the review.
 3. The regional office reviewer may request additional information, hold an informal conference with the claimant, and if requested by the claimant, may hold a hearing. 38 C.F.R. § 3.2600(c).
 4. The reviewer may not revise the decision to the detriment of the claimant, except for clear and unmistakable error.
 5. Like the original decision, the review decision must include a summary of the evidence, a citation to relevant laws and regulations, a discussion of how these affect the decision, and a summary of the reasons for the decision. 38 C.F.R. § 3.2600(d), (e).
 6. A request for review does not affect the claimant's right to proceed with an appeal, unless the claimant withdraws the appeal. 38 C.F.R. § 3.2600(f). This may happen if the claimant receives a favorable decision after review.
 7. If no request for review is filed in a timely fashion, the VA will proceed with the appeals process by issuing a Statement of the Case. 38 C.F.R. § 3.2600(a), (b).
- D. Veterans who lose at the BVA can appeal the decision before the U.S. Court of Veteran Appeals.
1. A Notice of Appeal must be filed within 120 days of a BVA decision.
 2. As in all court appeals, the appellant should be represented by an attorney.
- E. Re-opening claims
1. A veteran may re-open a final claim upon submission of new and material evidence. 38 U.S.C. § 5108.

2. New evidence is that existing evidence not previously submitted to the VA, while material evidence relates to an unestablished fact necessary to substantiate the claim.
 3. It can not be cumulative nor redundant and must raise a reasonable possibility of substantiating the claim. 38 C.F.R. § 3.156(a).
- F. Requesting a revised or reversed decision:
1. A decision may be revised or reversed, upon the VA Secretary's own motion or request of the claimant, upon a showing that the decision of the VA Secretary was based on clear and unmistakable error.
 2. The request for revision may be made at any time. 38 U.S.C. § 5109A.

VII. Who Can Advocate Before the VA?

(See 38 C.F.R. §§ 14.626-635 and §§ 20.600-609 for further details regarding authorization to represent.)

- A. A claimant has a right to be represented in an appeal by a recognized organization, attorney, agent or other authorized person. 38 C.F.R. § 20.600. Rule 600.
- B. Representatives are regulated by the VA to ensure that claimants have responsible, qualified representation in the preparation, presentation, and prosecution of claims for veterans' benefits. 38 C.F.R. § 14.626
- C. Advocates who are not attorneys must be authorized by the VA to be representatives. *Veterans Benefits Manual*, Stichman, Abrams & Adlestone, Editors, 2003 Edition, LexisNexis, § 16.2.2.1, page 1293.
- D. Attorneys:
 1. There are 2 methods of authorizing an attorney to represent a claimant:
 - a. claimant signs a power of attorney on Department of VA Form 22a (Appointment of Attorney or Agent as Claimant's Representative); or
 - b. the attorney may state in a signed writing on his or her letterhead that the attorney is authorized to represent the

claimant. This evidence of authorization shall be equivalent to an executed power of attorney and shall be presented to the Department of Veterans Affairs regional office that has jurisdiction over the claim for filing the claimant's claims folder.

2. To access all the claimant's records, the attorney must have a signed consent from the claimant.
3. The designation must be of an individual attorney and not a firm.
4. Unless specifically noted to the contrary, designations of an attorney as a representative will extend to all matters with respect to claims for benefits under laws administered by the Department of Veterans Affairs.
5. Designations are effective when they are filed with the agency of original jurisdiction or, if the appellate record has been certified to the Board for review, by the Board of Veterans' Appeals. 38 C.F.R. § 20.603(a).
6. An attorney employed by the same legal services office as the attorney of record, may assist in representation of the appellant and may have access to the appellant's Department of Veterans Affairs records to the same extent as the attorney of record, provided the claimant has signed a specific written consent.
7. The consent must be filed with the agency of original jurisdiction or, if the appellate record has been certified to the Board for review, with the Board of Veterans' Appeals. 38 C.F.R. § 20.603(c).

E. Legal interns, law students, and paralegals:

1. May not be independently accredited to represent appellants. 38 C.F.R. § 20.603(a).
2. May assist with the appeal upon specific written consent of the claimant. 38 C.F.R. § 20.606(a).
3. Must be under the direct supervision of the recognized attorney in order to prepare and present a case before the BVA. 38 C.F.R. § 20.606(b).

F. A power of attorney, executed on either Department of Veterans Affairs Form 21-22 (Appointment of Veterans Service Organization as Claimant's

Representative) or Department of Veterans Affairs Form 22a (Appointment of Attorney or Agent as Claimant's Representative), is required to represent a claimant, except when representation is by an attorney who complies with paragraph (b) of this section or when representation by an individual is authorized under § 14.630. 38 C.F.R. § 16.631.

- G. Authorized officers of an organization may request recognition by letter to the Secretary of Veterans Affairs. The organization must meet the following requirements:
1. serving veterans must be a primary purpose of the organization;
 2. demonstrate a substantial commitment to veterans;
 3. commit a significant portion of its assets to veterans' services and have adequate funding to properly perform those services
 4. maintain a policy and capability of providing complete claims service to each claimant requesting representation or give written notice of any limitation in its claims service with advice concerning the availability of alternative sources of claims service, including evidence of its capability to represent the claimant before the Department of Veterans Affairs regional offices and before the Board of Veterans' Appeals;
 5. Ensure proper handling of claims by taking affirmative action, including training and monitoring of accredited representatives; 38 C.F.R. § 14.628.

VIII. Civilian Health and Medical Program of the Department of Veterans Affairs (CHAMPVA)

- A. CHAMPVA is a health and medical program for the following dependents and survivors of certain specified veterans:
1. the spouse or child of veteran adjudicated with a permanent and total service-connected disability;
 2. the surviving spouse or child of a veteran who died as a result of a service-connected condition or who, at time of death, was adjudicated with permanent and total service-connected disability;
 3. the surviving spouse or child of a person who died in the line of

- duty while on active military service, not due to his own misconduct,
4. who are not eligible for CHAMPUS. 38 U.S.C.A. § 1781(a).
 5. An eligible child retains eligibility for a period of time if he or she incurs a disabling illness or injury while pursuing a full-time course of instruction approved under 38 U.S.C. Chapter 36, not due to the child's own misconduct, and which results in an inability to continue said course of study. 38 U.S.C.A. § 1781(c).
- B. CHAMPVA is not to be confused with CHAMPUS, which is provided by the Department of Defense for certain dependents and survivors of active duty and retired members of the Armed Forces. Although CHAMPVA is intended to provide for medical care in the same or similar manner and subject to the same or similar limitations as CHAMPUS, there are differences in the programs. 38 U.S.C.A. § 1781(b), CHAMPVA Policy Manual, Ch. 1, § 1.1.
 - C. CHAMPVA covers a *percentage* of the cost of health care for eligible dependents and survivors of veterans, unless the service is available directly from a VA medical facility, in which case there is no cost. 38 C.F.R. § 17.274 (a). There is also an annual outpatient deductible of \$50 per person or \$100 per family.
 - D. The beneficiary cost-share is twenty-five percent (25%) of the CHAMPVA-determined allowable amount in excess of the annual calendar year deductible. (See CHAMPVA Policy Manual, Ch. 3, § 2.1). There is no deductible for inpatient services or for services provided through VA facilities. 38 C.F.R. § 17.274(b).
 - E. Covered benefits may have limitations and there are a number of exclusions, which can be found at 38 C.F.R. § 17.272(a).
 - F. To protect against the financial consequences of a long-term illness, the cap on cost sharing is \$3,000 per CHAMPVA-eligible family per year, effective January 1, 2002. 38 C.F.R. § 17.274(c)(l).
 - G. CHAMPVA is primary to Medicaid and State Victims of Crime Compensation Programs, but secondary to Medicare. 38 C.F.R. § 17.272
 - H. A dependent or survivor receiving care in Department medical facilities shall be eligible for the same medical services as a veteran. 38 U.S.C.A. § 1781(b).
 - I. Covered services or supplies must be medically necessary and

reasonable and not specifically excluded.

1. Durable medical equipment (DME)
 - a. Advance approval or pre-authorization is required for items having a purchase or total rental price in excess of \$300.00. 38 C.F.R. § 17.273(e). (Changed by policy from \$300 to \$2000 on August 30, 2006, Transmittal # 95 CHAMPVA Policy Manual.)
 - b. DME is equipment which:
 - (1) Is medically necessary for the treatment of a covered illness or injury;
 - (2) Improves the function of a malformed, diseased, or injured body part, or delays further deterioration of a patient's physical condition;
 - (3) Is primarily or customarily used to serve a medical purpose, rather than primarily for transportation, comfort or convenience;
 - (4) Provides the medically appropriate level of performance and quality for the medical condition present (that is, nonluxury and nondeluxe).
 - c. Medical devices must be FDA-approved, but not all FDA devices are covered. CHAMPVA Policy Manual, Ch. 2, § 17.1
 - d. Investigation and experimental devices are excluded. CHAMPVA Policy Manual, Ch. 2, § 16.5
 - e. Specific devices include:
 - (1) A wheelchair, or an approved alternative, which is necessary to provide basic mobility
 - (2) A car lift for a wheelchair, or an approved alternative, is considered an accessory that may be covered.
 - (3) Customization, accessories and supplies that are essential for beneficiary owned DME that otherwise meets the requirements to provide therapeutic

benefit, or to assure the proper functioning of the equipment or to make the equipment serviceable is covered (CHAMPVA Policy Manual, Ch. 2, § 17.1).

(4) Electric-powered, cart-type vehicles may be covered as an alternative to an electric wheelchair (CHAMPVA Policy Manual, Ch. 2, § 17.3).

(5) Air-fluidized beds (CHAMPVA Policy Manual, Ch. 2, § 17.9)

J. Appeals and reviews (38 C.F.R. § 17.276)

1. An initial determination regarding payment of a claim, called an Explanation of Benefits (EPB), must be sent to the claimant.
2. The claimant may request reconsideration within one year of the date of the determination.
3. The request must state why the beneficiary believes the decision is in error and must include any new and relevant information not previously considered.
4. After the reviewing the claim, the benefits' advisor will issue a new determination either affirming, reversing or modifying the initial determination.
5. A claimant still dissatisfied may make a written request for a review by the Center Director within 90 days of the reconsideration.
6. The Director will issue a written decision, which is final.
7. The decision may be appealed to the Board of Veterans Appeals, as discussed above.

K. For more information on CHAMPVA, see the VA website at www.va.gov/hac/forbeneficiaries/champva/champva.asp. For specific information about AT covered under categories such as durable medical equipment or prosthetic devices, see the *CHAMPVA Handbook*, on the VA website at www.va.gov/hac/forbeneficiaries/champva/handbook.asp.

IX. Veterans' Service Organizations

A. There are a number of organizations chartered by Congress or recognized by VA for claim representation. They include:

1. American Legion
 2. American Red Cross
 3. AMVETS
 4. Catholic War Veterans, USA, Inc.
 5. Disabled American Veterans
 6. Jewish War Veterans of the U.S.A., Inc.
 7. Military Order of the Purple Heart of the U.S.A., Inc.
 8. Paralyzed Veterans of America
 9. Veterans of Foreign Wars of the United States
 10. Vietnam Veterans of America
- B. Although these organizations are independent of the VA, they may have offices in the VA's regional offices. To contact a service officer with one of these organizations, look in the phone book under U.S. Government, Department of Veterans Affairs or under the name of the organization.
- C. A list of chartered and non-chartered veterans' service organizations can be accessed through the VA website, www.va.gov/vso. Check with each organization to determine what services they can offer your clients.

X. Veterans Reference Guide for AT Advocates

- A. *Veterans Benefits Manual*, Stichman, Abrams & Addlestone, Editors, 2003 Edition, LexisNexis
- B. *Federal Benefits for Veterans and Dependents* (Department of Veterans Affairs, 2008 Ed.): For sale by the U.S. Government Printing Office; also available on the the VA website, www.va.gov/OPA/vadocs/current_benefits.asp
- C. The Department of Veterans Affairs has a variety of helpful materials available on its web site located at www.va.gov.
1. Decisions of the Board of Veterans' Appeals, www.index.va.gov/search/va/bva.html
 2. Pamphlet: Appeals Process, www.va.gov/vbs/bva/pamphlet.htm
 3. Health Care - Veterans's Health Administration, www.va.gov/health
 4. Survivor Benefits, www.vba.va.gov/survivors/index.htm
 5. CHAMPVA benefits, www.va.gov/hac/forbeneficiaries/champva/champva.asp Veterans'
 6. Service Organizations, www.va.gov/vso

TRICARE: AT-Related Benefits for Some Active Duty Personnel, Retirees, and Family Members

This short outline covers some of the basic provisions governing the TRICARE program. If you intend to become involved in TRICARE, generally, or in specific cases, we urge you to use this as a starting point for your research and explore the issues much more thoroughly than we have below. More information about TRICARE can be found at: www.military.com/benefits/tricare.

I. What is TRICARE?

- A. TRICARE is a regionally managed health care program for Active Duty, Activated Guard and Reserves, Retired members of the uniformed services, their families, and survivors.
- B. TRICARE brings together the health care resources of the Army, Navy and Air Force and supplements them with networks of civilian health care professionals to provide better access and high quality service while maintaining the capability to support military operations.
- C. Active Duty and Guard and Reserve service members are automatically enrolled TRICARE Prime. However military dependents and retirees must choose the TRICARE option that best suits their needs.
- D. Think of TRICARE as you would a managed care plan. See 10 U.S.C. § 1072(7) (“The term ‘TRICARE program’ means the managed health care program that is established by the Department of Defense under the authority of this chapter, principally section 1097 of this title, and includes the competitive selection of contractors to financially underwrite the delivery of health care services under the Civilian Health and Medical Program of the Uniformed Services.”)

II. TRICARE Has Three Main Coverage Choices for Health Care

- A. TRICARE Prime - where Military Treatment Facilities (MTFs) are the principal source of health care
- B. TRICARE Extra - a preferred provider option that saves money
- C. TRICARE Standard - a fee-for-service option (the original CHAMPUS program)

- D. More extensive information on what each of these choices entails is available on the TRICARE website:
www.military.com/benefits/tricare/understanding-your-tricare-benefits

III. TRICARE Eligibility

- A. As explained on the TRICARE website, TRICARE is a health benefit program for all seven uniformed services: the Army, Navy, Marine Corps, Air Force, Coast Guard, Public Health Service, and the National Oceanic and Atmospheric Administration.
- B. TRICARE-eligible persons include the following:
1. Active duty service members (enrollment not required)
 2. Spouses and unmarried children of active duty service members
 3. Uniformed service retirees, their spouses, and unmarried children
 4. Medal of Honor (MOH) recipients and/or their families
 5. Un-remarried former spouse and unmarried children of active duty or retired service members who have died. Note: Family members of active duty service members who died while on active duty, and who were on active duty for at least 31 days before death, will continue to be treated as active duty family members for TRICARE cost-sharing purposes for 3 years after their active duty sponsor dies.
 6. Spouses and unmarried children of reservists and National Guard who are ordered to active duty for more than 30 consecutive days (they are covered only during the reservist's active duty tour) or of reservists and National Guard who die on active duty.
 7. Spouses and unmarried children of reservists and National Guard who die as a result of a line of duty condition may be eligible for health care.
 8. Persons who have received the Medal of Honor, and their family members, who are not otherwise TRICARE eligible. These persons will be able to obtain health care benefits under TRICARE in the same manner as if they were entitled to retired pay.
 9. Unmarried children up to age 21 (including stepchildren who are

adopted by the sponsor) are still covered by TRICARE even if the spouse gets divorced or remarried. But in the case of a stepchild who was not adopted by the sponsor and the marriage ends in divorce, the stepchild loses eligibility on the date the divorce decree is final. It should be emphasized that stepchildren don't have to be adopted by the sponsor to be covered by TRICARE while the sponsor and the mother or father of the stepchildren remains married. A child aged 21 or over may be covered if he or she is severely disabled and the condition existed prior to the child's 21st birthday—or, if the condition occurred between the ages of 21 and 23 while the child was enrolled in a full-time course of study in an approved institution of higher learning and is, or was at the time of the sponsor's death, dependent on the sponsor for more than one-half of his or her support. A child may also be covered up to the 23rd birthday if he or she is in school full-time.

10. Children placed in the custody of a service member or former member, by a court of law; or by a recognized adoption agency in anticipation of legal adoption by the member. TRICARE eligibility is effective July 1, 1994, if a court of law places the child. A child placed by a recognized adoption agency is eligible effective October 5, 1994.
11. Children of current or former service members or their spouses born out of wedlock may be eligible for TRICARE benefits under certain conditions. Check with your Beneficiary Counseling and Assistance Coordinator (BCAC)/Health Benefits Adviser (HBA), or TRICARE Service Center (TSC).
12. Certain family members of active duty service members who were court-martialed and separated for spouse or child abuse. The victims of the abuse within the family are eligible for health benefits for the period that the abused family member is receiving "transitional compensation" under Section 1059 of Title 10, U.S. Code. Cost sharing will be the same as for other active duty families.
13. Certain abused spouses, former spouses, and dependent children of service members who were eligible for retirement, but had that eligibility taken away as a result of abuse of the spouse or child. This benefit is effective for medically necessary services and supplies provided under TRICARE Standard (CHAMPUS) on or after October 23, 1992.
14. Spouses and children of North Atlantic Treaty Organization (NATO)

and "Partners for Peace" (PFP) nation representatives who are officially accompanying the NATO or PFP nation representatives while stationed in, or passing through, the United States on official business. These family members are eligible for outpatient benefits only (including ambulatory surgery). They are not listed in the DEERS files, and should check with a BCAC/HBA/TSC for assistance before getting care or filing claims. (NATO and PFP family members cannot enroll in TRICARE Prime.)

15. Former spouses of active, retired or former military members may be eligible for TRICARE if they meet the following requirements:
 - a. Must not have remarried. (If remarried, the loss of benefits remains applicable even if the remarriage ends in death or divorce.)
 - b. Must not be covered by an employer-sponsored health plan.
 - c. Must not be the former spouse of a North Atlantic Treaty Organization or Partners for Peace nation member.
 - d. Must meet the requirements of one (not all) of the following three situations:
 - (1) **Situation 1**
 - (a) Must have been married to the SAME member or former member for at least 20 years, and at least 20 of those years must have been creditable in determining the member's eligibility for retirement pay.
 - (b) If the date of the final decree of divorce or annulment was on or after February 1, 1983, the former spouse is eligible for TRICARE coverage of health care that is received after the date of the divorce or annulment.
 - (c) If the date of the final decree is before February 1, 1983, the former spouse is eligible for TRICARE coverage of health care received on or after January 1, 1985.
 - (d) Eligibility continues as long as the preceding requirements continue to be met.
 - (2) **Situation 2**
 - (a) Must have been married to the SAME member or former member for at least 20 years, and at

least 15, but less than 20, of those years must have been creditable in determining the member's eligibility for retirement pay.

- (b) If the date of the final decree of divorce or annulment is before April 1, 1985, the former spouse is eligible only for care received on or after January 1, 1985, or the date of the decree, whichever is later.
- (c) Eligibility continues as long as the preceding requirements continue to be met. However, if the date of the final divorce decree or annulment is on or after April 1, 1985, but before September 29, 1988, the former spouse is eligible for care received from the date of the decree until December 31, 1988, or two years from the date of the decree, whichever is later.

(3) **Situation 3**

- (a) Must have been married to the SAME member or former member for at least 20 years, and at least 15, but less than 20, of those years must have been creditable in determining the member's eligibility for retirement pay.
- (b) If the date of the final decree of divorce or annulment is on or after September 29, 1988, the former spouse is eligible only for care received for one year from the date of the decree.

C. Health Plan Options

- 1. If an individual qualifies for TRICARE coverage based on the requirements listed above, he or she is covered with the same benefits as a retired family member.
- 2. An individual can visit www.tricare.mil/enrollment/index.cfm for TRICARE Enrollment and Claim Forms.

IV. TRICARE Authorized Care

www.military.com/benefits/tricare/authorized-patient-care-list

- A. A wide range of medical services are available under TRICARE.
- B. If you work on individual cases, we urge you to look to the law, regulations, and military.com website to determine what may be available

to a particular individual.

V. Expansion in TRICARE Program's Coverage of Assistive Technology Through the 2001 Congressional Amendments

We wish to credit Peter W. Thomas, an attorney with the law firm of Powers, Pyles, Sutter & Verville, PC, out of Washington, D.C. for his article, "Congress Increases TRICARE Program's Coverage of Assistive Technology," which summarizes the 2001 legislative changes. Available at www.ppsv.com/news-publications-33.html. This was a helpful guide in preparing this section.

- A. The provisions in question are found in the Defense Reauthorization Act of 2001, PL 107-107, 10 U.S.C. §§ 1071 *et seq.*
- B. As referenced in the above article, "[t]he new TRICARE benefit package is a model for modernizing coverage of health care benefits required by persons with disabilities."
- C. Under the existing law a number of key provisions are important to AT advocates:
 1. Under 10 U.S.C. § 1077(e)(1), "a prosthetic device under subsection (a)(15) includes authority to provide the following:
 - (A) Any accessory or item of supply that is used in conjunction with the device for the purpose of achieving therapeutic benefit and proper functioning.
 - (B) Services necessary to train the recipient of the device in the use of the device.
 - (C) Repair of the device for normal wear and tear or damage.
 - (D) Replacement of the device if the device is lost or irreparably damaged or the cost of repair would exceed 60 percent of the cost of replacement."
 2. "An augmentative communication device may be provided as a voice prosthesis under subsection (a)(15)." 42 U.S.C. § 1077(e)(2).
 - a. As explained in the Peter Thomas article: "The fact that AACs are explicitly covered as 'voice prostheses' is also very significant, for it establishes a precedent that a device that replaces the function of a malformed body part, rather than the body part itself, can be considered a covered prosthetic device."

3. Under the provisions related to durable medical equipment, a number of key provisions appear in the legislation. 42 U.S.C. §§ 1077(f)(1) & (f)(2).
 - a. A patient is to be provided “Any durable medical equipment that can improve, restore, or maintain the function of a malformed, diseased, or injured body part, or can otherwise minimize or prevent the deterioration of the patient's function or condition.”
 - b. A patient is to be provided “Any durable medical equipment that can maximize the patient's function consistent with the patient's physiological or medical needs.”
 - c. “In addition to the authority to provide durable medical equipment under subsection (a)(12), any customization of equipment owned by the patient that is durable medical equipment authorized to be provided to the patient under this section or section 1079(a)(5) of this title, and any accessory or item of supply for any such equipment, may be provided to the patient if the customization, accessory, or item of supply is essential for—
 - (A) achieving therapeutic benefit for the patient;
 - (B) making the equipment serviceable; or
 - (C) otherwise assuring the proper functioning of the equipment.”
 - d. Hearing aids, which had previously been excluded, are now covered.