AUTHENTICATED
U.S. GOVERNMENT
INFORMATION
GPO

§ 16.121 [Reserved]

§ 16.122 Use of Federal funds.

Federal funds administered by a department or agency may not be expended for research involving human subjects unless the requirements of this policy have been satisfied.

§ 16.123 Early termination of research support: Evaluation of applications and proposals.

(a) The department or agency head may require that department or agency support for any project be terminated or suspended in the manner prescribed in applicable program requirements, when the department or agency head finds an institution has materially failed to comply with the terms of this policy.

(b) In making decisions about supporting or approving applications or proposals covered by this policy the department or agency head may take into account, in addition to all other eligibility requirements and program criteria, factors such as whether the applicant has been subject to a termination or suspension under paragarph (a) of this section and whether the applicant or the person or persons who would direct or has have directed the scientific and technical aspects of an activity has have, in the judgment of the department or agency head, materially failed to discharge responsibility for the protection of the rights and welfare of human subjects (whether or not the research was subject to federal regulation).

§ 16.124 Conditions.

With respect to any research project or any class of research projects the department or agency head may impose additional conditions prior to or at the time of approval when in the judgment of the department or agency head additional conditions are necessary for the protection of human subjects.

PART 17—MEDICAL

DEFINITIONS AND ACTIVE DUTY

Sec.
17.1 Incorporation by reference.
17.30 Definitions.
17.31 Duty periods defined.

PROTECTION OF PATIENT RIGHTS

17.32 Informed consent and advance care planning.
17.33 Patients' rights.

TENTATIVE ELIGIBILITY DETERMINATIONS

17.34 Tentative eligibility determinations.

HOSPITAL OR NURSING HOME CARE AND MEDICAL SERVICES IN FOREIGN COUNTRIES

17.35 Hospital care and medical services in foreign countries.

ENROLLMENT PROVISIONS AND MEDICAL BENEFITS PACKAGE

17.36 Enrollment—provision of hospital and outpatient care to veterans.
17.37 Enrollment not required—provision of hospital and outpatient care to veterans.
17.38 Medical benefits package.
17.39 Certain Filipino veterans.
17.40 Additional services for indigents.

EXAMINATIONS AND OBSERVATION AND EXAMINATION

17.41 Persons eligible for hospital observation and physical examination.
17.42 Examinations on an outpatient basis.

HOSPITAL, DOMICILIARY AND NURSING HOME CARE

17.43 Persons entitled to hospital or domiciliary care.
17.44 Hospital care for certain retirees with chronic disability (Executive Orders 10122, 10400 and 11733).
17.45 Hospital care for research purposes.
17.46 Eligibility for hospital, domiciliary or nursing home care of persons discharged or released from active military, naval, or air service.
17.47 Considerations applicable in determining eligibility for hospital, nursing home or domiciliary care.
17.48 Compensated Work Therapy/Transitional Residences program.
17.49 Priorities for outpatient medical services and inpatient hospital care.

USE OF DEPARTMENT OF DEFENSE, PUBLIC HEALTH SERVICE OR OTHER FEDERAL HOSPITALS

17.50 Use of Department of Defense, Public Health Service or other Federal hospitals with beds allocated to the Department of Veterans Affairs.
17.51 Emergency use of Department of Defense, Public Health Service or other Federal hospitals.

USE OF PUBLIC OR PRIVATE HOSPITALS

17.52 Hospital care and medical services in non-VA facilities.
17.53 Limitations on use of public or private hospitals.

17.54 Necessity for prior authorization.
17.55 Payment for authorized public or private hospital care.
17.56 VA payment for inpatient and outpatient health care professional services at non-departmental facilities and other medical charges associated with non-VA outpatient care.

USE OF COMMUNITY NURSING HOME CARE FACILITIES

17.57 Use of community nursing homes.
17.60 Extensions of community nursing home care beyond six months.

COMMUNITY RESIDENTIAL CARE

17.61 Eligibility.
17.62 Definitions.
17.63 Approval of community residental care facilities.
17.64 [Reserved]
17.65 Approvals and provisional approvals of community residential care facilities.
17.66 Notice of noncompliance with VA standards.
17.67 Request for a hearing.
17.68 Notice and conduct of hearing.
17.69 Waiver of opportunity for hearing.
17.70 Written decision following a hearing.
17.71 Revocation of VA approval.
17.72 Availability of information.

USE OF SERVICES OF OTHER FEDERAL AGENCIES

17.80 Alcohol and drug dependence or abuse treatment and rehabilitation in residential and nonresidential facilities by contract.
17.81 Contracts for residential treatment services for veterans with alcohol or drug dependence or abuse disabilities.
17.82 Contracts for outpatient services for veterans with alcohol or drug dependence or abuse disabilities.
17.83 Limitations on payment for alcohol and drug dependence or abuse treatment and rehabilitation.

RESEARCH-RELATED INJURIES

17.85 Treatment of research-related injuries to human subjects.

CARE DURING CERTAIN DISASTERS AND EMERGENCIES

17.86 Provision of hospital care and medical services during certain disasters and emergencies under 38 U.S.C. 1785.

VOCATIONAL TRAINING AND HEALTH-CARE ELIGIBILITY PROTECTION FOR PENSION RECIPIENTS

17.90 Medical care for veterans receiving vocational training under 38 U.S.C. chapter 15.
17.91 Protection of health-care eligibility.

OUTPATIENT TREATMENT

17.92 Outpatient care for research purposes.
17.93 Eligibility for outpatient services.
17.94 Outpatient medical services for military retirees and other beneficiaries.
17.95 Outpatient medical services for Department of Veterans Affairs employees and others in emergencies.
17.96 Medication prescribed by non-VA physicians.
17.97 Prescriptions in Alaska, and territories and possessions.
17.98 Mental health services.

BREAKING APPOINTMENTS

17.100 Refusal of treatment by unnecessarily breaking appointments.

CHARGES, WAIVERS, AND COLLECTIONS

17.101 Collection or recovery by VA for medical care or services provided or furnished to a veteran for a nonservice-connected disability.
17.102 Charges for care or services.
17.103 Referrals of compromise settlement offers.
17.104 Terminations and suspensions.
17.105 Waivers.

DISCIPLINARY CONTROL OF BENEFICIARIES RECEIVING HOSPITAL, DOMICILIARY OR NURSING HOME CARE

17.106 VA response to disruptive behavior of patients.

COPAYMENTS

17.108 Copayments for inpatient hospital care and outpatient medical care.
17.110 Copayments for medication.
17.111 Copayments for extended care services.

CEREMONIES

17.112 Services or ceremonies on Department of Veterans Affairs hospital or center reservations.

REIMBURSEMENT FOR LOSS BY NATURAL DISASTER OF PERSONAL EFFECTS OF HOSPITALIZED OR NURSING HOME PATIENTS

17.113 Conditions of custody.
17.114 Submittal of claim for reimbursement.
17.115 Claims in cases of incompetent patients.

REIMBURSEMENT TO EMPLOYEES FOR THE COST OF REPAIRING OR REPLACING CERTAIN PERSONAL PROPERTY DAMAGED OR DESTROYED BY PATIENTS OR MEMBERS

17.116 Adjudication of claims.

PAYMENT AND REIMBURSEMENT OF THE EXPENSES OF MEDICAL SERVICES NOT PREVIOUSLY AUTHORIZED

17.120 Payment or reimbursement of the expenses of hospital care and other medical services not previously authorized.
17.121 Limitations on payment or reimbursement of the costs of emergency hospital care and medical services not previously authorized.
17.122 Payment or reimbursement of the expenses of repairs to prosthetic appliances and similar devices furnished without prior authorization.
17.123 Claimants.
17.124 Preparation of claims.
17.125 Where to file claims.
17.126 Timely filing.
17.127 Date of filing claims.
17.128 Allowable rates and fees.
17.129 Retroactive payments prohibited.
17.130 Payment for treatment dependent upon preference prohibited.
17.131 Payment of abandoned claims prohibited.
17.132 Appeals.

RECONSIDERATION OF DENIED CLAIMS

17.133 Procedures.

DELEGATIONS OF AUTHORITY

17.140 Authority to adjudicate reimbursement claims.
17.141 Authority to adjudicate foreign reimbursement claims.
17.142 Authority to approve sharing agreements, contracts for scarce medical specialist services and contracts for other medical services.

PROSTHETIC, SENSORY, AND REHABILITATIVE AIDS

17.149 Sensori-neural aids.
17.150 Prosthetic and similar appliances.
17.151 Invalid lifts for recipients of aid and attendance allowance or special monthly compensation.
17.152 Devices to assist in overcoming the handicap of deafness.
17.153 Training in the use of appliances.
17.154 Dog-guides and equipment for blind.

AUTOMOTIVE EQUIPMENT AND DRIVER TRAINING

17.155 Minimum standards of safety and quality for automotive adaptive equipment.
17.156 Eligibility for automobile adaptive equipment.
17.157 Definition-adaptive equipment.
17.158 Limitations on assistance.
17.159 Obtaining vehicles for special driver training courses.

DENTAL SERVICES

17.160 Authorization of dental examinations.
17.161 Authorization of outpatient dental treatment.
17.162 Eligibility for Class II dental treatment without rating action.
17.163 Posthospital outpatient dental treatment.
17.164 Patient responsibility in making and keeping dental appointments.
17.165 Emergency outpatient dental treatment.
17.166 Dental services for hospital or nursing home patients and domiciled members.

AUTOPSIES

17.170 Autopsies.

VETERANS CANTEEN SERVICE

17.180 Delegation of authority.

AID TO STATES FOR CARE OF VETERANS IN STATE HOMES

17.190 Recognition of a State home.
17.191 Filing applications.
17.192 Approval of annexes and new facilities.
17.193 Prerequisites for payments to State homes.
17.194 Aid for domiciliary care.
17.196 Aid for hospital care.
17.197 Amount of aid payable.
17.198 Department of Veterans Affairs approval of eligibility required.
17.199 Inspection of recognized State homes.
17.200 Audit of State homes.

SHARING OF MEDICAL FACILITIES, EQUIPMENT, AND INFORMATION

17.230 Contingency backup to the Department of Defense.
17.240 Sharing specialized medical resources.
17.241 Sharing medical information services.
17.242 Coordination of programs with Department of Health and Human Services.

GRANTS FOR EXCHANGE OF INFORMATION

17.250 Scope of the grant program.
17.251 The Subcommittee on Academic Affairs.
17.252 Ex officio member of subcommittee.
17.253 Applicants for grants.
17.254 Applications.
17.255 Applications for grants for programs which include construction projects.
17.256 Amended or supplemental applications.
17.257 Awards procedures.
17.258 Terms and conditions to which awards are subject.
17.259 Direct costs.

17.260 Patient care costs to be excluded from direct costs.
17.261 Indirect costs.
17.262 Authority to approve applications discretionary.
17.263 Suspension and termination procedures.
17.264 Recoupments and releases.
17.265 Payments.
17.266 Copyrights and patents.

CIVILIAN HEALTH AND MEDICAL PROGRAM OF THE DEPARTMENT OF VETERANS AFFAIRS (CHAMPVA)—MEDICAL CARE FOR SURVIVORS AND DEPENDENTS OF CERTAIN VETERANS

17.270 General provisions.
17.271 Eligibility.
17.272 Benefit limitations/exclusions.
17.273 Preauthorization.
17.274 Cost sharing.
17.275 Claim filing deadline.
17.276 Appeal/review process.
17.277 Third party liability/medical care cost recovery.
17.278 Confidentiality of records.

GRANTS TO THE REPUBLIC OF THE PHILIPPINES

17.350 The program of assistance to the Philippines.
17.351 Grants for the replacement and upgrading of equipment at Veterans Memorial Medical Center.
17.352 Amounts and use of grant funds for the replacement and upgrading of equipment.
17.355 Awards procedures.
17.362 Acceptance of medical supplies as payment.
17.363 Length of stay.
17.364 Eligibility determinations.
17.365 Admission priorities.
17.366 Authorization of emergency admissions.
17.367 Republic of the Philippines to print forms.
17.369 Inspections.
17.370 Termination of payments.

CONFIDENTIALITY OF HEALTHCARE QUALITY ASSURANCE REVIEW RECORDS

17.500 General.
17.501 Confidential and privileged documents.
17.502 Applicability of other statutes.
17.503 Improper disclosure.
17.504 Disclosure methods.
17.505 Disclosure authorities.
17.506 Appeal of decision by Veterans Health Administration to deny disclosure.
17.507 Employee responsibilities.
17.508 Access to quality assurance records and documents within the agency.
17.509 Authorized disclosure: Non-Department of Veterans Affairs requests.
17.510 Redisclosure.
17.511 Penalties for violations.

VA HEALTH PROFESSIONAL SCHOLARSHIP PROGRAM

17.600 Purpose.
17.601 Definitions.
17.602 Eligibility.
17.603 Availability of scholarships.
17.604 Application for the scholarship program.
17.605 Selection of participants.
17.606 Award procedures.
17.607 Obligated service.
17.608 Deferment of obligated service.
17.609 Pay during period of obligated service.
17.610 Failure to comply with terms and conditions of participation.
17.611 Bankruptcy.
17.612 Cancellation, waiver, or suspension of obligation.

TRANSITIONAL HOUSING LOAN PROGRAM

17.800 Purpose.
17.801 Definitions.
17.802 Application provisions.
17.803 Order of consideration.
17.804 Loan approval criteria.
17.805 Additional terms of loans.

HEALTH CARE BENEFITS FOR CERTAIN CHILDREN OF VIETNAM VETERANS AND VETERANS WITH COVERED SERVICE IN KOREA—SPINA BIFIDA AND COVERED BIRTH DEFECTS

17.900 Definitions.
17.901 Provision of health care.
17.902 Preauthorization.
17.903 Payment.
17.904 Review and appeal process.
17.905 Medical records.

PAYMENT OR REIMBURSEMENT FOR EMERGENCY SERVICES FOR NONSERVICE-CONNECTED CONDITIONS IN NON-VA FACILITIES

17.1000 Payment or reimbursement for emergency services for nonservice-connected conditions in non-VA facilities.
17.1001 Definitions.
17.1002 Substantive conditions for payment or reimbursement.
17.1003 Emergency transportation.
17.1004 Filing claims.
17.1005 Payment limitations.
17.1006 Decisionmakers.
17.1007 Independent right of recovery.
17.1008 Balance billing prohibited.

AUTHORITY: 38 U.S.C. 501, and as noted in specific sections.

DEFINITIONS AND ACTIVE DUTY

§ 17.1 Incorporation by reference.

(a) Certain materials are incorporated by reference into this part

with the approval of the Director of the Federal Register under 5 U.S.C. 552(a) and 1 CFR part 51. To enforce an edition of a publication other than that specified in this section, VA will provide notice of the change in a notice of proposed rulemaking in the FEDERAL REGISTER and the material will be made available to the public. All approved materials are available for inspection at the Department of Veterans Affairs, Office of Regulation Policy and Management (02REG), 810 Vermont Avenue, NW., Room 1068, Washington, DC 20420, or at the National Archives and Records Administration (NARA). For information on the availability of approved materials at NARA, call (202) 741–6030, or go to: *http://www.archives.gov/federal_register/code_of_federal_regulations/ibr_locations.html*. Copies may be obtained from the National Fire Protection Association, 1 Batterymarch Park, Quincy, MA 02269. (For ordering information, call toll-free 1–800–344–3555.)

(b) The following materials are incorporated by reference into this part.

(1) NFPA 10, Standard for Portable Fire Extinguishers (2010 edition), Incorporation by Reference (IBR) approved for §§ 17.63 and 17.81.

(2) NFPA 101, Life Safety Code (2009 edition), IBR approved for §§ 17.63, 17.81, 17.82.

(3) NFPA 101A, Guide on Alternative Approaches to Life Safety (2010 edition), IBR approved for § 17.63.

(Authority: 5 U.S.C. 552(a), 38 U.S.C. 501, 1721.)

[76 FR 10248, Feb. 24, 2011]

§ 17.30 Definitions.

When used in Department of Veterans Affairs medical regulations, each of the following terms shall have the meaning ascribed to it in this section:

(a) *Medical services*. The term *medical services* includes, in addition to medical examination, treatment, and rehabilitative services:

(1) Surgical services, dental services and appliances as authorized in §§ 17.160 through 17.166, optometric and podiatric services, (in the case of a person otherwise receiving care or services under this chapter) the preventive health care services set forth in 38 U.S.C. 1762, noninstitutional extended care, wheelchairs, artificial limbs, trusses and similar appliances, special clothing made necessary by the wearing of prosthetic appliances, and such other supplies or services as are medically determined to be reasonable and necessary.

(Authority: 38 U.S.C. 1701(6)(A)(i))

(2) Consultation, professional counseling, marriage and family 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 certifies an intention to live, as necessary in connection with the veteran's treatment.

(3) Transportation and incidental expenses for any person entitled to such benefits under the provisions of § 17.143.

(Authority: 38 U.S.C. 1701(6))

(b) *Domiciliary care*. The term *domiciliary care* means the furnishing of a home to a veteran, embracing the furnishing of shelter, food, clothing and other comforts of home, including necessary medical services. The term further includes travel and incidental expenses pursuant to § 17.143.

(Authority: 38 U.S.C. 1701(4))

[23 FR 6498, Aug. 22, 1958]

EDITORIAL NOTE: For FEDERAL REGISTER citations affecting § 17.30, see the List of CFR Sections Affected, which appears in the Finding Aids section of the printed volume and at www.fdsys.gov.

§ 17.31 Duty periods defined.

Definitions of duty periods applicable to eligibility for medical benefits are as follows:

(a)–(c) [Reserved]

(d) *Inactive duty training*. The term *inactive duty training* means: (1) Duty (other than full-time duty) prescribed for Reserves (including commissioned officers of the Reserve Corps of the Public Health Service) by the Secretary concerned under section 206, title 37 U.S.C., or any other provision of law;

(2) Special additional duties authorized for Reserves (including commissioned officers of the Reserve Corps of

the Public Health Service) by an authority designated by the Secretary concerned and performed by them on a voluntary basis in connection with the prescribed training or maintenance activities of the units to which they are assigned.

(3) Duty (other than full-time duty) for members of the National Guard or Air National Guard of any State under the provisions of law stated in paragraph (c)(3) of this section.

(4) Inactive duty for training does not include work or study performed in connection with correspondence courses, or attendance at an educational institution in an inactive status, or duty performed as a temporary member of the Coast Guard Reserve.

[34 FR 9339, June 13, 1969, as amended at 45 FR 6934, Jan. 31, 1980; 45 FR 43169, June 26, 1980; 48 FR 56580, Dec. 22, 1983; 61 FR 21965, May 13, 1996; 75 FR 54497, Sept. 8, 2010]

PROTECTION OF PATIENT RIGHTS

§ 17.32 Informed consent and advance care planning.

(a) *Definitions*:

Advance Directive. Specific written statements made by a patient who has decision-making capacity regarding future health care decisions in any of the following:

(i) *VA Living Will*. A written statement made by a patient on an authorized VA form which sets forth the patient's wishes regarding the patient's health care treatment preferences including the withholding and withdrawal of life-sustaining treatment.

(ii) *VA Durable Power of Attorney for Health Care*. A written instruction on a VA form which designates the patient's choice of health care agent.

(iii) *State-Authorized Advance Directive*. A non-VA living will, durable power of attorney for health care, or other advance health care planning document, the validity of which is determined pursuant to applicable State law. For the purposes of this paragraph and paragraph (h) of this section, ''applicable State law'' means the law of the State where the advance directive was signed, the State where the patient resided when the advance directive was signed, the State where the patient now resides, or the State where the patient is receiving treatment. VA will resolve any conflict between those State laws regarding the validity of the advance directive by following the law of the State that gives effect to the expressed wishes in the advance directive.

Close friend. Any person eighteen years or older who has shown care and concern for the patient's welfare, who is familiar with the patient's activities, health, religious beliefs and values, and who has presented a signed written statement for the record that describes that person's relationship to and familiarity with the patient.

Decision-making capacity. The ability to understand and appreciate the nature and consequences of health care treatment decisions.

Health care agent. An individual named by the patient in a Durable Power of Attorney for Health Care.

Legal guardian. A person appointed by a court of appropriate jurisdiction to make decisions for an individual who has been judicially determined to be incompetent.

Practitioner. Any physician, dentist, or health care professional who has been granted specific clinical privileges to perform the treatment or procedure. For the purpose of obtaining informed consent for medical treatment, the term practitioner includes medical and dental residents and other appropriately trained health care professionals designated by VA regardless of whether they have been granted clinical privileges.

Signature consent. The patient's or surrogate's signature on a VA-authorized consent form.

Special guardian. A person appointed by a court of appropriate jurisdiction for the specific purpose of making health care decisions.

Surrogate. An individual, organization or other body authorized under this section to give informed consent on behalf of a patient who lacks decision-making capacity.

(b) *Policy*. Except as otherwise provided in this section, all patient care furnished under title 38 U.S.C. shall be carried out only with the full and informed consent of the patient or, in appropriate cases, a representative thereof. In order to give informed consent,

the patient must have decision-making capacity and be able to communicate decisions concerning health care. If the patient lacks decision-making capacity or has been declared incompetent, consent must be obtained from the patient's surrogate. Practitioners may provide necessary medical care in emergency situations without the patient's or surrogate's express consent when immediate medical care is necessary to preserve life or prevent serious impairment of the health of the patient or others and the patient is unable to consent and the practitioner determines that the patient has no surrogate or that waiting to obtain consent from the patient's surrogate would increase the hazard to the life or health of the patient or others. In such circumstances consent is implied.

(c) *General requirements for informed consent.* Informed consent is the freely given consent that follows a careful explanation by the practitioner to the patient or the patient's surrogate of the proposed diagnostic or therapeutic procedure or course of treatment. The practitioner, who has primary responsibility for the patient or who will perform the particular procedure or provide the treatment, must explain in language understandable to the patient or surrogate the nature of a proposed procedure or treatment; the expected benefits; reasonably foreseeable associated risks, complications or side effects; reasonable and available alternatives; and anticipated results if nothing is done. The patient or surrogate must be given the opportunity to ask questions, to indicate comprehension of the information provided, and to grant permission freely without coercion. The practitioner must advise the patient or surrogate if the proposed treatment is novel or unorthodox. The patient or surrogate may withhold or revoke his or her consent at any time.

(d) *Documentation of informed consent.* (1) The informed consent process must be appropriately documented in the health record. In addition, signature consent is required for all diagnostic and therapeutic treatments or procedures that:

(i) Require the use of sedation;

(ii) Require anesthesia or narcotic analgesia;

(iii) Are considered to produce significant discomfort to the patient;

(iv) Have a significant risk of complication or morbidity; or

(v) Require injections of any substance into a joint space or body cavity.

(2) A patient or surrogate will sign with an ''X'' when the patient or surrogate has a debilitating illness or disability, *i.e.*, significant physical impairment and/or difficulty in executing a signature due to an underlying health condition(s), or is unable to read and write. When the patient's or surrogate's signature is indicated by an ''X,'' two adults must witness the act of signing. By signing, the witnesses are attesting only to the fact that they saw the patient or surrogate and the practitioner sign the form. The signed form must be filed in the patient's health record. A properly executed VA-authorized consent form is valid for a period of 60 calendar days. If, however, the treatment plan involves multiple treatments or procedures, it will not be necessary to repeat the informed consent discussion and documentation so long as the course of treatment proceeds as planned, even if treatment extends beyond the 60-day period. If there is a change in the patient's condition that might alter the diagnostic or therapeutic decision, the consent is automatically rescinded.

(3) If it is impractical to consult with the surrogate in person, informed consent may be obtained by mail, facsimile, or telephone. A facsimile copy of a signed consent form is adequate to proceed with treatment. However, the surrogate must agree to submit a signed consent form to the practitioner. If consent is obtained by telephone, the conversation must be audiotaped or witnessed by a second VA employee. The name of the person giving consent and his or her authority to act as surrogate must be adequately identified for the record.

(e) *Surrogate consent.* If the practitioner who has primary responsibility for the patient determines that the patient lacks decision-making capacity and is unlikely to regain it within a reasonable period of time, informed

consent must be obtained from the patient's surrogate. Patients who are incapable of giving consent as a matter of law, *i.e.*, persons judicially determined to be incompetent and minors not otherwise able to provide informed consent, will be deemed to lack decision-making capacity for the purposes of this section. If the patient is considered a minor in the state where the VA facility is located and cannot consent to medical treatment, consent must be obtained from the patient's parent or legal guardian. The surrogate generally assumes the same rights and responsibilities as the patient in the informed consent process. The surrogate's decision must be based on his or her knowledge of what the patient would have wanted, *i.e.*, substituted judgment. If the patient's wishes are unknown, the decision must be based on the patient's best interest. The following persons are authorized to consent on behalf of patients who lack decision-making capacity in the following order of priority:

(1) Health care agent;

(2) Legal guardian or special guardian;

(3) Next-of-kin: a close relative of the patient eighteen years of age or older, in the following priority: spouse, child, parent, sibling, grandparent, or grandchild; or

(4) Close friend.

(f) *Consent for patients without surrogates.* (1) If none of the surrogates listed in paragraph (e) of this section are available, the practitioner may request Regional Counsel assistance to obtain a special guardian for health care or follow the procedures outlined in this paragraph (f).

(2) Facilities may use the following process to make treatment decisions for patients who lack decision-making capacity and have no surrogate. For treatments or procedures that involve minimal risk, the practitioner must verify that no authorized surrogate can be located. The practitioner must attempt to explain the nature and purpose of the proposed treatment to the patient and enter this information in the health record. For procedures that require signature consent, the practitioner must certify that the patient has no surrogate. The attending physician and the Chief of Service (or his or her designee) must indicate their approval of the treatment decision in writing. Any decision to withhold or withdraw life-sustaining treatment for such patients must be reviewed by a multi-disciplinary committee appointed by the facility Director. The committee functions as the patient's advocate and may not include members of the treatment team. The committee must submit its findings and recommendations in a written report to the Chief of Staff who must note his or her approval of the report in writing. After reviewing the record, the facility Director may concur with the decision to withhold or withdraw life support or request further review by Regional Counsel.

(g) *Special consent situations.* In addition to the other requirements of this section, additional protections are required in the following situations.

(1) No patient will undergo any unusual or extremely hazardous treatment or procedure, e.g., that which might result in irreversible brain damage or sterilization, except as provided in this paragraph (g). Before treatment is initiated, the patient or surrogate must be given adequate opportunity to consult with independent specialists, legal counsel or other interested parties of his or her choosing. The patient's or surrogate's signature on a VA authorized consent form must be witnessed by someone who is not affiliated with the VA health care facility, e.g., spouse, legal guardian, or patient advocate. If a surrogate makes the treatment decision, a multi-disciplinary committee, appointed by the facility Director, must review that decision to ensure it is consistent with the patient's wishes or in his or her best interest. The committee functions as the patient's advocate and may not include members of the treatment team. The committee must submit its findings and recommendations in a written report to the facility Director. The Director may authorize treatment consistent with the surrogate's decision or request that a special guardian for health care be appointed to make the treatment decision.

(2) Administration of psychotropic medication to an involuntarily committed patient against his or her will

must meet the following requirements. The patient or surrogate must be allowed to consult with independent specialists, legal counsel or other interested parties concerning the treatment with psychotropic medication. Any recommendation to administer or continue medication against the patient's or surrogate's will must be reviewed by a multi-disciplinary committee appointed by the facility Director for this purpose. This committee must include a psychiatrist or a physician who has psychopharmacology privileges. The facility Director must concur with the committee's recommendation to administer psychotropic medications contrary to the patient's or surrogate's wishes. Continued therapy with psychotropic medication must be reviewed every 30 days. The patient (or a representative on the patient's behalf) may appeal the treatment decision to a court of appropriate jurisdiction.

(3) If a proposed course of treatment or procedure involves approved medical research in whole or in part, the patient or representative shall be advised of this. Informed consent shall be obtained specifically for the administration or performance of that aspect of the treatment or procedure that involves research. Such consent shall be in addition to that obtained for the administration or performance of the nonresearch aspect of the treatment or procedure and must meet the requirements for informed consent set forth in 38 CFR Part 16, *Protection of Human Subjects*.

(h) *Advance health care planning*. Subject to the provisions of paragraphs (h)(1) through (h)(4) of this section, VA will follow the wishes of a patient expressed in an Advance Directive when the attending physician determines and documents in the patient's health record that the patient lacks decision-making capacity and is not expected to regain it. An advance directive that is valid in one or more States under applicable State law, as defined in paragraph (a) of this section, will be recognized throughout the VA health care system.

(1) *Witnesses*. A VA Advance Directive: Living Will and Durable Power of Attorney for Health Care must be signed by the patient in the presence of two witnesses. Neither witness may to the witness' knowledge be named in the patient's will, appointed as health care agent in the advance directive, or financially responsible for the patient's care. VA employees of the Chaplain Service, Psychology Service, Social Work Service, or nonclinical employees (e.g., Medical Administration Service, Voluntary Service, or Environmental Management Service) may serve as witnesses. Other individuals employed by the VA facility in which the patient is being treated may not sign as witnesses to the advance directive. Witnesses are attesting only to the fact that they saw the patient sign the form.

(2) *Instructions in critical situations*. VA will follow the unambiguous verbal or non-verbal instructions regarding future health care decisions of a patient who has decision-making capacity when the patient is admitted to care when critically ill and loss of capacity may be imminent and the patient is not physically able to sign an advance directive form, or the appropriate form is not readily available. The patient's instructions must have been expressed to at least two members of the health care team. The substance of the patient's instructions must be recorded in a progress note in the patient's health record and must be cosigned by at least two members of the health care team who were present and can attest to the wishes expressed by the patient. These instructions will be given effect only if the patient loses decision-making capacity during the presenting situation.

(3) *Revocation*. A patient who has decision-making capacity may revoke an advance directive or instructions in a critical situation at any time by using any means expressing the intent to revoke.

(4) *VA policy and disputes*. Neither the treatment team nor surrogate may override a patient's clear instructions in an Advance Directive or in instructions in critical situations, except that those portions of an Advance Directive

or instructions given in a critical situation that are not consistent with VA policy will not be given effect.

(Authority: 38 U.S.C. 7331–7334)

(The information collection requirements in this section have been approved by the Office of Management and Budget under control number 2900–0583)

[62 FR 53961, Oct. 17, 1997, as amended at 70 FR 71774, Nov. 30, 2005; 71 FR 68740, Nov. 28, 2006; 72 FR 10366, Mar. 8, 2007; 74 FR 34503, July 16, 2009]

§ 17.33 Patients' rights.

(a) *General.* (1) Patients have a right to be treated with dignity in a humane environment that affords them both reasonable protection from harm and appropriate privacy with regard to their personal needs.

(2) Patients have a right to receive, to the extent of eligibility therefor under the law, prompt and appropriate treatment for any physical or emotional disability.

(3) Patients have the right to the least restrictive conditions necessary to achieve treatment purposes.

(4) No patient in the Department of Veterans Affairs medical care system, except as otherwise provided by the applicable State law, shall be denied legal rights solely by virtue of being voluntarily admitted or involuntarily committed. Such legal rights include, but are not limited to, the following:

(i) The right to hold and to dispose of property except as may be limited in accordance with paragraph (c)(2) of this section;

(ii) The right to execute legal instruments (e.g., will);

(iii) The right to enter into contractual relationships;

(iv) The right to register and vote;

(v) The right to marry and to obtain a separation, divorce, or annulment;

(vi) The right to hold a professional, occupational, or vehicle operator's license.

(b) *Residents and inpatients.* Subject to paragraphs (c) and (d) of this section, patients admitted on a residential or inpatient care basis to the Department of Veterans Affairs medical care system have the following rights:

(1) *Visitations and communications.* Each patient has the right to communicate freely and privately with persons outside the facility, including government officials, attorneys, and clergymen. To facilitate these communications each patient shall be provided the opportunity to meet with visitors during regularly scheduled visiting hours, convenient and reasonable access to public telephones for making and receiving phone calls, and the opportunity to send and receive unopened mail.

(i) Communications with attorneys, law enforcement agencies, or government officials and representatives of recognized service organizations when the latter are acting as agents for the patient in a matter concerning Department of Veterans Affairs benefits, shall not be reviewed.

(ii) A patient may refuse visitors.

(iii) If a patient's right to receive unopened mail is restricted pursuant to paragraph (c) of this section, the patient shall be required to open the sealed mail while in the presence of an appropriate person for the sole purpose of ascertaining whether the mail contains contraband material, *i.e.*, implements which pose significant risk of bodily harm to the patient or others or any drugs or medication. Any such material will be held for the patient or disposed of in accordance with instructions concerning patients' mail published by the Veterans Health Administration, Department of Veterans Affairs, and/or the local health care facility.

(iv) Each patient shall be afforded the opportunity to purchase, at the patient's expense, letter writing material including stamps. In the event a patient needs assistance in purchasing writing material, or in writing, reading or sending mail, the medical facility will attempt, at the patient's request, to provide such assistance by means of volunteers, sufficient to mail at least one (1) letter each week.

(v) All information gained by staff personnel of a medical facility during the course of assisting a patient in writing, reading, or sending mail is to be kept strictly confidential except for any disclosure required by law.

(2) *Clothing.* Each patient has the right to wear his or her own clothing.

(3) *Personal Possessions.* Each patient has the right to keep and use his or her

own personal possessions consistent with available space, governing fire safety regulations, restrictions on noise, and restrictions on possession of contraband material, drugs and medications.

(4) *Money*. Each patient has the right to keep and spend his or her own money and to have access to funds in his or her account in accordance with instructions concerning personal funds of patients published by the Veterans Health Administration.

(5) *Social Interaction*. Each patient has the right to social interaction with others.

(6) *Exercise*. Each patient has the right to regular physical exercise and to be outdoors at regular and frequent intervals. Facilities and equipment for such exercise shall be provided.

(7) *Worship*. The opportunity for religious worship shall be made available to each patient who desires such opportunity. No patient will be coerced into engaging in any religious activities against his or her desires.

(c) *Restrictions*. (1) A right set forth in paragraph (b) of this section may be restricted within the patient's treatment plan by written order signed by the appropriate health care professional if—

(i) It is determined pursuant to paragraph (c)(2) of this section that a valid and sufficient reason exists for a restriction, and

(ii) The order imposing the restriction and a progress note detailing the indications therefor are both entered into the patient's permanent medical record.

(2) For the purpose of paragraph (c) of this section, a valid and sufficient reason exists when, after consideration of pertinent facts, including the patient's history, current condition and prognosis, a health care professional reasonably believes that the full exercise of the specific right would—

(i) Adversely affect the patient's physical or mental health,

(ii) Under prevailing community standards, likely stigmatize the patient's reputation to a degree that would adversely affect the patient's return to independent living,

(iii) Significantly infringe upon the rights of or jeopardize the health or safety of others, or

(iv) Have a significant adverse impact on the operation of the medical facility, to such an extent that the patient's exercise of the specific right should be restricted. In determining whether a patient's specific right should be restricted, the health care professional concerned must determine that the likelihood and seriousness of the consequences that are expected to result from the full exercise of the right are so compelling as to warrant the restriction. The Chief of Service or Chief of Staff, as designated by local policy, should concur with the decision to impose such restriction. In this connection, it should be noted that there is no intention to imply that each of the reasons specified in paragraphs (c)(2)(i) through (iv) of this section are logically relevant to each of the rights set forth in paragraph (b)(1) of this section.

(3) If it has been determined under paragraph (c)(2) of this section that a valid and sufficient reason exists for restricting any of the patient's rights set forth in paragraph (b) of this section, the least restrictive method for protecting the interest or interests specified in paragraphs (c)(2)(i) through (iv) of this section that are involved shall be employed.

(4) The patient must be promptly notified of any restriction imposed under paragraph (c) of this section and the reasons therefor.

(5) All restricting orders under paragraph (c) of this section must be reviewed at least once every 30 days by the practitioner and must be concurred in by the Chief of Service or Chief of Staff.

(d) *Restraint and seclusion of patients*. (1) Each patient has the right to be free from physical restraint or seclusion except in situations in which there is a substantial risk of imminent harm by the patient to himself, herself, or others and less restrictive means of preventing such harm have been determined to be inappropriate or insufficient. Patients will be physically restrained or placed in seclusion only on the written order of an appropriate licensed health care professional. The reason for any restraint order will be clearly documented in the progress notes of the patient's medical record.

The written order may be entered on the basis of telephonic authority, but in such an event, an appropriate licensed health care professional must examine the patient and sign a written order within an appropriate timeframe that is in compliance with current community and/or accreditation standards. In emergency situations, where inability to contact an appropriate licensed health care professional prior to restraint is likely to result in immediate harm to the patient or others, the patient may be temporarily restrained by a member of the staff until appropriate authorization can be received from an appropriate licensed health care professional . Use of restraints or seclusion may continue for a period of time that does not exceed current community and/or accreditation standards, within which time an appropriate licensed health care professional shall again be consulted to determine if continuance of such restraint or seclusion is required. Restraint or seclusion may not be used as a punishment, for the convenience of staff, or as a substitute for treatment programs.

(2) While in restraint or seclusion, the patient must be seen within appropriate timeframes in compliance with current community and/or accreditation standards:

(i) By an appropriate health care professional who will monitor and chart the patient's physical and mental condition; and

(ii) By other ward personnel as frequently as is reasonable under existing circumstances.

(3) Each patient in restraint or seclusion shall have bathroom privileges according to his or her needs.

(4) Each patient in restraint or seclusion shall have the opportunity to bathe at least every twenty-four (24) hours.

(5) Each patient in restraint or seclusion shall be provided nutrition and fluid appropriately.

(e) *Medication.* Patients have a right to be free from unnecessary or excessive medication. Except in an emergency, medication will be administered only on a written order of an appropriate health care professional in that patient's medical record. The written order may be entered on the basis of telephonic authority received from an appropriate health care professional, but in such event, the written order must be countersigned by an appropriate health care professional within 24 hours of the ordering of the medication. An appropriate health care professional will be responsible for all medication given or administered to a patient. A review by an appropriate health care professional of the drug regimen of each inpatient shall take place at least every thirty (30) days. It is recognized that administration of certain medications will be reviewed more frequently. Medication shall not be used as punishment, for the convenience of the staff, or in quantities which interfere with the patient's treatment program.

(f) *Confidentiality.* Information gained by staff from the patient or the patient's medical record will be kept confidential and will not be disclosed except in accordance with applicable law.

(g) *Patient grievances.* Each patient has the right to present grievances with respect to perceived infringement of the rights described in this section or concerning any other matter on behalf of himself, herself or others, to staff members at the facility in which the patient is receiving care, other Department of Veterans Affairs officials, government officials, members of Congress or any other person without fear or reprisal.

(h) *Notice of patient's rights.* Upon the admission of any patient, the patient or his/her representative shall be informed of the rights described in this section, shall be given a copy of a statement of those rights and shall be informed of the fact that the statement of rights is posted at each nursing station. All staff members assigned to work with patients will be given a copy of the statement of rights and these rights will be discussed with them by their immediate supervisor.

(i) *Other rights.* The rights described in this section are in addition to and not in derogation of any statutory, constitutional or other legal rights.

(Authority: 38 U.S.C. 501, 1721)

[47 FR 55486, Dec. 10, 1982. Redesignated at 61 FR 21965, May 13, 1996, as amended at 70 FR 67094, Nov. 4, 2005]

TENTATIVE ELIGIBILITY DETERMINATIONS

§ 17.34 Tentative eligibility determinations.

Subject to the provisions of §§ 17.36 through 17.38, when an application for hospital care or other medical services, except outpatient dental care, has been filed which requires an adjudication as to service connection or a determination as to any other eligibility prerequisite which cannot immediately be established, the service (including transportation) may be authorized without further delay if it is determined that eligibility for care probably will be established. Tentative eligibility determinations under this section, however, will only be made if:

(a) *In emergencies.* The applicant needs hospital care or other medical services in emergency circumstances, or

(b) *For persons recently discharged from service.* The application was filed within 6 months after date of honorable discharge from a period of not less than 6 months of active duty.

[35 FR 6586, Apr. 24, 1970. Redesignated at 61 FR 21965, May 13, 1996, as amended at 64 FR 54212, Oct. 6, 1999]

HOSPITAL OR NURSING HOME CARE AND MEDICAL SERVICES IN FOREIGN COUNTRIES

§ 17.35 Hospital care and medical services in foreign countries.

The Secretary may furnish hospital care and medical services to any veteran sojourning or residing outside the United States, without regard to the veteran's citizenship:

(a) If necessary for treatment of a service-connected disability, or any disability associated with and held to be aggravating a service-connected disability;

(b) If the care is furnished to a veteran participating in a rehabilitation program under 38 U.S.C. chapter 31 who requires care for the reasons enumerated in 38 CFR 17.47(i)(2).

(Authority: 38 U.S.C. 1724)

[55 FR 11370, Mar. 28, 1990. Redesignated at 61 FR 21965, May 13, 1996, as amended at 74 FR 30228, June 25, 2009]

ENROLLMENT PROVISIONS AND MEDICAL BENEFITS PACKAGE

§ 17.36 Enrollment—provision of hospital and outpatient care to veterans.

(a) *Enrollment requirement for veterans.* (1) Except as otherwise provided in § 17.37, a veteran must be enrolled in the VA healthcare system as a condition for receiving the 'medical benefits package' set forth in § 17.38.

NOTE TO PARAGRAPH (a)(1): A veteran may apply to be enrolled at any time. (See § 17.36(d)(1).)

(2) Except as provided in paragraph (a)(3) of this section, a veteran enrolled under this section and who, if required by law to do so, has agreed to make any applicable copayment is eligible for VA hospital and outpatient care as provided in the ''medical benefits package'' set forth in § 17.38.

NOTE TO PARAGRAPH (a)(2): A veteran's enrollment status will be recognized throughout the United States.

(3) A veteran enrolled based on having 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 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 in 38 U.S.C. 1710(e), is eligible for VA care provided in the ''medical benefits package'' set forth in § 17.38 for the disorder.

(b) *Categories of veterans eligible to be enrolled.* The Secretary will determine which categories of veterans are eligible to be enrolled based on the following order of priority:

(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 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 0 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. For purposes of this paragraph, VA will determine the income of veterans (to include the income of their spouses and dependents) using the rules in §§3.271, 3.272, 3.273, and 3.276. After determining the veterans' income and the number of persons in the veterans' family (including only the spouse and dependent children), VA will compare their income with the current applicable ''low-income'' income limit for the public housing and section 8 programs in their area that the U.S. Department of Housing and Urban Development publishes pursuant to 42 U.S.C. 1437a(b)(2). If the veteran's income is below the applicable ''low-income'' income limits for the area in which the veteran resides, the veteran will be considered to have ''low income'' for purposes of this paragraph. To avoid a hardship to a veteran, VA may use the projected income for the current year of the veteran, spouse, and dependent children if the projected income is below the ''low income'' income limit referenced above. This category is further prioritized into the following subcategories:

(i) Noncompensable zero percent service-connected veterans who are in an enrolled status on a specified date announced in a FEDERAL REGISTER document promulgated under paragraph (c) of this section and who subsequently do not request disenrollment;

(ii) Nonservice-connected veterans who are in an enrolled status on a specified date announced in a FEDERAL REGISTER document promulgated under paragraph (c) of this section and who subsequently do not request disenrollment;

(iii) Noncompensable zero percent service-connected veterans not included in paragraph (b)(7)(i) of this section; and

(iv) Nonservice-connected veterans not included in paragraph (b)(7)(ii) of this section.

(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 into the following subcategories:

(i) Noncompensable zero percent service-connected veterans who were in an enrolled status on January 17, 2003, or who are moved from a higher priority category or subcategory due to no longer being eligible for inclusion in such priority category or subcategory and who subsequently do not request disenrollment;

(ii) Noncompensable zero percent service-connected veterans not included in paragraph (b)(8)(i) of this section and whose income is not greater than ten percent more than the income that would permit their enrollment in priority category 5 or priority category 7, whichever is higher;

(iii) Nonservice-connected veterans who were in an enrolled status on January 17, 2003, or who are moved from a higher priority category or subcategory due to no longer being eligible for inclusion in such priority category or subcategory and who subsequently do not request disenrollment;

(iv) Nonservice-connected veterans not included in paragraph (b)(8)(iii) of this section and whose income is not greater than ten percent more than the income that would permit their enrollment in priority category 5 or priority category 7, whichever is higher;

(v) Noncompensable zero percent service-connected veterans not included in paragraph (b)(8)(i) or paragraph (b)(8)(ii) of this section; and

(vi) Nonservice-connected veterans not included in paragraph (b)(8)(iii) or paragraph (b)(8)(iv) of this section.

(c) FEDERAL REGISTER *notification of eligible enrollees.* (1) It is anticipated that each year the Secretary will consider whether to change the categories and subcategories of veterans eligible to be enrolled. The Secretary at any time may revise the categories or subcategories of veterans eligible to be enrolled by amending paragraph (c)(2) of this section. The preamble to a FEDERAL REGISTER document announcing which priority categories and subcategories are eligible to be enrolled must specify the projected number of fiscal year applicants for enrollment in each priority category, projected healthcare utilization and expenditures for veterans in each priority category, appropriated funds and other revenue projected to be available for fiscal year enrollees, and projected total expenditures for enrollees by priority category. The determination should include consideration of relevant internal and external factors, e.g., economic changes, changes in medical practices, and waiting times to obtain an appointment for care. Consistent with these criteria, the Secretary will determine which categories of veterans are eligible to be enrolled based on the order of priority specified in paragraph (b) of this section.

(2) Unless changed by a rulemaking document in accordance with paragraph (c)(1) of this section, VA will enroll the priority categories of veterans set forth in §17.36(b) beginning June 15, 2009, except that those veterans in subcategories (v) and (vi) of priority category 8 are not eligible to be enrolled.

(d) *Enrollment and disenrollment process*—(1) *Application for enrollment.* A veteran may apply to be enrolled in the VA healthcare system at any time. A veteran who wishes to be enrolled must apply by submitting a VA Form 10–10EZ to a VA medical facility or via an Online submission at *https://www.1010ez.med.va.gov/sec/vha/1010ez/.*

(2) *Action on application.* Upon receipt of a completed VA Form 10–10EZ, a VA network or facility director, or the Deputy Under Secretary for Health for Operations and Management or Chief, Health Administration Service or equivalent official at a VA medical facility, or Director, Health Eligibility Center, will accept a veteran as an enrollee upon determining that the veteran is in a priority category eligible to be enrolled as set forth in §17.36(c)(2). Upon determining that a veteran is not in a priority category eligible to be enrolled, the VA network or facility director, or the Deputy Under Secretary for Health for Operations and Management or Chief, Health Administration Service or equivalent official at a VA medical facility, or Director, Health Eligibility Center, will inform the applicant that the applicant is ineligible to be enrolled.

(3) *Placement in enrollment categories.* (i) Veterans will be placed in priority categories whether or not veterans in

that category are eligible to be enrolled.

(ii) A veteran will be placed in the highest priority category or categories for which the veteran qualifies.

(iii) A veteran may be placed in only one priority category, except that a veteran placed in priority category 6 based on a specified disorder or illness will also be placed in priority category 7 or priority category 8, as applicable, if the veteran has previously agreed to pay the applicable copayment, for all matters not covered by priority category 6.

(iv) A veteran who had been enrolled based on inclusion in priority category 5 and became no longer eligible for inclusion in priority category 5 due to failure to submit to VA a current VA Form 10–10EZ will be changed automatically to enrollment based on inclusion in priority category 6 or 8 (or more than one of these categories if the previous principle applies), as applicable, and be considered continuously enrolled. To meet the criteria for priority category 5, a veteran must be eligible for priority category 5 based on the information submitted to VA in a current VA Form 10–10EZ. To be current, after VA has sent a form 10–10EZ to the veteran at the veteran's last known address, the veteran must return the completed form (including signature) to the address on the return envelope within 60 days from the date VA sent the form to the veteran.

(v) Veterans will be disenrolled, and reenrolled, in the order of the priority categories listed with veterans in priority category 1 being the last to be disenrolled and the first to be reenrolled. Similarly, within priority categories 7 and 8, veterans will be disenrolled, and reenrolled, in the order of the priority subcategories listed with veterans in subcategory (i) being the last to be disenrolled and first to be reenrolled.

(4) [Reserved]

(5) *Disenrollment.* A veteran enrolled in the VA health care system under paragraph (d)(2) of this section will be disenrolled only if:

(i) The veteran submits to a VA Medical Center or to the VA Health Eligibility Center, 2957 Clairmont Road, NE., Suite 200, Atlanta, Georgia 30329–1647, a signed and dated document stating that the veteran no longer wishes to be enrolled; or

(ii) A VA network or facility director, or the Deputy Under Secretary for Health for Operations and Management or Chief, Health Administration Service or equivalent official at a VA medical facility, or Director, Health Eligibility Center, determines that the veteran is no longer in a priority category eligible to be enrolled, as set forth in § 17.36(c)(2).

(6) *Notification of enrollment status.* Notice of a decision by a VA network or facility director, or the Deputy Under Secretary for Health for Operations and Management or Chief, Health Administration Service or equivalent official at a VA medical facility, or Director, Health Eligibility Center, regarding enrollment status will be provided to the affected veteran by letter and will contain the reasons for the decision. The letter will include an effective date for any changes and a statement regarding appeal rights. The decision will be based on all information available to the decisionmaker, including the information contained in VA Form 10–10EZ.

(e) *Catastrophically disabled.* For purposes of this section, catastrophically disabled means to have a permanent severely disabling injury, disorder, or disease that compromises the ability to carry out the activities of daily living to such a degree that the individual requires personal or mechanical assistance to leave home or bed or requires constant supervision to avoid physical harm to self or others. This definition is met if an individual has been found by the Chief of Staff (or equivalent clinical official) at the VA facility where the individual was examined to have a permanent condition specified in paragraph (e)(1) of this section; to meet permanently one of the conditions specified in paragraph (e)(2) of this section by a clinical evaluation of the patient's medical records that documents that the patient previously met the permanent criteria and continues to meet such criteria (permanently) or would continue to meet such criteria (permanently) without the continuation of on-going treatment; or

to meet permanently one of the conditions specified in paragraph (e)(2) of this section by a current medical examination that documents that the patient meets the permanent criteria and will continue to meet such criteria (permanently) or would continue to meet such criteria (permanently) without the continuation of on-going treatment.

(1) Quadriplegia and quadriparesis (ICD–9–CM Code 344.0x: 344.00, 344.01, 344.02, 344.03, 344.04, 3.44.09), paraplegia (ICD–9–CM Code 344.1), blindness (ICD–9–CM Code 369.4), persistent vegetative state (ICD–9–CM Code 780.03), or a condition resulting from two of the following procedures (ICD–9–CM Code 84.x or associated V Codes when available or Current Procedural Terminology (CPT) Codes) provided the two procedures were not on the same limb:

(i) Amputation through hand (ICD–9–CM Code 84.03 or V Code V49.63 or CPT Code 25927);

(ii) Disarticulation of wrist (ICD–9–CM Code 84.04 or V Code V49.64 or CPT Code 25920);

(iii) Amputation through forearm (ICD–9–CM Code 84.05 or V Code V49.65 or CPT Codes 25900, 25905);

(iv) Disarticulation of forearm (ICD–9–CM Code 84.05 or V Code V49.66 or CPT Codes 25900, 25905);

(v) Amputation or disarticulation through elbow. (ICD–9–CM Code 84.06 or V Code V49.66 or CPT 24999);

(vi) Amputation through humerus (ICD–9–CM Code 84.07 or V Code V49.66 or CPT Codes 24900, 24920);

(vii) Shoulder disarticulation (ICD–9–CM Code 84.08 or V Code V49.67 or CPT Code 23920);

(viii) Forequarter amputation (ICD–9–CM Code 84.09 or CPT Code 23900);

(ix) Lower limb amputation not otherwise specified (ICD–9–CM Code 84.10 or V Code V49.70 or CPT Codes 27880, 27882);

(x) Amputation of great toe (ICD–9–CM Code 84.11 or V Code V49.71 or CPT Codes 28810, 28820);

(xi) Amputation through foot (ICD–9–CM Code 84.12 or V Code V49.73 or CPT Codes 28800, 28805);

(xii) Disarticulation of ankle (ICD–9–CM Code 84.13 or V Code V49.74 or CPT 27889);

(xiii) Amputation through malleoli (ICD–9–CM Code 84.14 or V Code V49.75 or CPT Code 27888);

(xiv) Other amputation below knee (ICD–9–CM Code 84.15 or V Code V49.75 or CPT Codes 27880, 27882);

(xv) Disarticulation of knee (ICD–9–CM Code 84.16 or V Code V49.76 or CPT Code 27598);

(xvi) Above knee amputation (ICD–9–CM Code 84.17 or V Code V49.76 or CPT Code 27598);

(xvii) Disarticulation of hip (ICD–9–CM Code 84.18 or V Code V49.77 or CPT Code 27295); and

(xviii) Hindquarter amputation (ICD–9–CM Code 84.19 or CPT Code 27290).

(2)(i) Dependent in 3 or more Activities of Daily Living (eating, dressing, bathing, toileting, transferring, incontinence of bowel and/or bladder), with at least 3 of the dependencies being permanent with a rating of 1, using the Katz scale.

(ii) A score of 10 or lower using the Folstein Mini-Mental State Examination.

(iii) A score of 2 or lower on at least 4 of the 13 motor items using the Functional Independence Measure.

(iv) A score of 30 or lower using the Global Assessment of Functioning.

(f) *VA Form 10–10EZ*. Copies of VA Form 10–10EZ are available at any VA medical center and at *https://www.1010ez.med.va.gov/sec/vha/1010ez/*.

(The Office of Management and Budget has approved the information collection requirements in this section under control number 2900–0091)

(Authority: 38 U.S.C 101, 501, 1521, 1701, 1705, 1710, 1721, 1722)

[64 FR 54212, Oct. 6, 1999, as amended at 67 FR 35039, May 17, 2002; 67 FR 62887, Oct. 9, 2002; 68 FR 2672, Jan. 17, 2003; 74 FR 22834, May 15, 2009; 74 FR 48012, Sept. 21, 2009; 75 FR 52628, Aug. 27, 2010]

§ 17.37 Enrollment not required—provision of hospital and outpatient care to veterans.

Even if not enrolled in the VA healthcare system:

(a) A veteran rated for service-connected disabilities at 50 percent or greater will receive VA care provided for in the ''medical benefits package'' set forth in § 17.38.

(b) A veteran who has a service-connected disability will receive VA care provided for in the ''medical benefits package'' set forth in § 17.38 for that service-connected disability.

(c) A veteran who was discharged or released from active military service for a disability incurred or aggravated in the line of duty will receive VA care provided for in the ''medical benefits package'' set forth in § 17.38 for that disability for the 12-month period following discharge or release.

(d) When there is a compelling medical need to complete a course of VA treatment started when the veteran was enrolled in the VA healthcare system, a veteran will receive that treatment.

(e) Subject to the provisions of § 21.240, a veteran participating in VA's vocational rehabilitation program described in §§ 21.1 through 21.430 will receive VA care provided for in the ''medical benefits package'' set forth in § 17.38.

(f) A veteran may receive care provided for in the 'medical benefits package' based on factors other than veteran status (e.g., a veteran who is a private-hospital patient and is referred to VA for a diagnostic test by that hospital under a sharing contract; a veteran who is a VA employee and is examined to determine physical or mental fitness to perform official duties; a Department of Defense retiree under a sharing agreement).

(g) For care not provided within a State, a veteran may receive VA care provided for in the ''medical benefits package'' set forth in § 17.38 if authorized under the provisions of 38 U.S.C. 1724 and 38 CFR 17.35.

(h) Commonwealth Army veterans and new Philippine Scouts may receive care provided for in the ''medical benefits package'' set forth in § 17.38 if authorized under the provisions of 38 U.S.C. 1724 and 38 CFR 17.35.

(i) A veteran may receive certain types of VA care not included in the ''medical benefits package'' set forth in § 17.38 if authorized by statute or other sections of 38 CFR (e.g., humanitarian emergency care for which the individual will be billed, compensation and pension examinations, dental care, domiciliary care, nursing home care, readjustment counseling, care as part of a VA-approved research project, seeing-eye or guide dogs, sexual trauma counseling and treatment, special registry examinations).

(j) A veteran may receive an examination to determine whether the veteran is catastrophically disabled and therefore eligible for inclusion in priority category 4.

(Authority: 38 U.S.C. 101, 501, 1701, 1705, 1710, 1721, 1722)

[64 FR 54217, Oct. 6, 1999, as amended at 67 FR 35039, May 17, 2002]

§ 17.38 Medical benefits package.

(a) Subject to paragraphs (b) and (c) of this section, the following hospital, outpatient, and extended care services constitute the ''medical benefits package'' (basic care and preventive care):

(1) Basic care.

(i) Outpatient medical, surgical, and mental healthcare, including care for substance abuse.

(ii) Inpatient hospital, medical, surgical, and mental healthcare, including care for substance abuse.

(iii) Prescription drugs, including over-the-counter drugs and medical and surgical supplies available under the VA national formulary system.

(iv) Emergency care in VA facilities; and emergency care in non-VA facilities in accordance with sharing contracts or if authorized by §§ 17.52(a)(3), 17.53, 17.54, 17.120–132.

(v) Bereavement counseling as authorized in § 17.98.

(vi) Comprehensive rehabilitative services other than vocational services provided under 38 U.S.C. chapter 31.

(vii) Consultation, professional counseling, marriage and family 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 certifies an intention to live, as necessary and appropriate, in connection with the veteran's treatment as authorized under 38 CFR 71.50.

(viii) Durable medical equipment and prosthetic and orthotic devices, including eyeglasses and hearing aids as authorized under § 17.149.

(ix) Home health services authorized under 38 U.S.C. 1717 and 1720C.

(x) Reconstructive (plastic) surgery required as a result of disease or trauma, but not including cosmetic surgery that is not medically necessary.

(xi)(A) Hospice care, palliative care, and institutional respite care; and

(B) Noninstitutional extended care services, including but not limited to noninstitutional geriatric evaluation, noninstitutional adult day health care, and noninstitutional respite care.

(xii) Payment of beneficiary travel as authorized under 38 CFR part 70.

(xiii) Pregnancy and delivery services, to the extent authorized by law.

(xiv) Completion of forms (e.g., Family Medical Leave forms, life insurance applications, Department of Education forms for loan repayment exemptions based on disability, non-VA disability program forms) by healthcare professionals based on an examination or knowledge of the veteran's condition, but not including the completion of forms for examinations if a third party customarily will pay health care practitioners for the examination but will not pay VA.

(2) Preventive care, as defined in 38 U.S.C. 1701(9), which includes:

(i) Periodic medical exams.

(ii) Health education, including nutrition education.

(iii) Maintenance of drug-use profiles, drug monitoring, and drug use education.

(iv) Mental health and substance abuse preventive services.

(v) Immunizations against infectious disease.

(vi) Prevention of musculoskeletal deformity or other gradually developing disabilities of a metabolic or degenerative nature.

(vii) Genetic counseling concerning inheritance of genetically determined diseases.

(viii) Routine vision testing and eyecare services.

(ix) Periodic reexamination of members of high-risk groups for selected diseases and for functional decline of sensory organs, and the services to treat these diseases and functional declines.

(b) *Provision of the ''medical benefits package''.* Care referred to in the ''medical benefits package'' will be provided to individuals only if it is determined by appropriate healthcare professionals that the care is needed to promote, preserve, or restore the health of the individual and is in accord with generally accepted standards of medical practice.

(1) *Promote health.* Care is deemed to promote health if the care will enhance the quality of life or daily functional level of the veteran, 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, and prevent future disease.

(2) *Preserve health.* Care is deemed to preserve health if the care will maintain the current quality of life or daily functional level of the veteran, prevent the progression of disease, cure disease, or extend life span.

(3) *Restoring health.* Care is deemed to restore health if the care will restore the quality of life or daily functional level that has been lost due to illness or injury.

(c) In addition to the care specifically excluded from the ''medical benefits package'' under paragraphs (a) and (b) of this section, the ''medical benefits package'' does not include the following:

(1) Abortions and abortion counseling.

(2) In vitro fertilization.

(3) Drugs, biologicals, and medical devices not approved by the Food and Drug Administration unless the treating medical facility is conducting formal clinical trials under an Investigational Device Exemption (IDE) or an Investigational New Drug (IND) application, or the drugs, biologicals, or medical devices are prescribed under a compassionate use exemption.

(4) Gender alterations.

(5) Hospital and outpatient care for a veteran who is either a patient or inmate in an institution of another government agency if that agency has a duty to give the care or services. This exclusion does not apply to veterans who are released from incarceration in a prison or jail into a temporary housing program (such as a community residential re-entry center or halfway house).

(6) Membership in spas and health clubs.

(Authority 38 U.S.C. 101, 501, 1701, 1705, 1710, 1710A, 1721, 1722, 1782)

[64 FR 54217, Oct. 6, 1999, as amended at 67 FR 35039, May 17, 2002; 73 FR 36798, June 30, 2008; 75 FR 54030, Sept. 3, 2010; 76 FR 11339, Mar. 2, 1011; 76 FR 26172, May 5, 2011]

§ 17.39 Certain Filipino veterans.

(a) Any Filipino Commonwealth Army veteran, including one who was recognized by authority of the U.S. Army as belonging to organized Filipino guerilla forces, or any new Philippine Scout is eligible for hospital care, nursing home care, and outpatient medical services within the United States in the same manner and subject to the same terms and conditions as apply to U.S. veterans, if such veteran or scout resides in the United States and is a citizen or lawfully admitted to the United States for permanent residence. For purposes of these VA health care benefits, the standards described in 38 CFR 3.42(c) will be accepted as proof of U.S. citizenship or lawful permanent residence.

(b) Commonwealth Army Veterans, including those who were recognized by authority of the U.S. Army as belonging to organized Filipino guerilla forces, and new Philippine Scouts are not eligible for VA health care benefits if they do not meet the residency and citizenship requirements described in § 3.42(c).

(The Office of Management and Budget has approved the information collection requirements in this section under control number 2900–0091)

(Authority: 38 U.S.C. 501, 1734)

[71 FR 6680, Feb. 9, 2006]

§ 17.40 Additional services for indigents.

In addition to the usual medical services agreed upon between the governments of the United States and the Republic of the Philippines to be made available to patients for whom the Department of Veterans Affairs has authorized care at the Veterans Memorial Medical Center, any such patient determined by the U.S. Department of Veterans Affairs to be indigent or without funds may be furnished toilet articles and barber services, including haircutting and shaving necessary for hygienic reasons.

[33 FR 5299, Apr. 3, 1968, as amended at 47 FR 58247, Dec. 30, 1982. Redesignated at 61 FR 21965, May 13, 1996]

EXAMINATIONS AND OBSERVATION AND EXAMINATION

§ 17.41 Persons eligible for hospital observation and physical examination.

Hospitalization for observation and physical (including mental) examination may be effected when requested by an authorized official, or when found necessary in examination of the following persons:

(a) Claimants or beneficiaries of VA for purposes of disability compensation, pension, participation in a rehabilitation program under 38 U.S.C. chapter 31, and Government insurance. (38 U.S.C. 1711(a))

(b) Claimants or beneficiaries referred to a diagnostic center for study to determine the clinical identity of an obscure disorder.

(c) Employees of the Department of Veterans Affairs when necessary to determine their mental or physical fitness to perform official duties.

(d) Claimants or beneficiaries of other Federal agencies:

(1) Department of Justice—plaintiffs in Government insurance suits.

(2) United States Civil Service Commission—annuitants or applicants for retirement annuity, and such examinations of prospective appointees as may be requested.

(3) Office of Workers' Compensation Programs—to determine identity, severity, or persistence of disability.

(4) Railroad Retirement Board—applicants for annuity under Public No. 162, 75th Congress.

(5) Other Federal agencies.

(e) Pensioners of nations allied with the United States in World War I and World War II, upon authorization from

accredited officials of the respective governments.

[13 FR 7156, Nov. 27, 1948, as amended at 16 FR 12091, Nov. 30, 1951; 19 FR 6716, Oct. 19, 1954; 32 FR 13813, Oct. 4, 1967; 39 FR 32606, Sept. 10, 1974; 49 FR 5616, Feb. 14, 1984. Redesignated and amended at 61 FR 21965, 21966, May 13, 1996]

§ 17.42 Examinations on an outpatient basis.

Physical examinations on an outpatient basis may be furnished to applicants who have been tentatively determined to be eligible for Department of Veterans Affairs hospital or domiciliary care to determine their need for such care and to the same categories of persons for whom hospitalization for observation and examination may be authorized under § 17.41.

[35 FR 6586, Apr. 24, 1970. Redesignated and amended at 61 FR 21965, 21966, May 13, 1996]

HOSPITAL, DOMICILIARY AND NURSING HOME CARE

§ 17.43 Persons entitled to hospital or domiciliary care.

Hospital or domiciliary care may be provided:

(a) Not subject to the eligibility provisions of 38 U.S.C. 1710, 1722, and 1729, and 38 CFR 17.44 and 17.45, for:

(1) Persons in the Armed Forces when duly referred with authorization therefor, may be furnished hospital care. Emergency treatment may be rendered, without obtaining formal authorization, to such persons upon their own application, when absent from their commands. Identification of active duty members of the uniformed services will be made by military identification card.

(2) Hospital care may be provided, upon authorization, for beneficiaries of the Public Health Service, Office of Workers' Compensation Programs, and other Federal agencies.

(3) Pensioners of nations allied with the United States in World War I and World War II may be supplied hospital care when duly authorized.

(b) Emergency hospital care may be provided for:

(1) Persons having no eligibility, as a humanitarian service.

(2) Persons admitted because of presumed discharge or retirement from the Armed Forces, but subsequently found to be ineligible as such.

(3) Employees (not potentially eligible as ex-members of the Armed Forces) and members of their families, when residing on reservations of field facilities of the Department of Veterans Affairs, and when they cannot feasibly obtain emergency treatment from private facilities.

(c) Hospital care when incidental to, and to the extent necessary for, the use of a specialized Department of Veterans Affairs medical resource pursuant to a sharing agreement entered into under § 17.210, may be authorized for any person designated by the other party to the agreement as a patient to be benefited under the agreement.

(d) The authorization of services under any provision of this section, except services for eligible veterans, is subject to charges as required by § 17.101.

[23 FR 6498, Aug. 22, 1958, as amended at 24 FR 8327, Oct. 14, 1959; 32 FR 6841, May 4, 1967; 34 FR 9340, June 13, 1969; 35 FR 6586, Apr. 24, 1970; 39 FR 32606, Sept. 10, 1974. Redesignated and amended at 61 FR 21965, 21966, May 13, 1996; 64 FR 54218, Oct. 6, 1999]

§ 17.44 Hospital care for certain retirees with chronic disability (Executive Orders 10122, 10400 and 11733).

Hospital care may be furnished when beds are available to members or former members of the uniformed services (Army, Navy, Air Force, Marine Corps, Coast Guard, Coast and Geodetic Survey, now National Oceanic and Atmospheric Administration hereinafter referred to as *NOAA*, and Public Health Service) temporarily or permanently retired for physical disability or receiving disability retirement pay who require hospital care for chronic diseases and who have no eligibility for hospital care under laws governing the Department of Veterans Affairs, or who having eligibility do not elect hospitalization as Department of Veterans Affairs beneficiaries. Care under this section is subject to the following conditions:

(a) Persons defined in this section who are members or former members of

the active military, naval, or air service must agree to pay the subsistence rate set by the Secretary of Veterans Affairs, except that no subsistence charge will be made for those persons who are members or former members of the Public Health Service, Coast Guard, Coast and Geodetic Survey now *NOAA,* and enlisted personnel of the Army, Navy, Marine Corps, and Air Force.

(b) Under this section, the term *chronic diseases* shall include chronic arthritis, malignancy, psychiatric disorders, poliomyelitis with residuals, neurological disabilities, diseases of the nervous system, severe injuries to the nervous system, including quadriplegia, hemiplegia and paraplegia, tuberculosis, blindness and deafness requiring definitive rehabilitation, disability from major amputation, and other diseases as may be agreed upon from time to time by the Under Secretary for Health and designated officials of the Department of Defense and Department of Health and Human Services. For the purpose of this section, blindness is defined as corrected visual acuity of 20/200 or less in the better eye, or corrected central visual acuity of more than 20/200 if there is a field defect in which the peripheral field has contracted to such an extent that its widest diameter subtends the widest diameter of the field of the better eye at an angle no greater than 20°.

(c) In the case of persons who are former members of the Coast and Geodetic Survey, care may be furnished under this section even though their retirement for disability was from the Environmental Science Services Administration or NOAA.

[34 FR 9340, June 13, 1969, as amended at 39 FR 1841, Jan. 15, 1974; 47 FR 58247, Dec. 30, 1982. Redesignated at 61 FR 21965, May 13, 1996, as amended at 62 FR 17072, Apr. 9, 1997]

§ 17.45 Hospital care for research purposes.

Subject to the provisions of § 17.62(g), any person who is a bona fide volunteer may be admitted to a Department of Veterans Affairs hospital when the treatment to be rendered is part of an approved Department of Veterans Affairs research project and there are insufficient veteran-patients suitable for the project.

[35 FR 11470, July 17, 1970. Redesignated at 61 FR 21965, May 13, 1996]

§ 17.46 Eligibility for hospital, domiciliary or nursing home care of persons discharged or released from active military, naval, or air service.

(a) In furnishing hospital care under 38 U.S.C. 1710(a)(1), VA officials shall:

(1) If the veteran is in immediate need of hospitalization, furnish care at VA facility where the veteran applies or, if that facility is incapable of furnishing care, arrange to admit the veteran to the nearest VA medical center, or Department of Defense hospital with which VA has a sharing agreement under 38 U.S.C. 8111, which is capable of providing the needed care, or if VA or DOD facilities are not available, arrange for care on a contract basis if authorized by 38 U.S.C. 1703 and 38 CFR 17.52; or

(2) If the veteran needs non-immediate hospitalization, schedule the veteran for admission at VA facility where the veteran applies, if the schedule permits, or refer the veteran for admission or scheduling for admission at the nearest VA medical center, or Department of Defense facility with which VA has a sharing agreement under 38 U.S.C. 8111.

(Authority: 38 U.S.C. 1703, 1710; secs. 19011–19012, Pub. L. 99–272)

(b) Domiciliary care may be furnished when needed to:

(1) Any veteran whose annual income does not exceed the maximum annual rate of pension payable to a veteran in need of regular aid and attendance, or

(2) Any veteran who the Secretary determines had no adequate means of support. An additional requirement for eligibility for domiciliary care is the ability of the veteran to perform the following:

(i) Perform without assistance daily ablutions, such as brushing teeth; bathing; combing hair; body eliminations.

(ii) Dress self, with a minimum of assistance.

(iii) Proceed to and return from the dining hall without aid.

(iv) Feed Self.

(v) Secure medical attention on an ambulatory basis or by use of personally propelled wheelchair.

(vi) Have voluntary control over body eliminations or control by use of an appropriate prosthesis.

(vii) Share in some measure, however slight, in the maintenance and operation of the facility.

(viii) Make rational and competent decisions as to his or her desire to remain or leave the facility.

(Authority: 38 U.S.C. 1710(b), sec. 102, Pub. L. 100–322)

[24 FR 8328, Oct. 4, 1959, as amended at 30 FR 1787, Feb. 9, 1965; 32 FR 13813, Oct. 4, 1967; 34 FR 9340, June 13, 1969; 39 FR 1841, Jan. 15, 1974; 45 FR 6935, Jan. 31, 1980; 51 FR 25064, July 10, 1986; 52 FR 11259, Apr. 8, 1987; 53 FR 9627, Mar. 24, 1988; 53 FR 32391, Aug. 25, 1988; 56 FR 5757, Feb. 13, 1991. Redesignated and amended at 61 FR 21965, 21966, May 13, 1996]

§ 17.47 Considerations applicable in determining eligibility for hospital, nursing home or domiciliary care.

(a)(1) For applicants discharged or released for disability incurred or aggravated in line of duty and who are not in receipt of compensation for service-connected or service-aggravated disability, the official records of the Armed Forces relative to findings of line of duty for its purposes will be accepted in determining eligibility for hospital care. Where the official records of the Armed Forces show a finding of disability not incurred or aggravated in line of duty and evidence is submitted to the Department of Veterans Affairs which permits of a different finding, the decision of the Armed Forces will not be binding upon the Department of Veterans Affairs, which will be free to make its own determination of line of duty incurrence or aggravation upon evidence so submitted. It will be incumbent upon the applicant to present controverting evidence and, until such evidence is presented and a determination favorable to the applicant is made by the Department of Veterans Affairs, the finding of the Armed Forces will control and hospital care will not be authorized. Such controverting evidence, when received from an applicant, will be referred to the adjudicating agency which would have jurisdiction if the applicant was filing claim for pension or disability compensation, and the determination of such agency as to line of duty, which is promptly to be communicated to the head of the field facility receiving the application for hospital care, will govern the facility Director's disapproval or approval of admission, other eligibility requirements having been met. Where the official records of the Armed Forces show that the disability for which a veteran was discharged or released from the Armed Forces under other than dishonorable conditions was incurred or aggravated in the line of duty, such showing will be accepted for the purpose of determining his or her eligibility for hospitalization, notwithstanding the fact that the Department of Veterans Affairs has made a determination in connection with a claim for monetary benefits that the disability was incurred or aggravated not in line of duty.

(2) In those exceptional cases where the official records of the Armed Forces show discharge or release under other than dishonorable conditions because of expiration of period of enlistment or any other reason except disability, but also show a disability incurred or aggravated in line of duty during the said enlistment; and the disability so recorded is considered in medical judgment to be or to have been of such character, duration, and degree as to have justified a discharge or release for disability had the period of enlistment not expired or other reason for discharge or release been given, the Under Secretary for Health, upon consideration of a clear, full statement of circumstances, is authorized to approve admission of the applicant for hospital care, provided other eligibility requirements are met. A typical case of this kind will be one where the applicant was under treatment for the said disability recorded during his or her service at the time discharge or release was given for the reason other than disability.

(b)(1) Under 38 U.S.C. 1710(a)(1), veterans who are receiving disability compensation awarded under §3.800 of this chapter, where a disease, injury or the aggravation of an existing disease or

injury occurs as a result of VA examination, medical or surgical treatment, or of hospitalization in a VA health care facility or of participation in a rehabilitation program under 38 U.S.C. ch. 31, under any law administered by VA and not the result of his/her own willful misconduct. Treatment may be provided for the disability for which the compensation is being paid or for any other disability. Treatment under the authority of 38 U.S.C. 1710(a)(1) may not be authorized during any period when disability compensation under § 3.800 of this title is not being paid because of the provision of § 3.800(a)(2), except to the extent continuing eligibility for such treatment is provided for in the judgment for settlement described in § 3.800(a)(2) of this title.

(Authority: 38 U.S.C. 1710(a); sec. 701, Pub. L. 98–160, Pub. L. 99–272)

(2) For purposes of eligibility for domiciliary care, the phrase *no adequate means of support* refers to an applicant for domiciliary care whose annual income exceeds the annual rate of pension for a veteran in receipt of regular aid and attendance, as defined in 38 U.S.C. 1503, but who is able to demonstrate to competent VA medical authority, on the basis of objective evidence, that deficits in health and/or functional status render the applicant incapable of pursuing substantially gainful employment, as determined by the Chief of Staff, and who is otherwise without the means to provide adequately for self, or be provided for in the community.

(Authority: 38 U.S.C. 1710(a); sec. 701, Pub. L. 98–160, Pub. L. 99–272)

(c) A *disability, disease, or defect* will comprehend any acute, subacute, or chronic disease (or a general medical, tuberculous, or neuropsychiatric type) of any acute, subacute, or chronic surgical condition susceptible of cure or decided improvement by hospital care; or any condition which does not require hospital care for an acute or chronic condition but requires domiciliary care. Domiciliary care, as the term implies, is the provision of a home, with such ambulant medical care as is needed. To be provided with domiciliary care, the applicant must consistently have a disability, disease, or defect which is essentially chronic in type and is producing disablement of such degree and probable persistency as will incapacitate from earning a living for a prospective period.

(Authority: 38 U.S.C. 1701, 1710)

(d)(1) For purposes of determining eligibility for hospital or nursing home care under § 17.47(a), a veteran will be determined unable to defray the expenses of necessary care if the veteran agrees to provide verifiable evidence, as determined by the Secretary, that:

(i) The veteran is eligible to receive medical assistance under a State plan approved under title XIX of the Social Security Act;

(Authority: 42 U.S.C. 1396 *et seq.*)

(ii) The veteran is in receipt of pension under 38 U.S.C. 1521; or

(iii) The veteran's attributable income does not exceed $15,000 if the veteran has no dependents, $18,000 if the veteran has one dependent, plus $1,000 for each additional dependent.

(Authority: 38 U.S.C. 1722; sec. 19011, Pub. L. 99–272)

(2) For purposes of determining eligibility for hospital or nursing home care under § 17.47(c), a veteran will be determined eligible for necessary care if the veteran agrees to provide verifiable evidence, as determined by the Secretary, that: The veteran's attributable income does not exceed $20,000 if the veteran has no dependents, $25,000 if the veteran has one dependent, plus $1,000 for each additional dependent.

(Authority: 38 U.S.C. 1722; sec. 19011, Pub. L. 99–272)

(3) Effective on January 1 of each year after calendar year 1986, the amounts set forth in paragraph (d)(1) and (2) of this section shall be increased by the percentage by which the maximum rates of pension were increased under 38 U.S.C. 1111(a), during the preceding year.

(Authority: 38 U.S.C. 1722; sec. 19011, Pub. L. 99–272)

(4) Determinations with respect to attributable income made under paragraph (d)(1) and (2) of this section, shall be made in the same manner, including the same sources of income and exclusions from income, as determinations with respect to income are made for determining eligibility for pension under §§3.271 and 3.272 of this title. The term *attributable income* means income of a veteran for the calendar year preceding application for care, determined in the same manner as the manner in which a determination is made of the total amount of income by which the rate of pension for such veteran under 38 U.S.C. 1521 would be reduced if such veteran were eligible for pension under that section.

(Authority: 38 U.S.C. 1722; sec. 19011, Pub. L. 99–272)

(5) Notwithstanding the attributable income of a veteran, VA may determine that such veteran is not eligible under paragraph (d)(1) and (2) of this section if the corpus of the estate of the veteran is such that under all the circumstances it is reasonable that some part of the corpus of the estate of the veteran be consumed for the veteran's maintenance. The corpus of the estate of a veteran shall be determined in the same manner as determinations are made with respect to the determinations of eligibility for pension under §3.275 of this chapter. The term *corpus of the estate of the veteran* includes the corpus of the estates of the veteran's spouse and dependent children, if any.

(Authority: 38 U.S.C. 1722; sec. 19011, Pub. L. 99–272)

(6) In order to avoid hardship VA may determine that a veteran is eligible for care notwithstanding that the veteran does not meet the income requirements established in paragraph (d)(1)(iii) or (d)(2) of this section, if projections of the veteran's income for the year following application for care are substantially below the income requirements established in paragraph (d)(1)(iii) or (d)(2) of this section.

(Authority: 38 U.S.C. 1722; sec. 19011, Pub. L. 99–272)

(e)(1) If VA determines that an individual was incorrectly charged a copayment, VA will refund the amount of any copayment actually paid by that individual.

(Authority: 38 U.S.C. 501; sec. 19011, Pub. L. 99–272)

(2) In the event a veteran provided inaccurate information on an application and is incorrectly deemed eligible for care under 38 U.S.C. 1710(a)(1) or (a)(2) rather than 38 U.S.C. 1710(a)(3), VA shall retroactively bill the veteran for the applicable copayment.

(Authority: 38 U.S.C. 501 and 1710; sec. 19011, Pub. L. 99–272)

(f) If a veteran who receives hospital or nursing home care under 38 U.S.C. 1710(a)(2) or outpatient care under 38 U.S.C. 1712(a)(4) by virtue of the veteran's eligibility for hospital care under 38 U.S.C. 1710(a), fails to pay to the United States the amounts agreed to under those sections shall be grounds for determining, in accordance with guidelines promulgated by the Under Secretary for Health, that the veteran is not eligible to receive further care under those sections until such amounts have been paid in full.

(Authority: 38 U.S.C. 1710, 1721; sec. 19011, Pub. L. 99–272)

(g)(1) Persons hospitalized who have no service-connected disabilities pursuant to §17.47, and/or persons receiving outpatient medical services pursuant to paragraphs (e), (f), (i), (j), and/or (k) of §17.60 who have no service-connected disabilities who it is believed may be eligible for hospital care and/or medical services, or reimbursement for the expenses of care or services for all or part of the cost thereof by reason of the following:

(i) Membership in a union, fraternal or other organization, or

(ii) Coverage under an insurance policy, or contract, medical, or hospital service agreement, membership, or subscription contract or similar arrangement under which health services for individuals are provided or the expenses of such services are paid, will not be furnished hospital care or medical services without charge therefore to the extent of the amount for which

such parties referred to in paragraphs (g)(1)(i) or (g)(1)(ii) of this section, are, will become, or may be liable. Persons believed entitled to care under any of the plans discussed above will be required to provide such information as the Secretary may require. Provisions of this paragraph are effective April 7, 1986, except in the case of a health care policy or contract that was entered into before that date, the effective date shall be the day after the plan was modified or renewed or on which there was any change in premium or coverage and will apply only to care and services provided by VA after the date the plan was modified, renewed, or on which there was any change in premium or coverage.

(Authority: 38 U.S.C. 1729; sec. 19013, Pub. L. 99–272)

(2) Persons hospitalized for the treatment of nonservice-connected disabilities pursuant to §17.47, or persons receiving outpatient medical services pursuant to paragraph (e), (f), (h), (i), (j), or (k) of §17.60, and who it is believed may be entitled to hospital care and/or medical services or to reimbursement for all or part of the cost thereof from any one or more of the following parties:

(i) *Workers' Compensation* or employer's liability statutes, State or Federal;

(ii) By reason of statutory or other relationships with third parties, including those liable for damages because of negligence or other legal wrong;

(iii) By reason of a statute in a State, or political subdivision of a State;

(A) Which requires automobile accident reparations or;

(B) Which provides compensation or payment for medical care to victims suffering personal injuries as the result of a crime of personal violence;

(iv) Right to maintenance and cure in admiralty;

will not be furnished hospital care or medical services without charge therefore to the extent of the amount for which such parties are, will become, or may be liable. Persons believed entitled to care under circumstances described in paragraph (g)(2)(ii) of this section will be required to complete such forms as the Secretary may require, such as a power of attorney and assignment. Notice of this assignment will be mailed promptly to the party or parties believed to be liable. When the amount of charges is ascertained, a bill therefore will be mailed to such party or parties. Persons believed entitled to care under circumstances described in paragraph (g)(2)(i) or (g)(2)(iii) of this section will be required to complete such forms as the Secretary may require.

(Authority: 38 U.S.C. 1729, sec. 19013, Pub. L. 99–272)

(h) Within the limits of Department of Veterans Affairs facilities, any veteran who is receiving nursing home care in a hospital under the direct jurisdiction of the Department of Veterans Affairs, may be furnished medical services to correct or treat any nonservice-connected disability of such veteran, in addition to treatment incident to the disability for which the veteran is hospitalized, if the veteran is willing, and such services are reasonably necessary to protect the health of such veteran.

(i) *Participating in a rehabilitation program under 38 U.S.C. chapter 31* refers to any veteran

(1) Who is eligible for and entitled to participate in a rehabilitation program under chapter 31.

(i) Who is in an extended evaluation period for the purpose of determining feasibility, or

(ii) For whom a rehabilitation objective has been selected, or

(iii) Who is pursuing a rehabilitation program, or

(iv) Who is pursuing a program of independent living, or

(v) Who is being provided employment assistance under 38 U.S.C. chapter 31, and

(2) Who is medically determined to be in need of hospital care or medical services (including dental) for any of the following reasons:

(i) Make possible his or her entrance into a rehabilitation program; or

(ii) Achieve the goals of the veteran's vocational rehabilitation program; or

(iii) Prevent interruption of a rehabilitation program; or

(iv) Hasten the return to a rehabilitation program of a veteran in interrupted or leave status; or

(v) Hasten the return to a rehabilitation program of a veteran placed in discontinued status because of illness, injury or a dental condition; or

(vi) Secure and adjust to employment during the period of employment assistance; or

(vii) To enable the veteran to achieve maximum independence in daily living.

(Authority: 38 U.S.C. 3104(a)(9); Pub. L. 96–466, sec. 101(a))

(j) Veterans eligible for treatment under chapter 17 of 38 U.S.C. who are alcohol or drug abusers or who are infected with the human immunodeficiency virus (HIV) shall not be discriminated against in admission or treatment by any Department of Veterans Affairs health care facility solely because of their alcohol or drug abuse or dependency or because of their viral infection. This does not preclude the rule of clinical judgment in determining appropriate treatment which takes into account the patient's immune status and/or the infectivity of the HIV or other pathogens (such as tuberculosis, cytemegalovirus, cryptosporidiosis, etc.). Hospital Directors are responsible for assuring that admission criteria of all programs in the medical center do not discriminate solely on the basis of alcohol, drug abuse or infection with human immunodeficiency virus. Quality Assurance Programs should include indicators and monitors for nondiscrimination.

(Authority: 38 U.S.C. 7333)

(k) In seeking medical care from VA under 38 U.S.C. 1710 or 1712, a veteran shall furnish such information and evidence as the Secretary may require to establish eligibility.

(Authority: 38 U.S.C. 1722; sec. 19011, Pub. L. 99–272)

[32 FR 13813, Oct. 4, 1967]

EDITORIAL NOTE: For FEDERAL REGISTER citations affecting § 17.47, see the List of CFR Sections Affected, which appears in the Finding Aids section of the printed volume and at www.fdsys.gov.

§ 17.48 Compensated Work Therapy/Transitional Residences program.

(a) This section sets forth requirements for persons residing in housing under the Compensated Work Therapy/Transitional Residences program.

(b) House managers shall be responsible for coordinating and supervising the day-to-day operations of the facilities. The local VA program coordinator shall select each house manager and may give preference to an individual who is a current or past resident of the facility or the program. A house manager must have the following qualifications:

(1) A stable, responsible and caring demeanor;

(2) Leadership qualities including the ability to motivate;

(3) Effective communication skills including the ability to interact;

(4) A willingness to accept feedback;

(5) A willingness to follow a chain of command.

(c) Each resident admitted to the Transitional Residence, except for a house manager, must also be in the Compensated Work Therapy program.

(d) Each resident, except for a house manager, must bi-weekly, in advance, pay a fee to VA for living in the housing. The local VA program coordinator will establish the fee for each resident in accordance with the provisions of paragraph (d)(1) of this section.

(1) The total amount of actual operating expenses of the residence (utilities, maintenance, furnishings, appliances, service equipment, all other operating costs) for the previous fiscal year plus 15 percent of that amount equals the total operating budget for the current fiscal year. The total operating budget is to be divided by the average number of beds occupied during the previous fiscal year and the resulting amount is the average yearly amount per bed. The bi-weekly fee shall equal 1/26th of the average yearly amount per bed, except that a resident shall not, on average, pay more than 30 percent of their gross CWT (Compensated Work Therapy) bi-weekly earnings. The VA program manager shall, bi-annually, conduct a review of the factors in this paragraph for determining resident payments. If he or she determines that the payments are too

high or too low by more than 5 percent of the total operating budget, he or she shall recalculate resident payments under the criteria set forth in this paragraph, except that the calculations shall be based on the current fiscal year (actual amounts for the elapsed portion and projected amounts for the remainder).

(2) If the revenues of a residence do not meet the expenses of the residence resulting in an inability to pay actual operating expenses, the medical center of jurisdiction shall provide the funds necessary to return the residence to fiscal solvency in accordance with the provisions of this section.

(e) The length of stay in housing under the Compensated Work Therapy/Transitional Residences program is based on the individual needs of each resident, as determined by consensus of the resident and his/her VA Clinical Treatment team. However, the length of stay should not exceed 12 months.

(Authority: 38 U.S.C. 1772)

[70 FR 29627, May 24, 2005]

§ 17.49 Priorities for outpatient medical services and inpatient hospital care.

In scheduling appointments for outpatient medical services and admissions for inpatient hospital care, the Under Secretary for Health shall give priority to:

(a) Veterans with service-connected disabilities rated 50 percent or greater based on one or more disabilities or unemployability; and

(b) Veterans needing care for a service-connected disability.

(Authority: 38 U.S.C. 101, 501, 1705, 1710)

[67 FR 58529, Sept. 17, 2002]

USE OF DEPARTMENT OF DEFENSE, PUBLIC HEALTH SERVICE OR OTHER FEDERAL HOSPITALS

§ 17.50 Use of Department of Defense, Public Health Service or other Federal hospitals with beds allocated to the Department of Veterans Affairs.

Hospital facilities operated by the Department of Defense or the Public Health Service (or any other agency of the United States Government) may be used for the care of Department of Veterans Affairs patients pursuant to agreements between the Department of Veterans Affairs and the department or agency operating the facility. When such an agreement has been entered into and a bed allocation for Department of Veterans Affairs patients has been provided for in a specific hospital covered by the agreement, care may be authorized within the bed allocation for any veteran eligible under 38 U.S.C. 1710 or 38 CFR 17.44. Care in a Federal facility not operated by the Department of Veterans Affairs, however, shall not be authorized for any military retiree whose sole basis for eligibility is under § 17.46b, or, except in Alaska and Hawaii, for any retiree of the uniformed services suffering from a chronic disability whose entitlement is under § 17.46b, § 17.47(b)(2) or § 17.47(c)(2) regardless of whether he or she may have dual eligibility under other provisions of § 17.47.

[39 FR 1842, Jan. 15, 1974, as amended at 45 FR 6936, Jan. 31, 1980, as amended at 61 FR 21966, May 13, 1996]

§ 17.51 Emergency use of Department of Defense, Public Health Service or other Federal hospitals.

Hospital care in facilities operated by the Department of Defense or the Public Health Service (or any other agency of the U.S. Government) which do not have beds allocated for the care of Department of Veterans Affairs patients may be authorized subject to the limitations enumerated in § 17.50 only in emergency circumstances for any veteran otherwise eligible for hospital care under 38 U.S.C. 1710 or 38 CFR 17.46.

[33 FR 19010, Dec. 20, 1968. Redesignated and amended at 61 FR 21965, 21966, May 13, 1996]

USE OF PUBLIC OR PRIVATE HOSPITALS

§ 17.52 Hospital care and medical services in non-VA facilities.

(a) When VA facilities or other government facilities are not capable of furnishing economical hospital care or medical services because of geographic inaccessibility or are not capable of furnishing care or services required, VA may contract with non-VA facilities for care in accordance with the

provisions of this section. When demand is only for infrequent use, individual authorizations may be used. Care in public or private facilities, however, subject to the provisions of §§ 17.53, 17.54, 17.55 and 17.56, will only be authorized, whether under a contract or an individual authorization, for—

(1) Hospital care or medical services to a veteran for the treatment of—

(i) A service-connected disability; or

(ii) A disability for which a veteran was discharged or released from the active military, naval, or air service or

(iii) A disability of a veteran who has a total disability permanent in nature from a service-connected disability, or

(iv) For a disability associated with and held to be aggravating a service-connected disability, or

(v) For any disability of a veteran participating in a rehabilitation program under 38 U.S.C. ch. 31 and when there is a need for hospital care or medical services for any of the reasons enumerated in § 17.48(j).

(Authority: 38 U.S.C. 1703, 3104; sec. 101, Pub. L. 96–466; sec. 19012, Pub. L. 99–272)

(2) Medical services for the treatment of any disability of—

(i) A veteran who has a service-connected disability rated at 50 percent or more,

(ii) A veteran who has received VA inpatient care for treatment of non-service-connected conditions for which treatment was begun during the period of inpatient care. The treatment period (to include care furnished in both facilities of VA and non-VA facilities or any combination of such modes of care) may not continue for a period exceeding 12 months following discharge from the hospital except when it is determined that a longer period is required by virtue of the disabilities being treated, and

(iii) A veteran of the Mexican border period or World War I or who is in receipt of increased pension or additional compensation based on the need for aid and attendance or housebound benefits when it has been determined based on an examination by a physician employed by VA (or, in areas where no such physician is available, by a physician carrying out such function under a contract or fee arrangement), that the medical condition of such veteran precludes appropriate treatment in VA facilities;

(Authority: 38 U.S.C. 1703; sec. 19012, Pub. L. 99–272)

(3) Hospital care or medical services for the treatment of medical emergencies which pose a serious threat to the life or health of a veteran receiving hospital care or medical services in a facility over which the Secretary has direct jurisdiction or government facility with which the Secretary contracts, and for which the facility is not staffed or equipped to perform, and transfer to a public or private hospital which has the necessary staff or equipment is the only feasible means of providing the necessary treatment, until such time following the furnishing of care in the non-VA facility as the veteran can be safely transferred to a VA facility;

(Authority: 38 U.S.C. 1703; sec. 19012, Pub. L. 99–272)

(4) Hospital care for women veterans;

(Authority: 38 U.S.C. 1703; sec. 19012, Pub. L. 99–272)

(5) Through September 30, 1988, hospital care or medical services that will obviate the need for hospital admission for veterans in the Commonwealth of Puerto Rico, except that the dollar expenditure in Fiscal year 1986 cannot exceed 85% of the Fiscal year 1985 obligations, in Fiscal year 1987 the dollar expenditure cannot exceed 50% of the Fiscal year 1985 obligations and in Fiscal year 1988 the dollar expenditure cannot exceed 25% of the Fiscal year 1985 obligations.

(Authority: 38 U.S.C. 1703; sec. 102, Pub. L. 99–166; sec. 19012, Pub. L. 99–272)

(6) Hospital care or medical services that will obviate the need for hospital admission for veterans in Alaska, Hawaii, Virgin Islands and other territories of the United States except that the annually determined hospital patient load and incidence of the furnishing of medical services to veterans hospitalized or treated at the expense

of VA in government and non-VA facilities in each such State or territory shall be consistent with the patient load or incidence of the provision of medical services for veterans hospitalized or treated by VA within the 48 contiguous States.

(Authority: 38 U.S.C. 1703; sec. 19012, Pub. L. 99–272)

(7) Outpatient dental services and treatment, and related dental appliances, for a veteran who is a former prisoner of war and was detained or interned for a period of not less that 181 days.

(Authority: 38 U.S.C. 1703; sec. 19012, Pub. L. 99–272)

(8) Hospital care or medical services for the treatment of medical emergencies which pose a serious threat to the life or health of a veteran which developed during authorized travel to the hospital, or during authorized travel after hospital discharge preventing completion of travel to the originally designated point of return (and this will encompass any other medical services necessitated by the emergency, including extra ambulance or other transportation which may also be furnished at VA expense.

(Authority: 38 U.S.C. 1701(5))

(9) Diagnostic services necessary for determination of eligibility for, or of the appropriate course of treatment in connection with, furnishing medical services at independent VA outpatient clinics to obviate the need for hospital admission.

(Authority: 38 U.S.C. 1703; sec. 19012, Pub. L. 99–272)

(10) For any disability of a veteran receiving VA contract nursing home care. The veteran is receiving contract nursing home care and requires emergency treatment in non-VA facilities.

(Authority: 38 U.S.C. 1703(a))

(11) For completion of evaluation for observation and examination (O&E) purposes, clinic directors or their designees will authorize necessary diagnostic services at non-VA facilities (on an inpatient or outpatient basis) in order to complete requests from VA Regional Offices for O&E of a person to determine eligibility for VA benefits or services.

(b) The Under Secretary for Health shall only furnish care and treatment under paragraph (a) of this section to veterans described in § 17.47(d).

(1) To the extent that resources are available and are not otherwise required to assure that VA can furnish needed care and treatment to veterans described in § 17.47 (a) and (c), and

(2) If the veteran agrees to pay the United States an amount as determined in § 17.48(e).

(Authority: 38 U.S.C. 1703, 1710 and 1712; sec. 19011–19012, Pub. L. 99–272)

[51 FR 25066, July 10, 1986, as amended at 53 FR 32391, Aug. 25, 1988; 54 FR 53057, Dec. 27, 1989; 58 FR 32446, June 10, 1993. Redesignated and amended at 61 FR 21965, 21966, May 13, 1996; 62 FR 17072, Apr. 9, 1997; 75 FR 78915, Dec. 17, 2010]

§ 17.53 Limitations on use of public or private hospitals.

The admission of any patient to a private or public hospital at Department of Veterans Affairs expense will only be authorized if a Department of Veterans Affairs medical center or other Federal facility to which the patient would otherwise be eligible for admission is not feasibly available. A Department of Veterans Affairs facility may be considered as not feasibly available when the urgency of the applicant's medical condition, the relative distance of the travel involved, or the nature of the treatment required makes it necessary or economically advisable to use public or private facilities. In those instances where care in public or private hospitals at Department of Veterans Affairs expense is authorized because a Department of Veterans Affairs or other Federal facility was not feasibly available, as defined in this section, the authorization will be continued after admission only for the period of time required to stabilize or improve the patient's condition to the extent that further care is no longer required to satisfy the purpose for which it was initiated.

[39 FR 17223, May 14, 1974, as amended at 47 FR 58248, Dec. 30, 1982. Redesignated at 61 FR 21965, May 13, 1996]

§ 17.54 Necessity for prior authorization.

(a) The admission of a veteran to a non-Department of Veterans Affairs hospital at Department of Veterans Affairs expense must be authorized in advance. In the case of an emergency which existed at the time of admission, an authorization may be deemed a prior authorization if an application, whether formal or informal, by telephone, telegraph or other communication, made by the veteran or by others in his or her behalf is dispatched to the Department of Veterans Affairs (1) for veterans in the 48 contiguous States and Puerto Rico, within 72 hours after the hour of admission, including in the computation of time Saturday, Sunday and holidays, or (2) for veterans in a noncontiguous State, territory or possession of the United States (not including Puerto Rico) if facilities for dispatch of application as described in this section are not available within the 72-hour period, provided the application was filed within 72 hours after facilities became available.

(b) When an application for admission by a veteran in one of the 48 contiguous States in the United States or in Puerto Rico has been made more than 72 hours after admission, or more than 72 hours after facilities are available in a noncontiguous State, territory of possession of the United States, authorization for continued care at Department of Veterans Affairs expense shall be effective as of the postmark or dispatch date of the application, or the date of any telephone call constituting an informal application.

[42 FR 55212, Oct. 14, 1977. Redesignated at 61 FR 21965, May 13, 1996]

§ 17.55 Payment for authorized public or private hospital care.

Except as otherwise provided in this section, payment for public or private hospital care authorized under 38 U.S.C. 1703 and 38 CFR 17.52 of this part or under 38 U.S.C. 1728 and 38 CFR 17.120 of this part shall be based on a prospective payment system similar to that used in the Medicare program for paying for similar inpatient hospital services in the community. Payment shall be made using the Health Care Financing Administration (HCFA) PRICER for each diagnosis-related group (DRG) applicable to the episode of care.

(a) Payment shall be made of the full prospective payment amount per discharge, as determined according to the methodology in subparts D and G of 42 CFR part 412, as appropriate.

(b)(1) In the case of a veteran who was transferred to another facility before completion of care, VA shall pay the transferring hospital an amount calculated by the HCFA PRICER for each patient day of care, not to exceed the full DRG rate as provided in paragraph (a) of this section. The hospital that ultimately discharges the patient will receive the full DRG payment.

(2) In the case of a veteran who has transferred from a hospital and/or distinct part unit excluded by Medicare from the DRG-based prospective payment system or from a hospital that does not participate in Medicare, the transferring hospital will receive a payment for each patient day of care not to exceed the amount provided in paragraph (i) of this section.

(c) VA shall pay the providing facility the full DRG-based rate or reasonable cost, without regard to any copayments or deductible required by any Federal law that is not applicable to VA.

(d) If the cost or length of a veteran's care exceeds an applicable threshold amount, as determined by the HCFA PRICER program, VA shall pay, in addition to the amount payable under paragraph (a) of this section, an outlier payment calculated by the HCFA PRICER program, in accordance with subpart F of 42 CFR part 412.

(e) In addition to the amount payable under paragraph (a) of this section, VA shall pay, for each discharge, an amount to cover the non-Federal hospital's capital-related costs, kidney, heart and liver acquisition costs incurred by hospitals with approved transplantation centers, direct costs of medical education, and the costs of qualified nonphysician anesthetists in small rural hospitals. These amounts will be determined by the Under Secretary for Health on an annual basis and published in the ''Notices'' section of the FEDERAL REGISTER.

(f) Payment shall be made only for those services authorized by VA.

(g) Payments made in accordance with this section shall constitute payment in full and the provider or agent for the provider may not impose any additional charge on a veteran or his or her health care insurer for any inpatient services for which payment is made by the VA.

(h) Hospitals of distinct part hospital units excluded from the prospective payment system by Medicare and hospitals that do not participate in Medicare will be paid at the national cost-to-charge ratio times the billed charges that are reasonable, usual, customary, and not in excess of rates or fees the hospital charges the general public for similar services in the community.

(i) A hospital participating in an alternative payment system that has been granted a Federal waiver from the prospective payment system under the provisions of 42 U.S.C. section 1395f(b)(3) or 42 U.S.C. section 1395ww(c) for the purposes of Medicare payment shall not be subject to the payment methodology set forth in this section so long as such Federal waiver remains in effect.

(j) Payments for episodes of hospital care furnished in Alaska that begin during the period starting on the effective date of this section through the 364th day thereafter will be in the amount determined by the HCFA PRICER plus 50 percent of the difference between the amount billed by the hospital and the amount determined by the PRICER. Claims for services provided during that period will be accepted for payment by VA under this paragraph (k) until December 31 of the year following the year in which this section became effective.

(k) Notwithstanding other provisions of this section, VA, for public or private hospital care covered by this section, will pay the lesser of the amount determined under paragraphs (a) through (j) of this section or the amount negotiated with the hospital or its agent.

(Authority: 38 USC 513, 1703, 1728; § 233 of P. L. 99–576)

[55 FR 42852, Oct. 24, 1990. Redesignated and amended at 61 FR 21965, 21966, May 13, 1996; 62 FR 17072, Apr. 9, 1997; 63 FR 39515, July 23, 1998; 65 FR 66637, Nov. 7, 2000]

§ 17.56 VA payment for inpatient and outpatient health care professional services at non-departmental facilities and other medical charges associated with non-VA outpatient care.

(a) Except for health care professional services provided in the state of Alaska (see paragraph (b) of this section) and except for non-contractual payments for home health services and hospice care, VA will determine the amounts paid under §§ 17.52 or 17.120 for health care professional services, and all other medical services associated with non-VA outpatient care, using the applicable method in this section:

(1) If a specific amount has been negotiated with a specific provider, VA will pay that amount.

(2) If an amount has not been negotiated under paragraph (a)(1) of this section, VA will pay the lowest of the following amounts:

(i) The applicable Medicare fee schedule or prospective payment system amount (''Medicare rate'') for the period in which the service was provided (without any changes based on the subsequent development of information under Medicare authorities), subject to the following:

(A) In the event of a Medicare waiver, the payment amount will be calculated in accordance with such waiver.

(B) In the absence of a Medicare rate or Medicare waiver, payment will be the VA Fee Schedule amount for the period in which the service was provided. The VA Fee Schedule amount is determined by the authorizing VA medical facility, which ranks all billings (if the facility has had at least eight billings) from non-VA facilities under the corresponding procedure code during the previous fiscal year, with billings ranked from the highest to the lowest. The VA Fee Schedule amount is the charge falling at the 75th percentile. If the authorizing facility has not had at least eight such billings, then this paragraph does not apply.

(ii) The amount negotiated by a repricing agent if the provider is participating within the repricing agent's network and VA has a contract with that repricing agent. For the purposes of this section, *repricing agent* means a contractor that seeks to connect VA

with discounted rates from non-VA providers as a result of existing contracts that the non-VA provider may have within the commercial health care industry.

(iii) The amount that the provider bills the general public for the same service.

(b) For physician and non-physician professional services rendered in Alaska, VA will pay for services in accordance with a fee schedule that uses the Health Insurance Portability and Accountability Act mandated national standard coding sets. VA will pay a specific amount for each service for which there is a corresponding code. Under the VA Alaska Fee Schedule, the amount paid in Alaska for each code will be 90 percent of the average amount VA actually paid in Alaska for the same services in Fiscal Year (FY) 2003. For services that VA provided less than eight times in Alaska in FY 2003, for services represented by codes established after FY 2003, and for unit-based codes prior to FY 2004, VA will take the Centers for Medicare and Medicaid Services' rate for each code and multiply it times the average percentage paid by VA in Alaska for Centers for Medicare and Medicaid Services-like codes. VA will increase the amounts on the VA Alaska Fee Schedule annually in accordance with the published national Medicare Economic Index (MEI). For those years where the annual average is a negative percentage, the fee schedule will remain the same as the previous year. Payment for non-VA health care professional services in Alaska shall be the lesser of the amount billed or the amount calculated under this subpart.

(c) Payments made by VA to a non-VA facility or provider under this section shall be considered payment in full. Accordingly, the facility or provider or agent for the facility or provider may not impose any additional charge for any services for which payment is made by VA.

(d) In a case where a veteran has paid for emergency treatment for which VA may reimburse the veteran under § 17.120, VA will reimburse the amount that the veteran actually paid. Any amounts due to the provider but unpaid by the veteran will be reimbursed to the provider under paragraphs (a) and (b) of this section.

(Authority: 38 U.S.C. 1703, 1728)

[75 FR 78915, Dec. 17, 2010]

USE OF COMMUNITY NURSING HOME CARE FACILITIES

§ 17.57 Use of community nursing homes.

(a) Nursing home care in a contract public or private nursing home facility may be authorized for the following: Any veteran who has been discharged from a hospital under the direct jurisdiction of VA and is currently receiving VA hospital based home health services.

(Authority: 38 U.S.C. 1720; sec. 108, Pub. L. 99–166)

(b) To the extent that resources are available and are not otherwise required to assure that VA can furnish needed care and treatment to veterans described in 38 U.S.C. 1710(a)(1), the Under Secretary for Health may furnish care under this paragraph to any veteran described in 38 U.S.C. 1710(a)(2) if the veteran agrees to pay the United States an amount as determined in 38 U.S.C. 1710(f).

(Authority: 38 U.S.C. 1710, 1720; sec. 19011, Pub. L. 99–272)

(Authority: 38 U.S.C. 1720(b)

[51 FR 25067, July 10, 1986. Redesignated and amended at 61 FR 21965, 21966, May 13, 1996 and further redesignated at 63 FR 39515, July 23, 1998]

§ 17.60 Extensions of community nursing home care beyond six months.

Directors of health care facilities may authorize, for any veteran whose hospitalization was not primarily for a service-connected disability, an extension of nursing care in a public or private nursing home care facility at VA expense beyond six months when the need for nursing home care continues to exist and

(a) Arrangements for payment of such care through a public assistance program (such as Medicaid) for which the veteran has applied, have been delayed due to unforeseen eligibility

problems which can reasonably be expected to be resolved within the extension period, or

(b) The veteran has made specific arrangements for private payment for such care, and

(1) Such arrangements cannot be effectuated as planned because of unforseen, unavoidable difficulties, such as a temporary obstacle to liquidation of property, and

(2) Such difficulties can reasonably be expected to be resolved within the extension period; or

(c) The veteran is terminally ill and life expectancy has been medically determined to be less than six months.

(d) In no case may an extension under paragraph (a) or (b) of this section exceed 45 days.

(Authority: 38 U.S.C. 501, 1720(a))

[53 FR 13121, Apr. 21, 1988. Redesignated at 61 FR 21965, May 13, 1996]

COMMUNITY RESIDENTIAL CARE

SOURCE: 54 FR 20842, May 15, 1989, unless otherwise noted.

§ 17.61 Eligibility.

VA health care personnel may assist a veteran by referring such veteran for placement in a privately or publicly-owned community residential care facility if:

(a) At the time of initiating the assistance:

(1) The veteran is receiving VA medical services on an outpatient basis or VA medical center, domiciliary, or nursing home care; or

(2) Such care or services were furnished the veteran within the preceding 12 months;

(b) The veteran does not need hospital or nursing home care but is unable to live independently because of medical (including psychiatric) conditions and has no suitable family resources to provide needed monitoring, supervision, and any necessary assistance in the veteran's daily living activities; and

(c) The facility has been approved in accordance with § 17.63 of this part.

(Authority: 38 U.S.C. 1730)

[54 FR 20842, May 15, 1989. Redesignated and amended at 61 FR 21965, 21966, May 13, 1996]

§ 17.62 Definitions.

For the purpose of §§ 17.61 through 17.72:

(a) The term *community residential care* means the monitoring, supervision, and assistance, in accordance with a statement of needed care, of the daily living activities of referred veterans in an approved home in the community by the facility's provider.

(b) The term *daily living activities* includes:

(1) Walking;

(2) Bathing, shaving, brushing teeth, combing hair;

(3) Dressing;

(4) Eating;

(5) Getting in or getting out of bed;

(6) Laundry;

(7) Cleaning room;

(8) Managing money;

(9) Shopping;

(10) Using public transportation;

(11) Writing letters;

(12) Making telephone calls;

(13) Obtaining appointments;

(14) Self-administration of medications;

(15) Recreational and leisure activities; and

(16) Other similar activities.

(c) The term *paper hearing* means a review of the written evidence of record by the hearing official.

(d) The term *oral hearing* means the in person testimony of representatives of a community residential care facility and of VA before the hearing official and the review of the written evidence of record by that official.

(e) The term *approving official* means the Director or, if designated by the Director, the Associate Director or Chief of Staff of a Department of Veterans Affairs Medical Center or Outpatient Clinic which has jurisdiction to approve a community residential care facility.

(f) The term *hearing official* means the Director or, if designated by the Director, the Associate Director or Chief of Staff of a Department of Veterans Affairs Medical Center or Outpatient Clinic which has jurisdiction to

approve a community residential care facility.

(Authority: 38 U.S.C. 1730)

[54 FR 20842, May 15, 1989. Redesignated and amended at 61 FR 21965, 21966, May 13, 1996; 74 FR 63308, Dec. 3, 2009]

§ 17.63 Approval of community residential care facilities.

The approving official may approve a community residential care facility, based on the report of a VA inspection and on any findings of necessary interim monitoring of the facility, if that facility meets the following standards:

(a) *Health and safety standards.* The facility must:

(1) Meet all State and local regulations including construction, maintenance, and sanitation regulations;

(2) Meet the requirements in the applicable provisions of NFPA 101 and NFPA 101A (incorporated by reference, *see* § 17.1) and the other publications referenced in those provisions. The institution shall provide sufficient staff to assist patients in the event of fire or other emergency. Any equivalencies or variances to VA requirements must be approved by the appropriate Veterans Health Administration Veterans Integrated Service Network (VISN) Director;

(3) Have safe and functioning systems for heating and/or cooling, as needed (a heating or cooling system is deemed to be needed if VA determines that, in the county, parish, or similar jurisdiction where the facility is located, a majority of community residential care facilities or other extended care facilities have one), hot and cold water, electricity, plumbing, sewage, cooking, laundry, artificial and natural light, and ventilation.

(4) Meet the following additional requirements, if the provisions for One and Two-Family Dwellings, as defined in NFPA 101, are applicable to the facility:

(i) Portable fire extinguishers must be installed, inspected, and maintained in accordance with NFPA 10 (incorporated by reference, *see* § 17.1); and

(ii) The facility must meet the requirements in section 33.7 of NFPA 101.

(b) [Reserved]

(c) *Interior plan.* The facility must:

(1) Have comfortable dining areas, adequate in size for the number of residents;

(2) Have confortable living room areas, adequate in size to accommodate a reasonable proportion of residents; and

(3) Maintain at least one functional toilet and lavatory, and bathing or shower facility for every six people living in the facility, including provider and staff.

(d) *Laundry service.* The facility must provide or arrange for laundry service.

(e) *Residents' bedrooms.* Residents' bedrooms must:

(1) Contain no more than four beds;

(2) Measure, exclusive of closet space, at least 100 square feet for a single-resident room, or 80 square feet for each resident in a multiresident room; and

(3) Contain a suitable bed for each resident and appropriate furniture and furnishings.

(f) *Nutrition.* The facility must:

(1) Provide a safe and sanitary food service that meets individual nutritional requirements and residents' preferences;

(2) Plan menus to meet currently recommended dietary allowances;

(g) *Activities.* The facility must plan and facilitate appropriate recreational and leisure activities to meet individual needs.

(h) *Residents' rights.* The facility must have written policies and procedures that ensure the following rights for each resident:

(1) Each resident has the right to:

(i) Be informed of the rights described in this section;

(ii) The confidentiality and nondisclosure of information obtained by community residential care facility staff on the residents and the residents' records subject to the requirements of applicable law;

(iii) Be able to inspect the residents' own records kept by the community residential care facility;

(iv) Exercise rights as a citizen; and

(v) Voice grievances and make recommendations concerning the policies and procedures of the facility.

(2) *Financial affairs.* Residents must be allowed to manage their own personal financial affairs, except when the resident has been restricted in this

right by law. If a resident requests assistance from the facility in managing personal financial affairs the request must be documented.

(3) *Privacy*. Residents must:

(i) Be treated with respect, consideration, and dignity;

(ii) Have access, in reasonable privacy, to a telephone within the facility;

(iii) Be able to send and receive mail unopened and uncensored; and

(iv) Have privacy of self and possessions.

(4) *Work*. No resident will perform household duties, other than personal housekeeping tasks, unless the resident receives compensation for these duties or is told in advance they are voluntary and the patient agrees to do them.

(5) *Freedom of association*. Residents have the right to:

(i) Receive visitors and associate freely with persons and groups of their own choosing both within and outside the facility;

(ii) Make contacts in the community and achieve the highest level of independence, autonomy, and interaction in the community of which the resident is capable;

(iii) Leave and return freely to the facility, and

(iv) Practice the religion of their own choosing or choose to abstain from religious practice.

(6) *Transfer*. Residents have the right to transfer to another facility or to an independent living situation.

(i) *Records*. (1) The facility must maintain records on each resident in a secure place.

(2) Facility records must include:

(i) Emergency notification procedures; and

(ii) A copy of all signed agreements with the resident.

(3) Records may only be disclosed with the resident's permission, or when required by law.

(Approved by the Office of Management and Budget under control number 2900–0491)

(j) *Staff requirements*. (1) Sufficient, qualified staff must be on duty and available to care for the resident and ensure the health and safety of each resident.

(2) The community residential care provider and staff must have the following qualifications: Adequate education, training, or experience to maintain the facility.

(k) *Cost of community residential care*. (1) Payment for the charges of community residential care is not the responsibility of the United States Government or VA.

(2) The resident or an authorized personal representative and a representative of the community residential care facility must agree upon the charge and payment procedures for community residential care.

(3) The charges for community residential care must be reasonable:

(i) For residents in a community residential care facility as of June 14, 1989, the rates charged for care are pegged to the facility's basic rate for care as of July 31, 1987. Increases in the pegged rate during any calendar year cannot exceed the annual percentage increase in the National Consumer Price Index (CPI) for that year;

(ii) For community residential care facilities approved after July 31, 1987, the rates for care shall not exceed 110 percent of the average rate for approved facilities in that State as of March 31, 1987. Increases in this rate during any calendar year cannot exceed the annual percentage increase in the National Consumer Price Index (CPI) for that year.

(iii) The approving official may approve a deviation from the requirements of paragraphs (k)(3)(i) through (ii) of this section upon request from a community residential care facility representative, a resident in the facility, or an applicant for residency, if the approving official determines that the cost of care for the resident will be greater than the average cost of care for other residents, or if the resident chooses to pay more for the care provided at a facility which exceeds VA standards.

(Authority: 38 U.S.C. 1730)

[54 FR 20842, May 15, 1989, as amended at 54 FR 22754, May 26, 1989. Redesignated at 61 FR 21965, May 13, 1996, as amended at 61 FR 63720, Dec. 2, 1996; 69 FR 18803, Apr. 9, 2004; 74 FR 63308, Dec. 3, 2009; 76 FR 10248, Feb. 24, 2011]

§ 17.64 [Reserved]

§ 17.65 Approvals and provisional approvals of community residential care facilities.

(a) An approval of a facility meeting all of the standards in 38 CFR 17.63 based on the report of a VA inspection and any findings of necessary interim monitoring of the facility shall be for a 12-month period.

(b) The approving official, based on the report of a VA inspection and on any findings of necessary interim monitoring of the facility, may provide a community residential care facility with a provisional approval if that facility does not meet one or more of the standards in 38 CFR 17.63, provided that the deficiencies do not jeopardize the health or safety of the residents, and that the facility management and VA agree to a plan of correcting the deficiencies in a specified amount of time. A provisional approval shall not be for more than 12 months and shall not be for more time than VA determines is reasonable for correcting the specific deficiencies.

(c) An approval may be changed to a provisional approval or terminated under the provisions of §§ 17.66 through 17.71 because of a subsequent failure to meet the standards of § 17.63 and a provisional approval may be terminated under the provisions of §§ 17.66 through 17.71 based on failure to meet the plan of correction or failure otherwise to meet the standards of § 17.63.

(Authority: 38 U.S.C. 1730)

[74 FR 63308, Dec. 3, 2009]

§ 17.66 Notice of noncompliance with VA standards.

If the hearing official determines that an approved community residential care facility does not comply with the standards set forth in § 17.63 of this part, the hearing official shall notify the community residential care facility in writing of:

(a) The standards which have not been met;

(b) The date by which the standards must be met in order to avoid revocation of VA approval;

(c) The community residential care facility's opportunity to request an oral or paper hearing under § 17.51n of this part before VA approval is revoked; and

(d) The date by which the hearing official must receive the community residential care facility's request for a hearing, which shall not be less than 10 calendar days and not more than 20 calendar days after the date of VA notice of noncompliance, unless the hearing official determines that noncompliance with the standards threatens the lives of community residential care residents in which case the hearing official must receive the community residential care facility's request for an oral or paper hearing within 36 hours of receipt of VA notice.

(Authority: 38 U.S.C. 1730)

[54 FR 20842, May 15, 1989. Redesignated and amended at 61 FR 21965, 21967, May 13, 1996]

§ 17.67 Request for a hearing.

The community residential care facility operator must specify in writing whether an oral or paper hearing is requested. The request for the hearing must be sent to the hearing official. Timely receipt of a request for a hearing will stay the revocation of VA approval until the hearing official issues a written decision on the community residential care facility's compliance with VA standards. The hearing official may accept a request for a hearing received after the time limit, if the community residential care facility shows that the failure of the request to be received by the hearing official's office by the required date was due to circumstances beyond its control.

(Authority: 38 U.S.C. 1730)

[54 FR 20842, May 15, 1989. Redesignated at 61 FR 21965, May 13, 1996]

§ 17.68 Notice and conduct of hearing.

(a) Upon receipt of a request for an oral hearing, the hearing official shall:

(1) Notify the community residential care facility operator of the date, time, and location for the hearing; and

(2) Notify the community residential care facility operator that written statements and other evidence for the record may be submitted to the hearing official before the date of the hearing. An oral hearing shall be informal.

The rules of evidence shall not be followed. Witnesses shall testify under oath or affirmation. A recording or transcript of every oral hearing shall be made. The hearing official may exclude irrelevant, immaterial, or unduly repetitious testimony.

(b) Upon the receipt of a community residential care facility's request for a paper hearing, the hearing official shall notify the community residential care facility operator that written statements and other evidence must be submitted to the hearing official by a specified date in order to be considered as part of the record.

(c) In all hearings, the community residential care facility operator and VA may be represented by counsel.

(Authority: 38 U.S.C. 1730)

[54 FR 20842, May 15, 1989. Redesignated at 61 FR 21965, May 13, 1996]

§ 17.69 Waiver of opportunity for hearing.

If representatives of a community residential care facility which receive a notice of noncompliance under § 17.66 of this part fail to appear at an oral hearing of which they have been notified or fail to submit written statements for a paper hearing in accordance with § 17.68 of this part, unless the hearing official determines that their failure was due to circumstances beyond their control, the hearing official shall:

(a) Consider the representatives of the community residential care facility to have waived their opportunity for a hearing; and,

(b) Revoke VA approval of the community residential care facility and notify the community residential care facility of this revocation.

(Authority: 38 U.S.C. 1730)

[54 FR 20842, May 15, 1989. Redesignated and amended at 61 FR 21965, 21967, May 13, 1996]

§ 17.70 Written decision following a hearing.

(a) The hearing official shall issue a written decision within 20 days of the completion of the hearing. An oral hearing shall be considered completed when the hearing ceases to receive in person testimony. A paper hearing shall be considered complete on the date by which written statements must be submitted to the hearing official in order to be considered as part of the record.

(b) The hearing official's determination of a community residential care facility's noncompliance with VA standards shall be based on the preponderance of the evidence.

(c) The written decision shall include:

(1) A statement of the facts;

(2) A determination whether the community residential care facility complies with the standards set forth in § 17.63 of this part; and

(3) A determination of the time period, if any, the community residential care facility shall have to remedy any noncompliance with VA standards before revocation of VA approval occurs.

(d) The hearing official's determination of any time period under paragraph (c)(3) of this section shall consider the safety and health of the residents of the community residential care facility and the length of time since the community residential care facility received notice of the noncompliance.

(Authority: 38 U.S.C. 1730)

[54 FR 20842, May 15, 1989. Redesignated and amended at 61 FR 21965, 21967, May 13, 1996]

§ 17.71 Revocation of VA approval.

(a) If a hearing official determines under § 17.70 of this part that a community residential care facility does not comply with the standards set forth in § 17.63 of this part and determines that the community residential care facility shall not have further time to remedy the noncompliance, the hearing official shall revoke approval of the community residential care facility and notify the community residential care facility of this revocation.

(b) Upon revocation of VA approval, VA health care personnel shall:

(1) Cease referring veterans to the community residential care facility; and,

(2) Notify any veteran residing in the community residential care facility of the facility's disapproval and request permission to assist in the veteran's removal from the facility. If a veteran has a person or entity authorized by law to give permission on behalf of the

veteran, VA health care personnel shall notify that person or entity of the community residential care facility's disapproval and request permission to assist in removing the veteran from the community residential care facility.

(c) If the hearing official determines that a community residential care facility fails to comply with the standards set forth in § 17.63 of this part and determines that the community residential care facility shall have an additional time period to remedy the noncompliance, the hearing official shall review at the end of the time period the evidence of the community residential care facility's compliance with the standards which were to have been met by the end of that time period and determine if the community residential care facility complies with the standards. If the community residential care facility fails to comply with these or any other standards, the procedures set forth in §§ 17.66–17.71 of this part shall be followed.

(Authority: 38 U.S.C. 1730)

[54 FR 20842, May 15, 1989. Redesignated and amended at 61 FR 21965, 21967, May 13, 1996]

§ 17.72 Availability of information.

VA standards will be made available to other Federal, State and local agencies charged with the responsibility of licensing, or otherwise regulating or inspecting community residential care facilities.

(Authority: 38 U.S.C. 1730)

[54 FR 20842, May 15, 1989. Redesignated at 61 FR 21965, May 13, 1996]

USE OF SERVICES OF OTHER FEDERAL AGENCIES

§ 17.80 Alcohol and drug dependence or abuse treatment and rehabilitation in residential and nonresidential facilities by contract.

(a) Alcohol and drug dependence or abuse treatment and rehabilitation may be authorized by contract in nonresidential facilities and in residential facilities provided by halfway houses, therapeutic communities, psychiatric residential treatment centers and other community-based treatment facilities, when considered to be medically advantageous and cost effective for the following:

(1) Veterans who have been or are being furnished care by professional staff over which the Secretary has jurisdiction and such transitional care is reasonably necessary to continue treatment;

(2) Persons in the Armed Forces who, upon discharge therefrom will become eligible veterans, when duly referred with authorization for Department of Veterans Affairs medical center hospital care in preparation for treatment and rehabilitation in this program under the following limitations:

(i) Such persons may be accepted by transfer only during the last 30 days of such person's enlistment or tour of duty,

(ii) The person requests transfer in writing for treatment for a specified period of time during the last 30 days of such person's enlistment period or tour of duty,

(iii) Treatment does not extend beyond the period of time specified in the request unless such person requests in writing an extension for a further specified period of time and such request is approved by the Department of Veterans Affairs Medical Center Director authorizing treatment and rehabilitation,

(iv) Such care and treatment will be provided as if the person were a veteran, subject to reimbursement by the respective military service for the costs of hospital care and control treatment provided while the person is an active duty member.

(b) The maximum period for one treatment episode is limited to 60 days. The Department of Veterans Affairs Medical Center Director may authorize one 30-day extension.

(c) Any person who has been discharged or released from active military, naval or air service, and who, upon application for treatment and rehabilitative services under the authority of this section is determined to be legally ineligible for such treatment or rehabilitation services shall be:

(1) Provided referral services to assist the person, to the maximum extent possible, in obtaining treatment and rehabilitation services from sources

outside the Department of Veterans Affairs, not at Department of Veterans Affairs expense and,

(2) If pertinent, advised of the right to apply to the appropriate military, naval or air service and the Department of Veterans Affairs for review of such person's discharge or release from such service.

(Authority: 38 U.S.C. 1720A)

[47 FR 57706, Dec. 28, 1982. Redesignated at 61 FR 21965, May 13, 1996, as amended at 61 FR 56897, Nov. 5, 1996]

§ 17.81 Contracts for residential treatment services for veterans with alcohol or drug dependence or abuse disabilities.

(a) Contracts for treatment services authorized under §17.80(a) may be awarded in accordance with applicable Department of Veterans Affairs and Federal procurement procedures. Such contracts will be awarded only after the quality and effectiveness, including adequate protection for the safety of the residents of the contractor's program, has been determined and then only to contractors, determined by the Under Secretary for Health or designee to meet the following requirements.

(1) Meet fire safety requirements as follows:

(i) The building must meet the requirements in the applicable provisions of NFPA 101 (incorporated by reference, *see* §17.1) and the other publications referenced in those provisions. Any equivalencies or variances to VA requirements must be approved by the appropriate Veterans Health Administration Veterans Integrated Service Network (VISN) Director.

(ii) Where applicable, the home must have a current occupancy permit issued by the local and state governments in the jurisdiction where the home is located.

(iii) All Department of Veterans Affairs sponsored residents will be mentally and physically capable of leaving the building, unaided, in the event of an emergency. Halfway house, therapeutic community and other residential program management must agree that all the other residents in any building housing veterans will also have such capability.

(iv) There must be at least one staff member on duty 24 hours a day.

(v) The facility must meet the following additional requirements, if the provisions for One and Two-Family Dwellings, as defined in NFPA 101, are applicable to the facility:

(A) Portable fire extinguishers shall be installed, inspected, and maintained in accordance with NFPA 10 (incorporated by reference, *see* §17.1).

(B) The facility shall meet the requirements in section 33.7 of NFPA 101.

(vi) An annual fire and safety inspection shall be conducted at the halfway house or residential facility by qualified Department of Veterans Affairs personnel. If a review of past Department of Veterans Affairs inspections or inspections made by the local authorities indicates that a fire and safety inspection would not be necessary, then the visit to the facility may be waived.

(2) Be in compliance with existing standards of State safety codes and local, and/or State health and sanitation codes.

(3) Be licensed under State or local authority.

(4) Where applicable, be accredited by the State.

(5) Comply with the requirements of the ''Confidentiality of Alcohol and Drug Abuse Patient Records'' (42 CFR part II) and the ''Confidentiality of Certain Medical Records'' (38 U.S.C. 7332), which shall be part of the contract.

(6) Demonstrate an existing capability to furnish the following:

(i) A supervised alcohol and drug free environment, including active affiliation with Alcoholics Anonymous (AA) programs.

(ii) Staff sufficient in numbers and position qualifications to carry out the policies, responsibilities, and programs of the facility.

(iii) Board and room.

(iv) Laundry facilities for residents to do their own laundry.

(v) Structured activities.

(vi) Appropriate group activities, including physical activities.

(vii) Health and personal hygiene maintenance.

(viii) Monitoring administration of medications.

(ix) Supportive social service.

(x) Individual counseling as appropriate.

(xi) Opportunities for learning/development of skills and habits which will enable Department of Veterans Affairs sponsored residents to adjust to and maintain freedom from dependence on or involvement with alcohol or drug abuse or dependence during or subsequent to leaving the facility.

(xii) Support for the individual desire for sobriety (alcohol/drug abuse-free life style).

(xiii) Opportunities for learning, testing, and internalizing knowledge of illness/recovery process, and for upgrading skills and improving personal relationships.

(7) Data normally maintained and included in a medical record as a function of compliance with State or community licensing standards will be accessible.

(b) Representatives of the Department of Veterans Affairs will inspect the facility prior to award of a contract to assure that prescribed requirements can be met. Inspections may also be carried out at such other times as deemed necessary by the Department of Veterans Affairs.

(c) All requirements in this rule, and Department of Veterans Affairs reports of inspection of residential facilities furnishing treatment and rehabilitation services to eligible veterans shall to the extent possible, be made available to all government agencies charged with the responsibility of licensing or otherwise regulating or inspecting such institutions.

(d) An individual case record will be created for each client which shall be maintained in security and confidence as required by the ''Confidentiality of Alcohol and Drug Abuse Patient Records'' (42 CFR part 2) and the ''Confidentiality of Certain Medical Records'' (38 U.S.C. 7332), and will be made available on a need to know basis to appropriate Department of Veterans Affairs staff members involved with the treatment program of the veterans concerned.

(e) Contractors under this section shall provide reports of budget and case load experience upon request from a Department of Veterans Affairs official.

(Authority: 38 U.S.C. 1720A)

[47 FR 57707, Dec. 28, 1982. Redesignated and amended at 61 FR 21965, 21967, May 13, 1996; 61 FR 63720, Dec. 2, 1996; 69 FR 18803, Apr. 9, 2004; 76 FR 10249, Feb. 24, 2011]

§ 17.82 Contracts for outpatient services for veterans with alcohol or drug dependence or abuse disabilities.

(a) Contracts for treatment services authorized under § 17.80 may be awarded in accordance with applicable Department of Veterans Affairs and Federal procurement procedures. Such contracts will be awarded only after the quality and effectiveness, including adequate protection for the safety of the participants of the contractor's program, has been determined and then only to contractors determined by the Under Secretary for Health or designee to be fully capable of meeting the following standards:

(1) The following minimum fire safety requirements must be met:

(i) The building must meet the requirements in the applicable provisions of the NFPA 101 (incorporated by reference, *see* § 17.1) and the other publications referenced in those provisions. Any equivalencies or variances to VA requirements must be approved by the appropriate Veterans Health Administration Veterans Integrated Service Network (VISN) Director.

(ii) Where applicable, the facility must have a current occupancy permit issued by the local and state governments in the jurisdiction where the home is located.

(iii) All Department of Veterans Affairs sponsored patients will be mentally and physically capable of leaving the building, unaided, in the event of an emergency.

(iv) As a minimum, fire exit drills must be held at least quarterly, and a written plan for evacuation in the event of fire shall be developed and reviewed annually. The plan shall outline the duties, responsibilities and actions to be taken by the staff in the event of a fire emergency. This plan shall be implemented during fire exit drills.

(v) An annual fire and safety inspection shall be conducted at the facility

by qualified Department of Veterans Affairs personnel. If a review of past Department of Veterans Affairs inspections or inspections made by the local authorities indicates that a fire and safety inspection would not be necessary, then the visit to the facility may be waived.

(2) Conform to existing standards of State safety codes and local and/or State health and sanitation codes.

(3) Be licensed under State or local authority.

(4) Where applicable, be accredited by the State.

(5) Comply with the requirements of the ''Confidentiality of Alcohol and Drug Abuse Patient Records'' (42 CFR part 2) and the ''Confidentiality of Certain Medical Records'' (38 U.S.C. 7332), which shall be part of the contract.

(6) Demonstrate an existing capability to furnish the following:

(i) A supervised, alcohol and drug free environment, including active affiliation with Alcoholics Anonymous (AA) programs.

(ii) Staff sufficient in numbers and position qualifications to carry out the policies, responsibilities, and programs of the facility.

(iii) Structured activities.

(iv) Appropriate group activities.

(v) Monitoring medications.

(vi) Supportive social service.

(vii) Individual counseling as appropriate.

(viii) Opportunities for learning/development of skills and habits which will enable Department of Veterans Affairs sponsored residents to adjust to and maintain freedom from dependence on or involvement with alcohol or drug abuse or dependence during or subsequent to leaving the facility.

(ix) Support for the individual desire for sobriety (alcohol/drug abuse-free life style).

(x) Opportunities for learning, testing, and internalizing knowledge of illness/recovery process, and to upgrade skills and improve personal relationships.

(7) Data normally maintained and included in a medical record as a function of compliance with State or community licensing standards will be accessible.

(b) Representatives of the Department of Veterans Affairs will inspect the facility prior to award of a contract to assure that prescribed requirements can be met. Inspections may also be carried out at such other times as deemed necessary by the Department of Veterans Affairs.

(c) All requirements in this rule and Department of Veterans Affairs reports of inspection of residential facilities furnishing treatment and rehabilitation services to eligible veterans shall, to the extent possible, be made available to all government agencies charged with the responsibility of licensing or otherwise regulating or inspecting such institutions.

(d) An individual case record will be created for each client which shall be maintained in security and confidence as required by the ''Confidentiality of Alcohol and Drug Abuse Patient Records'' (42 CFR part 2) and the ''Confidentiality of Certain Medical Records'' (38 U.S.C. 7332), and will be made available on a need to know basis to appropriate Department of Veterans Affairs staff members involved with the treatment program of the veterans concerned.

(Authority: 38 U.S.C. 1720A)

[47 FR 57708, Dec. 28, 1982. Redesignated and amended at 61 FR 21965, 21967, May 13, 1996; 61 FR 63720, Dec. 2, 1996; 62 FR 17072, Apr. 9, 1997; 69 FR 18803, Apr. 9, 2004; 76 FR 10249, Feb. 24, 2011]

§ 17.83 Limitations on payment for alcohol and drug dependence or abuse treatment and rehabilitation.

The authority to enter into contracts shall be effective for any fiscal year only to such extent or in such amounts as are provided in appropriation acts, and payments shall not exceed these amounts.

(Authority: Pub. L. 96–22, 38 U.S.C. 1720A)

[47 FR 57708, Dec. 28, 1982. Redesignated at 61 FR 21965, May 13, 1996]

RESEARCH-RELATED INJURIES

§ 17.85 Treatment of research-related injuries to human subjects.

(a) VA medical facilities shall provide necessary medical treatment to a research subject injured as a result of

participation in a research project approved by a VA Research and Development Committee and conducted under the supervision of one or more VA employees. This section does not apply to:

(1) Treatment for injuries due to noncompliance by a subject with study procedures, or

(2) Research conducted for VA under a contract with an individual or a non-VA institution.

NOTE TO §17.85(a)(1) AND (a)(2): Veterans who are injured as a result of participation in such research may be eligible for care from VA under other provisions of this part.

(b) Except in the following situations, care for VA research subjects under this section shall be provided in VA medical facilities.

(1) If VA medical facilities are not capable of furnishing economical care or are not capable of furnishing the care or services required, VA medical facility directors shall contract for the needed care.

(2) If inpatient care must be provided to a non-veteran under this section, VA medical facility directors may contract for such care.

(3) If a research subject needs treatment in a medical emergency for a condition covered by this section, VA medical facility directors shall provide reasonable reimbursement for the emergency treatment in a non-VA facility.

(c) For purposes of this section, ''VA employee'' means any person appointed by VA as an officer or employee and acting within the scope of his or her appointment (VA appoints officers and employees under title 5 and title 38 of the United States Code).

(Authority: 38 U.S.C. 501, 7303)

[63 FR 11124, Mar. 6, 1998]

CARE DURING CERTAIN DISASTERS AND EMERGENCIES

§17.86 Provision of hospital care and medical services during certain disasters and emergencies under 38 U.S.C. 1785.

(a) This section sets forth regulations regarding the provision of hospital care and medical services under 38 U.S.C. 1785.

(b) During and immediately following a disaster or emergency referred to in paragraph (c) of this section, VA under 38 U.S.C. 1785 may furnish hospital care and medical services to individuals (including those who otherwise do not have VA eligibility for such care and services) responding to, involved in, or otherwise affected by that disaster or emergency.

(c) For purposes of this section, a *disaster* or *emergency* means:

(1) A major disaster or emergency declared by the President under the Robert T. Stafford Disaster Relief and Emergency Assistance Act (42 U.S.C. 5121 *et seq.*) (Stafford Act); or

(2) A disaster or emergency in which the National Disaster Medical System established pursuant to section 2811(b) of the Public Health Service Act (42 U.S.C. 300hh–11(b)) is activated either by the Secretary of Health and Human Services under paragraph (3)(A) of that section or as otherwise authorized by law.

(d) For purposes of paragraph (b) of this section, the terms *hospital care* and *medical services* have the meanings given such terms by 38 U.S.C. 1701(5) and 1701(6).

(e) Unless the cost of care is charged at rates agreed upon in a sharing agreement as described in §17.102(e), the cost of hospital care and medical services provided under this section to an officer or employee of a department or agency of the United States (other than VA) or to a member of the Armed Forces shall be calculated in accordance with the provisions of §17.102(c) and (h). Other individuals who receive hospital care or medical services under this section are responsible for the cost of the hospital care or medical services when charges are mandated by Federal law (including applicable appropriation acts) or when the cost of care or services is not reimbursed by other-than-VA Federal departments or agencies. When individuals are responsible under this section for the cost of hospital care or medical services, VA will bill in the amounts calculated in accordance with the provisions of §17.102(h), without applying the exception provided in the first paragraph of §17.102.

(f) VA may furnish care and services under this section to a veteran without regard to whether that individual is enrolled in the VA healthcare system

under 38 U.S.C. 1705 and § 17.36 of this part.

(Authority: 38 U.S.C. 501, 1785)

[73 FR 26946, May 12, 2008]

VOCATIONAL TRAINING AND HEALTH-CARE ELIGIBILITY PROTECTION FOR PENSION RECIPIENTS

§ 17.90 Medical care for veterans receiving vocational training under 38 U.S.C. chapter 15.

Hospital care, nursing home care and medical services may be provided to any veteran who is participating in a vocational training program under 38 U.S.C. chapter 15.

(a) For purposes of determining eligibility for this medical benefit, the term *participating in a vocational training program under 38 U.S.C. chapter 15* means the same as the term *participating in a rehabilitation program under 38 U.S.C. chapter 31* as defined in § 17.47(j). Eligibility for such medical care will continue only while the veteran is participating in the vocational training program.

(b) The term *hospital care and medical services* means class V dental care, priority III medical services, nursing home care and non-VA hospital care and/or fee medical/dental care if VA is unable to provide the required medical care economically at VA or other government facilities because of geographic inaccessibility or because of the unavailability of the required services at VA facilities.

(Authority: 38 U.S.C. 1524, 1525, 1516)

[51 FR 19330, May 29, 1986, as amended at 56 FR 3422, Jan. 30, 1991. Redesignated and amended at 61 FR 21965, 21967, May 13, 1996]

§ 17.91 Protection of health-care eligibility.

Any veteran whose entitlement to VA pension is terminated by reason of income from work or training shall, subject to paragraphs (a) and (b) of this section, retain for 3 years after the termination, the eligibility for hospital care, nursing home care and medical services (not including dental) which the veteran otherwise would have had if the pension had not been terminated as a result of the veteran's receipt of earnings from activity performed for remuneration or gain by the veteran but only if the veteran's annual income from sources other than such earnings would, taken alone, not result in the termination of the veteran's pension.

(a) A veteran who participates in a vocational training program under 38 U.S.C. chapter 15 is eligible for the one-time 3 year retention of hospital care, nursing home care and medical services benefits at any time that the veteran's pension is terminated by reason of income from the veteran's employment.

(b) A veteran who does not participate in a vocational training program under 38 U.S.C. chapter 15 is eligible for the one-time 3 year retention of hospital care and medical services benefits only if the veteran's pension is terminated by reason of income from the veteran's employment during the period February 1, 1985 through January 31, 1989.

(Authority: 38 U.S.C. 1524, 1525, 1516)

[51 FR 19330, May 29, 1986. Redesignated at 61 FR 21965, May 13, 1996]

OUTPATIENT TREATMENT

§ 17.92 Outpatient care for research purposes.

Subject to the provisions of § 17.101, any person who is a bona fide volunteer may be furnished outpatient treatment when the treatment to be rendered is part of an approved Department of Veterans Affairs research project and there are insufficient veteran-patients suitable for the project.

[35 FR 11470, July 17, 1970. Redesignated and amended at 61 FR 21965, 21967, May 13, 1996]

§ 17.93 Eligibility for outpatient services.

(a) VA shall furnish on an ambulatory or outpatient basis medical services as are needed, to the following applicants under the conditions stated, except that applications for dental treatment must also meet the provisions of § 17.161.

(Authority: 38 U.S.C. 1712)

(1) *For compensation and pension examinations.* A compensation and pension examination shall be performed

for any veteran who is directed to have such an examination by VA.

(Authority: 38 U.S.C. 111 and 501)

(2) *For adjunct treatment.* Subject to the provisions of §§ 17.36 through 17.38, medical services on an ambulatory or outpatient basis shall be provided to veteans for an adjunct nonservice-connected condition associated with and held to be aggravating a disability from a disease or injury adjudicated as being service-connected.

(b) The term ''shall furnish'' in this section and 38 U.S.C. 1712 (a)(1) and (a)(2) means that, if the veteran is in immediate need of outpatient medical services, VA shall furnish care at the VA facility where the veteran applies. If the needed medical services are not available there, VA shall arrange for care at the nearest VA medical facility or Department of Defense facility (with which VA has a sharing agreement) that can provide the needed care. If VA and Department of Defense facilities are not available, VA shall arrange for care on a fee basis, but only if the veteran is eligible to receive medical services in non-VA facilities under § 17.52.

If the veteran is not in immediate need of outpatient medical services, VA shall schedule the veteran for care where the veteran applied, if the schedule there permits, or refer the veteran for scheduling to the nearest VA medical center or Department of Defense facility (with which VA has a sharing agreement).

(c) VA may furnish on an ambulatory or outpatient basis medical services as needed to the following applicants, except that applications for dental treatment must also meet the provisions of § 17.123.

(1) *For veterans participating in a rehabilitation program under 38 U.S.C. chapter 31.* Medical services on an ambulatory or outpatient basis may be provided as determined medically necessary for a veteran participating in a rehabilitation program under 38 U.S.C. chapter 31 as defined in § 17.47(j).

(2) [Reserved]

(Authority: 38 U.S.C. 1717)

[55 FR 20150, May 15, 1990, as amended at 58 FR 25565, Apr. 27, 1993. Redesignated and amended at 61 FR 21965, 21967, May 13, 1996; 64 FR 54218, Oct. 6, 1999]

§ 17.94 Outpatient medical services for military retirees and other beneficiaries.

Outpatient medical services for military retirees and other beneficiaries for which charges shall be made as required by § 17.101, may be authorized for persons properly referred by authorized officials of other Federal agencies for which the Secretary of Veterans Affairs may agree to render such service under the conditions stipulated by the Secretary and pensioners of nations allied with the United States in World War I and World War II when duly authorized.

[32 FR 13815, Oct. 4, 1967, as amended at 45 FR 6937, Jan. 31, 1980; 47 FR 58249, Dec. 30, 1982. Redesignated and amended at 61 FR 21965, 21967, May 13, 1996]

§ 17.95 Outpatient medical services for Department of Veterans Affairs employees and others in emergencies.

Outpatient medical services for which charges shall be made as required by § 17.101 may be authorized for employees of the Department of Veterans Affairs, their families, and the general public in emergencies, subject to conditions stipulated by the Secretary of Veterans Affairs.

(Authority: 38 U.S.C. 1711(c)(1))

[47 FR 58249, Dec. 30, 1982. Redesignated and amended at 61 FR 21965, 21967, May 13, 1996]

§ 17.96 Medication prescribed by non-VA physicians.

Any prescription, which is not part of authorized Department of Veterans Affairs hospital or outpatient care, for drugs and medicines ordered by a private or non-Department of Veterans Affairs doctor of medicine or doctor of osteopathy duly licensed to practice in the jurisdiction where the prescription is written, shall be filled by a Department of Veterans Affairs pharmacy or a non-VA pharmacy in a state home

under contract with VA for filling prescriptions for patients in state homes, provided:

(a) The prescription is for:

(1) A veteran who by reason of being permanently housebound or in need of regular aid and attendance is in receipt of increased compensation under 38 U.S.C. chapter 11, or increased pension under section 3.1(u) (Section 306 Pension) or section 3.1(w) (Improved Pension), of this title, as a veteran of the Mexican Border Period, World War I, World War II, the Korean Conflict, or the Vietnam Era (or, although eligible for such pension, is in receipt of compensation as the greater benefit), or

(2) A veteran in need of regular aid and attendance who was formerly in receipt of increased pension as described in paragraph (a)(1) of this section whose pension has been discontinued solely by reason of excess income, but only so long as such veteran's annual income does not exceed the maximum annual income limitation by more than $ 1,000, and

(b) The drugs and medicines are prescribed as specific therapy in the treatment of any of the veteran's illnesses or injuries.

(Authority: 38 U.S.C. 1706, 1710, 17.12(d))

[68 FR 43929, July 25, 2003, as amended at 74 FR 44291, Aug. 28, 2009]

§ 17.97 Prescriptions in Alaska, and territories and possessions.

In Alaska and territories and possessions, where there are no Department of Veterans Affairs pharmacies, the expenses of any prescriptions filled by a private pharmacist which otherwise could have been filled by a Department of Veterans Affairs pharmacy under 38 U.S.C. 1712(h), may be reimbursed.

[32 FR 13816, Oct. 4, 1967. Redesignated and amended at 61 FR 21965, 21967, May 13, 1996]

§ 17.98 Mental health services.

(a) Following the death of a veteran, bereavement counseling involving services defined in 38 U.S.C. 1701(6)(B), may be furnished to persons who were receiving mental health services in connection with treatment of the veteran under 38 U.S.C. 1710, 1712, 1712A, 1713, or 1717, or 38 CFR 17.84 of this part, prior to the veteran's death, but may only be furnished in instances where the veteran's death had been unexpected or occurred while the veteran was participating in a VA hospice or similar program. Bereavement counseling may be provided only to assist individuals with the emotional and psychological stress accompanying the veteran's death, and only for a limited period of time, as determined by the Medical Center Director, but not to exceed 60 days. The Medical Center Director may approve a longer period of time when medically indicated.

(b) For purposes of paragraph (a) of this section, an unexpected death is one which occurs when in the course of an illness the provider of care did not or could not have anticipated the timing of the death. Ordinarily, the provider of care can anticipate the patient's death and can inform the patient and family of the immediacy and certainty of death. If that has not taken place, a death can be described as unexpected.

(Authority: 38 U.S.C. 1701(6)(B))

[53 FR 7186, Mar. 7, 1988. Redesignated and amended at 61 FR 21965, 21967, May 13, 1996]

BREAKING APPOINTMENTS

§ 17.100 Refusal of treatment by unnecessarily breaking appointments.

A patient under medical treatment who breaks an appointment without a reasonable excuse will be informed that breaking an additional appointment will be deemed to be a refusal to accept VA treatment. If such a patient fails to keep a second appointment, without at least 24 hours notice, such action will be deemed as a refusal to accept VA treatment. Thereafter, no further treatment will be furnished until the veteran has agreed to cooperate by keeping appointments. Treatment will not be discontinued until the treating physician has reviewed the treatment files, concurred in the action and signed a statement to this effect in the record. Consideration will be given to the veteran's ability to make a rational decision concerning the need for medical care and/or examination. The veteran will be advised of the final decision. Nothing in this section will be construed to prevent treatment for an emergent condition that

may arise during or subsequent to this action. Where an appointment is broken without notice and satisfactory reasons are advanced for breaking the appointment and circumstances were such that notice could not be given, the patient will not be deemed to have refused treatment.

(Authority: 38 U.S.C. 7304)

[51 FR 8672, Mar. 13, 1986. Redesignated at 61 FR 21965, May 13, 1996; 64 FR 54218, Oct. 6, 1999]

CHARGES, WAIVERS, AND COLLECTIONS

§ 17.101 Collection or recovery by VA for medical care or services provided or furnished to a veteran for a nonservice-connected disability.

(a)(1) *General*. This section covers collection or recovery by VA, under 38 U.S.C. 1729, for medical care or services provided or furnished to a veteran:

(i) For a nonservice-connected disability for which the veteran is entitled to care (or the payment of expenses of care) under a health plan contract;

(ii) For a nonservice-connected disability incurred incident to the veteran's employment and covered under a worker's compensation law or plan that provides reimbursement or indemnification for such care and services; or

(iii) For a nonservice-connected disability incurred as a result of a motor vehicle accident in a State that requires automobile accident reparations insurance.

(2) *Methodologies*. Based on the methodologies set forth in this section, the charges billed will include the following types of charges, as appropriate: Acute inpatient facility charges; skilled nursing facility/sub-acute inpatient facility charges; partial hospitalization facility charges; outpatient facility charges; physician and other professional charges, including professional charges for anesthesia services and dental services; pathology and laboratory charges; observation care facility charges; ambulance and other emergency transportation charges; and charges for durable medical equipment, drugs, injectables, and other medical services, items, and supplies identified by HCPCS Level II codes. In addition, the charges billed for prescription drugs not administered during treatment will be the amount determined under paragraph (m) of this section. Data for calculating actual charge amounts based on the methodologies set forth in this section will either be published in a notice in the FEDERAL REGISTER or will be posted on the Internet site of the Veterans Health Administration Chief Business Office, currently at *http://www.va.gov/cbo*, under ''Charge Data.'' For care for which VA has established a charge, VA will bill using its most recent published or posted charge. For care for which VA has not established a charge, VA will bill according to the methodology set forth in paragraph (a)(8) of this section.

(3) *Data sources*. In this section, data sources are identified by name. The specific editions of these data sources used to calculate actual charge amounts, and information on where these data sources may be obtained, will be presented along with the data for calculating actual charge amounts, either in notices in the FEDERAL REGISTER or on the Internet site of the Veterans Health Administration Chief Business Office, currently at *http://www.va.gov/cbo*, under ''Charge Data.''

(4) *Amount of recovery or collection—third party liability*. A third-party payer liable under a health plan contract has the option of paying either the billed charges described in this section or the amount the health plan demonstrates is the amount it would pay for care or services furnished by providers other than entities of the United States for the same care or services in the same geographic area. If the amount submitted by the health plan for payment is less than the amount billed, VA will accept the submission as payment, subject to verification at VA's discretion in accordance with this section. A VA employee having responsibility for collection of such charges may request that the third party health plan submit evidence or information to substantiate the appropriateness of the payment amount (e.g., health plan or insurance policies, provider agreements, medical evidence, proof of payment to other providers in the same geographic area for the same care and services VA provided).

(5) *Definitions.* For purposes of this section:

APC means Medicare Ambulatory Payment Classification.

CMS means the Centers for Medicare and Medicaid Services.

CPI-U means Consumer Price Index—All Urban Consumers.

CPT code and *CPT procedure code* mean Current Procedural Terminology code, a five-digit identifier defined by the American Medical Association for a specified physician service or procedure.

DME means Durable Medical Equipment.

DRG means Diagnosis Related Group.

Geographic area means a three-digit ZIP Code area, where three-digit ZIP Codes are the first three digits of standard U.S. Postal Service ZIP Codes.

HCPCS code means a Healthcare Common Procedure Coding System Level II identifier, consisting of a letter followed by four digits, defined by CMS for a specified physician service, procedure, test, supply, or other medical service.

ICU means Intensive Care Unit, including coronary care units.

MDR means Medical Data Research, a medical charge database published by Ingenix, Inc.

MedPAR means the Medicare Provider Analysis and Review file.

Non-provider-based means a VA health care entity (such as a small VA community-based outpatient clinic) that functions as the equivalent of a doctor's office or for other reasons does not meet CMS provider-based criteria, and, therefore, is not entitled to bill outpatient facility charges.

Provider-based means the outpatient department of a VA hospital or any other VA health care entity that meets CMS provider-based criteria. Provider-based entities are entitled to bill outpatient facility charges.

RBRVS means Resource-Based Relative Value Scale.

RVU means Relative Value Unit.

Unlisted procedures mean procedures, services, items, and supplies that have not been defined or specified by the American Medical Association or CMS, and the CPT and HCPCS codes used to report such procedures, services, items, and supplies.

(6) *Provider-based and non-provider-based entities and charges.* Each VA health care entity (medical center, hospital, community-based outpatient clinic, independent outpatient clinic, etc.) is designated as either provider-based or non-provider-based. Provider-based entities are entitled to bill outpatient facility charges; non-provider-based entities are not. The charges for physician and other professional services provided at non-provider-based entities will be billed as professional charges only. Professional charges for both provider-based entities and non-provider-based entities are produced by the methodologies set forth in this section, with professional charges for provider-based entities based on facility practice expense RVUs, and professional charges for non-provider-based entities based on non-facility practice expense RVUs.

(7) *Charges for medical care or services provided by non-VA providers at VA expense.* When medical care or services are furnished at the expense of the VA by non-VA providers, the charges billed for such care or services will be the higher of the charges determined according to this section, or the amount VA paid to the non-VA provider.

(8) *Charges when a new DRG or CPT/HCPCS code identifier does not have an established charge.* When VA does not have an established charge for a new DRG or CPT/HCPCS code to be used in determining a billing charge under the applicable methodology in this section, then VA will establish an interim billing charge or establish an interim charge to be used for determining a billing charge under the applicable methodology in paragraphs (a)(8)(i) through (a)(8)(viii) of this section.

(i) If a new DRG or CPT/HCPCS code identifier replaces a DRG or CPT/HCPCS code identifier, the most recently established charge for the identifier being replaced will continue to be used for determining a billing charge under paragraphs (b), (e), (f), (g), (h), (i), (k), or (l) of this section until such time as VA establishes a charge for the new identifier.

(ii) If medical care or service is provided or furnished at VA expense by a

non-VA provider and a charge cannot be established under paragraph (a)(8)(i) of this section, then VA's billing charge for such care or service will be the amount VA paid to the non-VA provider without additional calculations under this section.

(iii) If a new CPT/HCPCS code has been established for a prosthetic device or durable medical equipment subject to paragraph (l) of this section and a charge cannot be established under paragraphs (a)(8)(i) or (ii) of this section, VA's billing charge for such prosthetic device or durable medical equipment will be 1 and ½ times VA's average actual cost without additional calculations under this section.

(iv) If a new medical identifier DRG code has been assigned to a particular type of medical care or service and a charge cannot be established under paragraphs (a)(8)(i) through (iii) of this section, then until such time as VA establishes a charge for the new medical identifier DRG code, the interim charge for use in paragraph (b) of this section will be the average charge of all medical DRG codes that are within plus or minus 10 of the numerical relative weight assigned to the new medical identifier DRG code.

(v) If a new surgical identifier DRG code has been assigned to a particular type of medical care or service and a charge cannot be established under paragraphs (a)(8)(i) through (iv) of this section, then until such time as VA establishes a charge for the new surgical identifier DRG code, the interim charge for use in paragraph (b) of this section will be the average charge of all surgical DRG codes that are within plus or minus 10 of the numerical relative weight assigned to the new surgical identifier DRG code.

(vi) If a new identifier CPT/HCPCS code is assigned to a particular type or item of medical care or service and a charge cannot be established under paragraphs (a)(8)(i) through (v) of this section, then until such time as VA establishes a charge for the new identifier for use in paragraphs (e), (f), (g), (h), (i), (k), or (l) of this section, VA's billing charge will be the Medicare allowable charge multiplied by 1 and ½, without additional calculations under this section.

(vii) If a new identifier CPT/HCPCS code is assigned to a particular type or item of medical care or service and a charge cannot be established under paragraphs (a)(8)(i) through (vi) of this section, then until such time as VA establishes a charge for the new identifier, the interim charge for use in paragraphs (e), (f), (g), (h), (i), (k), or (l) of this section will be the charge for the CPT/HCPCS code that is closest in characteristics to the new CPT/HCPCS code.

(viii) If a charge cannot be established under paragraphs (a)(8)(i) through (a)(8)(vii) of this section, then VA will not charge under this section for the care or service.

(b) *Acute inpatient facility charges.* When VA provides or furnishes acute inpatient services within the scope of care referred to in paragraph (a)(1) of this section, acute inpatient facility charges billed for such services will be determined in accordance with the provisions of this paragraph. Acute inpatient facility charges consist of per diem charges for room and board and for ancillary services that vary by geographic area and by DRG. These charges are calculated as follows:

(1) *Formula.* For each acute inpatient stay, or portion thereof, for which a particular DRG assignment applies, the total acute inpatient facility charge is the sum of the applicable charges determined pursuant to paragraphs (b)(1)(i), (ii), and (iii) of this section. For purposes of this section, standard room and board days and ICU room and board days are mutually exclusive: VA will bill either a standard room and board per diem charge or an ICU room and board per diem charge, as applicable, for each day of a given acute inpatient stay.

(i) *Standard room and board charges.* Multiply the nationwide standard room and board per diem charge determined pursuant to paragraph (b)(2) of this section by the appropriate geographic area adjustment factor determined pursuant to paragraph (b)(3) of this section. The result constitutes the area-specific standard room and board per diem charge. Multiply this amount by the number of days for which standard

room and board charges apply to obtain the total acute inpatient facility standard room and board charge.

(ii) *ICU room and board charges.* Multiply the nationwide ICU room and board per diem charge determined pursuant to paragraph (b)(2) of this section by the appropriate geographic area adjustment factor determined pursuant to paragraph (b)(3) of this section. The result constitutes the area-specific ICU room and board per diem charge. Multiply this amount by the number of days for which ICU room and board per diem charges apply to obtain the total acute inpatient facility ICU room and board charge.

(iii) *Ancillary charges.* Multiply the nationwide ancillary per diem charge determined pursuant to paragraph (b)(2) of this section by the appropriate geographic area adjustment factor determined pursuant to paragraph (b)(3) of this section. The result constitutes the area-specific ancillary per diem charge. Multiply this amount by the number of days of acute inpatient care to obtain the total acute inpatient facility ancillary charge.

Note to paragraph (b)(1): If there is a change in a patient's condition and/or treatment during a single acute inpatient stay such that the DRG assignment changes (for example, a psychiatric patient who develops a medical or surgical problem), then calculations of acute inpatient facility charges will be made separately for each DRG, according to the number of days of care applicable for each DRG, and the total acute inpatient facility charge will be the sum of the total acute inpatient facility charges for the different DRGs.

(2) *Per diem charges.* To establish a baseline, two nationwide average per diem amounts for each DRG are calculated, one from the MedPAR file and one from the MedStat claims database, a database of nationwide commercial insurance claims. Average per diem charges are calculated based on all available charges, except for care reported for emergency room, ambulance, professional, and observation care. These two data sources may report charges for two differing periods of time; when this occurs, the data source charges with the earlier center date are trended forward to the center date of the other data source, based on changes to the inpatient hospital services component of the CPI-U. Results obtained from these two data sources are then combined into a single weighted average per diem charge for each DRG. The resulting charge for each DRG is then separated into its two components, a room and board component and an ancillary component, with the per diem charge for each component calculated by multiplying the weighted average per diem charge by the corresponding percentage determined pursuant to paragraph (b)(2)(i) of this section. The room and board per diem charge is further differentiated into a standard room and board per diem charge and an ICU room and board per diem charge by multiplying the average room and board charge by the corresponding DRG-specific ratios determined pursuant to paragraph (b)(2)(ii) of this section. The resulting per diem charges for standard room and board, ICU room and board, and ancillary services for each DRG are then each multiplied by the final ratio determined pursuant to paragraph (b)(2)(iii) of this section to reflect the nationwide 80th percentile charges. Finally, the resulting amounts are each trended forward from the center date of the trended data sources to the effective time period for the charges, as set forth in paragraph (b)(2)(iv) of this section. The results constitute the nationwide 80th percentile standard room and board, ICU room and board, and ancillary per diem charges.

(i) *Room and board charge and ancillary charge component percentages.* Using only those cases from the MedPAR file for which a distinction between room and board charges and ancillary charges can be determined, the percentage of the total charges for room and board compared to the combined total charges for room and board and ancillary services, and the percentage of the total charges for ancillary services compared to the combined total charges for room and board and ancillary services, are calculated by DRG.

(ii) *Standard room and board per diem charge and ICU room and board per diem charge ratios.* Using only those cases

from the MedPAR file for which a distinction between room and board and ancillary charges can be determined, overall average per diem room and board charges are calculated by DRG. Then, using the same cases, an average standard room and board per diem charge is calculated by dividing total non-ICU room and board charges by total non-ICU room and board days. Similarly, an average ICU room and board per diem charge is calculated by dividing total ICU room and board charges by total ICU room and board days. Finally, ratios of standard room and board per diem charges *to* average overall room and board per diem charges are calculated by DRG, as are ratios of ICU room and board per diem charges *to* average overall room and board per diem charges.

(iii) *80th percentile*. Using cases from the MedPAR file with separately identifiable semi-private room rates, the ratio of the day-weighted 80th percentile semi-private room and board per diem charge *to* the average semi-private room and board per diem charge is obtained for each geographic area. The geographic area-based ratios are averaged to obtain a final 80th percentile ratio.

(iv) *Trending forward*. 80th percentile charges for each DRG, obtained as described in paragraph (b)(2) of this section, are trended forward based on changes to the inpatient hospital services component of the CPI-U. Actual CPI-U changes are used from the center date of the trended data sources through the latest available month as of the time the calculations are performed. The three-month average annual trend rate as of the latest available month is then held constant to the midpoint of the calendar year in which the charges are primarily expected to be used. The projected total CPI-U change so obtained is then applied to the 80th percentile charges.

(3) *Geographic area adjustment factors*. For each geographic area, the average per diem room and board charges and ancillary charges from the MedPAR file are calculated for each DRG. The DRGs are separated into two groups, surgical and non-surgical. For each of these groups of DRGs, for each geographic area, average room and board per diem charges and ancillary per diem charges are calculated, weighted by nationwide VA discharges and by average lengths of stay from the combined MedPAR file and MedStat claims database. This results in four average per diem charges for each geographic area: room and board for surgical DRGs, ancillary for surgical DRGs, room and board for non-surgical DRGs, and ancillary for non-surgical DRGs. Four corresponding national average per diem charges are obtained from the MedPAR file, weighted by nationwide VA discharges and by average lengths of stay from the combined MedPAR file and MedStat claims database. Four geographic area adjustment factors are then calculated for each geographic area by dividing each geographic area average per diem charge by the corresponding national average per diem charge.

(c) *Skilled nursing facility/sub-acute inpatient facility charges*. When VA provides or furnishes skilled nursing/sub-acute inpatient services within the scope of care referred to in paragraph (a)(1) of this section, skilled nursing facility/sub-acute inpatient facility charges billed for such services will be determined in accordance with the provisions of this paragraph. The skilled nursing facility/sub-acute inpatient facility charges are per diem charges that vary by geographic area. The facility charges cover care, including room and board, nursing care, pharmaceuticals, supplies, and skilled rehabilitation services (e.g., physical therapy, inhalation therapy, occupational therapy, and speech-language pathology), that is provided in a nursing home or hospital inpatient setting, is provided under a physician's orders, and is performed by or under the general supervision of professional personnel such as registered nurses, licensed practical nurses, physical therapists, occupational therapists, speech-language pathologists, and audiologists. These charges are calculated as follows:

(1) *Formula*. For each stay, multiply the nationwide per diem charge determined pursuant to paragraph (c)(2) of this section by the appropriate geographic area adjustment factor determined pursuant to paragraph (c)(3) of

this section. The result constitutes the area-specific per diem charge. Finally, multiply the area-specific per diem charge by the number of days of care to obtain the total skilled nursing facility/sub-acute inpatient facility charge.

(2) *Per diem charge.* To establish a baseline, a nationwide average per diem billed charge is calculated based on charges reported in the MedPAR skilled nursing facility file. For this purpose, the following MedPAR charge categories are included: room and board (private, semi-private, and ward), physical therapy, occupational therapy, inhalation therapy, speech-language pathology, pharmacy, medical/surgical supplies, and ''other'' services. The following MedPAR charge categories are excluded from the calculation of the per diem charge and will be billed separately, using the charges determined as set forth in other applicable paragraphs of this section, when these services are provided to skilled nursing patients or sub-acute inpatients: ICU and CCU room and board, laboratory, radiology, cardiology, dialysis, operating room, blood and blood administration, ambulance, MRI, anesthesia, durable medical equipment, emergency room, clinic, outpatient, professional, lithotripsy, and organ acquisition services. The resulting average per diem billed charge is then multiplied by the 80th percentile adjustment factor determined pursuant to paragraph (c)(2)(i) of this section to obtain a nationwide 80th percentile charge level. Finally, the resulting amount is trended forward to the effective time period for the charges, as set forth in paragraph (c)(2)(ii) of this section.

(i) *80th percentile adjustment factor.* Using the MedPAR skilled nursing facility file, the ratio of the day-weighted 80th percentile room and board per diem charge to the day-weighted average room and board per diem charge is obtained for each geographic area. The geographic area-based ratios are averaged to obtain the 80th percentile adjustment factor.

(ii) *Trending forward.* The 80th percentile charge is trended forward based on changes to the inpatient hospital services component of the CPI-U. Actual CPI-U changes are used from the time period of the source data through the latest available month as of the time the calculations are performed. The three-month average annual trend rate as of the latest available month is then held constant to the midpoint of the calendar year in which the charges are primarily expected to be used. The projected total CPI-U change so obtained is then applied to the 80th percentile charge.

(3) *Geographic area adjustment factors.* The average billed per diem charge for each geographic area is calculated from the MedPAR skilled nursing facility file. This amount is divided by the nationwide average billed charge calculated in paragraph (c)(2) of this section. The geographic area adjustment factor for charges for each VA facility is the ratio for the geographic area in which the facility is located.

(d) *Partial hospitalization facility charges.* When VA provides or furnishes partial hospitalization services that are within the scope of care referred to in paragraph (a)(1) of this section, the facility charges billed for such services will be determined in accordance with the provisions of this paragraph. Partial hospitalization facility charges are per diem charges that vary by geographic area. These charges are calculated as follows:

(1) *Formula.* For each partial hospitalization stay, multiply the nationwide per diem charge determined pursuant to paragraph (d)(2) of this section by the appropriate geographic area adjustment factor determined pursuant to paragraph (d)(3) of this section. The result constitutes the area-specific per diem charge. Finally, multiply the area-specific per diem charge by the number of days of care to obtain the total partial hospitalization facility charge.

(2) *Per diem charge.* To establish a baseline, a nationwide median per diem billed charge is calculated based on charges associated with partial hospitalization from the outpatient facility component of the Medicare Standard Analytical File 5 percent Sample. That median per diem billed charge is then multiplied by the 80th percentile adjustment factor determined pursuant to paragraph (d)(2)(i) of this section to obtain a nationwide 80th percentile

charge level. Finally, the resulting amount is trended forward to the effective time period for the charges, as set forth in paragraph (d)(2)(ii) of this section.

(i) *80th percentile adjustment factor*. The 80th percentile adjustment factor for partial hospitalization facility charges is the same as that computed for skilled nursing facility/sub-acute inpatient facility charges under paragraph (c)(2)(i) of this section.

(ii) *Trending forward*. The 80th percentile charge is trended forward based on changes to the outpatient hospital services component of the CPI-U. Actual CPI-U changes are used from the time period of the source data through the latest available month as of the time the calculations are performed. The three-month average annual trend rate as of the latest available month is then held constant to the midpoint of the calendar year in which the charges are primarily expected to be used. The projected total CPI-U change so obtained is then applied to the 80th percentile charges, as described in paragraph (d)(2) of this section.

(3) *Geographic area adjustment factors*. The geographic area adjustment factors for partial hospitalization facility charges are the same as those computed for outpatient facility charges under paragraph (e)(4) of this section.

(e) *Outpatient facility charges*. When VA provides or furnishes outpatient facility services that are within the scope of care referred to in paragraph (a)(1) of this section, the charges billed for such services will be determined in accordance with the provisions of this paragraph. Charges for outpatient facility services vary by geographic area and by CPT/HCPCS code. These charges apply in the situations set forth in paragraph (e)(1) of this section and are calculated as set forth in paragraph (e)(2) of this section.

(1) *Settings and circumstances in which outpatient facility charges apply*. Outpatient facility charges consist of facility charges for procedures, diagnostic tests, evaluation and management services, and other medical services, items, and supplies provided in the following settings and circumstances:

(i) Outpatient departments and clinics at VA medical centers;

(ii) Other VA provider-based entities; and

(iii) VA non-provider-based entities, for procedures and tests for which no corresponding professional charge is established under the provisions of paragraph (f) of this section.

(2) *Formula*. For each outpatient facility charge CPT/HCPCS code, multiply the nationwide 80th percentile charge determined pursuant to paragraph (e)(3) of this section by the appropriate geographic area adjustment factor determined pursuant to paragraph (e)(4) of this section. The result constitutes the area-specific outpatient facility charge. When multiple surgical procedures are performed during the same outpatient encounter by a provider or provider team, the outpatient facility charges for such procedures will be reduced as set forth in paragraph (e)(5) of this section.

(3) *Nationwide 80th percentile charges by CPT/HCPCS code*. For each CPT/HCPCS code for which outpatient facility charges apply, the nationwide 80th percentile charge is calculated as set forth in either paragraph (e)(3)(i) or (e)(3)(ii) of this section. The resulting amount is trended forward to the effective time period for the charges, as set forth in paragraph (e)(3)(iii) of this section. The results constitute the nationwide 80th percentile outpatient facility charges by CPT/HCPCS code.

(i) *Nationwide 80th percentile charges for CPT/HCPCS codes which have APC assignments*. Using the outpatient facility charges reported in the outpatient facility component of the Medicare Standard Analytical File 5 percent Sample, claim records are selected for which all charges can be assigned to an APC. Using this subset of the 5 percent Sample data, nationwide median charge *to* Medicare APC payment amount ratios, by APC, and nationwide 80th percentile *to* median charge ratios, by APC, are computed according to the methodology set forth in paragraphs (e)(3)(i)(A) and (e)(3)(i)(B) of this section, respectively. The product of these two ratios by APC is then computed, resulting in a composite nationwide 80th percentile charge *to* Medicare APC payment amount ratio. This ratio is then compared to the alternate nationwide 80th percentile charge *to* Medicare

APC payment amount ratio computed in paragraph (e)(3)(i)(C) of this section, and the lesser amount is selected and multiplied by the current Medicare APC payment amount. The resulting product is the APC-specific nationwide 80th percentile charge amount for each applicable CPT/HCPCS code.

(A) *Nationwide median charge to Medicare APC payment amount ratios.* For each CPT/HCPCS code, the ratio of median billed charge *to* Medicare APC payment amount is determined. The weighted average of these ratios for each APC is then obtained, using the reported 5 percent Sample frequencies as weights. In addition, corresponding ratios are calculated for each of the APC categories set forth in paragraph (e)(3)(i)(D) of this section, again using the reported 5 percent Sample frequencies as weights. For APCs where the 5 percent Sample frequencies provide a statistically credible result, the APC-specific weighted average nationwide median charge *to* Medicare APC payment amount ratio so obtained is accepted without further adjustment. However, if the 5 percent Sample data do not produce statistically credible results for any specific APC, then the APC category-specific ratio is applied for that APC.

(B) *Nationwide 80th percentile to median charge ratios.* For each CPT/HCPCS code, a geographically normalized nationwide 80th percentile billed charge amount is divided by a similarly normalized nationwide median billed charge amount. The weighted average of these ratios for each APC is then obtained, using the reported 5 percent Sample frequencies as weights. In addition, corresponding ratios are calculated for each of the APC categories set forth in paragraph (e)(3)(i)(D) of this section, again using the reported 5 percent Sample frequencies as weights. For APCs where the 5 percent Sample frequencies provide a statistically credible result, the APC-specific weighted average nationwide 80th percentile *to* median charge ratio so obtained is accepted without further adjustment. However, if the 5 percent Sample data do not produce statistically credible results for any specific APC, then the APC category-specific ratio is applied for that APC.

(C) *Alternate nationwide 80th percentile charge to Medicare APC payment amount ratios.* A minimum 80th percentile charge *to* Medicare APC payment amount ratio is set at 2.0 for APCs with Medicare APC payment amounts of $25 or less. A maximum 80th percentile charge *to* Medicare APC payment amount ratio is set at 6.5 for APCs with Medicare APC payment amounts of $10,000 or more. Using linear interpolation with these endpoints, the alternate APC-specific nationwide 80th percentile charge *to* Medicare APC payment amount ratio is then computed, based on the Medicare APC payment amount.

(D) *APC categories for the purpose of establishing 80th percentile to median factors.* For the purpose of the statistical methodology set forth in paragraph (e)(3)(i) of this section, APCs are assigned to the following APC categories:

(*1*) Radiology.

(*2*) Drugs.

(*3*) Office, Home, and Urgent Care Visits.

(*4*) Cardiovascular.

(*5*) Emergency Room Visits.

(*6*) Outpatient Psychiatry, Alcohol and Drug Abuse.

(*7*) Pathology.

(*8*) Surgery.

(*9*) Allergy Immunotherapy, Allergy Testing, Immunizations, and Therapeutic Injections.

(*10*) All APCs not assigned to any of the above groups.

(ii) *Nationwide 80th percentile charges for CPT/HCPCS codes which do not have APC assignments.* Nationwide 80th percentile billed charge levels by CPT/HCPCS code are computed from the outpatient facility component of the MDR database, from the MedStat claims database, and from the outpatient facility component of the Medicare Standard Analytical File 5 percent Sample. If the MDR database contains sufficient data to provide a statistically credible 80th percentile charge, then that result is retained for this purpose. If the MDR database does not provide a statistically credible 80th percentile charge, then the result from the MedStat database is retained for this purpose, provided it is statistically credible. If neither the MDR nor the

MedStat databases provide statistically credible results, then the nationwide 80th percentile billed charge computed from the 5 percent Sample data is retained for this purpose. The nationwide 80th percentile charges retained from each of these data sources are trended forward to the effective time period for the charges, as set forth in paragraph (e)(3)(iii) of this section.

(iii) *Trending forward*. The charges for each CPT/HCPCS code, obtained as described in paragraph (e)(3) of this section, are trended forward based on changes to the outpatient hospital services component of the CPI-U. Actual CPI-U changes are used from the time period of the source data through the latest available month as of the time the calculations are performed. The three-month average annual trend rate as of the latest available month is then held constant to the midpoint of the calendar year in which the charges are primarily expected to be used. The projected total CPI-U change so obtained is then applied to the 80th percentile charges, as described in paragraph (e)(3) of this section.

(4) *Geographic area adjustment factors*. For each geographic area, a single adjustment factor is calculated as the arithmetic average of the outpatient geographic area adjustment factor published in the Milliman USA, Inc., Health Cost Guidelines (this factor constitutes the ratio of the level of charges for each geographic area *to* the nationwide level of charges), and a geographic area adjustment factor developed from the MDR database (*see* paragraph (a)(3) of this section for Data Sources). The MDR-based geographic area adjustment factors are calculated as the ratio of the CPT/HCPCS code weighted average charge level for each geographic area *to* the nationwide CPT/HCPCS code weighted average charge level.

(5) *Multiple surgical procedures*. When multiple surgical procedures are performed during the same outpatient encounter by a provider or provider team as indicated by multiple surgical CPT/HCPCS procedure codes, then each CPT/HCPCS procedure code will be billed at 100 percent of the charges established under this section.

(f) *Physician and other professional charges except for anesthesia services and certain dental services*. When VA provides or furnishes physician and other professional services, other than professional anesthesia services and certain professional dental services, within the scope of care referred to in paragraph (a)(1) of this section, physician and other professional charges billed for such services will be determined in accordance with the provisions of this paragraph. Charges for professional dental services identified by CPT code are determined in accordance with the provisions of this paragraph; charges for professional dental services identified by HCPCS Level II code are determined in accordance with the provisions of paragraph (h) of this section. Physician and other professional charges consist of charges for professional services that vary by geographic area, by CPT/HCPCS code, by site of service, and by modifier, where applicable. These charges are calculated as follows:

(1) *Formula*. For each CPT/HCPCS code or, where applicable, each CPT/HCPCS code and modifier combination, multiply the total geographically-adjusted RVUs determined pursuant to paragraph (f)(2) of this section by the applicable geographically-adjusted conversion factor (a monetary amount) determined pursuant to paragraph (f)(3) of this section to obtain the physician charge for each CPT/HCPCS code in a particular geographic area. Then, multiply this charge by the appropriate factors for any charge-significant modifiers, determined pursuant to paragraph (f)(4) of this section.

(2)(i) *Total geographically-adjusted RVUs for physician services that have Medicare RVUs*. The work expense and practice expense RVUs for CPT/HCPCS codes, other than the codes described in paragraphs (f)(2)(ii) and (f)(2)(iii) of this section, are compiled using Medicare Physician Fee Schedule RVUs. The sum of the geographically-adjusted work expense RVUs determined pursuant to paragraph (f)(2)(i)(A) of this section and the geographically-adjusted practice expense RVUs determined pursuant to paragraph (f)(2)(i)(B) of this section equals the total geographically-adjusted RVUs.

(A) *Geographically-adjusted work expense RVUs.* For each CPT/HCPCS code for each geographic area, the Medicare Physician Fee Schedule work expense RVUs are multiplied by the work expense Medicare Geographic Practice Cost Index. The result constitutes the geographically-adjusted work expense RVUs.

(B) *Geographically-adjusted practice expense RVUs.* For each CPT/HCPCS code for each geographic area, the Medicare Physician Fee Schedule practice expense RVUs are multiplied by the practice expense Medicare Geographic Practice Cost Index. The result constitutes the geographically-adjusted practice expense RVUs. In these calculations, facility practice expense RVUs are used to obtain geographically-adjusted practice expense RVUs for use by provider-based entities, and non-facility practice expense RVUs are used to obtain geographically-adjusted practice expense RVUs for use by non-provider-based entities.

(ii) *RVUs for CPT/HCPCS codes that do not have Medicare RVUs and are not designated as unlisted procedures.* For CPT/HCPCS codes that are not assigned RVUs in paragraphs (f)(2)(i) or (f)(2)(iii) of this section, total RVUs are developed based on various charge data sources. For these CPT/HCPCS codes, the nationwide 80th percentile billed charges are obtained, where statistically credible, from the MDR database. For any remaining CPT/HCPCS codes, the nationwide 80th percentile billed charges are obtained, where statistically credible, from the Part B component of the Medicare Standard Analytical File 5 percent Sample. For any remaining CPT/HCPCS codes, the nationwide 80th percentile billed charges are obtained, where statistically credible, from the Prevailing Healthcare Charges System nationwide commercial insurance database. For each of these CPT/HCPCS codes, nationwide total RVUs are obtained by taking the nationwide 80th percentile billed charges obtained using the preceding three databases and dividing by the untrended nationwide conversion factor for the corresponding CPT/HCPCS code group determined pursuant to paragraphs (f)(3) and (f)(3)(i) of this section. For any remaining CPT/HCPCS codes that have not been assigned RVUs using the preceding data sources, the nationwide total RVUs are calculated by summing the work expense and non-facility practice expense RVUs found in Ingenix/St. Anthony's RBRVS. The resulting nationwide total RVUs obtained using these four data sources are multiplied by the geographic area adjustment factors determined pursuant to paragraph (f)(2)(iv) of this section to obtain the area-specific total RVUs.

(iii) *RVUs for CPT/HCPCS codes designated as unlisted procedures.* For CPT/HCPCS codes designated as unlisted procedures, total RVUs are developed based on the weighted median of the total RVUs of CPT/HCPCS codes within the series in which the unlisted procedure code occurs. A nationwide VA distribution of procedures and services is used for the purpose of computing the weighted median. The resulting nationwide total RVUs are multiplied by the geographic area adjustment factors determined pursuant to paragraph (f)(2)(iv) of this section to obtain the area-specific total RVUs.

(iv) *RVU geographic area adjustment factors for CPT/HCPCS codes that do not have Medicare RVUs, including codes that are designated as unlisted procedures.* The adjustment factor for each geographic area consists of the weighted average of the work expense and practice expense Medicare Geographic Practice Cost Indices for each geographic area using charge data for representative CPT/HCPCS codes statistically selected and weighted for work expense and practice expense.

(3) *Geographically-adjusted 80th percentile conversion factors.* CPT/HCPCS codes are separated into the following 23 CPT/HCPCS code groups: allergy immunotherapy, allergy testing, cardiovascular, chiropractor, consults, emergency room visits and observation care, hearing/speech exams, immunizations, inpatient visits, maternity/cesarean deliveries, maternity/non-deliveries, maternity/normal deliveries, miscellaneous medical, office/home/urgent care visits, outpatient psychiatry/alcohol and drug abuse, pathology, physical exams, physical medicine, radiology, surgery, therapeutic injections, vision exams, and well baby

exams. For each of the 23 CPT/HCPCS code groups, representative CPT/HCPCS codes are statistically selected and weighted so as to give a weighted average RVU comparable to the weighted average RVU of the entire CPT/HCPCS code group (the selected CPT/HCPCS codes are set forth in the Milliman USA, Inc., Health Cost Guidelines fee survey); see paragraph (a)(3) of this section for Data Sources. The 80th percentile charge for each selected CPT/HCPCS code is obtained from the MDR database. A nationwide conversion factor (a monetary amount) is calculated for each CPT/HCPCS code group as set forth in paragraph (f)(3)(i) of this section. The nationwide conversion factors for each of the 23 CPT/HCPCS code groups are trended forward to the effective time period for the charges, as set forth in paragraph (f)(3)(ii) of this section. The resulting amounts for each of the 23 groups are multiplied by geographic area adjustment factors determined pursuant to paragraph (f)(3)(iii) of this section, resulting in geographically-adjusted 80th percentile conversion factors for each geographic area for the 23 CPT/HCPCS code groups for the effective charge period.

(i) *Nationwide conversion factors.* Using the nationwide 80th percentile charges for the selected CPT/HCPCS codes from paragraph (f)(3) of this section, a nationwide conversion factor is calculated for each of the 23 CPT/HCPCS code groups by dividing the weighted average charge by the weighted average RVU.

(ii) *Trending forward.* The nationwide conversion factors for each of the 23 CPT/HCPCS code groups, obtained as described in paragraph (f)(3)(i) of this section, are trended forward based on changes to the physicians' services component of the CPI-U. Actual CPI-U changes are used from the time period of the source data through the latest available month as of the time the calculations are performed. The three-month average annual trend rate as of the latest available month is then held constant to the midpoint of the calendar year in which the charges are primarily expected to be used. The projected total CPI-U change so obtained is then applied to the 23 conversion factors.

(iii) *Geographic area adjustment factors.* Using the 80th percentile charges for the selected CPT/HCPCS codes from paragraph (f)(3) of this section for each geographic area, a geographic area-specific conversion factor is calculated for each of the 23 CPT/HCPCS code groups by dividing the weighted average charge by the weighted average geographically-adjusted RVU. The resulting conversion factor for each geographic area for each of the 23 CPT/HCPCS code groups is divided by the corresponding nationwide conversion factor determined pursuant to paragraph (f)(3)(i) of this section. The resulting ratios are the geographic area adjustment factors for the conversion factors for each of the 23 CPT/HCPCS code groups for each geographic area.

(4) *Charge adjustment factors for specified CPT/HCPCS code modifiers.* Surcharges are calculated in the following manner: From the Part B component of the Medicare Standard Analytical File 5 percent Sample, the ratio of weighted average billed charges for CPT/HCPCS codes with the specified modifier to the weighted average billed charge for CPT/HCPCS codes with no charge modifier is calculated, using the frequency of procedure codes with the modifier as weights in both weighted average calculations. The resulting ratios constitute the surcharge factors for specified charge-significant CPT/HCPCS code modifiers.

(5) *Certain charges for providers other than physicians.* When services for which charges are established according to the preceding provisions of this paragraph (f) are performed by providers other than physicians, the charges for those services will be as determined by the preceding provisions of this paragraph, except as follows:

(i) *Outpatient facility charges.* When the services of providers other than physicians are furnished in outpatient facility settings or in other facilities designated as provider-based, and outpatient facility charges for those services have been established under paragraph (e) of this section, then the outpatient facility charges established under paragraph (e) will apply instead

of the charges established under this paragraph (f).

(ii) *Charges for professional services.* Charges for the professional services of the following providers will be 100 percent of the amount that would be charged if the care had been provided by a physician:

(A) Nurse practitioner.

(B) Clinical nurse specialist.

(C) Physician Assistant.

(D) Clinical psychologist.

(E) Clinical social worker.

(F) Dietitian.

(G) Clinical pharmacist.

(H) Marriage and family therapist.

(I) Licensed professional mental health counselor.

(g) *Professional charges for anesthesia services.* When VA provides or furnishes professional anesthesia services within the scope of care referred to in paragraph (a)(1) of this section, professional anesthesia charges billed for such services will be determined in accordance with the provisions of this paragraph. Charges for professional anesthesia services personally performed by anesthesiologists will be 100 percent of the charges determined as set forth in this paragraph. Charges for professional anesthesia services provided by non-medically directed certified registered nurse anesthetists will also be 100 percent of the charges determined as set forth in this paragraph. Charges for professional anesthesia services provided by medically directed certified registered nurse anesthetists will be 100 percent of the charges determined as set forth in this paragraph. Professional anesthesia charges consist of charges for professional services that vary by geographic area, by CPT/HCPCS code base units, and by number of time units. These charges are calculated as follows:

(1) *Formula.* For each anesthesia CPT/HCPCS code, multiply the total anesthesia RVUs determined pursuant to paragraph (g)(2) of this section by the applicable geographically-adjusted conversion factor (a monetary amount) determined pursuant to paragraph (g)(3) of this section to obtain the professional anesthesia charge for each CPT/HCPCS code in a particular geographic area.

(2) *Total RVUs for professional anesthesia services.* The total anesthesia RVUs for each anesthesia CPT/HCPCS code are the sum of the base units (as compiled by CMS) for that CPT/HCPCS code and the number of time units reported for the anesthesia service, where one time unit equals 15 minutes. For anesthesia CPT/HCPCS codes designated as unlisted procedures, base units are developed based on the weighted median base units for anesthesia CPT/HCPCS codes within the series in which the unlisted procedure code occurs. A nationwide VA distribution of procedures and services is used for the purpose of computing the weighted median base units.

(3) *Geographically-adjusted 80th percentile conversion factors.* A nationwide 80th percentile conversion factor is calculated according to the methodology set forth in paragraph (g)(3)(i) of this section. The nationwide conversion factor is then trended forward to the effective time period for the charges, as set forth in paragraph (g)(3)(ii) of this section. The resulting amount is multiplied by geographic area adjustment factors determined pursuant to paragraph (g)(3)(iii) of this section, resulting in geographically-adjusted 80th percentile conversion factors for each geographic area for the effective charge period.

(i) *Nationwide conversion factor.* Preliminary 80th percentile conversion factors for each area are compiled from the MDR database. Then, a preliminary nationwide weighted-average 80th percentile conversion factor is calculated, using as weights the population (census) frequencies for each geographic area as presented in the Milliman USA, Inc., Health Cost Guidelines (*see* paragraph (a)(3) of this section for Data Sources). A nationwide 80th percentile fee by CPT/HCPCS code is then computed by multiplying this conversion factor by the MDR base units for each CPT/HCPCS code. An adjusted 80th percentile conversion factor by CPT/HCPCS code is then calculated by dividing the nationwide 80th percentile fee for each procedure code by the anesthesia base units (as compiled by CMS) for that CPT/HCPCS code. Finally, a nationwide weighted average

80th percentile conversion factor is calculated using combined frequencies for billed base units and time units from the part B component of the Medicare Standard Analytical File 5 percent Sample as weights.

(ii) *Trending forward*. The nationwide conversion factor, obtained as described in paragraph (g)(3)(i) of this section, is trended forward based on changes to the physicians' services component of the CPI-U. Actual CPI-U changes are used from the time period of the source data through the latest available month as of the time the calculations are performed. The three-month average annual trend rate as of the latest available month is then held constant to the midpoint of the calendar year in which the charges are primarily expected to be used. The projected total CPI-U change so obtained is then applied to the conversion factor.

(iii) *Geographic area adjustment factors*. The preliminary 80th percentile conversion factors for each geographic area described in paragraph (g)(3)(i) of this section are divided by the corresponding preliminary nationwide 80th percentile conversion factor also described in paragraph (g)(3)(i). The resulting ratios are the adjustment factors for each geographic area.

(h) *Professional charges for dental services identified by HCPCS Level II codes*. When VA provides or furnishes outpatient dental professional services within the scope of care referred to in paragraph (a)(1) of this section, and such services are identified by HCPCS code rather than CPT code, the charges billed for such services will be determined in accordance with the provisions of this paragraph. The charges for dental services vary by geographic area and by HCPCS code. These charges are calculated as follows:

(1) *Formula*. For each HCPCS dental code, multiply the nationwide 80th percentile charge determined pursuant to paragraph (h)(2) of this section by the appropriate geographic area adjustment factor determined pursuant to paragraph (h)(3) of this section. The result constitutes the area-specific dental charge.

(2) *Nationwide 80th percentile charges by HCPCS code*. For each HCPCS dental code, 80th percentile charges are extracted from three independent data sources: Prevailing Healthcare Charges System database; National Dental Advisory Service nationwide pricing index; and the Dental UCR Module of the Comprehensive Healthcare Payment System, a release from Ingenix from a nationwide database of dental charges (*see* paragraph (a)(3) of this section for Data Sources). Charges for each database are then trended forward to a common date, based on actual changes to the dental services component of the CPI-U. Charges for each HCPCS dental code from each data source are combined into an average 80th percentile charge by means of the methodology set forth in paragraph (h)(2)(i) of this section. HCPCS dental codes designated as unlisted are assigned 80th percentile charges by means of the methodology set forth in paragraph (h)(2)(ii) of this section. Finally, the resulting amounts are each trended forward to the effective time period for the charges, as set forth in paragraph (h)(2)(iii) of this section. The results constitute the nationwide 80th percentile charge for each HCPCS dental code.

(i) *Averaging methodology*. The average charge for any particular HCPCS dental code is calculated by first computing a preliminary mean average of the three charges for each code. Statistical outliers are identified and removed by testing whether any charge differs from the preliminary mean charge by more than 50 percent of the preliminary mean charge. In such cases, the charge most distant from the preliminary mean is removed as an outlier, and the average charge is calculated as a mean of the two remaining charges. In cases where none of the charges differ from the preliminary mean charge by more than 50 percent of the preliminary mean charge, the average charge is calculated as a mean of all three reported charges.

(ii) *Nationwide 80th percentile charges for HCPCS dental codes designated as unlisted procedures*. For HCPCS dental codes designated as unlisted procedures, 80th percentile charges are developed based on the weighted median 80th percentile charge of HCPCS dental codes within the series in which the

unlisted procedure code occurs. The distribution of procedures and services from the Prevailing Healthcare Charges System nationwide commercial insurance database is used for the purpose of computing the weighted median.

(iii) *Trending forward.* 80th percentile charges for each dental procedure code, obtained as described in paragraph (h)(2) of this section, are trended forward based on the dental services component of the CPI-U. Actual CPI-U changes are used from the time period of the source data through the latest available month as of the time the calculations are performed. The three-month average annual trend rate as of the latest available month is then held constant to the midpoint of the calendar year in which the charges are primarily expected to be used. The projected total CPI-U change so obtained is then applied to the 80th percentile charges.

(3) *Geographic area adjustment factors.* A geographic adjustment factor (consisting of the ratio of the level of charges in a given geographic area *to* the nationwide level of charges) for each geographic area and dental class of service is obtained from Milliman USA, Inc., Dental Health Cost Guidelines, a database of nationwide commercial insurance charges and relative costs; and a normalized geographic adjustment factor computed from the Dental UCR Module of the Comprehensive Healthcare Payment System compiled by Ingenix, as follows: Using local and nationwide average charges reported in the Ingenix data, a local weighted average charge for each dental class of procedure codes is calculated using utilization frequencies from the Milliman USA, Inc., Dental Health Cost Guidelines as weights (*see* paragraph (a)(3) of this section for Data Sources). Similarly, using nationwide average charge levels, a nationwide average charge by dental class of procedure codes is calculated. The normalized geographic adjustment factor for each dental class of procedure codes and for each geographic area is the ratio of the local average charge divided by the corresponding nationwide average charge. Finally, the geographic area adjustment factor is the arithmetic average of the corresponding factors from the data sources mentioned in the first sentence of this paragraph (h)(3).

(i) *Pathology and laboratory charges.* When VA provides or furnishes pathology and laboratory services within the scope of care referred to in paragraph (a)(1) of this section, charges billed for such services will be determined in accordance with the provisions of this paragraph. Pathology and laboratory charges consist of charges for services that vary by geographic area and by CPT/HCPCS code. These charges are calculated as follows:

(1) *Formula.* For each CPT/HCPCS code, multiply the total geographically-adjusted RVUs determined pursuant to paragraph (i)(2) of this section by the applicable geographically-adjusted conversion factor (a monetary amount) determined pursuant to paragraph (i)(3) of this section to obtain the pathology/laboratory charge for each CPT/HCPCS code in a particular geographic area.

(2)(i) *Total geographically-adjusted RVUs for pathology and laboratory services that have Medicare-based RVUs.* Total RVUs are developed based on the Medicare Clinical Diagnostic Laboratory Fee Schedule (CLAB). The CLAB payment amounts are upwardly adjusted such that the adjusted payment amounts are, on average, equivalent to Medicare Physician Fee Schedule payment levels, using statistical comparisons to the 80th percentile derived from the MDR database. These adjusted payment amounts are then divided by the corresponding Medicare conversion factor to derive RVUs for each CPT/HCPCS code. The resulting nationwide total RVUs are multiplied by the geographic adjustment factors determined pursuant to paragraph (i)(2)(iv) of this section to obtain the area-specific total RVUs.

(ii) *RVUs for CPT/HCPCS codes that do not have Medicare-based RVUs and are not designated as unlisted procedures.* For CPT/HCPCS codes that are not assigned RVUs in paragraphs (i)(2)(i) or (i)(2)(iii) of this section, total RVUs are developed based on various charge data sources. For these CPT/HCPCS codes, the nationwide 80th percentile billed

charges are obtained, where statistically credible, from the MDR database. For any remaining CPT/HCPCS codes, the nationwide 80th percentile billed charges are obtained, where statistically credible, from the Part B component of the Medicare Standard Analytical File 5 percent Sample. For any remaining CPT/HCPCS codes, the nationwide 80th percentile billed charges are obtained, where statistically credible, from the Prevailing Healthcare Charges System nationwide commercial insurance database. For each of these CPT/HCPCS codes, nationwide total RVUs are obtained by taking the nationwide 80th percentile billed charges obtained using the preceding three databases and dividing by the untrended nationwide conversion factor determined pursuant to paragraphs (i)(3) and (i)(3)(i) of this section. For any remaining CPT/HCPCS codes that have not been assigned RVUs using the preceding data sources, the nationwide total RVUs are calculated by summing the work expense and nonfacility practice expense RVUs found in Ingenix/St. Anthony's RBRVS. The resulting nationwide total RVUs obtained using these four data sources are multiplied by the geographic area adjustment factors determined pursuant to paragraph (i)(2)(iv) of this section to obtain the area-specific total RVUs.

(iii) *RVUs for CPT/HCPCS codes designated as unlisted procedures*. For CPT/HCPCS codes designated as unlisted procedures, total RVUs are developed based on the weighted median of the total RVUs of CPT/HCPCS codes within the series in which the unlisted procedure code occurs. A nationwide VA distribution of procedures and services is used for the purpose of computing the weighted median. The resulting nationwide total RVUs are multiplied by the geographic area adjustment factors determined pursuant to paragraph (i)(2)(iv) of this section to obtain the area-specific total RVUs.

(iv) *RVU geographic area adjustment factors for CPT/HCPCS codes that do not have Medicare RVUs, including codes that are designated as unlisted procedures*. The adjustment factor for each geographic area consists of the weighted average of the work expense and practice expense Medicare Geographic Practice Cost Indices for each geographic area using charge data for representative CPT/HCPCS codes statistically selected and weighted for work expense and practice expense.

(3) *Geographically-adjusted 80th percentile conversion factors*. Representative CPT/HCPCS codes are statistically selected and weighted so as to give a weighted average RVU comparable to the weighted average RVU of the entire pathology/laboratory CPT/HCPCS code group (the selected CPT/HCPCS codes are set forth in the Milliman USA, Inc., Health Cost Guidelines fee survey). The 80th percentile charge for each selected CPT/HCPCS code is obtained from the MDR database. A nationwide conversion factor (a monetary amount) is calculated as set forth in paragraph (i)(3)(i) of this section. The nationwide conversion factor is trended forward to the effective time period for the charges, as set forth in paragraph (i)(3)(ii) of this section. The resulting amount is multiplied by a geographic area adjustment factor determined pursuant to paragraph (i)(3)(iv) of this section, resulting in the geographically-adjusted 80th percentile conversion factor for the effective charge period.

(i) *Nationwide conversion factors*. Using the nationwide 80th percentile charges for the selected CPT/HCPCS codes from paragraph (i)(3) of this section, a nationwide conversion factor is calculated by dividing the weighted average charge by the weighted average RVU.

(ii) *Trending forward*. The nationwide conversion factor, obtained as described in paragraph (i)(3) of this section, is trended forward based on changes to the physicians' services component of the CPI-U. Actual CPI-U changes are used from the time period of the source data through the latest available month as of the time the calculations are performed. The three-month average annual trend rate as of the latest available month is then held constant to the midpoint of the calendar year in which the charges are primarily expected to be used. The projected total CPI-U change so obtained is then applied to the pathology/laboratory conversion factor.

(iii) *Geographic area adjustment factor.* Using the 80th percentile charges for the selected CPT/HCPCS codes from paragraph (i)(3) of this section for each geographic area, a geographic area-specific conversion factor is calculated by dividing the weighted average charge by the weighted average geographically-adjusted RVU. The resulting geographic area conversion factor is divided by the corresponding nationwide conversion factor determined pursuant to paragraph (i)(3)(i) of this section. The resulting ratios are the geographic area adjustment factors for pathology and laboratory services for each geographic area.

(j) *Observation care facility charges.* When VA provides observation care within the scope of care referred to in paragraph (a)(1) of this section, the facility charges billed for such care will be determined in accordance with the provisions of this paragraph. The charges for this care vary by geographic area and number of hours of care. These charges are calculated as follows:

(1) *Formula.* For each occurrence of observation care, add the nationwide base charge determined pursuant to paragraph (j)(2) of this section to the product of the number of hours in observation care and the hourly charge also determined pursuant to paragraph (j)(2) of this section. Then multiply this amount by the appropriate geographic area adjustment factor determined pursuant to paragraph (j)(3) of this section. The result constitutes the area-specific observation care facility charge.

(2)(i) *Nationwide 80th percentile observation care facility charges.* To calculate nationwide base and hourly facility charges, all claims with observation care line items are selected from the outpatient facility component of the Medicare Standard Analytical File 5 percent Sample. Then, using the 80th percentile observation line item charges for each unique hourly length of stay, a standard linear regression technique is used to calculate the nationwide 80th percentile base charge and 80th percentile hourly charge. Finally, the resulting amounts are each trended forward to the effective time period for the charges, as set forth in paragraph (j)(2)(ii) of this section. The results constitute the nationwide 80th percentile base and hourly facility charges for observation care.

(ii) *Trending forward.* The nationwide 80th percentile base and hourly facility charges for observation care, obtained as described in paragraph (j)(2)(i) of this section, are trended forward based on changes to the outpatient hospital services component of the CPI-U. Actual CPI-U changes are used from the time period of the source data through the latest available month as of the time the calculations are performed. The three-month average annual trend rate as of the latest available month is then held constant to the midpoint of the calendar year in which the charges are primarily expected to be used. The projected total CPI-U change so obtained is then applied to the 80th percentile charges.

(3) *Geographic area adjustment factors.* The geographic area adjustment factors for observation care facility charges are the same as those computed for outpatient facility charges under paragraph (e)(4) of this section.

(k) *Ambulance and other emergency transportation charges.* When VA provides ambulance and other emergency transportation services that are within the scope of care referred to in paragraph (a)(1) of this section, the charges billed for such services will be determined in accordance with the provisions of this paragraph. The charges for these services vary by HCPCS code, length of trip, and geographic area. These charges are calculated as follows:

(1) *Formula.* For each occasion of ambulance or other emergency transportation service, add the nationwide base charge for the appropriate HCPCS code determined pursuant to paragraph (k)(2)(i) of this section to the product of the number of miles traveled and the appropriate HCPCS code mileage charge determined pursuant to paragraph (k)(2)(ii) of this section. Then multiply this amount by the appropriate geographic area adjustment factor determined pursuant to paragraph (k)(3) of this section. The result constitutes the area-specific ambulance or other emergency transportation service charge.

(2)(i) *Nationwide 80th percentile all-inclusive base charge.* To calculate a nationwide all-inclusive base charge, all ambulance and other emergency transportation claims are selected from the outpatient facility component of the Medicare Standard Analytical File 5 percent Sample. Excluding professional and mileage charges, as well as all-inclusive charges which are reported on such claims, the total charge per claim, including incidental supplies, is computed. Then, the 80th percentile amount for each HCPCS code is computed. Finally, the resulting amounts are each trended forward to the effective time period for the charges, as set forth in paragraph (k)(2)(iii) of this section. The results constitute the nationwide 80th percentile all-inclusive base charge for each HCPCS base charge code.

(ii) *Nationwide 80th percentile mileage charge.* To calculate a nationwide mileage charge, all ambulance and other emergency transportation claims are selected from the outpatient facility component of the Medicare Standard Analytical File 5 percent Sample. Excluding professional, incidental, and base charges, as well as claims with all-inclusive charges, the total mileage charge per claim is computed. This amount is divided by the number of miles reported on the claim. Then, the 80th percentile amount for each HCPCS code, using miles as weights, is computed. Finally, the resulting amounts are each trended forward to the effective time period for the charges, as set forth in paragraph (k)(2)(iii) of this section. The results constitute the nationwide 80th percentile mileage charge for each HCPCS mileage code.

(iii) *Trending forward.* The nationwide 80th percentile charge for each HCPCS code, obtained as described in paragraphs (k)(2)(i) and (k)(2)(ii) of this section, is trended forward based on changes to the outpatient hospital services component of the CPI-U. Actual CPI-U changes are used from the time period of the source data through the latest available month as of the time the calculations are performed. The three-month average annual trend rate as of the latest available month is then held constant to the midpoint of the calendar year in which the charges are primarily expected to be used. The projected total CPI-U change so obtained is then applied to the 80th percentile charges.

(3) *Geographic area adjustment factors.* The geographic area adjustment factors for ambulance and other emergency transportation charges are the same as those computed for outpatient facility charges under paragraph (e)(4) of this section.

(l) *Charges for durable medical equipment, drugs, injectables, and other medical services, items, and supplies identified by HCPCS Level II codes.* When VA provides DME, drugs, injectables, or other medical services, items, or supplies that are identified by HCPCS Level II codes and that are within the scope of care referred to in paragraph (a)(1) of this section, the charges billed for such services, items, and supplies will be determined in accordance with the provisions of this paragraph. The charges for these services, items, and supplies vary by geographic area, by HCPCS code, and by modifier, when applicable. These charges are calculated as follows:

(1) *Formula.* For each HCPCS code, multiply the nationwide charge determined pursuant to paragraphs (l)(2), (l)(3), and (l)(4) of this section by the appropriate geographic area adjustment factor determined pursuant to paragraph (l)(5) of this section. The result constitutes the area-specific charge.

(2) *Nationwide 80th percentile charges for HCPCS codes with RVUs.* For each applicable HCPCS code, RVUs are compiled from the data sources set forth in paragraph (l)(2)(i) of this section. The RVUs are multiplied by the charge amount for each incremental RVU determined pursuant to paragraph (l)(2)(ii) of this section, and this amount is added to the fixed charge amount also determined pursuant to paragraph (l)(2)(ii) of this section. Then, for each HCPCS code, this charge is multiplied by the appropriate 80th percentile to median charge ratio determined pursuant to paragraph (l)(2)(iii) of this section. Finally, the resulting amount is trended forward to the effective time period for the charges, as set forth in paragraph

(l)(2)(iv) of this section to obtain the nationwide 80th percentile charge.

(i) *RVUs for DME, drugs, injectables, and other medical services, items, and supplies.* For the purpose of the statistical methodology set forth in paragraph (l)(2)(ii) of this section, HCPCS codes are assigned to the following HCPCS code groups. For the HCPCS codes in each group, the RVUs or amounts indicated constitute the RVUs:

(A) Chemotherapy Drugs: Ingenix/St. Anthony's RBRVS Practice Expense RVUs.

(B) Other Drugs: Ingenix/St. Anthony's RBRVS Practice Expense RVUs.

(C) DME—Hospital Beds: Medicare DME Fee Schedule amounts.

(D) DME—Medical/Surgical Supplies: Medicare DME Fee Schedule amounts.

(E) DME—Orthotic Devices: Medicare DME Fee Schedule amounts.

(F) DME—Oxygen and Supplies: Medicare DME Fee Schedule amounts.

(G) DME—Wheelchairs: Medicare DME Fee Schedule amounts.

(H) Other DME: Medicare DME Fee Schedule amounts.

(I) Enteral/Parenteral Supplies: Medicare Parenteral and Enteral Nutrition Fee Schedule amounts.

(J) Surgical Dressings and Supplies: Medicare DME Fee Schedule amounts.

(K) Vision Items—Other Than Lenses: Medicare DME Fee Schedule amounts.

(L) Vision Items—Lenses: Medicare DME Fee Schedule amounts.

(M) Hearing Items: Ingenix/St. Anthony's RBRVS Practice Expense RVUs.

(ii) *Charge amounts.* Using combined Part B and DME components of the Medicare Standard Analytical File 5% Sample, the median billed charge is calculated for each HCPCS code. A mathematical approximation methodology based on least squares techniques is applied to the RVUs specified for each of the groups set forth in paragraph (l)(2)(i) of this section, yielding two charge amounts for each HCPCS code group: a charge amount per incremental RVU, and a fixed charge amount.

(iii) *80th Percentile to median charge ratios.* Two ratios are obtained for each HCPCS code group set forth in paragraph (l)(2)(i) of this section by dividing the weighted average 80th percentile charge by the weighted average median charge derived from two data sources: Medicare data, as represented by the combined Part B and DME components of the Medicare Standard Analytical File 5% Sample; and the MDR database. Charge frequencies from the Medicare data are used as weights when calculating all weighted averages. For each HCPCS code group, the smaller of the two ratios is selected as the adjustment from median to 80th percentile charges.

(iv) *Trending forward.* The charges for each HCPCS code, obtained as described in paragraph (l)(2)(iii) of this section, are trended forward based on changes to the medical care commodities component of the CPI-U. Actual CPI-U changes are used from the time period of the source data through the latest available month as of the time the calculations are performed. The three-month average annual trend rate as of the latest available month is then held constant to the midpoint of the calendar year in which the charges are primarily expected to be used. The projected total CPI-U change so obtained is then applied to the 80th percentile charges, as described in paragraph (l)(2)(iii) of this section.

(3) *Nationwide 80th percentile charges for HCPCS codes without RVUs.* For each applicable HCPCS code, 80th percentile charges are extracted from three independent data sources: the MDR database; Medicare, as represented by the combined Part B and DME components of the Medicare Standard Analytical File 5 percent Sample; and Milliman USA, Inc., Optimized HMO (Health Maintenance Organization) Data Sets (*see* paragraph (a)(3) of this section for Data Sources). Charges from each database are then trended forward to the effective time period for the charges, as set forth in paragraph (l)(3)(i) of this section. Charges for each HCPCS code from each data source are combined into an average 80th percentile charge by means of the methodology set forth in paragraph (l)(3)(ii) of this section. The results constitute the nationwide 80th percentile charge for each applicable HCPCS code.

(i) *Trending forward.* The charges from each database for each HCPCS code, obtained as described in paragraph (l)(3) of this section, are trended forward based on changes to the medical care commodities component of the CPI-U. Actual CPI-U changes are used from the time period of each source database through the latest available month as of the time the calculations are performed. The three-month average annual trend rate as of the latest available month is then held constant to the midpoint of the calendar year in which the charges are primarily expected to be used. The projected total CPI-U change so obtained is then applied to the 80th percentile charges, as described in paragraph (l)(3) of this section.

(ii) *Averaging methodology.* The average 80th percentile trended charge for any particular HCPCS code is calculated by first computing a preliminary mean average of the three charges for each HCPCS code. Statistical outliers are identified and removed by testing whether any charge differs from the preliminary mean charge by more than 5 times the preliminary mean charge, or by less than 0.2 times the preliminary mean charge. In such cases, the charge most distant from the preliminary mean is removed as an outlier, and the average charge is calculated as a mean of the two remaining charges. In cases where none of the charges differ from the preliminary mean charge by more than 5 times the preliminary mean charge, or less than 0.2 times the preliminary mean charge, the average charge is calculated as a mean of all three reported charges.

(4) *Nationwide 80th percentile charges for HCPCS codes designated as unlisted or unspecified.* For HCPCS codes designated as unlisted or unspecified procedures, services, items, or supplies, 80th percentile charges are developed based on the weighted median 80th percentile charges of HCPCS codes within the series in which the unlisted or unspecified code occurs. A nationwide VA distribution of procedures, services, items, and supplies is used for the purpose of computing the weighted median.

(5) *Geographic area adjustment factors.* For the purpose of geographic adjustment, HCPCS codes are combined into two groups: drugs and DME/supplies, as set forth in paragraph (l)(5)(i) of this section. The geographic area adjustment factor for each of these groups is calculated as the ratio of the area-specific weighted average charge determined pursuant to paragraph (l)(5)(ii) of this section divided by the nationwide weighted average charge determined pursuant to paragraph (l)(5)(iii) of this section.

(i) *Combined HCPCS code groups for geographic area adjustment factors for DME, drugs, injectables, and other medical services, items, and supplies.* For the purpose of the statistical methodology set forth in paragraph (l)(5) of this section, each of the HCPCS code groups set forth in paragraph (l)(2)(i) of this section is assigned to one of two combined HCPCS code groups, as follows:

(A) Chemotherapy Drugs: Drugs.

(B) Other Drugs: Drugs.

(C) DME—Hospital Beds: DME/supplies.

(D) DME—Medical/Surgical Supplies: DME/supplies.

(E) DME—Orthotic Devices: DME/supplies.

(F) DME—Oxygen and Supplies: DME/supplies.

(G) DME—Wheelchairs: DME/supplies.

(H) Other DME: DME/supplies.

(I) Enteral/Parenteral Supplies: DME/supplies.

(J) Surgical Dressings and Supplies: DME/supplies.

(K) Vision Items—Other Than Lenses: DME/supplies.

(L) Vision Items—Lenses: DME/supplies.

(M) Hearing Items: DME/supplies.

(ii) *Area-specific weighted average charges.* Using the median charges by HCPCS code from the MDR database for each geographic area and utilization frequencies by HCPCS code from the combined Part B and DME components of the Medicare Standard Analytical File 5 percent Sample, an area-specific weighted average charge is calculated for each combined HCPCS code group.

(iii) *Nationwide weighted average charges*. Using the area-specific weighted average charges determined pursuant to paragraph (l)(5)(ii) of this section, a nationwide weighted average charge is calculated for each combined HCPCS code group, using as weights the population (census) frequencies for each geographic area as presented in the Milliman USA, Inc., Health Cost Guidelines (see paragraph (a)(3) of this section for Data Sources).

(m) *Charges for prescription drugs not administered during treatment*. Notwithstanding other provisions of this section regarding VA charges, when VA provides or furnishes prescription drugs not administered during treatment, within the scope of care referred to in paragraph (a)(1) of this section, charges billed separately for such prescription drugs will consist of the amount that equals the total of the actual cost to VA for the drugs and the national average of VA administrative costs associated with dispensing the drugs for each prescription. The actual VA cost of a drug will be the actual amount expended by the VA facility for the purchase of the specific drug. The administrative cost will be determined annually using VA's managerial cost accounting system. Under this accounting system, the average administrative cost is determined by adding the total VA national drug general overhead costs (such as costs of buildings and maintenance, utilities, billing, and collections) to the total VA national drug dispensing costs (such as costs of the labor of the pharmacy department, packaging, and mailing) with the sum divided by the actual number of VA prescriptions filled nationally. Based on this accounting system, VA will determine the amount of the average administrative cost annually for the prior fiscal year (October through September) and then apply the charge at the start of the next calendar year.

NOTE TO §17.101: The charges generated by the methodology set forth in this section are the same charges prescribed by the Office of Management and Budget for use under the Federal Medical Care Recovery Act, 42 U.S.C. 2651–2653.

(Authority: 38 U.S.C. 101, 501, 1701, 1705, 1710, 1721, 1722, 1729)

(The Office of Management and Budget has approved the information collection requirements in this section under control number 2900–0606)

[68 FR 70715, Dec. 19, 2003, as amended at 69 FR 1061, Jan. 7, 2004; 72 FR 68072, Dec. 4, 2007; 75 FR 61623, Oct. 6, 2010]

§ 17.102 Charges for care or services.

Except as provided in §17.101, charges at the indicated rates shall be made for Department of Veterans Affairs hospital care or medical services (including, but not limited to, dental services, supplies, medicines, orthopedic and prosthetic appliances, and domiciliary or nursing home care) as follows:

(a) *Furnished in error or on tentative eligibility*. Charges at rates prescribed by the Under Secretary for Health shall be made for inpatient or outpatient care or services (including domiciliary care) authorized for any person on the basis of eligibility as a veteran or a tentative eligibility determination under §17.34 but he or she was subsequently found to have been ineligible for such care or services as a veteran because the military service or any other eligibility requirement was not met, or

(b) *Furnished in a medical emergency*. Charges at rates prescribed by the Under Secretary for Health shall be made for any inpatient or outpatient care or services rendered any person in a medical emergency who was not eligible for such care or services as a veteran, if:

(1) The care or services were rendered as a humanitarian service, under §17.43(b)(1) or §17.95 to a person neither claiming eligibility as a veteran nor for whom the establishment of eligibility as a veteran was expected, or

(2) The person for whom care or services were rendered was a Department of Veterans Affairs employee or a member of a Department of Veterans Affairs employee's family; or

(c) *Furnished beneficiaries of the Department of Defense or other Federal agencies*. Except as provided for in paragraph (f) of this section and the second sentence of this paragraph,

charges at rates prescribed by the Office of Management and Budget shall be made for any inpatient or outpatient care or services authorized for a member of the Armed Forces on active duty or for any beneficiary or designee of any other Federal agency. Charges for services provided a member or former member of a uniformed service who is entitled to retired or retainer pay, or equivalent pay, will be at rates prescribed by the Secretary (E.O. 11609, dated July 22, 1971, 36 FR 13747), or

(d) *Furnished pensioners of allied nations.* Charges at rates prescribed by the Under Secretary for Health shall be made for any inpatient or outpatient care or services rendered a pensioner of a nation allied with the United States in World War I and World War II; or

(e) *Furnished under sharing agreements.* Charges at rates agreed upon in an agreement for sharing specialized medical resources shall be made for all medical care or services, either on an inpatient or outpatient basis, rendered to a person designated by the other party to the agreement as a patient to be benefited under the agreement; or

(f) *Furnished military retirees with chronic disability.* Charges for subsistence at rates prescribed by the Under Secretary for Health shall be made for the period during which hospital care is rendered when such care is rendered to a member or former member of the Armed Forces required to pay the subsistence rate under §17.47 (b)(2) and (c)(2).

(g) *Furnished for research purposes.* Charges will not be made for medical services, including transportation, furnished as part of an approved Department of Veterans Affairs research project, except that if the services are furnished to a person who is not eligible for the services as a veteran, the medical care appropriation shall be reimbursed from the research appropriation at the same rates used for billings under paragraph (b) of this section.

(h) *Computation of charges.* The method for computing the charges under §17.86 and under paragraphs (a), (b), (d), (f), and (g) and the last sentence of paragraph (c) of this section is based on the Monthly Program Cost Report (MPCR), which sets forth the actual basic costs and per diem rates by type of inpatient care, and actual basic costs and rates for outpatient care visits or prescriptions filled. Factors for depreciation of buildings and equipment and Central Office overhead are added, based on accounting manual instructions. Additional factors are added for interest on capital investment and for standard fringe benefit costs covering government employee retirement and disability costs. The current year billing rates are projected on prior year actual rates by applying the budgeted percentage increase. In addition, based on the detail available in the MPCR, VA intends to, on each bill break down the all-inclusive rate into its three principal components; namely, physician cost, ancillary services cost, and nursing, room and board cost. The rates generated by the foregoing methodology will be published by either VA or OMB in the 'Notices' section of the FEDERAL REGISTER.

(Authority: 38 U.S.C. 1729; sec. 19013, Pub. L. 99–272)

[32 FR 11382, Aug. 5, 1967, as amended at 34 FR 7807, May 16, 1969; 35 FR 11470, July 17, 1970; 36 FR 18794, Sept. 22, 1971; 47 FR 50861, Nov. 10, 1982; 47 FR 58249, Dec. 1982; 52 FR 3010, Jan. 30, 1987. Redesignated and amended at 61 FR 21965, 21967, May 13, 1996; 62 FR 17072, Apr. 9, 1997. Redesignated and amended at 64 FR 22678, 22683, Apr. 27, 1999; 69 FR 1061, Jan. 7, 2004; 73 FR 26946, May 12, 2008]

§17.103 Referrals of compromise settlement offers.

Any offer to compromise or settle any charges or claim for $20,000 or less asserted by the Department of Veterans Affairs in connection with the medical program shall be referred as follows:

(a) *To Chiefs of Fiscal activities.* If the debt represents charges made under §17.101(a), the compromise offer shall be referred to the Chief of the Fiscal activity of the facility for application of the collection standards in §1.900 *et seq.* of this chapter, provided:

(1) The debt does not exceed $1,000, and

(2) There has been a previous denial of waiver of the debt by a field station Committee on Waivers and Compromises.

(b) *To Regional Counsel.* If the debt in any amount represents charges for medical services for which there is or may be a claim against a third party tort-feasor or under workers' compensation laws or Pub. L. 87–693; 76 Stat. 593 (see § 1.903 of this chapter) or involves a claim contemplated by § 1.902 of this chapter over which the Department of Veterans Affairs lacks jurisdiction, the compromise offer (or request for waiver or proposal to terminate or suspend collection action) shall be promptly referred to the field station Regional Counsel having jurisdiction in the area in which the claim arose, or

(c) *To Committee on Waivers and Compromises.* If one of the following situations contemplated in paragraph (c)(1) through (3) of this section applies

(1) If the debt represents charges made under § 17.101(a), but is not of a type contemplated in paragraph (a) of this section, or

(2) If the debt represents charges for medical services made under § 17.101(b), or

(3) A claim arising in connection with any transaction of the Veterans Health Administration for which the instructions in paragraph (a) or (b) of this section or in § 17.105(c) are not applicable, then, the compromise offer should be referred for disposition under § 1.900 *et seq.* of this chapter to the field station Committee on Waivers and Compromises which shall take final action.

[39 FR 26403, July 19, 1974, as amended at 47 FR 58250, Dec. 30, 1982. Redesignated and amended at 61 FR 21966, 21967, May 13, 1996; 62 FR 17072, Apr. 9, 1997]

§ 17.104 Terminations and suspensions.

Any proposal to suspend or terminate collection action on any charges or claim for $20,000 or less asserted by the Department of Veterans Affairs in connection with the medical program shall be referred as follows:

(a) *Of charges for medical services.* If the debt represents charges made under § 17.101 (a) or (b) questions concerning suspension or termination of collection action shall be referred to the Chief of the Fiscal activity of the station for application of the collection standards in § 1.900 *et seq.* of this chapter, or

(b) *Of other debts.* If the debt is of a type other than those contemplated in paragraph (a) of this section, questions concerning suspension or termination of collection action shall be referred in accordance with the same referral procedures for compromise offers (except the Fiscal activity shall make final determinations in terminations or suspensions involving claims of $150 or less pursuant to the provisions of § 1.900 *et seq.* of this chapter.)

[34 FR 7807, May 16, 1969, as amended at 39 FR 26403, July 19, 1974. Redesignated and amended at 61 FR 21966, 21967, May 13, 1996]

§ 17.105 Waivers.

Applications or requests for waiver of debts or claims asserted by the Department of Veterans Affairs in connection with the medical program generally will be denied by the facility Fiscal activity on the basis there is no legal authority to waive debts, unless the question of waiver should be referred as follows:

(a) *Of charges for medical services.* If the debt represents charges made under § 17.102, the application or request for waiver should be referred for disposition under § 1.900 *et seq.* of this chapter to the field facility Committee on Waivers and Compromises which shall take final action, or

(b) *Of claims against third persons and other claims.* If the debt is of a type contemplated in § 17.103(b), the waiver question should be referred in accordance with the same referral procedures for compromise offers in such categories of claims, or

(c) *Of charges for copayments.* If the debt represents charges for outpatient medical care, inpatient hospital care, medication or extended care services copayments made under §§ 17.108, 17.110 or 17.111 of this chapter, the claimant must request a waiver by submitting VA Form 5655 (Financial Status Report) to a Fiscal Officer at a VA medical facility where all or part of the debt was incurred. The claimant must submit this form within the time period provided in § 1.963(b) of this chapter and may request a hearing under § 1.966(a) of this chapter. The Fiscal Officer may extend the time period for

submitting a claim if the Chairperson of the Committee on Waivers and Compromises could do so under §1.963(b) of this chapter. The Fiscal Officer will apply the standard ''equity and good conscience'' in accordance with §§1.965 and 1.966(a) of this chapter, and may waive all or part of the claimant's debts. A decision by the Fiscal Officer under this provision is final (except that the decision may be reversed or modified based on new and material evidence, fraud, a change in law or interpretation of law, or clear and unmistakable error shown by the evidence in the file at the time of the prior decision as provided in §1.969 of this chapter) and may be appealed in accordance with 38 CFR parts 19 and 20.

(d) *Other debts*. If the debt represents any claim or charges other than those contemplated in paragraphs (a) and (b) of this section, and is a debt for which waiver has been specifically provided for by law or under the terms of a contract, initial action shall be taken at the station level for referral of the request for waiver through channels for action by the appropriate designated official. If, however, the question of waiver may also involve a concurrent opportunity to negotiate a compromise settlement, the application shall be referred to the Committee on Waivers and Compromises.

(The Office of Management and Budget has approved the information collection requirements in this section under control number 2900–0165)

(Authority: 38 U.S.C. 501, 1721, 1722A, 1724)

[39 FR 26403, July 19, 1974. Redesignated and amended at 61 FR 21966, 21967, May 13, 1996; 69 FR 62204, Oct. 25, 2004]

DISCIPLINARY CONTROL OF BENEFICIARIES RECEIVING HOSPITAL, DOMICILIARY OR NURSING HOME CARE

§17.106 VA response to disruptive behavior of patients.

(a) *Definition*. For the purposes of this section:

VA medical facility means VA medical centers, outpatient clinics, and domiciliaries.

(b) *Response to disruptive patients*. The time, place, and/or manner of the provision of a patient's medical care may be restricted by written order of the Chief of Staff of the VA Medical Center of jurisdiction or his or her designee if:

(1) The Chief of Staff or designee determines pursuant to paragraph (c) of this section that the patient's behavior at a VA medical facility has jeopardized or could jeopardize the health or safety of other patients, VA staff, or guests at the facility, or otherwise interfere with the delivery of safe medical care to another patient at the facility;

(2) The order is narrowly tailored to address the patient's disruptive behavior and avoid undue interference with the patient's care;

(3) The order is signed by the Chief of Staff or designee, and a copy is entered into the patient's permanent medical record;

(4) The patient receives a copy of the order and written notice of the procedure for appealing the order to the Network Director of jurisdiction as soon as possible after issuance; and

(5) The order contains an effective date and any appropriate limits on the duration of or conditions for continuing the restrictions. The Chief of Staff or designee may order restrictions for a definite period or until the conditions for removing conditions specified in the order are satisfied. Unless otherwise stated, the restrictions imposed by an order will take effect upon issuance by the Chief of Staff or designee. Any order issued by the Chief of Staff or designee shall include a summary of the pertinent facts and the bases for the Chief of Staff's or designee's determination regarding the need for restrictions.

(c) *Evaluation of disruptive behavior*. In making determinations under paragraph (b) of this section, the Chief of Staff or designee must consider all pertinent facts, including any prior counseling of the patient regarding his or her disruptive behavior or any pattern of such behavior, and whether the disruptive behavior is a result of the patient's individual fears, preferences, or perceived needs. A patient's disruptive behavior must be assessed in connection with VA's duty to provide good quality care, including care designed to reduce or otherwise clinically address the patient's behavior.

(d) *Restrictions*. The restrictions on care imposed under this section may include but are not limited to:

(1) Specifying the hours in which nonemergent outpatient care will be provided;

(2) Arranging for medical and any other services to be provided in a particular patient care area (*e.g.*, private exam room near an exit);

(3) Arranging for medical and any other services to be provided at a specific site of care;

(4) Specifying the health care provider, and related personnel, who will be involved with the patient's care;

(5) Requiring police escort; or

(6) Authorizing VA providers to terminate an encounter immediately if certain behaviors occur.

(e) *Review of restrictions*. The patient may request the Network Director's review of any order issued under this section within 30 days of the effective date of the order by submitting a written request to the Chief of Staff. The Chief of Staff shall forward the order and the patient's request to the Network Director for a final decision. The Network Director shall issue a final decision on this matter within 30 days. VA will enforce the order while it is under review by the Network Director. The Chief of Staff will provide the patient who made the request written notice of the Network Director's final decision.

NOTE TO §17.106: Although VA may restrict the time, place, and/or manner of care under this section, VA will continue to offer the full range of needed medical care to which a patient is eligible under title 38 of the United States Code or Code of Federal Regulations. Patients have the right to accept or refuse treatments or procedures, and such refusal by a patient is not a basis for restricting the provision of care under this section.

(Authority: 38 U.S.C. 501, 901, 1721)

[75 FR 69883, Nov. 16, 2010]

EFFECTIVE DATE NOTE: At 76 FR 37204,June 24, 2011, §17.106 was redesignated as §17.107 and a new §17.106 was added before the undesignated center heading ''Disciplinary Control of Beneficiaries Receiving Hospital, Domiciliary or Nursing Home Care'' effective July 25, 2011. For the convenience of the user, the added text is set forth as follows:

§17.106 VA collection rules; third-party payers.

(a)(1) *General rule*. VA has the right to recover or collect reasonable charges from a third-party payer for medical care and services provided for a nonservice-connected disability in or through any VA facility to a veteran who is also a beneficiary under the third-party payer's plan. VA's right to recover or collect is limited to the extent that the beneficiary or a nongovernment provider of care or services would be eligible to receive reimbursement or indemnification from the third-party payer if the beneficiary were to incur the costs on the beneficiary's own behalf.

(2) *Definitions*. For the purposes of this section:

Automobile liability insurance means insurance against legal liability for health and medical expenses resulting from personal injuries arising from operation of a motor vehicle. Automobile liability insurance includes:

(A) Circumstances in which liability benefits are paid to an injured party only when the insured party's tortious acts are the cause of the injuries; and

(B) Uninsured and underinsured coverage, in which there is a third-party tortfeasor who caused the injuries (i.e., benefits are not paid on a no-fault basis), but the insured party is not the tortfeasor.

Health-plan contract means any plan, policy, program, contract, or liability arrangement that provides compensation, coverage, or indemnification for expenses incurred by a beneficiary for medical care or services, items, products, and supplies. It includes but is not limited to:

(A) Any plan offered by an insurer, reinsurer, employer, corporation, organization, trust, organized health care group or other entity.

(B) Any plan for which the beneficiary pays a premium to an issuing agent as well as any plan to which the beneficiary is entitled as a result of employment or membership in or association with an organization or group.

(C) Any Employee Retirement Income and Security Act (ERISA) plan.

(D) Any Multiple Employer Trust (MET).

(E) Any Multiple Employer Welfare Arrangement (MEWA).

(F) Any Health Maintenance Organization (HMO) plan, including any such plan with a point-of-service provision or option.

(G) Any individual practice association (IPA) plan.

(H) Any exclusive provider organization (EPO) plan.

(I) Any physician hospital organization (PHO) plan.

(J) Any integrated delivery system (IDS) plan.

(K) Any management service organization (MSO) plan.

(L) Any group or individual medical services account.

(M) Any participating provider organization (PPO) plan or any PPO provision or option of any third-party payer plan.

(N) Any Medicare supplemental insurance plan.

(O) Any automobile liability insurance plan.

(P) Any no fault insurance plan, including any personal injury protection plan or medical payments benefit plan for personal injuries arising from the operation of a motor vehicle.

Medicare supplemental insurance plan means an insurance, medical service or health-plan contract primarily for the purpose of supplementing an eligible person's benefit under Medicare. The term has the same meaning as ''Medicare supplemental policy'' in section 1882(g)(1) of the Social Security Act (42 U.S.C. 1395, *et seq.*) and 42 CFR part 403, subpart B.

No-fault insurance means an insurance contract providing compensation for medical expenses relating to personal injury arising from the operation of a motor vehicle in which the compensation is not premised on who may have been responsible for causing such injury. No-fault insurance includes personal injury protection and medical payments benefits in cases involving personal injuries resulting from operation of a motor vehicle.

Participating provider organization means any arrangement in a third-party payer plan under which coverage is limited to services provided by a select group of providers who are members of the PPO or incentives (for example, reduced copayments) are provided for beneficiaries under the plan to receive health care services from the members of the PPO rather than from other providers who, although authorized to be paid, are not included in the PPO. However, a PPO does not include any organization that is recognized as a health maintenance organization.

Third-party payer means an entity, other than the person who received the medical care or services at issue (first party) and VA who provided the care or services (second party), responsible for the payment of medical expenses on behalf of a person through insurance, agreement or contract. This term includes, but is not limited to the following:

(A) State and local governments that provide such plans other than Medicaid.

(B) Insurance underwriters or carriers.

(C) Private employers or employer groups offering self-insured or partially self-insured medical service or health plans.

(D) Automobile liability insurance underwriter or carrier.

(E) No fault insurance underwriter or carrier.

(F) Workers' compensation program or plan sponsor, underwriter, carrier, or self-insurer.

(G) Any other plan or program that is designed to provide compensation or coverage for expenses incurred by a beneficiary for healthcare services or products.

(H) A third-party administrator.

(b) *Calculating reasonable charges.* (1) The ''reasonable charges'' subject to recovery or collection by VA under this section are calculated using the applicable method for such charges established by VA in 38 CFR 17.101.

(2) If the third-party payer's plan includes a requirement for a deductible or copayment by the beneficiary of the plan, VA will recover or collect reasonable charges less that deductible or copayment amount.

(c) *VA's right to recover or collect is exclusive.* The only way for a third-party payer to satisfy its obligation under this section is to pay the VA facility or other authorized representative of the United States. Payment by a third-party payer to the beneficiary does not satisfy the third-party's obligation under this section.

(1) Pursuant to 38 U.S.C. 1729(b)(2), the United States may file a claim or institute and prosecute legal proceedings against a third-party payer to enforce a right of the United States under 38 U.S.C. 1729 and this section. Such filing or proceedings must be instituted within six years after the last day of the provision of the medical care or services for which recovery or collection is sought.

(2) An authorized representative of the United States may compromise, settle or waive a claim of the United States under this section.

(3) The remedies authorized for collection of indebtedness due the United States under 31 U.S.C. 3701, *et seq.*, 4 CFR parts 101 through 104, 28 CFR part 11, 31 CFR part 900, and 38 CFR part 1, are available to effect collections under this section.

(4) A third-party payer may not, without the consent of a U.S. Government official authorized to take action under 38 U.S.C. 1729 and this part, offset or reduce any payment due under 38 U.S.C. 1729 or this part on the grounds that the payer considers itself due a refund from a VA facility. A written request for a refund must be submitted and adjudicated separately from any other claims submitted to the third-party payer under 38 U.S.C. 1729 or this part.

(d) *Assignment of benefits or other submission by beneficiary not necessary.* The obligation of the third-party payer to pay is not dependent upon the beneficiary executing an assignment of benefits to the United States. Nor is the obligation to pay dependent upon any other submission by the beneficiary to the third-party payer, including any claim or appeal. In any case in which VA makes a claim, appeal, representation, or other filing under the authority of this part, any procedural requirement in any third-party payer plan for the beneficiary of such plan to make

the claim, appeal, representation, or other filing must be deemed to be satisfied. A copy of the completed VA Form 10–10EZ or VA Form 10–10EZR that includes a veteran's insurance declaration will be provided to payers upon request, in lieu of a claimant's statement or coordination of benefits form.

(e) *Preemption of conflicting State laws and contracts.* Any provision of a law or regulation of a State or political subdivision thereof and any provision of any contract or agreement that purports to establish any requirement on a third-party payer that would have the effect of excluding from coverage or limiting payment for any medical care or services for which payment by the third-party payer under 38 U.S.C. 1729 or this part is required, is preempted by 38 U.S.C. 1729(f) and shall have no force or effect in connection with the third-party payer's obligations under 38 U.S.C. 1729 or this part.

(f) *Impermissible exclusions by third-party payers.* (1) *Statutory requirement.* Under 38 U.S.C. 1729(f), no provision of any third-party payer's plan having the effect of excluding from coverage or limiting payment for certain care if that care is provided in or through any VA facility shall operate to prevent collection by the United States.

(2) *General rules.* The following are general rules for the administration of 38 U.S.C. 1729 and this part, with examples provided for clarification. The examples provided are not exclusive. A third-party payer may not reduce, offset, or request a refund for payments made to VA under the following conditions:

(i) Express exclusions or limitations in third-party payer plans that are inconsistent with 38 U.S.C. 1729 are inoperative. For example, a provision in a third-party payer's plan that purports to disallow or limit payment for services provided by a government entity or paid for by a government program (or similar exclusion) is not a permissible ground for refusing or reducing third-party payment.

(ii) No objection, precondition or limitation may be asserted that defeats the statutory purpose of collecting from third-party payers. For example, a provision in a third-party payer's plan that purports to disallow or limit payment for services for which the patient has no obligation to pay (or similar exclusion) is not a permissible ground for refusing or reducing third-party payment.

(iii) Third-party payers may not treat claims arising from services provided in or through VA facilities less favorably than they treat claims arising from services provided in other hospitals. For example, no provision of an employer sponsored program or plan that purports to make ineligible for coverage individuals who are eligible to receive VA medical care and services shall be permissible.

(iv) The lack of a participation agreement or the absence of privity of contract between a third-party payer and VA is not a permissible ground for refusing or reducing third-party payment.

(v) A provision in a third-party payer plan, other than a Medicare supplemental plan, that seeks to make Medicare the primary payer and the plan the secondary payer or that would operate to carve out of the plan's coverage an amount equivalent to the Medicare payment that would be made if the services were provided by a provider to whom payment would be made under Part A or Part B of Medicare is not a permissible ground for refusing or reducing payment as the primary payer to VA by the third-party payer unless the provision expressly disallows payment as the primary payer to all providers to whom payment would not be made under Medicare (including payment under Part A, Part B, a Medicare HMO, or a Medicare Advantage plan).

(vi) A third-party payer may not refuse or reduce third-party payment to VA because VA's claim form did not report hospital acquired conditions (HAC) or present on admission conditions (POA). VA is exempt from the Medicare Inpatient prospective payment system and the Medicare rules for reporting POA or HAC information to third-party payers.

(vii) Health Maintenance Organizations (HMOs) may not exclude claims or refuse to certify emergent and urgent services provided within the HMO's service area or otherwise covered non-emergency services provided out of the HMO's service area. In addition, opt-out or point-of-service options available under an HMO plan may not exclude services otherwise payable under 38 U.S.C. 1729 or this part.

(g) *Records.* Pursuant to 38 U.S.C. 1729(h), VA shall make available for inspection and review to representatives of third-party payers, from which the United States seeks payment, recovery, or collection under 38 U.S.C. 1729, appropriate health care records (or copies of such records) of patients. However, the appropriate records will be made available only for the purposes of verifying the care and services which are the subject of the claim(s) for payment under 38 U.S.C. 1729, and for verifying that the care and services met the permissible criteria of the terms and conditions of the third-party payer's plan. Patient care records will not be made available under any other circumstances to any other entity. VA will not make available to a third-party payer any other patient or VA records.

(Authority: 31 U.S.C. 3711, 38 U.S.C. 501, 1729, 42 U.S.C. 2651)

COPAYMENTS

§ 17.108 Copayments for inpatient hospital care and outpatient medical care.

(a) *General*. This section sets forth requirements regarding copayments for inpatient hospital care and outpatient medical care provided to veterans by VA.

(b) *Copayments for inpatient hospital care*. (1) Except as provided in paragraphs (d) or (e) of this section, a veteran, as a condition of receiving inpatient hospital care provided by VA (provided either directly by VA or obtained by VA by contract), must agree to pay VA (and is obligated to pay VA) the applicable copayment, as set forth in paragraph (b)(2) or (b)(3) of this section.

(2) The copayment for inpatient hospital care shall be, during any 365-day period, a copayment equaling the sum of:

(i) $10 for every day the veteran receives inpatient hospital care, and

(ii) The lesser of:

(A) The sum of the inpatient Medicare deductible for the first 90 days of care and one-half of the inpatient Medicare deductible for each subsequent 90 days of care (or fraction thereof) after the first 90 days of such care during such 365-day period, or

(B) VA's cost of providing the care.

(3) The copayment for inpatient hospital care for veterans enrolled in priority category 7 shall be 20 percent of the amount computed under paragraph (b)(2) of this section.

NOTE TO § 17.108(b): The requirement that a veteran agree to pay the copayment would be met by submitting to VA a signed VA Form 10–10EZ. This is the application form for enrollment in the VA healthcare system and also is the document used for providing means-test information annually.

(c) *Copayments for outpatient medical care*. (1) Except as provided in paragraphs (d), (e) or (f) of this section, a veteran, as a condition of receiving outpatient medical care provided by VA, must agree to pay VA (and is obligated to pay VA) a copayment as set forth in paragraph (c)(2) of this section.

(2) The copayment for outpatient medical care is $15 for a primary care outpatient visit and $50 for a specialty care outpatient visit. If a veteran has more than one primary care encounter on the same day and no specialty care encounter on that day, the copayment amount is the copayment for one primary care outpatient visit. If a veteran has one or more primary care encounters and one or more specialty care encounters on the same day, the copayment amount is the copayment for one specialty care outpatient visit.

(3) For purposes of this section, a primary care visit is an episode of care furnished in a clinic that provides integrated, accessible healthcare services by clinicians who are accountable for addressing a large majority of personal healthcare needs, developing a sustained partnership with patients, and practicing in the context of family and community. Primary care includes, but is not limited to, diagnosis and management of acute and chronic biopsychosocial conditions, health promotion, disease prevention, overall care management, and patient and caregiver education. Each patient's identified primary care clinician delivers services in the context of a larger interdisciplinary primary care team. Patients have access to the primary care clinician and much of the primary care team without need of a referral. In contrast, specialty care is generally provided through referral. A specialty care outpatient visit is an episode of care furnished in a clinic that does not provide primary care, and is only provided through a referral. Some examples of specialty care provided at a specialty care clinic are radiology services requiring the immediate presence of a physician, audiology, optometry, magnetic resonance imagery (MRI), computerized axial tomography (CAT) scan, nuclear medicine studies, surgical consultative services, and ambulatory surgery.

NOTE TO § 17.108(c): The requirement that a veteran agree to pay the copayment would be met by submitting to VA a signed VA Form 10–10EZ. This is the application form for enrollment in the VA healthcare system and also is the document used for providing means-test information annually.

(d) *Veterans not subject to copayment requirements for inpatient hospital care or outpatient medical care*. The following

veterans are not subject to the copayment requirements of this section:

(1) A veteran with a compensable service-connected disability;

(2) A veteran who is a former prisoner of war;

(3) A veteran awarded a Purple Heart;

(4) A veteran who was discharged or released from active military service for a disability incurred or aggravated in the line of duty;

(5) A veteran who receives disability compensation under 38 U.S.C. 1151;

(6) A veteran whose entitlement to disability compensation is suspended pursuant to 38 U.S.C. 1151, but only to the extent that the veteran's continuing eligibility for care is provided for in the judgment or settlement described in 38 U.S.C. 1151;

(7) A veteran whose entitlement to disability compensation is suspended because of the receipt of military retirement pay;

(8) A veteran of the Mexican border period or of World War I;

(9) A military retiree provided care under an interagency agreement as defined in section 113 of Public Law 106–117, 113 Stat. 1545; or

(10) A veteran who VA determines to be unable to defray the expenses of necessary care under 38 U.S.C. 1722(a).

(e) *Services not subject to copayment requirements for inpatient hospital care or outpatient medical care.* The following are not subject to the copayment requirements under this section:

(1) Care provided to a veteran for a noncompensable zero percent service-connected disability;

(2) Care authorized under 38 U.S.C. 1710(e) for Vietnam-era herbicide-exposed veterans, radiation-exposed veterans, Gulf War veterans, or post-Gulf War combat-exposed veterans;

(3) Special registry examinations (including any follow-up examinations or testing ordered as part of the special registry examination) offered by VA to evaluate possible health risks associated with military service;

(4) Counseling and care for sexual trauma as authorized under 38 U.S.C 1720D;

(5) Compensation and pension examinations requested by the Veterans Benefits Administration;

(6) Care provided as part of a VA-approved research project authorized by 38 U.S.C. 7303;

(7) Outpatient dental care provided under 38 U.S.C. 1712;

(8) Readjustment counseling and related mental health services authorized under 38 U.S.C 1712A;

(9) Emergency treatment paid for under 38 U.S.C. 1725 or 1728;

(10) Care or services authorized under 38 U.S.C. 1720E for certain veterans regarding cancer of the head or neck;

(11) Publicly announced VA public health initiatives (*e.g.*, health fairs) or an outpatient visit solely consisting of preventive screening and immunizations (e.g., influenza immunization, pneumonococcal immunization, hypertension screening, hepatitis C screening, tobacco screening, alcohol screening, hyperlipidemia screening, breast cancer screening, cervical cancer screening, screening for colorectal cancer by fecal occult blood testing, and education about the risks and benefits of prostate cancer screening);

(12) Weight management counseling (individual and group);

(13) Smoking cessation counseling (individual and group);

(14) Laboratory services, flat film radiology services, and electrocardiograms; and

(15) Hospice care.

(f) *Additional care not subject to outpatient copayment.* Outpatient care is not subject to the outpatient copayment requirements under this section when provided to a veteran during a day for which the veteran is required to make a copayment for extended care services that were provided either directly by VA or obtained for VA by contract.

(Authority: 38 U.S.C. 1710)

[66 FR 63448, Dec. 6, 2001, as amended at 68 FR 60854, Oct. 24, 2003; 70 FR 22596, May 2, 2005; 73 FR 20532, Apr. 16, 2008; 75 FR 54030, Sept. 3, 2010]

§ 17.110 Copayments for medication.

(a) *General.* This section sets forth requirements regarding copayments for medications provided to veterans by VA.

(b) *Copayments.* (1) *Copayment amount.* Unless exempted under paragraph (c) of this section, a veteran is obligated to

pay VA a copayment for each 30-day or less supply of medication provided by VA on an outpatient basis (other than medication administered during treatment).

(i) For the period from January 1, 2010, through June 30, 2010, the copayment amount is $8.

(ii) For the period from July 1, 2010, through December 31, 2011, the copayment amount for veterans in priority categories 2 through 6 of VA's health care system (*see* § 17.36) is $8.

(iii) For veterans in priority categories 7 and 8 of VA's health care system (see § 17.36), the copayment amount from July 1, 2010, through December 31, 2011, is $9.

(iv) The copayment amount for all affected veterans for each calendar year after December 31, 2011, will be established by using the prescription drug component of the Medical Consumer Price Index as follows: For each calendar year, the Index as of the previous September 30 will be divided by the Index as of September 30, 2001 which was 304.8. The ratio so obtained will be multiplied by the original copayment amount of $7. The copayment amount for the new calendar year will be this result, rounded down to the whole dollar amount.

NOTE TO PARAGRAPH (b)(1)(iv): Example for determining copayment amount. The ratio of the prescription drug component of the Medical Consumer Price Index for September 30, 2005, to the corresponding Index for September 30, 2001 (304.8) was 1.1542. This ratio, when multiplied by the original copayment amount of $7 equals $8.08, and the copayment amount beginning in calendar year 2006, rounded down to the whole dollar amount, was set at $8.

(2) The total amount of copayments in a calendar year for a veteran enrolled in one of the priority categories 2 through 6 of VA's health care system (see § 17.36) shall not exceed the cap established for the calendar year. During the period from January 1, 2010 through December 31, 2011, the cap will be $960. If the copayment amount increases after December 31, 2011, the cap of $960 shall be increased by $120 for each $1 increase in the copayment amount.

(3) *Information on copayment/cap amounts.* Current copayment and cap amounts are available at any VA Medical Center and on our Web site, *http://www.va.gov*. Notice of any increases to the copayment and corresponding increases to annual cap amount will be published in the FEDERAL REGISTER.

(c) *Medication not subject to the copayment requirements.* The following are exempt from the copayment requirements of this section:

(1) Medication for a veteran who has a service-connected disability rated 50% or more based on a service-connected disability or unemployability;

(2) Medication for a veteran's service-connected disability;

(3) Medication for a veteran whose annual income (as determined under 38 U.S.C. 1503) does not exceed the maximum annual rate of VA pension which would be payable to such veteran if such veteran were eligible for pension under 38 U.S.C. 1521;

(4) Medication authorized under 38 U.S.C. 1710(e) for Vietnam-era herbicide-exposed veterans, radiation-exposed veterans, Persian Gulf War veterans, or post-Persian Gulf War combat-exposed veterans;

(5) Medication for treatment of sexual trauma as authorized under 38 U.S.C. 1720D;

(6) Medication for treatment of cancer of the head or neck authorized under 38 U.S.C. 1720E;

(7) Medications provided as part of a VA approved research project authorized by 38 U.S.C. 7303; and

(8) Medication for a veteran who is a former prisoner of war.

(Authority: 38 U.S.C. 501, 1710, 1720D, 1722A)

[66 FR 63451, Dec. 6, 2001, as amended at 74 FR 69285, Dec. 31, 2009; 75 FR 32672, June 9, 2010; 75 FR 54030, Sept. 3, 2010]

§ 17.111 Copayments for extended care services.

(a) *General.* This section sets forth requirements regarding copayments for extended care services provided to veterans by VA (either directly by VA or paid for by VA).

(b) *Copayments.* (1) Unless exempted under paragraph (f) of this section, as a condition of receiving extended care services from VA, a veteran must agree to pay VA and is obligated to pay VA a copayment as specified by this section. A veteran has no obligation to pay a copayment for the first 21 days of

extended care services that VA provided the veteran in any 12-month period (the 12-month period begins on the date that VA first provided extended care services to the veteran). However, for each day that extended care services are provided beyond the first 21 days, a veteran is obligated to pay VA the copayment amount set forth below to the extent the veteran has available resources. Available resources are based on monthly calculations, as determined under paragraph (d) of this section. The following sets forth the extended care services provided by VA and the corresponding copayment amount per day:

(i) Adult day health care—$15.

(ii) Domiciliary care—$5.

(iii) Institutional respite care—$97.

(iv) Institutional geriatric evaluation—$97.

(v) Non-institutional geriatric evaluation—$15.

(vi) Non-institutional respite care—$15.

(vii) Nursing home care—$97.

(2) For purposes of counting the number of days for which a veteran is obligated to make a copayment under this section, VA will count each day that adult day health care, non-institutional geriatric evaluation, and non-institutional respite care are provided and will count each full day and partial day for each inpatient stay except for the day of discharge.

(c) *Definitions*. For purposes of this section:

(1) *Adult day health care* is a therapeutic outpatient care program that provides medical services, rehabilitation, therapeutic activities, socialization, nutrition and transportation services to disabled veterans in a congregate setting.

(2) *Domiciliary care* is defined in § 17.30(b).

(3) *Extended care services* means adult day health care, domiciliary care, institutional geriatric evaluation, non-institutional geriatric evaluation, nursing home care, institutional respite care, and noninstitutional respite care.

(4) *Geriatric evaluation* is a specialized, diagnostic/consultative service provided by an interdisciplinary team that is for the purpose of providing a comprehensive assessment, care plan, and extended care service recommendations.

(5) *Institutional* means a setting in a hospital, domiciliary, or nursing home of overnight stays of one or more days.

(6) *Noninstitutional* means a service that does not include an overnight stay.

(7) *Nursing home care* means the accommodation of convalescents or other persons who are not acutely ill and not in need of hospital care, but who require nursing care and related medical services, if such nursing care and medical services are prescribed by, or are performed under the general direction of, persons duly licensed to provide such care (nursing services must be provided 24 hours a day). Such term includes services furnished in skilled nursing care facilities. Such term excludes hospice care.

(8) *Respite care* means care which is of limited duration, is furnished on an intermittent basis to a veteran who is suffering from a chronic illness and who resides primarily at home, and is furnished for the purpose of helping the veteran to continue residing primarily at home. (Respite providers temporarily replace the caregivers to provide services ranging from supervision to skilled care needs.)

(d) *Effect of the veteran's financial resources on obligation to pay copayment*. (1) A veteran is obligated to pay the copayment to the extent the veteran and the veteran's spouse have available resources. For veterans who have been receiving extended care services for 180 days or less, their available resources are the sum of the income of the veteran and the veteran's spouse, minus the sum of the veterans allowance, the spousal allowance, and expenses. For veterans who have been receiving extended care services for 181 days or more, their available resources are the sum of the value of the liquid assets, the fixed assets, and the income of the veteran and the veteran's spouse, minus the sum of the veterans allowance, the spousal allowance, the spousal resource protection amount, and (but only if the veteran—has a spouse

or dependents residing in the community who is not institutionalized) expenses. When a veteran is legally separated from a spouse, available resources do not include spousal income, expenses, and assets or a spousal allowance.

(2) For purposes of determining available resources under this section:

(i) *Income* means current income (including, but not limited to, wages and income from a business (minus business expenses), bonuses, tips, severance pay, accrued benefits, cash gifts, inheritance amounts, interest income, standard dividend income from non tax deferred annuities, retirement income, pension income, unemployment payments, worker's compensation payments, black lung payments, tort settlement payments, social security payments, court mandated payments, payments from VA or any other Federal programs, and any other income). The amount of current income will be stated in frequency of receipt, e.g., per week, per month.

(ii) *Expenses* means basic subsistence expenses, including current expenses for the following: rent/mortgage for primary residence; vehicle payment for one vehicle; food for veteran, veteran's spouse, and veteran's dependents; education for veteran, veteran's spouse, and veteran's dependents; court-ordered payments of veteran or veteran's spouse (e.g., alimony, child-support); and including the average monthly expenses during the past year for the following: utilities and insurance for the primary residence; out-of-pocket medical care costs not otherwise covered by health insurance; health insurance premiums for the veteran, veteran's spouse, and veteran's dependents; and taxes paid on income and personal property.

(iii) *Fixed Assets* means:

(A) Real property and other non-liquid assets; except that this does not include—

(*1*) Burial plots;

(*2*) A residence if the residence is:

(*i*) The primary residence of the veteran and the veteran is receiving only noninstitutional extended care service; or

(*ii*) The primary residence of the veteran's spouse or the veteran's dependents (if the veteran does not have a spouse) if the veteran is receiving institutional extended care service.

(*3*) A vehicle if the vehicle is:

(*i*) The vehicle of the veteran and the veteran is receiving only noninstitutional extended care service; or

(*ii*) The vehicle of the veteran's spouse or the veteran's dependents (if the veteran does not have a spouse) if the veteran is receiving institutional extended care service.

(B) [Reserved]

(iv) *Liquid assets* means cash, stocks, dividends received from IRA, 401K's and other tax deferred annuities, bonds, mutual funds, retirement accounts (e.g., IRA, 401Ks, annuities), art, rare coins, stamp collections, and collectibles of the veteran, spouse, and dependents. This includes household and personal items (e.g., furniture, clothing, and jewelry) except when the veteran's spouse or dependents are living in the community.

(v) *Spousal allowance* is an allowance of $20 per day that is included only if the spouse resides in the community (not institutionalized).

(vi) *Spousal resource protection* amount means the value of liquid assets but not to exceed $89,280 if the spouse is residing in the community (not institutionalized).

(vii) *Veterans allowance* is an allowance of $20 per day.

(3) The maximum amount of a copayment for any month equals the copayment amount specified in paragraph (b)(1) of this section multiplied by the number of days in the month. The copayment for any month may be less than the amount specified in paragraph (b)(1) of this section if the veteran provides information in accordance with this section to establish that the copayment should be reduced or eliminated.

(e) *Requirement to submit information.* (1) Unless exempted under paragraph (f) of this section, a veteran must submit to a VA medical facility a completed VA Form 10–10EC and documentation requested by the Form at the following times:

(i) At the time of initial request for an episode of extended care services;

(ii) At the time of request for extended care services after a break in

provision of extended care services for more than 30 days; and

(iii) Each year at the time of submission to VA of VA Form 10–10EZ.

(2) When there are changes that might change the copayment obligation (*i.e.*, changes regarding marital status, fixed assets, liquid assets, expenses, income (when received), or whether the veteran has a spouse or dependents residing in the community), the veteran must report those changes to a VA medical facility within 10 days of the change.

(f) *Veterans and care that are not subject to the copayment requirements.* The following veterans and care are not subject to the copayment requirements of this section:

(1) A veteran with a compensable service-connected disability;

(2) A veteran whose annual income (determined under 38 U.S.C. 1503) is less than the amount in effect under 38 U.S.C. 1521(b);

(3) Care for a veteran's noncompensable zero percent service-connected disability;

(4) An episode of extended care services that began on or before November 30, 1999;

(5) Care authorized under 38 U.S.C. 1710(e) for Vietnam-era herbicide-exposed veterans, radiation-exposed veterans, Persian Gulf War veterans, or post-Persian Gulf War combat-exposed veterans;

(6) Care for treatment of sexual trauma as authorized under 38 U.S.C. 1720D; or

(7) Care or services authorized under 38 U.S.C. 1720E for certain veterans regarding cancer of the head or neck.

(g) VA *Form 10–10EC.*

OMB Number: 2900-0629
Estimated Burden: 90 min.

Department of Veterans Affairs

APPLICATION FOR EXTENDED CARE SERVICES

Section I - General Information

1. VETERAN'S NAME *(Last, First, MI)*
2. SOCIAL SECURITY NUMBER

ANSWER YES OR NO WHERE APPLICABLE (OTHERWISE PROVIDE THE REQUESTED INFORMATION)

3. ARE YOU ELIGIBLE FOR MEDICAID? ☐ YES ☐ NO
3A. ARE YOU ENROLLED IN MEDICARE PART A *(Hospital Insurance)* ☐ YES ☐ NO
3B. EFFECTIVE DATE *(If "Yes")*
4. ARE YOU ENROLLED IN MEDICARE PART B *(Medical Insurance)* ☐ YES ☐ NO
4A. EFFECTIVE DATE *(If "Yes")*
4B. MEDICARE CLAIM NUMBER *(If applicable)*

Section II - INSURANCE INFORMATION

5. ARE YOU COVERED BY HEALTH INSURANCE *(including coverage through a spouse)? (If "YES" provide the following information for all insurance company(s) providing coverage to you)* ☐ YES ☐ NO

6. NAME OF INSURANCE COMPANY
6A. ADDRESS OF INSURANCE COMPANY
6B. PHONE NUMBER OF INSURANCE COMPANY
6C. NAME OF POLICY HOLDER
6D. RELATIONSHIP OF POLICY HOLDER
6E. POLICY NUMBER
6F. GROUP NAME AND/OR NUMBER

7. NAME OF INSURANCE COMPANY
7A. ADDRESS OF INSURANCE COMPANY
7B. PHONE NUMBER OF INSURANCE COMPANY
7C. NAME OF POLICY HOLDER
7D. RELATIONSHIP OF POLICY HOLDER
7E. POLICY NUMBER
7F. GROUP NAME AND/OR NUMBER

8. NAME OF INSURANCE COMPANY
8A. ADDRESS OF INSURANCE COMPANY
8B. PHONE NUMBER OF INSURANCE COMPANY
8C. NAME OF POLICY HOLDER
8D. RELATIONSHIP OF POLICY HOLDER
8E. POLICY NUMBER
8F. GROUP NAME AND/OR NUMBER

SECTION III - SPOUSE/DEPENDENT INFORMATION

9. SPOUSE'S NAME *(Last, First, MI)*
9A. SPOUSE RESIDING IN THE COMMUNITY? *(Provide address and phone number if different from veteran)* ☐ YES ☐ NO *(If "No", explain)*
9B. SPOUSE'S SOCIAL SECURITY NUMBER
10. DEPENDENT'S NAME *(Last, First, MI)*
10A. DEPENDENT'S DATE OF BIRTH
10B. DEPENDENT'S SOCIAL SECURITY NUMBER
10C. DEPENDENT RESIDING IN THE COMMUNITY? *(Provide address and phone number if different from veteran)* ☐ YES ☐ NO *(If "No", explain)*
11. DEPENDENT'S NAME *(Last, First, MI)*
11A. DEPENDENT'S DATE OF BIRTH
11B. DEPENDENT'S SOCIAL SECURITY
11C. DEPENDENT RESIDING IN THE COMMUNITY? *(Provide address and phone number if different from veteran)* ☐ YES ☐ NO *(If "No", explain)*

We need to collect information regarding income, assets and expenses for you and your spouse. If you do not wish to provide this information you must sign agreeing to make copayments and will be charged the maximum copayment amount for all services. See the top of page 2, read, sign and date.

VA FORM DEC 2000 **10-10EC**

APPLICATION FOR EXTENDED CARE SERVICES, Continued	VETERAN'S NAME	SOCIAL SECURITY NUMBER

I do not wish to provide my detailed financial information. I understand that I will be assessed the maximum copayment amount for extended care services and agree to pay the applicable VA copayment as required by law.

SIGNATURE	DATE

SECTION IV - FIXED ASSETS *(VETERAN AND SPOUSE))*	VETERAN	SPOUSE
1. Primary Residence *(Market value minus mortgages or liens. Exclude if veteran receiving only non-institutional extended care services or spouse or dependent residing in the community). If the veteran and spouse maintain separate residences, and the veteran is receiving institutional (inpatient) extended care services, include value of the veteran's primary residence.)*	$	$
2. Other Residences/Land/Farm or Ranch *(Market value minus mortgages or liens. This would include a second home, vacation home, rental property.)*	$	$
3. Vehicle(s) *(Value minus any outstanding lien. Exclude primary vehicle if veteran receiving only non-institutional extended care services or spouse or dependent residing in community. If the veteran and spouse maintain separate residences and vehicles, and the veteran is receiving institutional (inpatient) extended care services, include value of the veteran's primary vehicle.)*	$	$
SECTION V - LIQUID ASSETS *(VETERAN AND SPOUSE)*		
1. Cash, Amount in Bank Accounts *(e.g., checking and savings accounts, certificates of deposit, individual retirement accounts, stocks and bonds).*	$	$
2. Value of Other Liquid Assets *(e.g., art, rare coins, stamp collections, collectibles)* Minus the amount you owe on these items. *Exclude household effects, clothing, jewelry, and personal items if veteran receiving only non-institutional extended care services or spouse or dependent residing in the community.*	$	$
SUM OF ALL LINES FIXED AND LIQUID ASSETS — **TOTAL ASSETS**	$	$

SECTION VI - CURRENT GROSS INCOME OF VETERAN AND SPOUSE				
CATEGORY	VETERAN		SPOUSE	
	HOW MUCH	HOW OFTEN	HOW MUCH	HOW OFTEN
1. Gross annual income from employment *(e.g., wages, bonuses, tips, severances pay, accrued benefits)*	$		$	
2. Net income from your farm/ranch, property or business.	$		$	
3. List other income amounts *(e.g., social security, Retirement and pension, interest, dividends)* Refer to instructions.	$		$	

SECTION VII - DEDUCTIBLE EXPENSES	
ITEMS	AMOUNT
1. Educational expenses of veteran, spouse or dependent *(e.g., tuition, books, fees, material, etc.)*	$
2. Funeral and Burial *(spouse or child, amount you paid for funeral and burial expenses, including prepaid arrangements)*	$
3. Rent/Mortgage *(monthly amount or annual amount)*	$
4. Utilities *(calculate by average monthly amounts over the past 12 months)*	$
5. Car Payment for one vehicle only *(exclude gas, automobile insurance, parking fees, repairs)*	$
6. Food *(for veteran, spouse and dependent)*	$
7. Non-reimbursed medical expenses paid by you or spouse *(e.g., copayments for physicians, dentists, medications, Medicare, health insurance, hospital and nursing home expenses)*	$
8. Court-ordered payments *(e.g., alimony, child support)*	$
9. Insurance *(e.g., automobile insurance, homeowners insurance) Exclude Life Insurance*	$
10. Taxes *(e.g., personal property for home, automobile) Include average monthly expense for taxes paid on income over the past 12 months.*	$
TOTALS	$

SECTION VIII - CONSENT FOR ASSIGNMENT OF BENEFITS

I hereby authorize the Department of Veterans Affairs to disclose any such history, diagnostic and treatment information from my medical records to the contractor of any health plan contract under which I am apparently eligible for medical care or payment of the expense of care or to any other party against whom liability is asserted. I understand that I may revoke this authorization at any time, except to the extent that action has already been taken in reliance on it. Without my express revocation, this consent will automatically expire when all action arising from VA's claim for reimbursement for my medical care has been completed. I authorize payment of medical benefits to VA for any services for which payment is accepted.

SIGNATURE	DATE

VA FORM DEC 2002 **10-10EC** *Page 2 of 3*

APPLICATION FOR EXTENDED CARE SERVICES, Continued	VETERANS NAME	SOCIAL SECURITY NUMBER

SECTION IX - CONSENT TO AGREEMENT TO MAKE COPAYMENTS

Completion of this form with signature of the Veteran or veteran's representative is certification that the veteran/representative has received a copy of the Privacy Act Statement and agrees to make appropriate copayments.

I certify the foregoing statement(s) are true and correct to the best of my knowledge and belief and agree to make the applicable copayment for extended care services as required by law.

SIGNATURE	DATE

SECTION X- PAPERWORK PRIVACY ACT INFORMATION

The Paperwork Reduction Act of 1995 requires us to notify you that this information collection is in accordance with the clearance requirements of section 3507 of the Paperwork Reduction Act of 1995. We may not conduct or sponsor, and you are not required to respond to, a collection of information unless it displays a valid OMB number. We anticipate that the time expended by all individuals who must complete this form will average 90 minutes. This includes the time it will take to read instructions, gather the necessary facts and fill out the form. If you have comments regarding this burden estimate or any other aspect of this collection, call 202.273.8247 for mailing information on where to send your comments.

Privacy Act Information: The VA is asking you to provide the information on this form under Title 38, United States Code, sections 1710, 1712, 1722 and 1729 in order for VA to determine your eligibility for extended care benefits and to establish financial eligibility, if applicable, when placed in extended care services. The information you supply may be verified through a computer-matching program. VA may disclose the information that you put on the form as permitted by law. VA may make a "routine use" disclosure of the information as outlined in the Privacy Act systems of records notices and in accordance with the VHA Notice of Privacy Practices. You do not have to provide the information to VA, but if you don't, VA will be unable to process your request and serve your medical needs. Failure to furnish the information will not have any affect on any other benefits to which you may be entitled. If you provide VA your Social Security Number, VA will use it to administer your VA benefits. VA may also use this information to identify veterans and persons claiming or receiving VA benefits and their records, and for other purposes authorized or required by law.

ADDITIONAL COMMENTS:

VA FORM DEC 2002 **10-10EC** *Page 3 of 3*

(Authority: 38 U.S.C. 101(28), 501, 1701(7), 1710, 1710B, 1720B, 1720D, 1722A)

[67 FR 35040, May 17, 2002; as amended at 69 FR 39846, July 1, 2004]

CEREMONIES

§ 17.112 Services or ceremonies on Department of Veterans Affairs hospital or center reservations.

(a) Services or ceremonies on Department of Veterans Affairs hospital or center reservations are subject to the following limitations:

(1) All activities must be conducted with proper decorum, and not interfere with the care and treatment of patients. Organizations must provide assurance that their members will obey all rules in effect at the hospital or center involved, and act in a dignified and proper manner;

(2) Partisan activities are inappropriate and all activities must be nonpartisan in nature. An activity will be considered partisan and therefore inappropriate if it includes commentary in support of, or in opposition to, or attempts to influence, any current policy of the Government of the United States or any State of the United States. If the activity is closely related to partisan activities being conducted outside the hospital or center reservations, it will be considered partisan and therefore inappropriate.

(b) Requests for permission to hold services or ceremonies will be addressed to the Secretary, or the Director of the Department of Veterans Affairs hospital or center involved. Such applications will describe the proposed activity in sufficient detail to enable a determination as to whether it meets the standards set forth in paragraph (a) of this section. If permission is granted, the Director of the hospital or center involved will assign an appropriate time, and render assistance where appropriate. No organization will be given exclusive permission to use the hospital or center reservation on any particular occasion. Where several requests are received for separate activities, the Director will schedule each so as to avoid overlapping or interference, or require appropriate modifications in the scope or timing of the activity.

[35 FR 2389, Feb. 3, 1970. Redesignated at 61 FR 21966, May 13, 1996, and further redesignated at 67 FR 35040, May 17, 2002]

REIMBURSEMENT FOR LOSS BY NATURAL DISASTER OF PERSONAL EFFECTS OF HOSPITALIZED OR NURSING HOME PATIENTS

§ 17.113 Conditions of custody.

When the personal effects of a patient who has been or is hospitalized or receiving nursing home care in a Department of Veterans Affairs hospital or center were or are duly delivered to a designated location for custody and loss of such personal effects has occurred or occurs by fire, earthquake, or other natural disaster, either during such storage or during laundering, reimbursement will be made as provided in §§ 17.113 and 17.114.

[39 FR 1843, Jan. 15, 1974. Redesignated and amended at 61 FR 21966, 21967, May 13, 1996, and further redesignated at 67 FR 35039, May 17, 2002]

§ 17.114 Submittal of claim for reimbursement.

The claim for reimbursement for personal effects damaged or destroyed will be submitted by the patient to the Director. The patient will separately list and evaluate each article with a notation as to its condition at the time of the fire, earthquake, or other natural disaster *i.e.*, whether new, worn, etc. The date of the fire, earthquake, or other natural disaster will be stated. It will be certified by a responsible official that each article listed was stored in a designated location at the time of loss by fire, earthquake, or other natural disaster or was in process of laundering. The patient will further state whether the loss of each article was complete or partial, permitting of some further use of the article. The responsible official will certify that the amount of reimbursement claimed on each article of personal effects is not in excess of the fair value thereof at time of loss. The certification will be prepared in triplicate, signed by the responsible officer who made it, and countersigned by the Director of the medical center. After the above papers

have been secured, voucher will be prepared, signed, and certified, and forwarded to the Fiscal Officer for approval, payment to be made in accordance with fiscal procedure. The original list of property and certificate are to be attached to voucher.

[39 FR 1843, Jan. 15, 1974, as amended at 49 FR 5616, Feb. 14, 1984. Redesignated at 61 FR 21966, May 13, 1996, and further redesignated at 67 FR 35039, May 17, 2002]

§ 17.115 Claims in cases of incompetent patients.

Where the patient is insane and incompetent, the patient will not be required to make claim for reimbursement for personal effects lost by fire, earthquake, or other natural disaster as required under the provisions of § 17.113. The responsible official will make claim for the patient, adding the certification in all details as provided for in § 17.113. After countersignature of this certification by the Director, payment will be made as provided in § 17.113, and the amount thereby disbursed will be turned over to the Director for custody.

[39 FR 1843, Jan. 15, 1974, as amended at 49 FR 5616, Feb. 14, 1984. Redesignated and amended at 61 FR 21966, 21967, May 13, 1996, and further redesignated at 67 FR 35039, May 17, 2002]

Reimbursement to Employees for the Cost of Repairing or Replacing Certain Personal Property Damaged or Destroyed by Patients or Members

§ 17.116 Adjudication of claims.

Claims comprehended. Claims for reimbursing Department of Veterans Affairs employees for cost of repairing or replacing their personal property damaged or destroyed by patients or members while such employees are engaged in the performance of their official duties will be adjudicated by the Director of the medical center concerned. Such claims will be considered under the following conditions, both of which must have existed and, if either one is lacking, reimbursement or payment for the cost or repair of the damaged article will not be authorized:

(a) The claim must be for an item of personal property normally used by the employee in his or her day to day employment, e.g., eyeglasses, hearing aids, clothing, etc., and,

(b) Such personal property was damaged or destroyed by a patient or domiciliary member while the employee was engaged in the performance of official duties.

Reimbursement or payment as provided in this paragraph will be made in a fair and reasonable amount, taking into consideration the condition and reasonable value of the article at the time it was damaged or destroyed.

[28 FR 5083, May 22, 1963, as amended at 39 FR 1843, Jan. 15, 1974; 49 FR 5616, Feb. 14, 1984. Redesignated and amended at 61 FR 21965, May 13, 1996, and further redesignated at 67 FR 35039, May 17, 2002]

Payment and Reimbursement of the Expenses of Medical Services Not Previously Authorized

§ 17.120 Payment or reimbursement of the expenses of hospital care and other medical services not previously authorized.

To the extent allowable, payment or reimbursement of the expenses of care, not previously authorized, in a private or public (or Federal) hospital not operated by the Department of Veterans Affairs, or of any medical services not previously authorized including transportation (except prosthetic appliances, similar devices, and repairs) may be paid on the basis of a claim timely filed, under the following circumstances:

(a) *For veterans with service connected disabilities.* Care or services not previously authorized were rendered to a veteran in need of such care or services:

(1) For an adjudicated service-connected disability;

(2) For nonservice-connected disabilities associated with and held to be aggravating an adjudicated service-connected disability;

(3) For *any disability* of a veteran who has a total disability permanent in nature resulting from a service-connected disability (does not apply outside of the States, Territories, and possessions of the United State, the District of Columbia, and the Commonwealth of Puerto Rico);

(4) For any illness, injury or dental condition in the case of a veteran who is participating in a rehabilitation program under 38 U.S.C. ch. 31 and who is medically determined to be in need of hospital care or medical services for any of the reasons enumerated in § 17.48(j); and

(Authority: 38 U.S.C. 1724, 1728)

(b) *In a medical emergency*. Care and services not previously authorized were rendered in a medical emergency of such nature that delay would have been hazardous to life or health, and

(c) *When Federal facilities are unavailable*. VA or other Federal facilities were not feasibly available, and an attempt to use them beforehand or obtain prior VA authorization for the services required would not have been reasonable, sound, wise, or practicable, or treatment had been or would have been refused.

(Authority: 38 U.S.C. 1724, 1728, 7304)

[39 FR 1844, Jan. 15, 1974, as amended at 49 FR 5616, Feb. 14, 1984; 51 FR 8672, Mar. 13, 1986; 56 FR 3422, Jan. 30, 1991. Redesignated at 61 FR 21966, May 13, 1996]

§ 17.121 Limitations on payment or reimbursement of the costs of emergency hospital care and medical services not previously authorized.

Claims for payment or reimbursement of the costs of emergency hospital care or medical services not previously authorized will not be approved for any period beyond the date on which the medical emergency ended. For the purpose of payment or reimbursement of the expense of emergency hospital care or medical services not previously authorized, an emergency shall be deemed to have ended at that point when a VA physician has determined that, based on sound medical judgment, a veteran:

(a) Who received emergency hospital care could have been transferred from the non-VA facility to a VA medical center for continuation of treatment for the disability, or

(b) Who received emergency medical services, could have reported to a VA medical center for continuation of treatment for the disability. From that point on, no additional care in a non-VA facility will be approved for payment by VA.

(Authority: 38 U.S.C. 501(c)(1))

[49 FR 15548, Apr. 19, 1984. Redesignated at 61 FR 21966, May 13, 1996]

§ 17.122 Payment or reimbursement of the expenses of repairs to prosthetic appliances and similar devices furnished without prior authorization.

The expenses of repairs to prosthetic appliances, or similar appliances, therapeutic or rehabilitative aids or devices, furnished without prior authorization, but incurred in the care of an adjudicated service-connected disability (or, in the case of a veteran who is participating in a rehabilitation program under 38 U.S.C. ch. 31 and who is determined to be in need of the repairs for any of the reasons enumerated in § 17.47(g)) may be paid or reimbursed on the basis of a timely filed claim, if

(Authority: 38 U.S.C. 1728)

(a) Obtaining the repairs locally was necessary, expedient, and not a matter of preference to using authorized sources, and

(b) The costs were reasonable, except that where it is determined the costs were excessive or unreasonable, the claim may be allowed to the extent the costs were deemed reasonable and disallowed as to the remainder. In no circumstances will any claim for repairs be allowed to the extent the costs exceed $125.

(Authority: 38 U.S.C. 1728, 7304)

[33 FR 19011, Dec. 20, 1968, as amended at 49 FR 5616, Feb. 14, 1984; 51 FR 8672, Mar. 13, 1986. Redesignated and amended at 61 FR 21966, 21967, May 13, 1996]

§ 17.123 Claimants.

A claim for payment or reimbursement of services not previously authorized may be filed by the veteran who received the services (or his/her guardian) or by the hospital, clinic, or community resource which provided the services, or by a person other than the veteran who paid for the services.

[39 FR 1844, Jan. 15, 1974, as amended at 45 FR 53807, Aug. 13, 1980. Redesignated at 61 FR 21966, May 13, 1996]

§ 17.124 Preparation of claims.

Claims for costs of services not previously authorized shall be on such forms as shall be prescribed and shall include the following:

(a) The claimant shall specify the amount claimed and furnish bills, vouchers, invoices, or receipts or other documentary evidence establishing that such amount was paid or is owed, and

(b) The claimant shall provide an explanation of the circumstances necessitating the use of community medical care, services, or supplies instead of Department of Veterans Affairs care, services, or supplies, and

(c) The claimant shall furnish such other evidence or statements as are deemed necessary and requested for adjudication of the claim.

[33 FR 19011, Dec. 20, 1968, as amended at 39 FR 1844, Jan. 15, 1974. Redesignated at 61 FR 21966, May 13, 1996]

§ 17.125 Where to file claims.

Claims for payment or reimbursement of the expenses of services not previously authorized should be filed as follows:

(a) *For services rendered in the U.S.* Claims for the expenses of care or services rendered in the United States, including the Territories or possessions of the United States, should be filed with the Chief, Outpatient Service, or Clinic Director of the VA facility designated as a clinic or jurisdiction which serves the region in which the care or services were rendered.

(Authority: 38 U.S.C. 7304)

(b) *For services rendered in the Philippines.* Claims for the expenses of care or services rendered in the Republic of the Philippines should be filed with the Department of Veterans Affairs Outpatient Clinic (358/00), 2201 Roxas Blvd., Pasay City, 1300, Republic of the Philippines.

(c) *For services rendered in other foreign countries.* Claims for the expenses of care or services rendered in other foreign countries must be mailed to the Health Administration Center, P.O. Box 469063, Denver, CO 80246–9063.

(Authority: 38 U.S.C. 7304)

(d) *For services rendered in Puerto Rico.* Claims for the expenses of care or services rendered in the Commonwealth of Puerto Rico should be filed with the Department of Veterans Affairs Medical and Regional Office Center, San Juan, PR.

[33 FR 19011, Dec. 20, 1968, as amended at 39 FR 1844, Jan. 15, 1974; 45 FR 53807, Aug. 13, 1980; 51 FR 8673, Mar. 13, 1986. Redesignated and amended at 61 FR 21966, 21967, May 13, 1996; 74 FR 30228, June 25, 2009]

§ 17.126 Timely filing.

Claims for payment or reimbursement of the expenses of medical care or services not previously authorized must be filed within the following time limits:

(a) A claim must be filed within 2 years after the date the care or services were rendered (and in the case of continuous care, payment will not be made for any part of the care rendered more than 2 years prior to filing claim), or

(b) In the case of case or services rendered prior to a VA adjudication allowing service-connection:

(1) The claim must be filed within 2 years of the date the veteran was notified by VA of the allowance of the award of service-connection.

(2) VA payment may be made for care related to the service-connected disability received only within a 2-year period prior to the date the veteran filed the original or reopened claim which resulted in the award of service-connection but never prior to the effective date of the award of service-connection within that 2-year period.

(3) VA payment will never be made for any care received beyond this 2-year period whether service connected or not.

(Authority: 38 U.S.C. 7304)

[33 FR 19012, Dec. 20, 1968, as amended at 39 FR 1844, Jan. 15, 1974; 45 FR 53807, Aug. 13, 1980; 51 FR 8673, Mar. 13, 1986. Redesignated at 61 FR 21966, May 13, 1996]

§ 17.127 Date of filing claims.

The date of filing any claim for payment or reimbursement of the expenses of medical care and services not previously authorized shall be the postmark date of a formal claim, or the date of any preceding telephone call,

telegram, or other communication constituting an informal claim.

[39 FR 1844, Jan. 15, 1974. Redesignated at 61 FR 21966, May 13, 1996]

§ 17.128 Allowable rates and fees.

When it has been determined that a veteran has received public or private hospital care or outpatient medical services, the expenses of which may be paid under § 17.120 of this part, the payment of such expenses shall be paid in accordance with §§ 17.55 and 17.56 of this part.

(Authority: Section 233, Pub. L. 99–576)

[63 FR 39515, July 23, 1998]

§ 17.129 Retroactive payments prohibited.

When a claim for payment or reimbursement of expenses of services not previously authorized has not been timely filed in accordance with the provisions of § 17.126, the expenses of any such care or services rendered prior to the date of filing the claim shall not be paid or reimbursed. In no event will a bill or claim be paid or allowed for any care or services rendered prior to the effective date of any law, or amendment to the law, under which eligibility for the medical services at Department of Veterans Affairs expense has been established.

[39 FR 1844, Jan. 15, 1974. Redesignated and amended at 61 FR 21966, 21968, May 13, 1996]

§ 17.130 Payment for treatment dependent upon preference prohibited.

No reimbursement or payment of services not previously authorized will be made when such treatment was procured through private sources in preference to available Government facilities.

[39 FR 1844, Jan. 15, 1974. Redesignated at 61 FR 21966, May 13, 1996]

§ 17.131 Payment of abandoned claims prohibited.

Any informal claim for the payment or reimbursement of medical expenses which is not followed by a formal claim, or any formal claim which is not followed by necessary supporting evidence, within 1 year from the date of the request for a formal claim or supporting evidence shall be deemed abandoned, and payment or reimbursement shall not be authorized on the basis of such abandoned claim or any future claim for the same expenses. For the purpose of this section, time limitations shall be computed from the date following the date of request for a formal claim or supporting evidence.

[33 FR 19012, Dec. 20, 1968. Redesignated at 61 FR 21966, May 13, 1996]

§ 17.132 Appeals.

When any claim for payment or reimbursement of expenses of medical care or services rendered in non-Department of Veterans Affairs facilities or from non-Department of Veterans Affairs resources has been disallowed, the claimant shall be notified of the reasons for the disallowance and of the right to initiate an appeal to the Board of Veterans Appeals by filing a Notice of Disagreement, and shall be furnished such other notices or statements as are required by part 19 of this chapter, governing appeals.

[33 FR 19012, Dec. 20, 1968. Redesignated at 61 FR 21966, May 13, 1996]

RECONSIDERATION OF DENIED CLAIMS

§ 17.133 Procedures.

(a) *Scope*. This section sets forth reconsideration procedures regarding claims for benefits administered by the Veterans Health Administration (VHA). These procedures apply to claims for VHA benefits regarding decisions that are appealable to the Board of Veterans' Appeals (e.g., reimbursement for non-VA care not authorized in advance, reimbursement for beneficiary travel expenses, reimbursement for home improvements or structural alterations, etc.). These procedures do not apply when other regulations providing reconsideration procedures do apply (this includes CHAMPVA (38 CFR 17.270 through 17.278) and spina bifida (38 CFR 17.904) and any other regulations that contain reconsideration procedures). Also, these procedures do not apply to decisions made outside of VHA, such as decisions made by the Veterans Benefits Administration and adopted by VHA for decisionmaking. These procedures are not mandatory,

and a claimant may choose to appeal the denied claim to the Board of Veterans' Appeals pursuant to 38 U.S.C. 7105 without utilizing the provisions of this section. Submitting a request for reconsideration shall constitute a notice of disagreement for purposes of filing a timely notice of disagreement under 38 U.S.C. 7105(b).

(b) *Process*. An individual who disagrees with the initial decision denying the claim in whole or in part may obtain reconsideration under this section by submitting a reconsideration request in writing to the Director of the healthcare facility of jurisdiction within one year of the date of the initial decision. The reconsideration decision will be made by the immediate supervisor of the initial VA decision-maker. The request must state why it is concluded that the decision is in error and must include any new and relevant information not previously considered. Any request for reconsideration that does not identify the reason for the dispute will be returned to the sender without further consideration. The request for reconsideration may include a request for a meeting with the immediate supervisor of the initial VA decision-maker, the claimant, and the claimant's representative (if the claimant wishes to have a representative present). Such a meeting shall only be for the purpose of discussing the issues and shall not include formal procedures (e.g., presentation, cross-examination of witnesses, etc.). The meeting will be taped and transcribed by VA if requested by the claimant and a copy of the transcription shall be provided to the claimant. After reviewing the matter, the immediate supervisor of the initial VA decision-maker shall issue a written decision that affirms, reverses, or modifies the initial decision.

NOTE TO §17.133: The final decision of the immediate supervisor of the initial VA decision-maker will inform the claimant of further appellate rights for an appeal to the Board of Veterans' Appeals.

(The Office of Management and Budget has approved the information collection requirements in this section under control number 2900–0600)

(Authority: 38 U.S.C. 511, 38 U.S.C. 7105)

[64 FR 44660, Aug. 17, 1999]

DELEGATIONS OF AUTHORITY

§ 17.140 Authority to adjudicate reimbursement claims.

The Department of Veterans Affairs medical installation having responsibility for the fee basis program in the region or territory (including the Republic of the Philippines) served by such medical installation shall adjudicate all claims for the payment or reimbursement of the expenses of services not previously authorized rendered in the region or territory.

[39 FR 1844, Jan. 15, 1974. Redesignated at 61 FR 21966, May 13, 1996]

§ 17.141 Authority to adjudicate foreign reimbursement claims.

The Health Administration Center in Denver, CO, shall adjudicate claims for the payment or reimbursement of the expenses of services not previously authorized rendered in any foreign country except the Republic of the Philippines which will be referred to the VA Outpatient Clinic in Pasay City.

[39 FR 1844, Jan. 15, 1974, as amended at 45 FR 6938, Jan. 31, 1980. Redesignated and amended at 61 FR 21966, 21968, May 13, 1996; 74 FR 30228, June 25, 2009]

§ 17.142 Authority to approve sharing agreements, contracts for scarce medical specialist services and contracts for other medical services.

The Under Secretary for Health is delegated authority to enter into

(a) Sharing agreements authorized under the provisions of 38 U.S.C. 8153 and §17.210 and which may be negotiated pursuant to the provisions of 41 CFR 8–3.204(c);

(b) Contracts with schools and colleges of medicine, osteopathy, dentistry, podiatry, optometry, and nursing, clinics, and any other group or individual capable of furnishing such services to provide scarce medical specialist services at Department of Veterans Affairs health care facilities (including, but not limited to, services of physicians, dentists, podiatrists, optometrists, nurses, physicians' assistants, expanded function dental auxiliaries, technicians, and other medical support personnel); and

(c) When a sharing agreement or contract for scarce medical specialist services is not warranted, contracts authorized under the provisions of 38 U.S.C. 513 for medical and ancillary services. The authority under this section generally will be exercised by approval of proposed contracts or agreements negotiated at the health care facility level. Such approval, however, will not be necessary in the case of any purchase order or individual authorization for which authority has been delegated in § 17.99. All such contracts and agreements will be negotiated pursuant to 41 CFR chapters 1 and 8.

(Authority: 38 U.S.C. 512, 513, 7409, 8153)

[45 FR 6938, Jan. 31, 1980. Redesignated at 61 FR 21966, May 13, 1996, as amended at 62 FR 17072, Apr. 9, 1997]

PROSTHETIC, SENSORY, AND REHABILITATIVE AIDS

§ 17.149 Sensori-neural aids.

(a) Notwithstanding any other provision of this part, VA will furnish needed sensori-neural aids (*i.e.*, eyeglasses, contact lenses, hearing aids) only to veterans otherwise receiving VA care or services and only as provided in this section.

(b) VA will furnish needed sensori-neural aids (*i.e.*, eyeglasses, contact lenses, hearing aids) to the following veterans:

(1) Those with a compensable service-connected disability;

(2) Those who are former prisoners of war;

(3) Those awarded a Purple Heart;

(4) Those in receipt of benefits under 38 U.S.C. 1151;

(5) Those in receipt of increased pension based on the need for regular aid and attendance or by reason of being permanently housebound;

(6) Those who have a visual or hearing impairment that resulted from the existence of another medical condition for which the veteran is receiving VA care, or which resulted from treatment of that medical condition;

(7) Those with a significant functional or cognitive impairment evidenced by deficiencies in activities of daily living, but not including normally occurring visual or hearing impairments; and

(8) Those visually or hearing impaired so severely that the provision of sensori-neural aids is necessary to permit active participation in their own medical treatment.

(c) VA will furnish needed hearing aids to those veterans who have service-connected hearing disabilities rated 0 percent if there is organic conductive, mixed, or sensory hearing impairment, and loss of pure tone hearing sensitivity in the low, mid, or high-frequency range or a combination of frequency ranges which contribute to a loss of communication ability; however, hearing aids are to be provided only as needed for the service-connected hearing disability.

(Authority: 38 U.S.C. 501,1707(b)

[62 FR 30242, June 3, 1997, as amended at 69 FR 33575, June 16, 2004]

§ 17.150 Prosthetic and similar appliances.

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, may be purchased, made or repaired for any veteran upon a determination of feasibility and medical need, provided:

(a) *As part of outpatient care.* The appliances or repairs are a necessary part of outpatient care for which the veteran is eligible under 38 U.S.C. 1712 and 38 CFR 17.93 (or a necessary part of outpatient care authorized under § 17.94) or

(b) *As part of hospital care.* The appliances or repairs are a necessary part of inpatient care for any service-connected disability or any nonservice-connected disability, if:

(1) The nonservice-connected disability is associated with an aggravating a service-connected disability, or

(2) The nonservice-connected disability is one for which hospital admission was authorized, or

(3) The nonservice-connected disability is associated with and aggravating a nonservice-connected disability for which hospital admission was authorized, or

(4) The nonservice-connected disability is one for which treatment may

be authorized under the provisions of § 17.48(f), or

(c) *As part of domiciliary care.* The appliances or repairs are necessary for continued domiciliary care, or are necessary to treat a member's service-connected disability, or nonservice-connected disability associated with and aggravating a service-connected disability, or

(d) *As part of nursing home care.* The appliances or repairs are a necessary part of nursing home care furnished in facilities under the direct and exclusive jurisdiction of the Department of Veterans Affairs.

[32 FR 13816, Oct. 4, 1967, as amended at 33 FR 12315, Aug. 31, 1968; 34 FR 9341, June 13, 1969; 35 FR 17948, Nov. 21, 1970; 54 FR 34983, Aug. 23, 1989. Redesignated and amended at 61 FR 21966, 21968, May 13, 1996]

§ 17.151 Invalid lifts for recipients of aid and attendance allowance or special monthly compensation.

An invalid lift may be furnished if:

(a) The applicant is a veteran who is receiving (1) special monthly compensation (including special monthly compensation based on the need for aid and attendance) under the provisions of 38 U.S.C. 1114(r), or (2) comparable compensation benefits at the rates prescribed under 38 U.S.C. 1134, or (3) increased pension based on the need for aid and attendance or a greater compensation benefit rather than aid and attendance pension to which he or she has been adjudicated to be presently eligible; and

(b) The veteran has loss, or loss of use, of both lower extremities and at least one upper extremity (loss of use may result from paralysis or other impairment to muscle power and includes all cases in which the veteran cannot use his or her extremities or is medically prohibited from doing so because of a serious disease or disability); and

(c) The veteran has been medically determined incapable of moving himself or herself from his or her bed to a wheelchair, or from his or her wheelchair to his or her bed, without the aid of an attendant, because of the disability involving the use of his or her extremities; and

(d) An invalid lift would be a feasible means by which the veteran could accomplish the necessary maneuvers between bed and wheelchair, and is medically determined necessary.

[33 FR 12315, Aug. 31, 1968, as amended at 36 FR 3117, Feb. 13, 1971; 54 FR 34983, Aug. 23, 1989. Redesignated at 61 FR 21966, May 13, 1996]

§ 17.152 Devices to assist in overcoming the handicap of deafness.

Devices for assisting in overcoming the handicap of deafness (including telecaptioning television decoders) may be furnished to any veteran who is profoundly deaf (rated 80% or more disabled for hearing impairment by the Department of Veterans Affairs) and is entitled to compensation on account of such hearing impairment.

(Authority: 38 U.S.C. 3902)

[53 FR 46607, Nov. 18, 1988. Redesignated at 61 FR 21966, May 13, 1996]

§ 17.153 Training in the use of appliances.

Beneficiaries supplied prosthetic and similar appliances will be additionally entitled to fitting and training in the use of the appliances. Such training will usually be given in Department of Veterans Affairs facilities and by Department of Veterans Affairs employees, but may be obtained under contract if determined necessary.

[26 FR 5871, June 30, 1961. Redesignated at 61 FR 21966, May 13, 1996]

§ 17.154 Dog-guides and equipment for blind.

(a) Blind ex-members of the Armed Forces entitled to disability compensation for a service-connected disability may be furnished a trained dog-guide. In addition, they may be furnished necessary travel expense to and from their places of residence to the point where adjustment to the dog-guide is available and meals and lodging during the period of adjustment, provided they are required to be away from their usual places of residence during the period of adjustment.

(b) Mechanical and/or electronic equipment considered necessary as aids

to overcoming the handicap of blindness may also be supplied to beneficiaries defined in paragraph (a) of this section.

[26 FR 5872, June 30, 1961. Redesignated at 61 FR 21966, May 13, 1996]

AUTOMOTIVE EQUIPMENT AND DRIVER TRAINING

§ 17.155 Minimum standards of safety and quality for automotive adaptive equipment.

(a) The Under Secretary for Health or designee is authorized to develop and establish minimum standards of safety and quality for adaptive equipment provided under 38 U.S.C. chapter 39.

(b) In the performance of this function, the following considerations will apply:

(1) Minimum standards of safety and quality will be developed and promulgated for basic adaptive equipment specifically designed to facilitate operation and use of standard passenger motor vehicles by persons who have specified types of disablement and for the installation of such equipment.

(2) In those instances where custom-built adaptive equipment is designed and installed to meet the peculiar needs of uniquely disabled persons and where the incidence of probable usage is not such as to justify development of formal standards, such equipment will be inspected and, if in order, approved for use by a qualified designee of the Under Secretary for Health.

(3) Adaptive equipment, available to the general public, which is manufactured under standards of safety imposed by a Federal agency having authority to establish the same, shall be deemed to meet required standards for use as adaptive equipment. These include such items as automatic transmissions, power brakes, power steering and other automotive options.

(c) For those items where specific Department of Veterans Affairs standards of safety and quality have not as yet been developed, or where such standards are otherwise provided as with custom-designed or factory option items, authorization of suitable adaptive equipment will not be delayed. Approval of such adaptive equipment, however, shall be subject to the judgment of designated certifying officials that it meets implicit standards of safety and quality adopted by the industry or as later developed by the Department of Veterans Affairs.

[40 FR 8819, Mar. 3, 1975. Redesignated at 61 FR 21966, May 13, 1996, as amended at 62 FR 17072, Apr. 9, 1997]

§ 17.156 Eligibility for automobile adaptive equipment.

Automobile adaptive equipment may be authorized if the Under Secretary for Health or designee determines that such equipment is deemed necessary to insure that the eligible person will be able to operate the automobile or other conveyance in a manner consistent with such person's safety and so as to satisfy the applicable standards of licensure established by the State of such person's residency or other proper licensing authority.

(a) Persons eligible for adaptive equipment are:

(1) Veterans who are entitled to receive compensation for the loss or permanent loss of use of one or both feet; or the loss or permanent loss of use of one or both hands; or ankylosis of one or both knees, or one of both hips if the disability is the result of injury incurred or disease contracted in or aggravated by active military, naval or air service.

(2) Members of the Armed Forces serving on active duty who are suffering from any disability described in paragraph (a)(1) of this section incurred or contracted during or aggravated by active military service are eligible to receive automobile adaptive equipment.

(b) Payment or reimbursement of reasonable costs for the repair, replacement, or reinstallation of adaptive equipment deemed necessary for the operation of the automobile may be authorized by the Under Secretary for Health or designee.

(Authority: 38 U.S.C. 3902)

[53 FR 46607, Nov. 18, 1988. Redesignated at 61 FR 21966, May 13, 1996, as amended at 62 FR 17072, Apr. 9, 1997]

§ 17.157 Definition-adaptive equipment.

The term, adaptive equipment, means equipment which must be part of or added to a conveyance manufactured for sale to the general public to make it safe for use by the claimant, and enable that person to meet the applicable standards of licensure. Adaptive equipment includes any term specified by the Under Secretary for Health or designee as ordinarily necessary for any of the classes of losses or combination of such losses specified in § 17.156 of this part, or as deemed necessary in an individual case. Adaptive equipment includes, but is not limited to, a basic automatic transmission, power steering, power brakes, power window lifts, power seats, air-conditioning equipment when necessary for the health and safety of the veteran, and special equipment necessary to assist the eligible person into or out of the automobile or other conveyance, regardless of whether the automobile or other conveyance is to be operated by the eligible person or is to be operated for such person by another person; and any modification of the interior space of the automobile or other conveyance if needed because of the physical condition of such person in order for such person to enter or operate the vehicle.

(Authority: 38 U.S.C. 3901, 3902)

[53 FR 46608, Nov. 18, 1988. Redesignated and amended at 61 FR 21966, 21968, May 13, 1996]

§ 17.158 Limitations on assistance.

(a) An eligible person shall not be entitled to adaptive equipment for more than two automobiles or other conveyances at any one time or during any four-year period except when due to circumstances beyond control of such person, one of the automobiles or conveyances for which adaptive equipment was provided during the applicable four-year period is no longer available for the use of such person.

(1) Circumstances beyond the control of the eligible person are those where the vehicle was lost due to fire, theft, accident, court action, or when repairs are so costly as to be prohibitive or a different vehicle is required due to a change in the eligible person's physical condition.

(2) For purposes of paragraph (a)(1) of this section, an eligible person shall be deemed to have access to and use of an automobile or other conveyance for which the Department of Veterans Affairs has provided adaptive equipment if that person has sold, given or transferred the vehicle to a spouse, family member or other person residing in the same household as the eligible person, or to a business owned by such person.

(Authority: 38 U.S.C. 3903)

(b) Eligible persons may be reimbursed for the actual cost of adaptive equipment subject to a dollar amount for specific items established from time to time by the Under Secretary for Health.

(Authority: 38 U.S.C. 3902)

(c) Reimbursement for a repair to an item of adaptive equipment is limited to the current vehicles of record and only to the basic components authorized as automobile adaptive equipment. Reimbursable amounts for repairs are limited to the cost of parts and labor based on the amounts published in generally acceptable commercial estimating guides for domestic automobiles.

(Authority: 38 U.S.C. 3902)

[53 FR 46608, Nov. 18, 1988. Redesignated and amended at 61 FR 21966, 21968, May 13, 1996]

§ 17.159 Obtaining vehicles for special driver training courses.

The Secretary may obtain by purchase, lease, gift or otherwise, any automobile, motor vehicle, or other conveyance deemed necessary to conduct special driver training courses at Department of Veterans Affairs health care facilities. The Secretary may sell, assign, transfer or convey any such automobile, vehicle or conveyance to which the Department of Veterans Affairs holds title for such price or under such terms deemed appropriate by the Secretary. Any proceeds received from such disposition shall be credited to

the applicable Department of Veterans Affairs appropriation.

(Authority: 38 U.S.C. 3903(e)(3))

[45 FR 6939, Jan. 31, 1980. Redesignated at 54 FR 46607, Nov. 18, 1988, and further redesignated at 61 FR 21966, May 13, 1996]

DENTAL SERVICES

§ 17.160 Authorization of dental examinations.

When a detailed report of dental examination is essential for a determination of eligibility for benefits, dental examinations may be authorized for the following classes of claimants or beneficiaries:

(a) Those having a dental disability adjudicated as incurred or aggravated in active military, naval, or air service or those requiring examination to determine whether the dental disability is service connected.

(b) Those having disability from disease or injury other than dental, adjudicated as incurred or aggravated in active military, naval, or air service but with an associated dental condition that is considered to be aggravating the basic service-connected disorder.

(c) Those for whom a dental examination is ordered as a part of a general physical examination.

(d) Those requiring dental examination during hospital, nursing home, or domiciliary care.

(e) Those held to have suffered dental injury or aggravation of an existing dental injury, as the result of examination, hospitalization, or medical or surgical (including dental) treatment that had been awarded.

(f) Veterans who are participating in a rehabilitation program under 38 U.S.C. chapter 31 are entitled to such dental services as are professionally determined necessary for any of the reasons enumerated in § 17.47(g).

(Authority: 38 U.S.C. 1712(b); ch. 31)

(g) Those for whom a special dental examination is authorized by the Under Secretary for Health or the Assistant Chief Medical Director for Dentistry.

(h) Persons defined in § 17.60(d).

[13 FR 7162, Nov. 27, 1948, as amended at 21 FR 10388, Dec. 28, 1956; 23 FR 6503, Aug. 22, 1958; 27 FR 11424, Nov. 20, 1962; 29 FR 1463, Jan. 29, 1964; 30 FR 1789, Feb. 9, 1965; 32 FR 13817, Oct. 4, 1967; 33 FR 5300, Apr. 3, 1968; 35 FR 6586, Apr. 24, 1970; 49 FR 5617, Feb. 14, 1984. Redesignated and amended at 61 FR 21966, 21968, May 13, 1996]

§ 17.161 Authorization of outpatient dental treatment.

Outpatient dental treatment may be authorized by the Chief, Dental Service, for beneficiaries defined in 38 U.S.C. 1712(b) and 38 CFR 17.93 to the extent prescribed and in accordance with the applicable classification and provisions set forth in this section.

(a) *Class I.* Those having a service-connected compensable dental disability or condition, may be authorized any dental treatment indicated as reasonably necessary to maintain oral health and masticatory function. There is no time limitation for making application for treatment and no restriction as to the number of repeat episodes of treatment.

(b) *Class II.* (1)(i) Those having a service-connected noncompensable dental condition or disability shown to have been in existence at time of discharge or release from active service, which took place after September 30, 1981, may be authorized any treatment indicated as reasonably necessary for the one-time correction of the service-connected noncompensable condition, but only if:

(A) They served on active duty during the Persian Gulf War and were discharged or released, under conditions other than dishonorable, from a period of active military, naval, or air service of not less than 90 days, or they were discharged or released under conditions other than dishonorable, from any other period of active military, naval, or air service of not less than 180 days;

(B) Application for treatment is made within 180 days after such discharge or release.

(C) The certificate of discharge or release does not bear a certification that the veteran was provided, within the 90-day period immediately before such discharge or release, a complete dental examination (including dental X-rays) and all appropriate dental treatment

indicated by the examination to be needed, and

(D) Department of Veterans Affairs dental examination is completed within six months after discharge or release, unless delayed through no fault of the veteran.

(ii) Those veterans discharged from their final period of service after August 12, 1981, who had reentered active military service within 90 days after the date of a discharge or release from a prior period of active military service, may apply for treatment of service-connected noncompensable dental conditions relating to any such periods of service within 180 days from the date of their final discharge or release.

(iii) If a disqualifying discharge or release has been corrected by competent authority, application may be made within 180 days after the date of correction.

(2)(i) Those having a service-connected noncompensable dental condition or disability shown to have been in existence at time of discharge or release from active service, which took place before October 1, 1981, may be authorized any treatment indicated as reasonably necessary for the one-time correction of the service-connected noncompensable condition, but only if:

(A) They were discharged or released, under conditions other than dishonorable, from a period of active military, naval or air service of not less than 180 days.

(B) Application for treatment is made within one year after such discharge or release.

(C) Department of Veterans Affairs dental examination is completed within 14 months after discharge or release, unless delayed through no fault of the veteran.

(ii) Those veterans discharged from their final period of service before August 13, 1981, who had reentered active military service within one year from the date of a prior discharge or release, may apply for treatment of service-connected noncompensable dental conditions relating to any such prior periods of service within one year of their final discharge or release.

(iii) If a disqualifying discharge or release has been corrected by competent authority, application may be made within one year after the date of correction.

(Authority: 38 U.S.C. 1712)

(c) *Class II (a)*. Those having a service-connected noncompensable dental condition or disability adjudicated as resulting from combat wounds or service trauma may be authorized any treatment indicated as reasonably necessary for the correction of such service-connected noncompensable condition or disability.

(Authority: 38 U.S.C. 501; 1712(a)(1)(C))

(d) *Class II(b)*. Certain homeless and other enrolled veterans eligible for a one-time course of dental care under 38 U.S.C. 2062.

(Authority: 38 U.S.C. 2062; 38 U.S.C. 1712(a)(1)(H))

(e) *Class II(c)*. Those who were prisoners of war, as determined by the concerned military service department, may be authorized any needed outpatient dental treatment.

(Authority: Pub. L. 100–322; Pub. L. 108–170; 38 U.S.C. 1712(b)(1)(F))

(f) *Class IIR (Retroactive)*. Any veteran who had made prior application for and received dental treatment from the Department of Veterans Affairs for noncompensable dental conditions, but was denied replacement of missing teeth which were lost during any period of service prior to his/her last period of service may be authorized such previously denied benefits under the following conditions:

(1) Application for such retroactive benefits is made within one year of April 5, 1983.

(2) Existing Department of Veterans Affairs records reflect the prior denial of the claim.

All Class IIR (Retroactive) treatment authorized will be completed on a fee basis status.

(Authority: 38 U.S.C. 1712)

(g) *Class III*. Those having a dental condition professionally determined to be aggravating disability from an associated service-connected condition or disability may be authorized dental

treatment for only those dental conditions which, in sound professional judgment, are having a direct and material detrimental effect upon the associated basic condition or disability.

(h) *Class IV.* Those whose service-connected disabilities are rated at 100% by schedular evaluation or who are entitled to the 100% rate by reason of individual unemployability may be authorized any needed dental treatment.

(Authority: 38 U.S.C. 1712)

(i) *Class V.* A veteran who is participating in a rehabilitation program under 38 U.S.C. chapter 31 may be authorized such dental services as are professionally determined necessary for any of the reasons enumerated in § 17.47(g).

(Authority: 38 U.S.C. 1712(b); chapter 31)

(j) *Class VI.* Any veterans scheduled for admission or otherwise receiving care and services under chapter 17 of 38 U.S.C. may receive outpatient dental care which is medically necessary, *i.e.*, is for dental condition clinically determined to be complicating a medical condition currently under treatment.

(Authority: 38 U.S.C. 1712)

[20 FR 9505, Dec. 20, 1955]

EDITORIAL NOTE: For FEDERAL REGISTER citations affecting § 17.161, see the List of CFR Sections Affected, which appears in the Finding Aids section of the printed volume and at www.fdsys.gov.

§ 17.162 Eligibility for Class II dental treatment without rating action.

When an application has been made for class II dental treatment under § 17.161(b), the applicant may be deemed eligible and dental treatment authorized on a one-time basis without rating action if:

(a) The examination to determine the need for dental care has been accomplished within the specified time limit after date of discharge or release unless delayed through no fault of the veteran, and sound dental judgment warrants a conclusion the condition originated in or was aggravated during service and the condition existed at the time of discharge or release from active service, and

(Authority: 38 U.S.C. 1712)

(b) The treatment will not involve replacement of a missing tooth noted at the time of Department of Veterans Affairs examination except:

(1) In conjunction with authorized extraction replacement, or

(2) When a determination can be made on the basis of sound professional judgment that a tooth was extracted or lost on active duty.

(c) Individuals whose entire tour of duty consisted of active or inactive duty for training shall not be eligible for treatment under this section.

[37 FR 6847, Apr. 5, 1972, as amended at 48 FR 16682, Apr. 19, 1983. Redesignated and amended at 61 FR 21966, 21968, May 13, 1996]

§ 17.163 Posthospital outpatient dental treatment.

The Chief, Dental Service may authorize outpatient dental care which is reasonably necessary to complete treatment of a nonservice-connected dental condition which was begun while the veteran was receiving Department of Veterans Affairs authorized hospital care.

(Authority: 38 U.S.C. 1712(b)(5))

[45 FR 6939, Jan. 31, 1980. Redesignated at 61 FR 21966, May 13, 1996]

§ 17.164 Patient responsibility in making and keeping dental appointments.

Any veteran eligible for dental treatment on a one-time completion basis only and who has not received such treatment within 3 years after filing the application shall be presumed to have abandoned the claim for dental treatment.

[45 FR 6939, Jan. 31, 1980. Redesignated at 61 FR 21966, May 13, 1996]

§ 17.165 Emergency outpatient dental treatment.

When outpatient emergency dental care is provided, as a humanitarian service, to individuals who have no established eligibility for outpatient dental care, the treatment will be restricted to the alleviation of pain or extreme discomfort, or the remediation

of a dental condition which is determined to be endangering life or health. The provision of emergency treatment to persons found ineligible for dental care will not entitle the applicant to further dental treatment. Individuals provided emergency dental care who are found to be ineligible for such care will be billed.

(Authority: 38 U.S.C. 501)

[50 FR 14704, Apr. 15, 1985; 50 FR 21604, May 28, 1985. Redesignated at 61 FR 21966, May 13, 1996]

§ 17.166 Dental services for hospital or nursing home patients and domiciled members.

Persons receiving hospital, nursing home, or domiciliary care pursuant to the provisions of §§ 17.46 and 17.47, will be furnished such dental services as are professionally determined necessary to the patients' or members' overall hospital, nursing home, or domiciliary care.

[30 FR 1790, Feb. 9, 1965. Redesignated at 61 FR 21966, May 13, 1996]

AUTOPSIES

§ 17.170 Autopsies.

(a) Except as provided in this section, no autopsy will be performed by the Department of Veterans Affairs unless there is no known surviving spouse or known next of kin; or without the consent of the surviving spouse or, in a proper case, the next of kin, unless the patient or domiciled person was abandoned by the spouse, if any, or, if no spouse, by the next of kin for a period of not less than 6 months next preceding death. Where no inquiry has been made for or in regard to the decedent for a period of 6 months next preceding his death, he or she shall be deemed to have been abandoned.

(b) If there is no known surviving spouse or known next of kin, or if the decedent shall have been abandoned or if the request is sent and the spouse or, in proper cases, the next of kin fails to reply within the reasonable time stated in such request of the Department of Veterans Affairs for permission to perform the autopsy, the Director is hereby authorized to cause an autopsy to be performed if in the Director's discretion he or she concludes that such autopsy is reasonably required for any necessary purpose of the Department of Veterans Affairs, including the completion of official records and advancement of medical knowledge.

(c) If it is suspected that death resulted from crime and if the United States has jurisdiction over the area where the body is found, the Director of the Department of Veterans Affairs facility will inform the Office of Inspector General of the known facts concerning the death. Thereupon the Office of Inspector General will transmit all such information to the United States Attorney for such action as may be deemed appropriate and will inquire whether the United States Attorney objects to an autopsy if otherwise it be appropriate. If the United States Attorney has no objection, the procedure as to autopsy will be the same as if the death had not been reported to him or her.

(d) If the United States does not have exclusive jurisdiction over the area where the body is found the local medical examiner/coroner will be informed. If the local medical examiner/coroner declines to assume jurisdiction the procedure will be the same as is provided in paragraph (c) of this section. If a Federal crime is indicated by the evidence, the procedure of paragraph (c) of this section will also be followed.

(e) The laws of the decedent's domicile are determinative as to whether the spouse or the next of kin is the proper person to grant permission to perform an autopsy and of the question as to the order of preference among such persons. Usually the spouse is first entitled, except in some situations of separation; followed by children, parents, brothers and sisters, etc. When the next of kin as defined by the laws of decedent's domicile consists of a number of persons as children, parents, brothers and sisters, etc., permission to perform an autopsy may be accepted when granted by the person in the appropriate class who assumes the right and duty of burial.

(f) The Director of a Department of Veterans Affairs facility is authorized to cause an autopsy to be performed on a veteran who dies outside of a Department of Veterans Affairs facility while undergoing post-hospital care under

the provisions of 38 U.S.C. 1712 and 38 CFR 17.93, if the Director determines such autopsy is reasonably required for any necessary purpose of the Department of Veterans Affairs, including the completion of official records and advancement of medical knowledge. Such authority also encompasses the furnishing of transportation of the body at Department of Veterans Affairs expense to the Department of Veterans Affairs facility and return of the body. Consent for the autopsy will be obtained as provided for in paragraph (e) of this section.

[16 FR 5701, June 15, 1951, as amended at 18 FR 2414, Apr. 24, 1953; 24 FR 8330, Oct. 14, 1959; 35 FR 6586, Apr. 24, 1970; 36 FR 23386, Dec. 9, 1971; 45 FR 6939, Jan. 31, 1980. Redesignated and amended at 61 FR 21966, 21968, May 13, 1996; 61 FR 29294, June 10, 1996; 68 FR 17551, Apr. 10, 2003]

VETERANS CANTEEN SERVICE

§ 17.180 Delegation of authority.

In connection with the Veterans Canteen Service, the Under Secretary for Health is hereby delegated authority as follows:

(a) To exercise the powers and functions of the Secretary with respect to the maintenance and operation of the Veterans Canteen Service.

(b) To designate the Assistant Chief Medical Director for Administration to administer the overall operation of the Veterans Canteen Service and to designate selected employees of the Veterans Canteen Service to perform the functions described in the enabling statute, 38 U.S.C. ch. 75, so as to effectively maintain and operate the Veterans Canteen Service.

[20 FR 337, Jan. 14, 1955, as amended at 36 FR 23386, Dec. 9, 1971; 45 FR 6939, Jan 31, 1980. Redesignated at 61 FR 21966, May 13, 1996, as amended at 62 FR 17072, Apr. 9, 1997]

AID TO STATES FOR CARE OF VETERANS IN STATE HOMES

NOTE: Sections 17.190 through 17.200 do not apply to nursing home care in State homes. The provisions for nursing home care in State homes are set forth in 38 CFR part 51.

§ 17.190 Recognition of a State home.

A State-operated facility which provides hospital or domiciliary care to veterans must be formally recognized by the Secretary as a State home before Federal aid payments can be made for the care of such veterans. Any agency of a State (exclusive of a territory or possession) responsible for the maintenance or administration of a State home may apply for recognition by the Department of Veterans Affairs for the purpose of receiving aid for the care of veterans in such State home. A State home may be recognized if:

(Authority: 38 U.S.C. 501, 1741)

(a) The State home is a facility which exists primarily for the accommodation of veterans incapable of earning a living and who are in need of domiciliary, and

(b) The majority of such veterans who are domiciliary members in the home are veterans who may be included in the computation of the amount of aid payable from the Department of Veterans Affairs, and

(c) The personnel, building and other facilities and improvements at the home are devoted primarily to the care of veterans.

[35 FR 3166, Feb. 19, 1970, as amended at 45 FR 6939, Jan. 31, 1980. Redesignated and amended at 61 FR 21966, 21968, May 13, 1996; 65 FR 968, Jan. 6, 2000; 72 FR 18128, Apr. 11, 2007]

§ 17.191 Filing applications.

Applications for Department of Veterans Affairs recognition of a State home may be filed with the Under Secretary for Health, Department of Veterans Affairs. After arranging for an inspection of the State home's facilities for furnishing domiciliary or hospital care, the Under Secretary for Health will make a recommendation to the Secretary who will notify the State official in writing of a decision.

[35 FR 3166, Feb. 19, 1970, as amended at 45 FR 6939, Jan. 31, 1980. Redesignated and amended at 61 FR 21966, 21968, May 13, 1996; 65 FR 968, Jan. 6, 2000]

§ 17.192 Approval of annexes and new facilities.

Separate applications for recognition must be filed for any annex, branch, enlargement, expansion, or relocation of a recognized home which is not on the same or contiguous grounds on which the parent facility is located.

When a recognized State home establishes hospital care facilities which have not been inspected and approved by the Department of Veterans Affairs, a request for separate approval of such facilities must be made.

(Authority: 38 U.S.C. 1741, 501)

[35 FR 3166, Feb. 19, 1970, as amended at 45 FR 6939, Jan. 31, 1980. Redesignated and amended at 61 FR 21966, 21968, May 13, 1996; 65 FR 968, Jan. 6, 2000]

§ 17.193 Prerequisites for payments to State homes.

No payment or grant may be made to any State home unless the State home meets the standards prescribed by the Secretary.

(Authority: 38 U.S.C. 1742(a))

[45 FR 6939, Jan. 31, 1980. Redesignated at 61 FR 21966, May 13, 1996; 65 FR 968, Jan. 6, 2000]

§ 17.194 Aid for domiciliary care.

Aid may be paid to the designated State official for domiciliary care furnished in a recognized State home for any veteran if the veteran is eligible for domiciliary care in a Department of Veterans Affairs facility.

(Authority: 38 U.S.C. 1741)

[45 FR 6939, Jan. 31, 1980. Redesignated at 61 FR 21966, May 13, 1996]

§ 17.196 Aid for hospital care.

Aid may be paid to the designated State official for hospital care furnished in a recognized State home for any veteran if:

(a) The veteran is eligible for hospital care in a Department of Veterans Affairs facility, and

(b) The quarters in which the hospital care is carried out are in an area clearly designated for such care, specifically established, staffed and equipped to provide hospital type care, are not intermingled with the quarters of nursing home care patients or domiciliary members, and meet such other minimum standards as the Department of Veterans Affairs may prescribe.

[45 FR 6940, Jan. 31, 1980. Redesignated at 61 FR 21966, May 13, 1996]

§ 17.197 Amount of aid payable.

The amount of aid payable to a recognized State home shall be at the per diem rates established by title 38 U.S.C., section 1741(a)(1) for domiciliary care; and section 1741(a)(3) for hospital care. In no case shall the payments made with respect to any veteran exceed one-half of the cost of the veteran's care in the State home. VA will publish the actual per diem rates, whenever they change, in a FEDERAL REGISTER notice.

(Authority: 38 U.S.C. 1741)

[50 FR 32568, Aug. 13, 1985. Redesignated at 61 FR 21966, May 13, 1996; 65 FR 968, Jan. 6, 2000]

§ 17.198 Department of Veterans Affairs approval of eligibility required.

Federal aid will be paid only for the care of veterans whose separate eligibility for hospital or domiciliary care has been approved by the Department of Veterans Affairs. To obtain such approval, State homes will complete a Department of Veterans Affairs application form for each veteran for the type of care to be provided and submit it to the Department of Veterans Affairs office of jurisdiction for determination of eligibility. Payments shall be made only from the date the Department of Veterans Affairs office of jurisdiction receives such application; however, if such request is received by the Department of Veterans Affairs office of jurisdiction within 10 days after the beginning of the care of such veteran for which he or she is determined to be eligible, payment shall be made on account of such veteran from the date care began.

(Authority: 38 U.S.C. 1743)

[35 FR 3167, Feb. 19, 1970, as amended at 45 FR 6940, Jan. 31, 1980. Redesignated at 61 FR 21966, May 13, 1996; 65 FR 968, Jan. 6, 2000]

§ 17.199 Inspection of recognized State homes.

Representatives of the Department of Veterans Affairs may inspect any State home at such times as are deemed necessary. Such inspections shall be concerned with the physical plant; records relating to admissions, discharges and occupancy; fiscal records; and all other areas of interest necessary to a determination of compliance with applicable laws and regulations relating to the payment of Federal aid. The authority

to inspect carries with it no authority over the management or control of any State home.

(Authority: 38 U.S.C. 1742)

[30 FR 221, Jan. 8, 1965, as amended at 35 FR 3167, Feb. 19, 1970. Redesignated at 61 FR 21966, May 13, 1996]

§ 17.200 Audit of State homes.

The State must comply with the Single Audit Act of 1984 (part 41 of this chapter).

(Authority: 31 U.S.C. 7501–7507)

[52 FR 23825, June 25, 1987. Redesignated at 61 FR 21966, May 13, 1996]

SHARING OF MEDICAL FACILITIES, EQUIPMENT, AND INFORMATION

§ 17.230 Contingency backup to the Department of Defense.

(a) *Priority care to active duty personnel.* The Secretary, during and/or immediately following a period of war or national emergency declared by the Congress or the President that involves the use of United States Armed Forces in armed conflict, is authorized to furnish hospital care, nursing home care, and medical services to members of the Armed Forces on active duty. The Secretary may give higher priority in the furnishing of such care and services in VA facilities to members of the Armed Forces on active duty than to any other group of persons eligible for such care and services with the exception of veterans with service-connected disabilities.

(Authority: 38 U.S.C. 8111A, Pub. L. 97–174)

(b) *Contract authority.* During a period in which the Secretary is authorized to furnish care and services to members of the Armed Forces under paragraph (a) of this section, the Secretary, to the extent authorized by the President and subject to the availability of appropriations or reimbursements, may authorize VA facilities to enter into contracts with private facilities for the provision during such period of hospital care and medical services for certain veterans. These veterans include only those who are receiving hospital care under 38 U.S.C. 1710 or, in emergencies, for those who are eligible for treatment under that section, or who are receiving care under 38 U.S.C. 1712 (f) and (g). This authorization pertains only to circumstances in which VA facilities are not capable of furnishing or continuing to furnish the care or services required because of the furnishing of care and services to members of the Armed Forces.

(Authority: 38 U.S.C. 8111A)

(Authority: Sec. 501 and 1720(a) of Title 38, U.S.C.)

[49 FR 5617, Feb. 14, 1984. Redesignated at 61 FR 21966, May 13, 1996]

§ 17.240 Sharing specialized medical resources.

Subject to such terms and conditions as the Under Secretary for Health shall prescribe, agreements may be entered into for sharing medical resources with other hospitals, including State or local, public or private hospitals or other medical installations having hospital facilities or organ banks, blood banks, or similar institutions, or medical schools or clinics in a medical community with geographical limitations determined by the Under Secretary for Health, provided:

(a) The agreement will achieve one of the following purposes: (1) It will secure the use of a specialized medical resource which otherwise might not be feasibly available by providing for the mutual use or exchange of use of specialized medical resources when such an agreement will obviate the need for a similar resource to be installed or provided at a facility operated by the Department of Veterans Affairs, or

(2) It will secure effective use of Department of Veterans Affairs specialized medical resources by providing for the mutual use, or exchange of use, of specialized medical resources in a facility operated by the Department of Veterans Affairs, which have been justified on the basis of veterans' care, but which are not utilized to their maximum effective capacity; and

(b) The agreement is determined to be in the best interest of the prevailing standards of the Department of Veterans Affairs Medical Program; and

(c) The agreement provides for reciprocal reimbursement based on a charge which covers the full cost of the use of

specialized medical resources, incidental hospital care or other needed services, supplies used, and normal depreciation and amortization costs of equipment.

(d) Reimbursement for medical care rendered to an individual who is entitled to hospital or medical services (Medicare) under subchapter XVIII of chapter 7 of title 42 U.S.C., and who has no entitlement to medical care from the Department of Veterans Affairs, will be made to such facility, or if the contract or agreement so provides, to the community health care facility which is party to the agreement, in accordance with:

(1) Rates prescribed by the Secretary of Health and Human Services, after consultation with the Secretary of Veterans Affairs, and

(2) Procedures jointly prescribed by the Secretary of Health and Human Services and the Secretary of Veterans Affairs to assure reasonable quality of care and service and efficient and economical utilization of resources.

(Authority: 38 U.S.C. 8153)

[32 FR 6841, May 4, 1967, as amended at 35 FR 18198, Nov. 28, 1970; 39 FR 1846, Jan. 15, 1974; 45 FR 6940, Jan. 31, 1980; 47 FR 58250, Dec. 30, 1982; 54 FR 34983, Aug. 23, 1989. Redesignated at 61 FR 21966, May 13, 1996, as amended at 62 FR 17072, Apr. 9, 1997]

§ 17.241 Sharing medical information services.

(a) *Agreements for exchange of information.* Subject to such terms and conditions as the Under Secretary for Health shall prescribe, Directors of Department of Veterans Affairs medical centers, may enter into agreements with medical schools, Federal, State or local, public or private hospitals, research centers, and individual members of the medical profession, under which medical information and techniques will be freely exchanged and the medical information services of all parties to the agreement will be available for use by any party to the agreement under conditions specified in the agreement.

(b) *Purpose of sharing agreements.* Agreements for the exchange of information shall be used to the maximum extent practicable to create at each Department of Veterans Affairs medical center which has entered into such an agreement, an environment of academic medicine which will help the hospital attract and retain highly trained and qualified members of the medical profession.

(c) *Use of electronic equipment.* Recent developments in electronic equipment shall be utilized under information sharing programs to provide a close educational, scientific, and professional link between Department of Veterans Affairs medical centers and major medical centers.

(d) *Furnishing information services on a fee basis.* The educational facilities and programs established at Department of Veterans Affairs Medical Centers and the electronic link to medical centers shall be made available for use by medical entities in the surrounding medical community which have not entered into sharing agreements with the Department of Veterans Affairs, in order to bring about utilization of all medical information in the surrounding medical community, particularly in remote areas, and to foster and encourage the widest possible cooperation and consultation among all members of the medical profession in the surrounding medical community.

(e) *Establishing fees for information services.* Subject to such terms and conditions as the Under Secretary for Health shall prescribe, Directors of Department of Veterans Affairs medical centers shall charge for information and educational facilities and services made available under paragraph (d) of this section. The fee may be on an annual or other periodic basis, at rates determined, after appropriate study, to be fair and equitable. The financial status of any user of such services shall be taken into consideration in establishing the amount of the fee to be paid.

[32 FR 6841, May 4, 1967, as amended at 47 FR 58250, Dec. 30, 1982. Redesignated at 61 FR 21966, May 13, 1996, as amended at 62 FR 17072, Apr. 9, 1997]

§ 17.242 Coordination of programs with Department of Health and Human Services.

Programs for sharing specialized medical resources or medical information services shall be coordinated to a

maximum extent practicable, with programs carried out under part F, title XVI of the Public Health Service Act under the jurisdiction of the Department of Health and Human Services.

[32 FR 6842, May 4, 1967, as amended at 45 FR 6940, Jan. 31, 1980; 47 FR 58250, Dec. 30, 1982. Redesignated at 61 FR 21966, May 13, 1996]

GRANTS FOR EXCHANGE OF INFORMATION

§ 17.250 Scope of the grant program.

The provisions of § 17.250 through § 17.266 are applicable to grants under 38 U.S.C. 8155 for programs for the exchange of medical information. The purpose of these grants is to assist medical schools, hospitals, and research centers in planning and carrying out agreements for the exchange of medical information, techniques, and information services. The grant funds may be used for the employment of personnel, the construction of facilities, the purchasing of equipment, research, training or demonstration activities when necessary to implement exchange of information agreements.

[33 FR 6011, Apr. 19, 1968. Redesignated and amended at 61 FR 21966, 21968, May 13, 1996]

§ 17.251 The Subcommittee on Academic Affairs.

There is established within the Special Medical Advisory Group authorized under the provisions of 38 U.S.C. 7312 a Subcommittee on Academic Affairs, and the Subcommittee shall advise the Secretary, through the Under Secretary for Health, in matters pertinent to achieving the objectives of programs for exchange of medical information. The Subcommittee shall review each application for a grant and prepare a written report setting forth recommendations as to the final action to be taken on the application.

[42 FR 54804, Oct. 11, 1977. Redesignated at 61 FR 21966, May 13, 1996, as amended at 62 FR 17072, Apr. 9, 1997]

§ 17.252 Ex officio member of subcommittee.

The Assistant Chief Medical Director for Academic Affairs shall be an ex officio member of the Subcommittee on Academic Affairs.

[42 FR 54804, Oct. 11, 1977. Redesignated at 61 FR 21966, May 13, 1996]

§ 17.253 Applicants for grants.

Applicants for grants generally will be persons authorized to represent a medical school, hospital, or research center which has in effect or has tentatively approved an agreement with the Department of Veterans Affairs to exchange medical information.

[33 FR 6011, Apr. 19, 1968. Redesignated at 61 FR 21966, May 13, 1996]

§ 17.254 Applications.

Each application for a grant shall be submitted to the Under Secretary for Health on such forms as shall be prescribed and shall include the following evidence, assurances, and supporting documents:

(a) *To specify amount.* Each application shall show the amount of the grant requested, and if the grant is to be for more than one objective, the amounts allocated to each objective (e.g., to training, demonstrations, or construction) shall be specified, and

(b) *To include copy of agreement.* Each application shall be accompanied by a copy of the agreement for the exchange of information or information services which the grant funds applied for will implement, and

(c) *To include descriptions and plans.* Each application shall include a description of the use to which the grant funds will be applied in sufficient detail to show need, purpose, and justifications, and shall be illustrated by financial and budgetary data, and

(d) *To include cost participation information.* Each application shall show the amount of the grant requested to be used for direct expenses by category of direct expenses, the amount requested for indirect expenses related to the direct expenses, any additional amounts which will be applied to the program or planning from other Federal agencies, and from other sources, and amounts or expenses which will be borne by the applicant, and

(e) *To include assurance records will be kept.* Each application shall include

sufficient assurances that the applicant shall keep records which fully disclose the amount and disposition of the proceeds of the grant, the total cost of the project or undertaking in connection with which the grant is made or used, the portion of the costs supplied by non-Federal sources, and such other records as will facilitate an effective audit. All such records shall be retained by the applicant (grantee) for a period of 3 years after the submission of the final expenditure report, or if litigation, claim or audit is started before the expiration of the 3-year period, the records shall be retained until all litigation, claims or audit findings involving the records have been resolved, and

(f) *To include assurance records will be made available.* Each application shall include sufficient assurances the applicant will give the Secretary and the Comptroller General of the United States, or any of their authorized representatives, access to its books, documents, papers, and records which are pertinent to the grant for the purposes of audit and examination, and

(g) *To include assurance progress reports will be made.* Each application shall include sufficient assurances the applicant will furnish the Under Secretary for Health periodic progress reports in sufficient detail showing the status of the project, planning, program, or system funded by the grant for which application is made, and the extent to which the stated objectives will have been achieved, and

(h) *To include civil rights assurances.* Each application shall include sufficient assurances that no part of the grant funds will be used either by the grantee or by any contractor or subcontractor to be paid from grant funds for any purpose which is inconsistent with regulations promulgated by the Secretary (part 18 of this chapter) implementing title VI of the Civil Rights Act of 1964, or inconsistent with Executive Order 11246 (30 FR 12319) and any implementing regulations the Secretary of Labor may promulgate.

[33 FR 6011, Apr. 19, 1968, as amended at 36 FR 320, Jan. 9, 1971; 42 FR 54804, Oct. 11, 1977. Redesignated and amended at 61 FR 21966, 21969, May 13, 1996]

§ 17.255 Applications for grants for programs which include construction projects.

In addition to the documents and evidence required by § 17.254, any application for a grant for the construction of any facility, structure or system which is part of an exchange of information program shall include the following:

(a) Each application shall include complete descriptions, maps, and surveys of the construction site, and documentary evidence and explanations showing ownership, and

(b) Each application shall include complete plans and specifications for the construction project, and where applicable, sufficient explanations of technical applications so that they may be understood by the layman, and

(c) Each application shall contain assurance that the rates of pay for laborers and mechanics engaged in construction activities will not be less than the prevailing local wage rates for similar work as determined in accordance with the provisions of 40 U.S.C. 276a—276a–5 (The Davis-Bacon Act).

[33 FR 6012, Apr. 19, 1968. Redesignated and amended at 61 FR 21966, 21969, May 13, 1996]

§ 17.256 Amended or supplemental applications.

An amended application, or an application for a supplemental grant, may be considered either before or after final action has been taken on the original application. Amended applications and applications for supplemental grants shall be subject to the same terms, conditions and requirements necessary for original applications.

[33 FR 6012, Apr. 19, 1968. Redesignated at 61 FR 21966, May 13, 1996]

§ 17.257 Awards procedures.

Applications for grants for planning or implementing agreements for the exchange of medical information or information facilities shall be reviewed by the Under Secretary for Health or designee. If it is determined approval of the grant is warranted, recommendations to that effect shall be made to the Secretary in writing and shall be accompanied by the following:

(a) The recommendation for approval shall be accompanied by the written

recommendation of the Subcommittee on Academic Affairs, and

(b) The recommendation for approval shall be accompanied by the written draft of the certificate of award stating all conditions which the grantee is required to agree to under the provisions of § 17.258 and all other conditions to which it has been determined the grant will be subject, and

(c) The recommendation shall include a certification that sufficient appropriated funds are available, and that the application for the grant is sufficient in all details as specified in §§ 17.254 through 17.256.

[33 FR 6012, Apr. 19, 1968, as amended at 42 FR 54805, Oct. 11, 1977. Redesignated and amended at 61 FR 21966, 21969, May 13, 1996]

§ 17.258 Terms and conditions to which awards are subject.

Each certificate of award of a grant for planning or implementing an agreement for the exchange of information or information facilities shall specify that the grant is subject to the following terms and conditions:

(a) *Grants subject to terms of agreement for exchange of information.* Each grant shall be subject to, and the certificate shall incorporate by reference, all terms, conditions, and obligations specified in the agreement or planning protocols which the grant will implement, and

(b) *Grants subject to assurances in application.* Each grant shall be subject to all assurances made by the grantee in its application for the grant as required by §§ 17.254 through 17.256, and

(c) *Grants subject to limitations on use of funds.* Each grant shall be subject to the limitations on the use of grant funds, either for direct or indirect costs, as prescribed in §§ 17.259 through 17.261, and

(d) *Grants subject to special provisions.* Each grant shall be subject to any special terms or conditions which may be warranted by circumstances applicable to individual applications, and specified in the certificate of award.

[33 FR 6012, Apr. 19, 1968. Redesignated and amended at 61 FR 21966, 21969, May 13, 1996]

§ 17.259 Direct costs.

Direct costs to which grant funds may be applied may include in proportion to time and effort spent, but are not limited to, fees and costs directly paid to personnel or for fringe benefits, rent, publications, educational programs, training, research, demonstration activities, or construction carried out in connection with pilot programs for planning or exchange of information.

[33 FR 6012, Apr. 19, 1968. Redesignated at 61 FR 21966, May 13, 1996]

§ 17.260 Patient care costs to be excluded from direct costs.

Grant funds for planning or implementing agreements for the exchange of medical information shall not be available for the payment of any hospital, medical, or other costs involving the care of patients except to the extent that such costs are determined to be incident to research, training, or demonstration activities carried out in connection with an exchange of information program.

[33 FR 6012, Apr. 19, 1968. Redesignated at 61 FR 21966, May 13, 1996]

§ 17.261 Indirect costs.

The grantee shall allocate expenditures as between direct and indirect costs according to generally accepted accounting procedures. The amount allocated for indirect costs may be computed on a percentage basis or on the basis of a negotiated lump-sum allowance. In the method of computation used, only indirect costs shall be included which bear a reasonable relationship to the planning or program funded by the grant and shall not exceed a percentage greater than the percentage the total institutional indirect cost is of the total direct salaries and wages paid by the institution.

[33 FR 6012, Apr. 19, 1968. Redesignated at 61 FR 21966, May 13, 1996]

§ 17.262 Authority to approve applications discretionary.

Notwithstanding any recommendation by the Subcommittee on Academic Affairs of the Special Medical Advisory Group, or any recommendation by the Under Secretary for Health or designee, the final determination on

any application for a grant rests solely with the Secretary.

[42 FR 54805, Oct. 11, 1977. Redesignated and amended at 61 FR 21966, 21969, May 13, 1996]

§ 17.263 Suspension and termination procedures.

Termination of a grant means the cancellation of Department of Veterans Affairs sponsorship, in whole or in part, under an agreement at any time prior to the date of completion. Suspension of a grant is an action by the Department of Veterans Affairs which temporarily suspends Department of Veterans Affairs sponsorship under the grant pending corrective action by the grantee or pending a decision to terminate the grant by the Department of Veterans Affairs.

(a) *Posttermination appeal.* The following procedures are applicable for reviewing postaward disputes which may arise in the administration of or carrying out of the Exchange of Medical Information Grant Program.

(1) *Reviewable decisions.* The Department of Veterans Affairs reserves the right to terminate any grant in whole or in part at any time before the date of completion, whenever it determines that the grantee has failed to comply with conditions of the agreement, or otherwise failed to comply with any law, regulation, assurance, term, or condition applicable to the grant.

(2) *Notice.* The Department of Veterans Affairs shall promptly notify the grantee in writing of the determination. The notice shall set forth the reason for the determination in sufficient detail to enable the grantee to respond, and shall inform the grantee of his or her opportunity for review by the Assistant Chief Medical Director as provided in this section.

(3) *Request for appeal.* A grantee with respect to whom a determination described in paragraph (a)(1) of this section has been made, and who desires review, may file with the Assistant Chief Medical Director for Academic Affairs an application for review of such determination. The grantee's application for review must be post-marked no later than 30 days after the postmarked date of notification provided pursuant to paragraph (a)(2) of this section.

(4) *Contents of request.* The application for review must clearly identify the question or questions in dispute, contain a full statement of the grantee's position in respect to such question or questions, and provide pertinent facts and reasons in support of his or her position. The Assistant Chief Medical Director for Academic Affairs will promptly send a copy of the grantee's application to the Department of Veterans Affairs official responsible for the determination which is to be reviewed.

(5) *Effect of submission.* When an application for review has been filed no action may be taken by the Department of Veterans Affairs pursuant to such determination until such application has been disposed of, except that the filing of the application shall not affect the authority which the constituent agency may have to suspend the system under a grant during proceedings under this section or otherwise to withhold or defer payments under the grant.

(6) *Consideration of request.* When an application for review has been filed with the Assistant Chief Medical Director for Academic Affairs, and it has been determined that the application meets the requirements stated in this paragraph, all background material of the issues shall be reviewed. If the application does not meet the requirements, the grantee shall be notified of the deficiencies.

(7) *Presentation of case.* If the Assistant Chief Medical Director for Academic Affairs believes there is no dispute as to material fact, the resolution of which would be materially assisted by oral testimony, both parties shall be notified of the issues to be considered, and take steps to afford both parties the opportunity for presenting their cases, at the option of the Assistant Chief Medical Director for Academic Affairs, in whole or in part in writing, or in an informal conference. Where it is concluded that oral testimony is required to resolve a dispute over a material fact, both parties shall be afforded an opportunity to present and cross-examine witnesses at a hearing.

(8) *Decision.* After both parties have presented their cases, the Assistant Chief Medical Director for Academic

Affairs shall prepare an initial written decision which shall include findings of fact and conclusions based thereon. Copies of the decision shall be mailed promptly to each of the parties together with a notice informing them of their right to appeal the decision of the Secretary, or to the officer or employee to whom the Secretary has delegated such authority, by submitting written comments thereon within a specified reasonable time.

(9) *Final decision*. Upon filing comments with the Secretary, or designated officer or employee, the review of the initial decision shall be conducted on the basis of the decision, the hearing record, if any, and written comments submitted by both parties. The decision shall be final.

(10) *Participation by a party*. Either party may participate in person, or by counsel pursuant to the procedure set forth in this section.

(b) *Termination for convenience*. The Department of Veterans Affairs or the grantee may terminate a grant in whole or in part when both parties agree that the continuation of the project would not produce beneficial results commensurate with the further expenditure of funds. The two parties shall agree upon the termination conditions, including the effective date and, in the case of partial terminations, the portion to be terminated. The grantee shall not incur new obligations for the terminated portion after the effective date, and shall cancel as many outstanding obligations as possible. The Department of Veterans Affairs shall allow full credit to the grantee for the Department of Veterans Affairs share of the noncancellable obligations, properly incurred by the grantee prior to termination.

(c) *Suspension procedures*. When a grantee has failed to comply with the terms of the grant agreement and conditions or standards, the Department of Veterans Affairs may, on reasonable notice to the grantee, suspend the grant and withhold further payments, prohibit the grantee from incurring additional obligations of funds, pending corrective action by the grantee, or make a decision to terminate as described in paragraph (a) of this section. The Department of Veterans Affairs shall allow all necessary and proper costs that the grantee could not reasonably avoid during the period of suspension provided that they meet the provisions of the applicable Federal cost principles.

[42 FR 54805, Oct. 11, 1977. Redesignated at 61 FR 21966, May 13, 1996]

§ 17.264 Recoupments and releases.

In any case where the Department of Veterans Affairs or a grantee's obligations under an exchange of information agreement implemented by grant funds are terminated, or where grant-financed equipment or facilities cease to be used for the purposes for which grant support was given, or when grant-financed property is transferred, the grantee shall return the proportionate value of such equipment or facility as was financed by the grant. When it is determined the Department of Veterans Affairs equitable interest is greater that proportionate value, then a claim in such greater amount shall be asserted. If it is determined an amount less than proportionate value or less than the Department of Veterans Affairs equitable interest should be recouped, or that the Department of Veterans Affairs should execute any releases, then a proposal concerning such a settlement or releases complete with explanations and justifications shall be submitted to the Assistant Chief Medical Director for Academic Affairs for a final determination.

[42 FR 54805, Oct. 11, 1977. Redesignated at 61 FR 21966, May 13, 1996]

§ 17.265 Payments.

Payments of grant funds are made to grantees through a letter-of-credit, an advance by Treasury check, or a reimbursement by Treasury check, as appropriate. A letter-of-credit is an instrument certified by an authorized official of the Department of Veterans Affairs which authorizes the grantee to draw funds when needed from the Treasury, through a Federal Reserve bank and the grantee's commercial bank and shall be used by the Department of Veterans Affairs where all the following conditions exist:

(a) When there is or will be a continuing relationship between the grantee and the Department of Veterans Affairs for at least a 12-month period and the total amount of advance payments expected to be received within that period is $250,000, or more;

(b) When the grantee has established or demonstrated the willingness and ability to maintain procedures that will minimize the time elapsing between the transfer of funds and their disbursement by the grantee; and

(c) When the grantee's financial management meets the standards for fund control and accountability. An advance by Treasury check is a payment made to a grantee upon its request before outlays are made by the grantee, or through use of predetermined payment schedules and shall be used by the Department of Veterans Affairs when the grantee meets all of the above requirements of this section except that advances will be less than $250,000, or for a period less than 12 months. Reimbursement by Treasury check is a payment made to a grantee upon request for reimbursement from the grantee and shall be the preferred method when the grantee does not meet the requirements of paragraphs (b) and (c) of this section. This method may be used on any construction agreement, or if the major portion of the program is accomplished through private market financing or Federal loans, and the Federal assistance constitutes a minor portion of the program. When the reimbursement method is used, the Department of Veterans Affairs shall make payment within 30 days after receipt of the billing, unless billing is improper. Unless otherwise required by law, payments shall not be withheld for proper charges at any time during the grant period unless a grantee has failed to comply with the program objectives, award conditions, or Federal reporting requirements; or the grantee is indebted.

[42 FR 54806, Oct. 11, 1977. Redesignated at 61 FR 21966, May 13, 1996]

§ 17.266 Copyrights and patents.

If a grant-supported program results in copyrightable material or patentable inventions or discoveries, the United States Government shall have the right to use such publications or inventions on a royalty-free basis.

[33 FR 6013, Apr. 19, 1968. Redesignated at 61 FR 21966, May 13, 1996]

CIVILIAN HEALTH AND MEDICAL PROGRAM OF THE DEPARTMENT OF VETERANS AFFAIRS (CHAMPVA)—MEDICAL CARE FOR SURVIVORS AND DEPENDENTS OF CERTAIN VETERANS

SOURCE: 63 FR 48102, Sept. 9, 1998, unless otherwise noted.

§ 17.270 General provisions.

(a) CHAMPVA is the Civilian Health and Medical Program of the Department of Veterans Affairs and is administered by the Health Administration Center, Denver, Colorado. Pursuant to 38 U.S.C. 1781, VA is authorized to provide medical care in the same or similar manner and subject to the same or similar limitations as medical care furnished to certain dependents and survivors of active duty and retired members of the Armed Forces. The CHAMPVA program is designed to accomplish this purpose. Under CHAMPVA, VA shares the cost of medically necessary services and supplies for eligible beneficiaries as set forth in §§ 17.271 through 17.278.

(b) For purposes of §§ 17.270 through 17.278, the definitions of ''child,'' ''service-connected condition/disability,'' ''spouse,'' and ''surviving spouse'' must be those set forth further in 38 U.S.C. 101. The term ''fiscal year'' refers to October 1, through September 30.

(Authority: 38 U.S.C. 501, 1781)

[63 FR 48102, Sept. 9, 1998, as amended at 73 FR 65553, Nov. 4, 2008]

§ 17.271 Eligibility.

(a) *General entitlement*. The following persons are eligible for CHAMPVA benefits provided that they are not eligible under Title 10 for the TRICARE Program or Part A of Title XVIII of the Social Security Act (Medicare) except as provided in paragraph (b) of this section.

(1) The spouse or child of a veteran who has been adjudicated by VA as having a permanent and total service-connected disability;

(2) The surviving spouse or child of a veteran who died as a result of an adjudicated service-connected condition(s); or who at the time of death was adjudicated permanently and totally disabled from a service-connected condition(s);

(3) The surviving spouse or child of a person who died on active military service and in the line of duty and not due to such person's own misconduct; and

(4) An eligible child who is pursuing a full-time course of instruction approved under 38 U.S.C. Chapter 36, and who incurs a disabling illness or injury while pursuing such course (between terms, semesters or quarters; or during a vacation or holiday period) that is not the result of his or her own willful misconduct and that results in the inability to continue or resume the chosen program of education must remain eligible for medical care until:

(i) The end of the six-month period beginning on the date the disability is removed; or

(ii) The end of the two-year period beginning on the date of the onset of the disability; or

(iii) The twenty-third birthday of the child, whichever occurs first.

(Authority: 38 U.S.C. 501, 1781)

(b) *CHAMPVA and Medicare entitlement.* (1) Individuals under age 65 who are entitled to Medicare Part A and enrolled in Medicare Part B, retain CHAMPVA eligibility as secondary payer to Medicare Parts A and B, Medicare supplemental insurance plans, and Medicare HMO plans.

(2) Individuals age 65 or older, and not entitled to Medicare Part A, retain CHAMPVA eligibility.

NOTE TO PARAGRAPH (b)(2): If the person is not eligible for Part A of Medicare, a Social Security Administration ''Notice of Disallowance'' certifying that fact must be submitted. Additionally, if the individual is entitled to only Part B of Medicare, but not Part A, or Part A through the Premium HI provisions, a copy of the individual's Medicare card or other official documentation noting this must be provided.

(3) Individuals age 65 on or after June 5, 2001, who are entitled to Medicare Part A and enrolled in Medicare Part B, are eligible for CHAMPVA as secondary payer to Medicare Parts A and B, Medicare supplemental insurance plans, and Medicare HMO plans for services received on or after October 1, 2001.

(4) Individuals age 65 or older prior to June 5, 2001, who are entitled to Medicare Part A and who have not purchased Medicare Part B, are eligible for CHAMPVA as secondary payer to Medicare Part A and any other health insurance for services received on or after October 1, 2001.

(5) Individuals age 65 or older prior to June 5, 2001, who are entitled to Medicare Part A and who have purchased Medicare Part B must continue to carry Part B to retain CHAMPVA eligibility as secondary payer for services received on or after October 1, 2001.

(Authority: 38 U.S.C. 501, 1781)

NOTE TO § 17.271: Eligibility criteria specific to Dependency and Indemnity Compensation (DIC) benefits are not applicable to CHAMPVA eligibility determinations.

[63 FR 48102, Sept. 9, 1998, as amended at 67 FR 4359, Jan. 30, 2002; 73 FR 65553, Nov. 4, 2008]

§ 17.272 Benefits limitations/exclusions.

(a) Benefits cover allowable expenses for medical services and supplies that are medically necessary and appropriate for the treatment of a condition and that are not specifically excluded from program coverage. Covered benefits may have limitations. The fact that a physician may prescribe, order, recommend, or approve a service or supply does not, of itself, make it medically necessary or make the charge an allowable expense, even though it is not listed specifically as an exclusion. The following are specifically excluded from program coverage:

(1) Services, procedures or supplies for which the beneficiary has no legal obligation to pay, or for which no charge would be made in the absence of coverage under a health benefits plan.

(2) Services and supplies required as a result of an occupational disease or injury for which benefits are payable under workers' compensation or similar protection plan (whether or not such benefits have been applied for or

paid) except when such benefits are exhausted and are otherwise not excluded from CHAMPVA coverage.

(3) Services and supplies that are paid directly or indirectly by a local, State or Federal government agency (Medicaid excluded), including court-ordered treatment. In the case of the following exceptions, CHAMPVA assumes primary payer status:

(i) Medicaid.

(ii) State Victims of Crime Compensation Programs.

(4) Services and supplies that are not medically or psychologically necessary for the diagnosis or treatment of a covered condition (including mental disorder) or injury.

(5) Radiology, laboratory, and pathological services and machine diagnostic testing not related to a specific illness or injury or a definitive set of symptoms.

(6) Services and supplies above the appropriate level required to provide necessary medical care.

(7) Services and supplies related to an inpatient admission primarily to perform diagnostic tests, examinations, and procedures that could have been and are performed routinely on an outpatient basis.

(8) Postpartum inpatient stay of a mother for purposes of staying with the newborn infant (primarily for the purpose of breast feeding the infant) when the infant (but not the mother) requires the extended stay; or continued inpatient stay of a newborn infant primarily for purposes of remaining with the mother when the mother (but not the newborn infant) requires extended postpartum inpatient stay.

(9) Therapeutic absences from an inpatient facility or residential treatment center (RTC).

(10) Custodial care.

(11) Inpatient stays primarily for domiciliary care purposes.

(12) Inpatient stays primarily for rest or rest cures.

(13) Services and supplies provided as a part of, or under, a scientific or medical study, grant, or research program.

(14) Services and supplies not provided in accordance with accepted professional medical standards or related to experimental or investigational procedures or treatment regimens.

(15) Services or supplies prescribed or provided by a member of the beneficiary's immediate family, or a person living in the beneficiary's or sponsor's household.

(16) Services and supplies that are (or are eligible to be) payable under another medical insurance or program, either private or governmental, such as coverage through employment or Medicare.

(17) Services or supplies subject to preauthorization (see § 17.273) that were obtained without the required preauthorization; and services and supplies that were not provided according to the terms of the preauthorization.

(18) Inpatient stays primarily to control or detain a runaway child, whether or not admission is to an authorized institution.

(19) Services and supplies (to include prescription medications) in connection with cosmetic surgery which is performed to primarily improve physical appearance or for psychological purposes or to restore form without correcting or materially improving a bodily function.

(20) Electrolysis.

(21) Dental care with the following exceptions:

(i) Dental care that is medically necessary in the treatment of an otherwise covered medical condition, is an integral part of the treatment of such medical condition, and is essential to the control of the primary medical condition.

(ii) Dental care required in preparation for, or as a result of, radiation therapy for oral or facial cancer.

(iii) Gingival Hyperplasia.

(iv) Loss of jaw substance due to direct trauma to the jaw or due to treatment of neoplasm.

(v) Intraoral abscess when it extends beyond the dental alveolus.

(vi) Extraoral abscess.

(vii) Cellulitis and osteitis which is clearly exacerbating and directly affecting a medical condition currently under treatment.

(viii) Repair of fracture, dislocation, and other injuries of the jaw, to include removal of teeth and tooth fragments only when such removal is incidental to the repair of the jaw.

(ix) Treatment for stabilization of myofascial pain dysfunction syndrome, also referred to as temporomandibular joint (TMJ) syndrome. Authorization is limited to initial radiographs, up to four office visits, and the construction of an occlusal splint.

(x) Total or complete ankyloglossia.

(xi) Adjunctive dental and orthodontic support for cleft palate.

(xii) Prosthetic replacement of jaw due to trauma or cancer.

(22) Nonsurgical treatment of obesity or morbid obesity for dietary control or weight reduction (with the exception of gastric bypass, gastric stapling, or gastroplasty procedures in connection with morbid obesity when determined to be medically necessary) including prescription medications.

(23) Services and supplies related to transsexualism or other similar conditions such as gender dysphoria (including, but not limited to, intersex surgery and psychotherapy, except for ambiguous genitalia which was documented to be present at birth).

(24) Sex therapy, sexual advice, sexual counseling, sex behavior modification, psychotherapy for mental disorders involving sexual deviations (e.g., transvestic fetish), or other similar services, and any supplies provided in connection with therapy for sexual dysfunctions or inadequacies.

(25) Removal of corns or calluses or trimming of toenails and other routine foot care services, except those required as a result of a diagnosed systemic medical disease affecting the lower limbs, such as severe diabetes.

(26) Services and supplies, to include psychological testing, provided in connection with a specific developmental disorder. The following exception applies: Diagnostic and evaluative services required to arrive at a differential diagnosis for an otherwise eligible child unless the state is required to provide those services under Public Law 94–142, *Education for All Handicapped Children Act of 1975 as amended, see 20 U.S.C. chapter 33*.

(27) Surgery to reverse voluntary surgical sterilization procedures.

(28) Services and supplies related to artificial insemination (including semen donors and semen banks), in vitro fertilization, gamete intrafallopian transfer and all other noncoital reproductive technologies.

(29) Nonprescription contraceptives.

(30) Diagnostic tests to establish paternity of a child; or tests to determine sex of an unborn child.

(31) Preventive care (such as routine, annual, or employment-requested physical examinations; routine screening procedures; and immunizations). The following exceptions apply:

(i) Well-child care from birth to age six. Periodic health examinations designed for prevention, early detection, and treatment of disease are covered to include screening procedures, immunizations, and risk counseling. The following services are payable when required as part of a well-child care program and when rendered by the attending pediatrician, family physician, or a pediatric nurse practitioner.

(A) Newborn examination, heredity and metabolic screening, and newborn circumcision.

(B) Periodic health supervision visits intended to promote optimal health for infants and children to include the following services:

(*1*) History and physical examination.

(*2*) Vision, hearing, and dental screening.

(*3*) Developmental appraisal to include body measurement.

(*4*) Immunizations as recommended by the Centers for Disease Control (CDC) and Prevention Advisory Committee on Immunization Practices.

(*5*) Pediatric blood lead level test.

(*6*) Tuberculosis screening.

(*7*) Blood pressure screening.

(*8*) Measurement of hemoglobin and hematocrit for anemia.

(*9*) Urinalysis.

(C) Additional services or visits required because of specific findings or because the particular circumstances of the individual case are covered if medically necessary and otherwise authorized for benefits under CHAMPVA.

(ii) Rabies vaccine following an animal bite.

(iii) Tetanus vaccine following an accidental injury.

(iv) Rh immune globulin.

(v) Pap smears.

(vi) Mammography tests.

(vii) Genetic testing and counseling determined to be medically necessary.

(viii) Chromosome analysis in cases of habitual abortion or infertility.

(ix) Gamma globulin.

(x) School-required physical examinations for beneficiaries through age 17 that are provided on or after October 1, 2001.

(32) Chiropractic and naturopathic services.

(33) Counseling services that are not medically necessary in the treatment of a diagnosed medical condition (such as educational counseling; vocational counseling; and counseling for socioeconomic purposes, stress management, life style modification, etc.).

(34) Acupuncture, whether used as a therapeutic agent or as an anesthetic.

(35) Hair transplants, wigs, or hairpieces, except that benefits may be extended for one wig or hairpiece per beneficiary (lifetime maximum) when the attending physician certifies that alopecia has resulted from treatment of malignant disease and the beneficiary certifies that a wig or hairpiece has not been obtained previously through the U.S. Government (including the Department of Veterans Affairs). The wig or hairpiece benefit does not include coverage for the following:

(i) Maintenance, wig or hairpiece supplies, or replacement of the wig or hairpiece.

(ii) Hair transplant or any other surgical procedure involving the attachment of hair or a wig or hairpiece to the scalp.

(iii) Any diagnostic or therapeutic method or supply intended to encourage hair growth.

(36) Self-help, academic education or vocational training services and supplies.

(37) Exercise equipment, spas, whirlpools, hot tubs, swimming pools, health club membership or other such charges or items.

(38) General exercise programs, even if recommended by a physician.

(39) Services of an audiologist or speech therapist, except when prescribed by a physician and rendered as a part of treatment addressed to the physical defect itself and not to any educational or occupational deficit.

(40) Eye exercises or visual training (orthoptics).

(41) Eye and hearing examinations except when rendered in connection with medical or surgical treatment of a covered illness or injury or in connection with well-child care.

(42) Eyeglasses, spectacles, contact lenses, or other optical devices with the following exceptions:

(i) When necessary to perform the function of the human lens, lost as a result of intraocular surgery, ocular injury or congenital absence.

(ii) Pinhole glasses prescribed for use after surgery for detached retina.

(iii) Lenses prescribed as ''treatment'' instead of surgery for the following conditions:

(A) Contact lenses used for treatment of infantile glaucoma.

(B) Corneal or scleral lenses prescribed in connection with treatment of keratoconus.

(C) Scleral lenses prescribed to retain moisture when normal tearing is not present or is inadequate.

(D) Corneal or scleral lenses prescribed to reduce a corneal irregularity other than astigmatism.

(iv) The specified benefits are limited to one set of lenses related to one qualifying eye condition as set forth in paragraphs (a)(42)(iii)(A) through (D) of this section. If there is a prescription change requiring a new set of lenses, but still related to the qualifying eye condition, benefits may be extended for a second set of lenses, subject to medical review.

(43) Hearing aids or other auditory sensory enhancing devices.

(44) Prostheses with the following exceptions:

(i) Dental prostheses specifically required in connection with otherwise covered orthodontia directly related to the surgical correction of a cleft palate anomaly.

(ii) Any prostheses, other than dental prostheses, determined to be medically necessary because of significant conditions resulting from trauma, congenital anomalies, or disease, including, but not limited to:

(A) Artificial limbs.

(B) Voice prostheses.

(C) Eyes.

(D) Items surgically inserted in the body as an integral part of a surgical procedure.

(E) Ears, noses, and fingers.

(45) Orthopedic shoes, arch supports, shoe inserts, and other supportive devices for the feet, including special ordered, custom-made built-up shoes, or regular shoes later built up with the following exceptions:

(i) Shoes that are an integral part of an orthopedic brace, and which cannot be used separately from the brace.

(ii) Extra-depth shoes with inserts or custom molded shoes with inserts for individuals with diabetes.

(46) Services or advice rendered by telephone are excluded except that a diagnostic or monitoring procedure which incorporates electronic transmission of data or remote detection and measurement of a condition, activity, or function (biotelemetry) is covered when:

(i) The procedure, without electronic data transmission, is a covered benefit; and

(ii) The addition of electronic data transmission or biotelemetry improves the management of a clinical condition in defined circumstances; and

(iii) The electronic data or biotelemetry device has been classified by the U.S. Food and Drug Administration, either separately or as part of a system, for use consistent with the medical condition and clinical management of such condition.

(47) Air conditioners, humidifiers, dehumidifiers, and purifiers.

(48) Elevators.

(49) Alterations to living spaces or permanent features attached thereto, even when necessary to accommodate installation of covered durable medical equipment or to facilitate entrance or exit.

(50) Items of clothing, even if required by virtue of an allergy (such as cotton fabric versus synthetic fabric and vegetable-dyed shoes).

(51) Food, food substitutes, vitamins or other nutritional supplements, including those related to prenatal care for a home patient whose condition permits oral feeding.

(52) Enuretic (bed-wetting) conditioning programs.

(53) Autopsy and post-mortem examinations.

(54) All camping, even when organized for a specific therapeutic purpose (such as diabetic camp or a camp for emotionally disturbed children), or when offered as a part of an otherwise covered treatment plan.

(55) Housekeeping, homemaker, or attendant services, including a sitter or companion.

(56) Personal comfort or convenience items, such as beauty and barber services, radio, television, and telephone.

(57) Smoking cessation services and supplies.

(58) Megavitamin psychiatric therapy; orthomolecular psychiatric therapy.

(59) All transportation except for specialized transportation with life sustaining equipment, when medically required for the treatment of a covered condition.

(60) Inpatient mental health services in excess of 30 days in any fiscal year (or in an admission), in the case of a patient nineteen years of age or older; 45 days in any fiscal year (or in an admission), in the case of a patient under 19 years of age; or 150 days of residential treatment care in any fiscal year (or in an admission) unless a waiver for extended coverage is granted in advance.

(61) Outpatient mental health services in excess of 23 visits in a fiscal year unless a waiver for extended coverage is granted in advance.

(62) Institutional services for partial hospitalization in excess of 60 treatment days in any fiscal year (or in an admission) unless a waiver for extended coverage is granted in advance.

(63) Detoxification in a hospital setting or rehabilitation facility in excess of seven days.

(64) Outpatient substance abuse services in excess of 60 visits during a benefit period. A benefit period begins with the first date of covered service and ends 365 days later.

(65) Family therapy for substance abuse in excess of 15 visits during a benefit period. A benefit period begins with the first date of covered service and ends 365 days later.

(66) Services that are provided to a beneficiary who is referred to a provider of such services by a provider who has an economic interest in the facility to which the patient is referred, unless a waiver is granted.

(67) Abortion except when a physician certifies that the life of the mother would be endangered if the fetus were carried to term.

(68) Abortion counseling.

(69) Aversion therapy.

(70) Rental or purchase of biofeedback equipment.

(71) Biofeedback therapy for treatment of ordinary muscle tension states (including tension headaches) or for psychosomatic conditions.

(72) Drug maintenance programs where one addictive drug is substituted for another, such as methadone substituted for heroin.

(73) Immunotherapy for malignant diseases except for treatment of Stage O and Stage A carcinoma of the bladder.

(74) Services and supplies provided by other than a hospital, such as nonskilled nursing homes, intermediate care facilities, halfway houses, homes for the aged, or other institutions of similar purpose.

(75) Services performed when the patient is not physically present.

(76) Medical photography.

(77) Special tutoring.

(78) Surgery for psychological reasons.

(79) Treatment of premenstrual syndrome (PMS).

(80) Medications not requiring a prescription, except for insulin and related diabetic testing supplies and syringes.

(81) Thermography.

(82) Removal of tattoos.

(83) Penile implant/testicular prosthesis procedures and related supplies for psychological impotence.

(84) Dermabrasion of the face except in those cases where coverage has been authorized for reconstructive or plastic surgery required to restore body form following an accidental injury or to revise disfiguring and extensive scars resulting from neoplastic surgery.

(85) Chemical peeling for facial wrinkles.

(86) Panniculectomy, body sculpting procedures.

(b) CHAMPVA-determined allowable amount.

(1) The term allowable amount is the maximum CHAMPVA-determined level of payment to a hospital or other authorized institutional provider, a physician or other authorized individual professional provider, or other authorized provider for covered services. The CHAMPVA-allowable amount is determined prior to cost sharing and the application of deductibles and/or other health insurance.

(2) A Medicare-participating hospital must accept the CHAMPVA-determined allowable amount for inpatient services as payment-in-full. (Reference 42 CFR parts 489 and 1003).

(3) An authorized provider of covered medical services or supplies must accept the CHAMPVA-determined allowable amount as payment-in-full.

(4) A provider who has collected and not made appropriate refund, or attempts to collect from the beneficiary, any amount in excess of the CHAMPVA-determined allowable amount may be subject to exclusion from Federal benefit programs.

(Authority: 38 U.S.C. 501, 1781)

[63 FR 48102, Sept. 9, 1998, as amended at 67 FR 4359, Jan. 30, 2002; 73 FR 65553, Nov. 4, 2008]

§ 17.273 Preauthorization.

Preauthorization or advance approval is required for any of the following:

(a) Non-emergent inpatient mental health and substance abuse care including admission of emotionally disturbed children and adolescents to residential treatment centers.

(b) All admissions to a partial hospitalization program (including alcohol rehabilitation).

(c) Outpatient mental health visits in excess of 23 per calendar year and/or more than two (2) sessions per week.

(d) Dental care.

(e) Durable medical equipment with a purchase or total rental price in excess of $2,000.

(f) Organ transplants.

(Authority: 38 U.S.C. 501, 1781)

[63 FR 48102, Sept. 9, 1998, as amended at 74 FR 31374, July 1, 2009]

§ 17.274 Cost sharing.

(a) With the exception of services obtained through VA facilities, CHAMPVA is a cost-sharing program in which the cost of covered services is shared with the beneficiary.

CHAMPVA pays the CHAMPVA-determined allowable amount less the deductible, if applicable, and less the beneficiary cost share.

(b) In addition to the beneficiary cost share, an annual (calendar year) outpatient deductible requirement ($50 per beneficiary or $100 per family) must be satisfied prior to the payment of outpatient benefits. There is no deductible requirement for inpatient services or for services provided through VA facilities.

(c) To provide financial protection against the impact of a long-term illness or injury, a calendar year cost limit or ''catastrophic cap'' has been placed on the beneficiary cost-share amount for covered services and supplies. Credits to the annual catastrophic cap are limited to the applied annual deductible(s) and the beneficiary cost-share amount. Costs above the CHAMPVA-allowable amount, as well as costs associated with non-covered services are not credited to the catastrophic cap computation. After a family has paid the maximum cost-share and deductible amounts for a calendar year, CHAMPVA will pay allowable amounts for the remaining covered services through the end of that calendar year.

(i) Through December 31, 2001, the annual cap on cost sharing is $7,500 per CHAMPVA-eligible family.

(ii) Effective January 1, 2002, the cap on cost sharing is $3,000 per CHAMPVA-eligible family.

(d) If the CHAMPVA benefit payment is under $1.00, payment will not be issued. Catastrophic cap and deductible will, however, be credited.

(Authority: 38 U.S.C. 501, 1781)

[67 FR 4359, Jan. 30, 2002, as amended at 67 FR 6875, Feb. 14, 2002]

§ 17.275 Claim filing deadline.

(a) Unless an exception is granted under paragraph (b) of this section, claims for medical services and supplies must be filed with the Center no later than:

(1) One year after the date of service; or

(2) In the case of inpatient care, one year after the date of discharge; or

(3) In the case of retroactive approval for medical services/supplies, 180 days following beneficiary notification of authorization; or

(4) In the case of retroactive approval of CHAMPVA eligibility, 180 days following notification to the beneficiary of authorization for services occurring on or after the date of first eligibility.

(b) Requests for an exception to the claim filing deadline must be submitted, in writing, to the Center and include a complete explanation of the circumstances resulting in late filing along with all available supporting documentation. Each request for an exception to the claim filing deadline willbe reviewed individually and considered on its own merit. The Director, Health Administration Center, or his or her designee may grant exceptions to the requirements in paragraph (a) of this section if he or she determines that there was good cause for missing the filing deadline. For example, when dual coverage exists CHAMPVA payment, if any, cannot be determined until after the primary insurance carrier has adjudicated the claim. In such circumstances an exception may be granted provided that the delay on the part of the primary insurance carrier is not attributable to the beneficiary. Delays due to provider billing procedures do not constitute a valid basis for an exception.

(Authority: 38 U.S.C. 501, 1781)

[63 FR 48102, Sept. 9, 1998, as amended at 73 FR 65553, Nov. 4, 2008]

§ 17.276 Appeal/review process.

Notice of the initial determination regarding payment of CHAMPVA benefits will be provided to the beneficiary on a CHAMPVA Explanation of Benefits (EOB) form. The EOB form is generated by the CHAMPVA automated payment processing system. If a beneficiary disagrees with the determination concerning covered services or calculation of benefits, he or she may request reconsideration. Such requests must be submitted to the Center in writing within one year of the date of the initial determination. The request must state why the beneficiary believes the decision is in error and must

include any new and relevant information not previously considered. Any request for reconsideration that does not identify the reason for dispute will be returned to the claimant without further consideration. After reviewing the claim and any relevant supporting documentation, a CHAMPVA benefits advisor will issue a written determination to the beneficiary that affirms, reverses or modifies the previous decision. If the beneficiary is still dissatisfied, within 90 days of the date of the decision he or she may make a written request for review by the Director, Health Administration Center, or his or her designee. The Director, Health Administration Center, or his or her designee will review the claim, and any relevant supporting documentation, and issue a decision in writing that affirms, reverses or modifies the previous decision. The decision of the Director, Health Administration Center, or his or her designee with respect to benefit coverage and computation of benefits is final.

(Authority: 38 U.S.C. 501, 1781)

NOTE TO § 17.276: Denial of CHAMPVA benefits based on legal eligibility requirements may be appealed to the Board of Veterans' Appeals in accordance with 38 CFR part 20. Medical determinations are not appealable to the Board. 38 CFR 20.101.

[63 FR 48102, Sept. 9, 1998, as amended at 73 FR 65553, Nov. 4, 2008]

§ 17.277 Third-party liability/medical care cost recovery.

The Center will actively pursue third-party liability/medical care cost recovery in accordance with applicable law.

(Authority: 28 U.S.C. 2651; 38 U.S.C. 501, 1781)

§ 17.278 Confidentiality of records.

Confidentiality of records will be maintained in accordance with 38 CFR 1.460 through 1.582.

(Authority: 5 U.S.C. 552, 552a; 38 U.S.C. 501, 1781, 5701, 7332)

GRANTS TO THE REPUBLIC OF THE PHILIPPINES

§ 17.350 The program of assistance to the Philippines.

The provisions of this section through § 17.370 are applicable to grants to the Republic of the Philippines and to furnishing medical services under 38 U.S.C. 1724 and 1732, and 38 CFR 17.36 through 17.40, and implement the ''Agreement between the Government of the United States of America and the Government of the Republic of the Philippines on the Use of the Veterans Memorial Medical Center and the Provision of Inpatient and Outpatient Medical Care and Treatment of Veterans by the Government of the Philippines and Furnishing of Grants-in-Aid Thereof by the Government of the United States of America,'' dated April 25, 1967 (Treaties and Other International Acts Series 6248), and a subsidiary agreement of the same date, both of which were entered into pursuant to the provisions of 38 U.S.C. 1731–1734. All such implementing regulations have been approved by the Director of the Office of Management and Budget.

[33 FR 5300, Apr. 3, 1968, as amended at 45 FR 47680, July 16, 1980; 47 FR 58250, Dec. 30, 1982; 61 FR 21969, May 13, 1996]

§ 17.351 Grants for the replacement and upgrading of equipment at Veterans Memorial Medical Center.

Grants to assist the Republic of the Philippines in the replacement and upgrading of equipment and in rehabilitating the physical plant and facilities of the Veterans Memorial Medical Center, which the Secretary may make under the authority cited in § 17.350, shall be subject to such terms and conditions as the Secretary may prescribe. Among such terms and conditions to which the grants will be subject, will be advance approval by the U.S. Department of Veterans Affairs of equipment purchases, maintenance or repair projects. The awarding of such grants is further subject to the limitations on available funds in § 17.352.

(Authority: 38 U.S.C. 1732, as amended by Pub. L. 97–72, sec. 107(c)(1))

[33 FR 5300, Apr. 3, 1968, as amended at 45 FR 47680, July 16, 1980; 47 FR 58250, Dec. 30, 1982]

§ 17.352 Amounts and use of grant funds for the replacement and upgrading of equipment.

Grants awarded under § 17.351 shall not exceed the amounts provided by the appropriation acts of the Congress of the United States for the purpose. Funds appropriated for the upgrading and replacement of equipment at the Veterans Memorial Medical Center, or for rehabilitating its equipment, shall remain available in consecutive fiscal years until expanded, but in no event shall exceed the amount of $500,000 per year. It is not intended that such funds will be utilized to expand the medical center facilities. Upgrading of equipment, however, would permit purchase of new and additional equipment not now possessed by the medical center.

(Authority: 38 U.S.C. 1732)

[47 FR 58250, Dec. 30, 1982]

§ 17.355 Awards procedures.

All applications for grants to the Republic of the Philippines under the provisions of § 17.351 shall be submitted to the Under Secretary for Health or a designee for consideration.

(Authority: 38 U.S.C. 1732)

[47 FR 58250, Dec. 30, 1982, as amended at 61 FR 21969, May 13, 1996]

§ 17.362 Acceptance of medical supplies as payment.

Upon request of the Government of the Republic of the Philippines, payment for medical and nursing home services provided to eligible United States veterans may consist in whole or in part, of available medicines, medical supplies, or equipment furnished by the Department of Veterans Affairs to the Veterans Memorial Medical Center at valuations determined by the Secretary. Such valuations shall not be less than the cost of the items and shall include the cost of transportation, arrastre, brokerage, shipping and handling charges.

(Authority: 38 U.S.C. 1732(a)(2))

[47 FR 58250, Dec. 30, 1982]

§ 17.363 Length of stay.

In computing the length of stay for which payment will be made, the day of admission will be counted, but not the day of discharge, death, or transfer. Where a veteran for whom hospitalization has been authorized in Veterans Memorial Medical Center or a contract facility, is absent from the hospital for a period longer than 24 hours, no payment will be made for hospital care during that absence.

(Authority: 38 U.S.C. 1732)

[47 FR 58250, Dec. 30, 1982]

§ 17.364 Eligibility determinations.

Determinations of legal eligibility and medical need for hospitalization of United States veterans for treatment rest exclusively with the United States Department of Veterans Affairs. Determinations as to various factors upon which eligibility may depend shall be made as follows:

(a) *Determinations of service connection.* For the purpose of meeting any requirement in 38 U.S.C. 1724 and 1732, and 38 CFR 17.36 through 17.37 for service-connected disability, the United States Department of Veterans Affairs shall determine that under laws it administers the disability in question was incurred in or aggravated by service, and

(b) *Determinations of valid service.* For the purpose of determining the necessary prerequisite service, determinations by the Department of Defense of the United States as to military service shall be accepted. In those cases in which the United States Department of Veterans Affairs shall have information which it deems reliable and in conflict with the information upon which the Department of Defense determination was made, the conflicting information shall be referred to the Department of Defense for reconsideration and redetermination. Such determinations and redeterminations as to military service shall be conclusive.

(Authority: 38 U.S.C. 1712)

[47 FR 58250, Dec. 30, 1982, as amended at 61 FR 21969, May 13, 1996]

§ 17.365 Admission priorities.

Appropriate provisions of § 17.49 apply.

(Authority: 38 U.S.C. 1712)

[47 FR 58251, Dec. 30, 1982]

§ 17.366 Authorization of emergency admissions.

The Secretary of National Defense of the Republic of the Philippines shall make determinations as to whether any patient should be admitted in emergency circumstances before the U.S. Department of Veterans Affairs has made a legal determination of eligibility, except that liability for payment will not accrue to the United States until such eligibility determination has been made. Eligibility determinations will be given effect retroactively to the date of admission when the U.S. Department of Veterans Affairs has been notified by telephone, telegram, letter, or other communication of the emergency admission within 72 hours of the hour of admission. The Clinic Director of the VA Regional Office, Manila, may make an exception to the 72-hour limitation when it is determined that the delay in notification was fully justified. When any authorization cannot be made effective retroactively to the date of admission, it shall be effective from the date of receipt of notification.

[33 FR 5301, Apr. 3, 1968, as amended at 47 FR 58251, Dec. 30, 1982]

§ 17.367 Republic of the Philippines to print forms.

The Secretary of National Defense of the Republic of the Philippines will, with the concurrence of the Secretary of Veterans Affairs, print all forms for applications for hospitalization, forms for physical examination reports, forms for billings for services rendered, and such other forms as may be necessary and incident to the efficient execution of the program governed by the provisions of 38 U.S.C. 1724 and 1732, and 38 CFR 17.36 through 17.40 and §§ 17.350 through 17.370. The forms will be used whenever applicable in the general operation of the program.

[33 FR 5301, Apr. 3, 1968, as amended at 61 FR 21969, May 13, 1996]

§ 17.369 Inspections.

The U.S. Department of Veterans Affairs, through authorized representatives, has the right under the agreements cited in § 17.350, to inspect the Veterans Memorial Medical Center, its premises and all appurtenances and records to determine completeness and correctness of such records, and to determine according to the provisions of the cited agreements whether standards maintained conform to the necessary requirements.

[33 FR 5301, Apr. 3, 1968, as amended at 47 FR 58251, Dec. 30, 1982]

§ 17.370 Termination of payments.

Payments may be terminated if the U.S. Department of Veterans Affairs determines the Veterans Memorial Medical Center has not replaced and upgraded as needed equipment during the period in which the agreements cited in § 17.50 are in effect or has not rehabilitated the existing physical plant and facilities to place the medical center on a sound and effective operating basis, or has not maintained the medical center in a well-equipped and effective operating condition. Payments, however, will not be stopped unless the Veterans Memorial Medical Center has been given at least 60 days advance written notice of intent to stop payments.

(Authority: 38 U.S.C. 1732)

[33 FR 5301, Apr. 3, 1968, as amended at 47 FR 58251, Dec. 30, 1982]

CONFIDENTIALITY OF HEALTHCARE QUALITY ASSURANCE REVIEW RECORDS

AUTHORITY: 38 U.S.C. 5705.

SOURCE: 59 FR 53355, Oct. 24, 1994, unless otherwise noted.

§ 17.500 General.

(a) Section 5705, title 38, United States Code was enacted to protect the integrity of the VA's medical quality assurance program by making confidential and privileged certain records and documents generated by this program and information contained therein. Disclosure of quality assurance records and documents made confidential and privileged by 38 U.S.C. 5705 and the regulations in §§ 17.500 through 17.511 may only be made in accordance with the provisions of 38 U.S.C. 5705 and those regulations.

(b) The purpose of the regulations in §§ 17.500 through 17.511 is to specify and provide for the limited disclosure of

those quality assurance documents which are confidential under the provisions of 38 U.S.C. 5705.

(c) For purposes of the regulations in §§ 17.500 through 17.511, the VA's medical quality assurance program consists of systematic healthcare reviews carried out by or for VA for the purpose of improving the quality of medical care or improving the utilization of healthcare resources in VA medical facilities. These review activities may involve continuous or periodic data collection and may relate to either the structure, process, or outcome of health care provided in the VA.

(d) Nothing in the regulations in §§ 17.500 through 17.511 shall be construed as authority to withhold any record or document from a committee or subcommittee of either House of Congress or any joint committee or subcommittee of Congress, if such record or document pertains to any matter within the jurisdiction of such committee or joint committee.

(e) The regulations in §§ 17.500 through 17.511 do not waive the sovereign immunity of the United States, and do not waive the confidentiality provisions and disclosure restrictions of 38 U.S.C. 5705.

(Authority: 38 U.S.C. 5705)

§ 17.501 Confidential and privileged documents.

(a) Documents and parts of documents are considered confidential and privileged if they were produced by or for the VA in the process of conducting systematic healthcare reviews for the purpose of improving the quality of health care or improving the utilization of healthcare resources in VA healthcare facilities and meet the criteria in paragraphs (b) and (c) of this section. The four classes of healthcare quality assurance reviews with examples are:

(1) Monitoring and evaluation reviews conducted by a facility:

(i) Medical records reviews,

(ii) Drug usage evaluations,

(iii) Blood usage reviews,

(iv) Surgical case/invasive procedure reviews,

(v) Service and program monitoring including monitoring performed by individual services or programs, several services or programs working together, or individuals from several services or programs working together as a team,

(vi) Mortality and morbidity reviews,

(vii) Infection control review and surveillance,

(viii) Occurrence screening,

(ix) Tort claims peer reviews (except reviews performed to satisfy the requirements of a governmental body or a professional health care organization which is licensing practitioners or monitoring their professional performance),

(x) Admission and continued stay reviews,

(xi) Diagnostic studies utilization reviews,

(xii) Reports of special incidents (VA Form 10-2633 or similar forms) and follow-up documents unless developed during or as a result of a Board of Investigation;

(2) Focused reviews which address specific issues or incidents and which are designated by the reviewing office at the outset of the review as protected by 38 U.S.C. 5705 and the regulations in §§ 17.500 through 17.511; focused reviews may be either:

(i) Facility focused reviews;

(ii) VA Central Office or Regional focused reviews;

(3) VA Central Office or Regional general oversight reviews to assess facility compliance with VA program requirements if the reviews are designated by the reviewing office at the outset of the review as protected by 38 U.S.C. 5705 and the regulations in §§ 17.500 through 17.511; and

(4) Contracted external reviews of care, specifically designated in the contract or agreement as reviews protected by 38 U.S.C. 5705 and the regulations in §§ 17.500 through 17.511.

(b) The Under Secretary for Health, Regional Director or facility Director will describe in advance in writing those quality assurance activities included under the classes of healthcare quality assurance reviews listed in paragraph (a) of this section. Only documents and parts of documents resulting from those activities which have been so described are protected by 38 U.S.C. 5705 and the regulations in §§ 17.500 through 17.511. If an activity is not described in a VA Central Office or

Regional policy document, this requirement may be satisfied at the facility level by description in advance of the activity and its designation as protected in the facility quality assurance plan or other policy document.

(c) Documents and parts of documents generated by activities which meet the criteria in paragraphs (a) and (b) of this section shall be confidential and privileged only if they:

(1) Identify, either implicitly or explicitly, individual practitioners, patients, or reviewers except as provided in paragraph (g)(6) of this section; or

(2) Contain discussions relating to the quality of VA medical care or utilization of VA medical resources by healthcare evaluators during the course of a review of quality assurance information or data, even if they do not identify practitioners, patients, or reviewers; or

(3) Are individual committee, service, or study team minutes, notes, reports, memoranda, or other documents either produced by healthcare evaluators in deliberating on the findings of healthcare reviews, or prepared for purposes of discussion or consideration by healthcare evaluators during a quality assurance review; or

(4) Are memoranda, letters, or other documents from the medical facility to the Regional Director or VA Central Office which contain information generated by a quality assurance activity meeting the criteria in §17.501 (a) and (b); or

(5) Are memoranda, letters, or other documents produced by the Regional Director or VA Central Office which either respond to or contain information generated by a quality assurance activity meeting the criteria in §17.501 (a) and (b).

(d) Documents which meet the criteria in this section are confidential and privileged whether they are produced at the medical facility, Regional or VA Central Office levels, or by external contractors performing healthcare quality assurance reviews.

(e) Documents which are confidential and privileged may be in written, computer, electronic, photographic or any other form.

(f) Documents which contain confidential and privileged material in one part, but not in others, such as Clinical Executive Board minutes, should be filed and maintained as if the entire document was protected by 38 U.S.C. 5705. This is not required if the confidential and privileged material is deleted.

(g) The following records and documents and parts of records and documents are not confidential even if they meet the criteria in paragraphs (a) through (c) of this section:

(1) Statistical information regarding VA healthcare programs or activities that does not implicitly or explicitly identify individual VA patients or VA employees or individuals involved in the quality assurance process;

(2) Summary documents or records which only identify study topics, the period of time covered by the study, criteria, norms, and/or major overall findings, but which do not identify individual healthcare practitioners, even by implication;

(3) The contents of Credentialing and Privileging folders as described in VACO policy documents (38 U.S.C. 5705-protected records shall not be filed in Credentialing and Privileging folders);

(4) Records and documents developed during or as a result of Boards of Investigations;

(5) Completed patient satisfaction survey questionnaires and findings from patient satisfaction surveys;

(6) Records and documents which only indicate the number of patients treated by a practitioner, either by diagnosis or in aggregate, or number of procedures performed by a practitioner, either by procedure or in aggregate;

(7) Records and documents developed during or as a result of reviews performed to satisfy the requirements of a governmental body or a professional healthcare organization which is licensing practitioners or monitoring their professional performance, e.g., National Practitioner Data Bank, Federation of State Medical Boards, and National Council of State Boards of Nursing;

(8) Documents and reports developed during or as a result of site visits by the Office of the Medical Inspector except to the extent that the documents and reports contain information that

meets the criteria described in this section and are produced by or for VA by other than the Office of Medical Inspector;

(9) External reviews conducted by VA Central Office or a Region other than those designated by the reviewing office under paragraph (a)(2) or (a)(3) of this section as protected by 38 U.S.C. 5705 and the regulations in §§17.500 through 17.511;

(10) Documents and reports of Professional Standards Boards, Credentialing Committees, Executive Committees of Medical Staff, and similar bodies, insofar as the documents relate to the credentialing and privileging of practitioners;

(11) Documents and reports developed during or as a result of data validation activities;

(12) Documents and reports developed during or as a result of occupational health monitoring;

(13) Documents and reports developed during or as a result of safety monitoring not directly related to the care of specified individual patients;

(14) Documents and reports developed during or as a result of resource management activities not directly related to the care of specified individual patients; and

(15) Information and records derived from patient medical records or facility administrative records, which are not protected by 38 U.S.C. 5705 and the regulations in §§17.500 through 17.511, may be sent or communicated to a third party payor who has asked for this information in response to a VA request for reimbursement based on Public Law 99–272 and Public Law 101–508. Reviews conducted at the request of the third party payor do not generate records protected by 38 U.S.C. 5705 and the regulations in §§17.500 through 17.511 since the reviews are not undertaken as part of the VA's quality assurance program.

(Authority: 38 U.S.C. 5705)

§ 17.502 Applicability of other statutes.

(a) Disclosure of quality assurance records and documents which are not confidential and privileged under 38 U.S.C. 5705 and the confidentiality regulations in §§17.500 through 17.511 will be governed by the provisions of the Freedom of Information Act, and, if applicable, the Privacy Act and any other VA or federal confidentiality statutes.

(b) When included in a quality assurance review, confidential records protected by other confidentiality statutes such as 5 U.S.C. 552a (the Privacy Act), 38 U.S.C. 7332 (drug and alcohol abuse, sickle cell anemia, HIV infection), and 38 U.S.C. 5701 (veterans' names and addresses) retain whatever confidentiality protection they have under these laws and applicable regulations and will be handled accordingly. To the extent that information protected by 38 U.S.C. 5701 or 7332 or the Privacy Act is incorporated into quality assurance records, the information in the quality assurance records is still protected by these statutes.

(Authority: 38 U.S.C. 5705)

§ 17.503 Improper disclosure.

(a) Improper disclosure is the disclosure of confidential and privileged healthcare quality assurance review records or documents (or information contained therein), as defined in §17.501, to any person who is not authorized access to the records or documents under the statute and the regulations in §§17.500 through 17.511.

(b) ''Disclosure'' means the communication, transmission, or conveyance in any way of any confidential and privileged quality assurance records or documents or information contained in them to any individual or organization in any form by any means.

(Authority: 38 U.S.C. 5705)

§ 17.504 Disclosure methods.

(a) Disclosure of confidential and privileged quality assurance records and documents or the information contained therein outside VA, where permitted by the statute and the regulations in §§17.500 through 17.511, will always be by copies, abstracts, summaries, or similar records or documents prepared by the Department of Veterans Affairs and released to the requestor. The original confidential and privileged quality assurance records and documents will not be removed from the VA facility by any person, VA

employee or otherwise, except in accordance with § 17.508(c) or where otherwise legally required.

(b) Disclosure of confidential and privileged quality assurance records and documents to authorized individuals under either § 17.508 or § 17.509 shall bear the following statement: ''These documents or records (or information contained herein) are confidential and privileged under the provisions of 38 U.S.C. 5705, which provide for fines up to $20,000 for unauthorized disclosures thereof, and the implementing regulations. This material shall not be disclosed to anyone without authorization as provided for by that law or the regulations in §§ 17.500 through 17.511.''

(Authority: 38 U.S.C. 5705)

§ 17.505 Disclosure authorities.

The VA medical facility Director, Regional Director, Under Secretary for Health, or their designees are authorized to disclose any confidential and privileged quality assurance records or documents under their control to other agencies, organizations, or individuals where 38 U.S.C. 5705 or the regulations in §§ 17.500 through 17.511 expressly provide for disclosure.

(Authority: 38 U.S.C. 5705)

§ 17.506 Appeal of decision by Veterans Health Administration to deny disclosure.

When a request for records or documents subject to the regulations in §§ 17.500 through 17.511 is denied in whole or in part by the VA medical facility Director, Regional Director or Under Secretary for Health, the VA official denying the request in whole or in part will notify the requestor in writing of the right to appeal this decision to the General Counsel of the Department of Veterans Affairs within 60 days of the date of the denial letter. The final Department decision will be made by the General Counsel or the Deputy General Counsel.

(Authority: 38 U.S.C. 5705)

§ 17.507 Employee responsibilities.

(a) All VA employees and other individuals who have access to records designated as confidential and privileged under 38 U.S.C. 5705 and the regulations in §§ 17.500 through 17.511 will treat the findings, views, and actions relating to quality assurance in a confidential manner.

(b) All individuals who have had access to records designated as confidential and privileged under 38 U.S.C. 5705 and the regulations in §§ 17.500 through 17.511 will not disclose such records or information therein to any person or organization after voluntary or involuntary termination of their relationship to the VA.

(Authority: 38 U.S.C. 5705)

§ 17.508 Access to quality assurance records and documents within the agency.

(a) Access to confidential and privileged quality assurance records and documents within the Department pursuant to this section is restricted to VA employees (including consultants and contractors of VA) who have a need for such information to perform their government duties or contractual responsibilities and who are authorized access by the VA medical facility Director, Regional Director, the Under Secretary for Health, or their designees or by the regulations in §§ 17.500 through 17.511.

(b) To foster continuous quality improvement, practitioners on VA rolls, whether paid or not, will have access to confidential and privileged quality assurance records and documents relating to evaluation of the care they provided.

(c) Any quality assurance record or document, whether confidential and privileged or not, may be provided to the General Counsel or any attorney within the Office of General Counsel, wherever located. These documents may also be provided to a Department of Justice (DOJ) attorney who is investigating a claim or potential claim against the VA or who is preparing for litigation involving the VA. If necessary, such a record or document may be removed from the VA medical facility to the site where the General Counsel or any attorney within the Office of General Counsel or the DOJ attorney is conducting an investigation or preparing for litigation.

(d) Any quality assurance record or document or the information contained

therein, whether confidential and privileged or not, will be provided to the Department of Veterans Affairs Office of Inspector General upon request. A written request is not required.

(e) To the extent practicable, documents accessed under paragraph (b) of this section will not include the identity of peer reviewers. Reasonable efforts will be made to edit documents so as to protect the identities of reviewers, but the inability to completely do so will not bar access under paragraph (b).

(f) No individual shall be permitted access to confidential and privileged quality assurance records and documents identified in §17.501 unless such individual has been informed of the penalties for unauthorized disclosure. Any misuse of confidential and privileged quality assurance records or documents shall be reported to the appropriate VHA official, e.g., Service Chief, Medical Center Director.

(g) In general, confidential and privileged quality assurance records and documents will be maintained for a minimum of 3 years and may be held longer if needed for research studies or quality assurance or legal purposes.

(Authority: 38 U.S.C. 5705)

§ 17.509 Authorized disclosure: Non-Department of Veterans Affairs requests.

(a) Requests for confidential and privileged quality assurance records and documents from organizations or individuals outside VA must be made to the Department and must specify the nature and content of the information requested, to whom the information should be transmitted or disclosed, and the purpose listed in paragraphs (b) through (j) of this section for which the information requested will be used. In addition, the requestor will specify to the extent possible the beginning and final dates of the period for which disclosure or access is requested. The request must be in writing and signed by the requestor. Except as specified in paragraphs (b) and (c) of this section, these requests should be forwarded to the Director of the facility in possession of the records or documents for response. The procedures outlined in 38 CFR 1.500 through 1.584 will be followed where applicable.

(b) Disclosure shall be made to Federal agencies upon their written request to permit VA's participation in healthcare programs including healthcare delivery, research, planning, and related activities with the requesting agencies. Any Federal agency may apply to the Under Secretary for Health for approval. If the VA decides to participate in the healthcare program with the requestor, the requesting agency will enter into an agreement with VA to ensure that the agency and its staff will ensure the confidentiality of any quality assurance records or documents shared with the agency.

(c) Qualified persons or organizations, including academic institutions, engaged in healthcare program activities shall, upon request to and approval by the Under Secretary for Health, Regional Director, medical facility Director, or their designees, have access to confidential and privileged medical quality assurance records and documents to permit VA participation in a healthcare activity with the requestor, provided that no records or documents are removed from the VA facility in possession of the records.

(d) When a request under paragraphs (b) or (c) of this section concerns access for research purposes, the request, together with the research plan or protocol, shall first be submitted to and approved by an appropriate VA medical facility Research and Development Committee and then approved by the Director of the VA medical facility. The VA medical facility staff together with the qualified person(s) conducting the research shall be responsible for the preservation of the anonymity of the patients, clients, and providers and shall not disseminate any records or documents which identify such individuals directly or indirectly without the individual's consent. This applies to the handling of data or information as well as reporting or publication of findings. These requirements are in addition to other applicable protections for the research.

(e) Individually identified patient medical record information which is

protected by another statute as provided in § 17.502 may not be disclosed to a non-VA person or organization, including disclosures for research purposes under paragraph (d), except as provided in that statute.

(f) Under paragraph (b), the Under Secretary for Health or designee or under paragraph (c), the Under Secretary for Health, Regional Director, medical facility Director, or their designees may approve a written request if it meets the following criteria:

(1) Participation by VA will benefit VA patient care; or

(2) Participation by VA will enhance VA medical research; or

(3) Participation by VA will enhance VA health services research; or

(4) Participation by VA will enhance VA healthcare planning or program development activities; or

(5) Participation by VA will enhance related VA healthcare program activities; and

(6) Access to the record by the requester is required for VA to participate in a healthcare program with the requester.

(g) Protected quality assurance records or documents, including records pertaining to a specific individual, will for purposes authorized under law be disclosed to a civil or criminal law enforcement governmental agency or instrumentality charged under applicable law with the protection of public health or safety, including state licensing and disciplinary agencies, if a written request for such records or documents is received from an official of such an organization. The request must state the purpose authorized by law for which the records will be used. The Under Secretary for Health, Regional Director, medical facility Director, or their designees will determine the extent to which the information is disclosable.

(h) Federal agencies charged with protecting the public health and welfare, federal and private agencies which engage in various monitoring and quality control activities, agencies responsible for licensure of individual health care facilities or programs, and similar organizations will be provided confidential and privileged quality assurance records and documents if a written request for such records or documents is received from an official of such an organization. The request must state the purpose for which the records will be used. The Under Secretary for Health, Regional Director, medical facility Director, or their designees will determine the extent to which the information is disclosable.

(i) JCAHO (Joint Commission on Accreditation of Healthcare Organizations) survey teams and similar national accreditation agencies or boards and other organizations requested by VA to assess the effectiveness of quality assurance program activities or to consult regarding these programs are entitled to disclosure of confidential and privileged quality assurance documents with the following qualifications:

(1) Accreditation agencies which are charged with assessing all aspects of medical facility patient care, e.g., JCAHO, may have access to all confidential and privileged quality assurance records and documents.

(2) Accreditation agencies charged with more narrowly focused review (e.g., College of American Pathologists, American Association of Blood Banks, Nuclear Regulatory Commission, etc.) may have access only to such confidential and privileged records and documents as are relevant to their respective focus.

(j) Confidential and privileged quality assurance records and documents shall be released to the General Accounting Office if such records or documents pertain to any matter within its jurisdiction.

(k) Confidential and privileged quality assurance records and documents shall be released to both VA and non-VA healthcare personnel upon request to the extent necessary to meet a medical emergency affecting the health or safety of any individual.

(l) For any disclosure made under paragraphs (a) through (i) of this section, the name of and other identifying information regarding any individual VA patient, employee, or other individual associated with VA shall be deleted from any confidential and privileged quality assurance record or document before any disclosure under these quality assurance regulations in

§§ 17.500 through 17.511 is made, if disclosure of such name and identifying information would constitute a clearly unwarranted invasion of personal privacy.

(m) Disclosure of the confidential and privileged quality assurance records and documents identified in § 17.501 will not be made to any individual or agency until that individual or agency has been informed of the penalties for unauthorized disclosure or redisclosure.

(Authority: 38 U.S.C. 5705)

§ 17.510 Redisclosure.

No person or entity to whom a quality assurance record or document has been disclosed under § 17.508 or § 17.509 shall make further disclosure of such record or document except as provided for in 38 U.S.C. 5705 and the regulations in §§ 17.500 through 17.511.

(Authority: 38 U.S.C. 5705)

§ 17.511 Penalties for violations.

Any person who knows that a document or record is a confidential and privileged quality assurance document or record described in §§ 17.500 through 17.511 and willfully discloses such confidential and privileged quality assurance record or document or information contained therein, except as authorized by 38 U.S.C. 5705 or the regulations in §§ 17.500 through 17.511, shall be fined not more than $5,000 in the case of a first offense and not more than $20,000 in the case of each subsequent offense.

(Authority: 38 U.S.C. 5705)

VA Health Professional Scholarship Program

AUTHORITY: 38 U.S.C. 7601–7655.

§ 17.600 Purpose.

The purpose of §§ 17.600 through 17.612 is to set forth the requirements for the award of scholarships under the Department of Veterans Affairs Health Professional Scholarship Program to students receiving education or training in a direct or indirect health-care services discipline to assist in providing an adequate supply of such personnel for VA and for the Nation. Disciplines include nursing, physical therapy, occupational therapy, and other specified direct or indirect health-care disciplines if needed by VA.

[55 FR 40170, Oct. 2, 1990]

§ 17.601 Definitions.

For the purpose of these regulations:

(a) *Acceptable level of academic standing* means the level at which a student retains eligibility to continue in attendance in school under the school's standards and practices in the course of study for which the scholarship was awarded.

(b) *Act* means the Department of Veterans Affairs Health-Care Amendments of 1980, Pub. L. 96–330, (38 U.S.C. 7601–7655), as amended by Pub. L. 97–251, the Department of Veterans Affairs Health-Care Programs Improvement and Extension Act of 1982, Pub. L. 99–576, Veterans Benefits Improvement and Health Care Authorization Act of 1986, and Pub. L. 100–322, the Veterans' Benefits and Services Act of 1988.

(Authority: Pub. L. 96–330; 38 U.S.C. 7601–7655, as amended by Pub. L. 97–251; Pub. L. 99–576 and Pub. L. 100–322)

(c) *Affiliation agreement* means a Memorandum of Affiliation between a Department of Veterans Affairs health care facility and a school of medicine or osteopathy.

(d) *Advanced clinical training* means those programs of graduate training in medicine including osteopathy which (1) lead to eligibility for board certification or which provide other evidence of completion, and (2) have been approved by the appropriate body as determined by the Administrator.

(e) *Secretary* means the Secretary of Veterans Affairs or designee.

(f) *Under Secretary for Health* means the Under Secretary for Health for Veterans Health Administration or designee.

(g) *Citizen of the United States* means any person born, or lawfully naturalized in the United States, subject to its jurisdiction and protection, and owing allegiance thereto.

(h) *Degree* means a course of study leading to a doctor of medicine, doctor of osteopathy, doctor of dentistry, doctor of optometry, doctor of podiatry, or

an associate degree, baccalaureate degree, or master's degree in a nursing specialty needed by VA; or a baccalaureate or master's degree in another direct or indirect health-care service discipline needed by VA.

(i) *Full-time student* means an individual pursuing a course of study leading to a degree who is enrolled for a sufficient number of credit hours in any academic term to complete the course of study within not more than the number of academic terms normally required by the school, college or university. If an individual is enrolled in a school and is pursuing a course of study which is designed to be completed in more than 4 years, the individual will be considered a full-time student for only the last 4 years of the course study.

(j) *Other educational expenses* means a reasonable amount of funds determined by the Secretary to cover expenses such as books, and laboratory equipment.

(k) *Required educational equipment* means educational equipment which must be rented or purchased by all students pursuing a similar curriculum in the same school.

(l) *Required fees* means those fees which are charged by the school to all students pursuing a similar curriculum in the same school.

(m) *Scholarship Program* or *Scholarship* means the Department of Veterans Affairs Health Professional Scholarship Program authorized by section 216 of the Act.

(n) *Participant* or *Scholarship Program Participant* means an individual whose application to the Scholarship Program has been approved and whose contract has been accepted by the Secretary and who has yet to complete the period of obligated service or otherwise satisfy the obligation or financial liabilities of the Scholarship Contract.

(o) *School* means an academic institution which (1) provides training leading to a degree in a direct or indirect health-care service discipline needed by the Department of Veterans Affairs, and (2) which is accredited by a body or bodies recognized for accreditation by the Secretary.

(Authority: 38 U.S.C. 7602(a))

(p) *School year* means, for purposes of the stipend payment, all or part of the 12-month period from September 1 through August 31 during which a participant is enrolled in the school as a full-time student.

(q) *State* means one of the several States, Territories and possessions of the United States, the District of Columbia and the Commonwealth of Puerto Rico.

(r) *Part-time student* means an individual who is a Department of Veterans Affairs employee permanently assigned to a Department of Veterans Affairs health care facility who has been accepted for enrollment or enrolled for study leading to a degree on a less than full-time but not less than half-time basis.

(s) *Department of Veterans Affairs employee* means an individual employed and permanently assigned to a VA health care facility.

(t) *Degree completion date* means the date on which a participant completes all requirements of the degree program.

(Authority: 38 U.S.C. 7452)

(u) *VA health care facility* means Department of Veterans Affairs medical centers, medical and regional office centers, domiciliaries, independent outpatient clinics, and outpatient clinics in regional offices.

(Authority: 38 U.S.C. 7633)

(Approved by the Office of Management and Budget under control number 2900–0352)

[47 FR 10810, Mar. 12, 1982, as amended at 48 FR 37399, Aug. 18, 1983; 54 FR 28674, July 7, 1989; 55 FR 40170, Oct. 2, 1990; 61 FR 21969, May 13, 1996]

§ 17.602 Eligibility.

(a) To be eligible for a scholarship under this program an applicant must—

(1) Be accepted for enrollment or be enrolled as a full-time student in an accredited school located in a State;

(2) Be pursuing a degree annually designated by the Secretary for participation in the Scholarship Program;

(Authority: 38 U.S.C. 7602(a)(1), 7612(b)(1))

(3) Be in a discipline or program annually designated by the Secretary for

participation in the Scholarship Program;

(4) Be a citizen of the United States; and

(5) Submit an application to participate in the Scholarship Program together with a signed contract.

(Authority: 38 U.S.C. 7602(a))

(b) To be eligible for a scholarship as a part-time student under this program, an applicant must satisfy requirements of paragraph (a) of this section and in addition must—

(1) Be a full-time VA employee permanently assigned to a VA health care facility at the time of application and on the date when the scholarship is awarded;

(2) Remain a VA employee for the duration of the scholarship award.

(Authority: 38 U.S.C. 7612(c)(3)(B))

(c) Any applicant who, at the time of application, owes a service obligation to any other entity to perform service after completion of the course of study is ineligible to receive a scholarship under the Department of Veterans Affairs Scholarship Program.

(Authority: 38 U.S.C. 7602(b))

(Approved by the Office of Management and Budget under control number 2900–0352)

[47 FR 10810, Mar. 12, 1982, as amended at 48 FR 37399, Aug. 18, 1983; 54 FR 28674, July 7, 1989]

§ 17.603 Availability of scholarships.

Scholarships will be awarded only when necessary to assist the Department of Veterans Affairs in alleviating shortages or anticipated shortages of personnel in particular health professions. The existence of a shortage of personnel will be determined in accordance with specific criteria for each health profession, promulgated by the Under Secretary for Health. The Secretary has the authority to determine the number of scholarships to be awarded in a fiscal year, and the number that will be awarded to full-time and part-time students.

(Authority: 38 U.S.C. 7612(b)(4) and 7603(b)(1))

[54 FR 28674, July 7, 1989, as amended at 61 FR 21969, May 13, 1996]

§ 17.604 Application for the scholarship program.

Each individual desiring a scholarship under this program must submit an accurate and complete application in the form and at the time prescribed by the Secretary. Included with the application will be a signed written contract to accept payment of a scholarship and to serve *a period of obligated service* (as defined in § 17.607) if the application is approved and if the contract is accepted by the Secretary.

(Authority: 38 U.S.C. 7612(c)(1)(B))

[47 FR 10810, Mar. 12, 1982]

§ 17.605 Selection of participants.

(a) *General.* In deciding which Scholarship Program applications will be approved by the Secretary, priority will be given to applicants entering their final year of education or training and priority will be given to applicants who previously received scholarship awards and who meet the conditions of paragraph (d) of this section. Except for continuation awards (see paragraph (d) of this section), applicants will be evaluated under the criteria specified in paragraph (b) of this section. A situation may occur in which there are a larger number of equally qualified applicants than there are awards to be made. In such cases, a random method may be used as the basis for selection. In selecting participants to receive awards as part-time students, the Secretary may, at the Secretary's discretion—

(Authority: 38 U.S.C. 7612(b)(5))

(1) Award scholarships geographically to part-time students so that available scholarships may be distributed on a relatively equal basis to students working throughout the VA health care system, and/or

(2) Award scholarships on the basis of retention needs within the VA health care system.

(Authority: 38 U.S.C. 7603(d))

(b) *Selection.* In evaluating and selecting participants, the Secretary will take into consideration those factors determined necessary to assure effective participation in the Scholarship

Program. The factors may include, but not be limited to—

(1) Work/volunteer experience, including prior health care employment and Department of Veterans Affairs employment;

(2) Faculty and employer recommendations;

(3) Academic performance; and

(4) Career goals.

(Authority: 38 U.S.C. 7633)

(c) *Selection of part-time students.* Factors in addition to those specified in paragraph (b) of this section, which may be considered in awarding scholarships to part-time students may include, but are not limited to:

(1) Length of service of a VA employee in a health care facility;

(2) Honors and awards received from VA, and other sources;

(3) VA work performance evaluation;

(4) A recommendation for selection for a part-time scholarship from a VA Medical District.

(Authority: 38 U.S.C. 7452(d)(1))

(d) *Duration of scholarship award.* Subject to the availability of funds for the Scholarship Program, the Secretary will award a participant a full-time scholarship under these regulations for a period of from 1 to 4 school years and a participant of a part-time scholarship for a period of 1 to 6 school years.

(Authority: 38 U.S.C. 7612(c)(1)(A) and 7614(3))

(e) *Continuation awards.* Subject to the availability of funds for the Scholarship Program and selection, the Secretary will award a continuation scholarship for completion of the degree for which the scholarship was awarded if—

(1) The award will not extend the total period of Scholarship Program support beyond 4 years for a full-time scholarship, and beyond 6 years for a part-time scholarship; and

(2) The participant remains eligible for continued participation in the Scholarship Program.

(Authority: 38 U.S.C. 7603(d))

(Approved by the Office of Management and Budget under control number 2900–0352)

[48 FR 37399, Aug. 18, 1983, as amended at 54 FR 28674, July 7, 1989]

§ 17.606 Award procedures.

(a) *Amount of scholarship.* (1) A scholarship award will consist of (i) tuition and required fees, (ii) other educational expenses, including books and laboratory equipment, and (iii) except as provided in paragraph (a)(2) of this section, a monthly stipend, for the duration of the scholarship award. All such payments to scholarship participants are exempt from Federal taxation.

(Authority: 38 U.S.C. 7636)

(2) No stipend may be paid to a participant who is a full-time VA employee.

(3) The Secretary may determine the amount of the stipend paid to participants, whether part-time students or full-time students, but that amount may not exceed the maximum amount provided for in 38 U.S.C. 7613(b).

(4) In the case of a part-time student who is a part-time employee, the maximum stipend, if more than a nominal stipend is paid, will be reduced in accordance with the proportion that the number of credit hours carried by such participant bears to the number of credit hours required to be carried by a full-time student in the course of training being pursued by the participant.

(5) A full stipend may be paid only for the months the part-time student is attending classes.

(Authority: 38 U.S.C. 7614(2))

(6) The Secretary may make arrangements with the school in which the participant is enrolled for the direct payment of the amount of tuition and/or reasonable educational expenses on the participant's behalf.

(Authority: 38 U.S.C. 7613(c))

(7) A participant's eligibility for a stipend ends at the close of the month in which degree requirements are met.

(b) *Leave-of-absence, repeated course work.* The Secretary may suspend scholarship payments to or on behalf of a participant if the school (1) approves a leave-of-absence for the participant for health, personal, or other reasons, or (2) requires the participant to repeat course work for which the Secretary previously has made payments under the Scholarship Program. Additional costs relating to the repeated course work will not be paid under this program. Any scholarship payments suspended under this section will be resumed by the Secretary upon notification by the school that the participant has returned from the leave-of-absense or has satisfactorily completed the repeated course work and is proceeding as a full-time student in the course of study for which the scholarship was awarded.

(Authority: 38 U.S.C. 7633)

[48 FR 37400, Aug. 18, 1983, as amended at 55 FR 40170, Oct. 2, 1990]

§ 17.607 Obligated service.

(a) *General.* Except as provided in paragraph (d) of this section, each participant is obligated to provide service as a Department of Veterans Affairs employee in full-time clinical practice in the participant's discipline in an assignment or location determined by the Secretary.

(Authority: 38 U.S.C. 7616(a))

(b) *Beginning of service.* (1) Except as provided in paragraph (b)(2) of this section, a participant's obligated service shall begin on the date the Secretary appoints the participant as a full-time VA employee in the Department of Veterans Affairs Veterans Health Administration in a position for which the degree program prepared the participant. The Secretary shall appoint the participant to such position within 60 days after the participant's degree completion date, or the date the participant becomes licensed in a State to practice in the discipline for which the degree program prepared the participant, whichever is later. At least 60 days prior to the appointment date, the Secretary shall notify the participant of the work assignment, its location, and the date work must begin.

(2) Obligated service shall begin on the degree completion date for a participant who, on that date, is a full-time VA employee working in a capacity for which the degree program prepared the participant.

(Authority: 38 U.S.C. 7616 (b) and (c))

(c) *Duration of service.* The period of obligated service for a participant who attended school as a full-time student shall be 1 year for each school year or part thereof for which the participant received a scholarship award under these regulations. The period of obligated service for a participant who attended school as a part-time student shall be reduced from that which a full-time student must serve in accordance with the proportion that the number of credit hours carried by the part-time student in any school year bears to the number of credit hours required to be carried by a full-time student, whichever is the greater, but shall be a minimum of 1 year of full-time employment.

(Authority: 38 U.S.C. 7612(c)(1)(B) and (3)(A))

(d) *Location for service.* The Secretary reserves the right to make final decisions on location for service obligation. A participant who received a scholarship as a full-time student must be willing to move to another geographic location for service obligation. A participant who received a scholarship as a part-time student may be allowed to serve the period of obligated service at the health care facility where the individual was assigned when the scholarship was authorized.

(Authority: 38 U.S.C. 7616(a))

(e) *Creditability of advanced clinical training.* No period of advanced clinical training will be credited toward satisfying the period of obligated service incurred under the Scholarship Program.

(Authority: 38 U.S.C. 7616(b)(3)(A)(ii)

[47 FR 10810, Mar. 12, 1982, as amended at 48 FR 37400, Aug. 18, 1983; 54 FR 28675, July 7, 1989]

§ 17.608 Deferment of obligated service.

(a) *Request for deferment.* A participant receiving a degree from a school

of medicine, osteopathy, dentistry, optometry, or podiatry, may request deferment of obligated service to complete an approved program of advanced clinical training. The Secretary may defer the beginning date of the obligated service to allow the participant to complete the advanced clinical training program. The period of this deferment will be the time designated for the specialty training.

(Authority: 38 U.S.C. 7616(a)(A)(i))

(b) *Deferment requirements*. Any participant whose period of obligated service is deferred shall be required to take all or part of the advanced clinical training in an accredited program in an educational institution having an Affiliation Agreement with a Department of Veterans Affairs health care facility, and such training will be undertaken in a Department of Veterans Affairs health-care facility.

(Authority: 38 U.S.C. 7616(b)(4))

(c) *Additional service obligation*. A participant who has requested and received deferment for approved advanced clinical training may, at the time of approval of such deferment and at the discretion of the Secretary and upon the recommendation of the Under Secretary for Health, incur an additional period of obligated service—

(1) At the rate of one-half of a calendar year for each year of approved clinical training (or a proportionate ratio thereof) if the training is in a specialty determined to be necessary to meet health care requirements of the Veterans Health Administration; Department of Veterans Affairs; or

(2) At the rate of three-quarters of a calendar year for each year of approved graduate training (or a proportionate ratio thereof) if the training is in a medical specialty determined not to be necessary to meet the health care requirements of the Veterans Health Administration. Specialties necessary to meet the health care requirements of the Veterans Health Administration will be prescribed periodically by the Secretary when, and if, this provision for an additional period of obligated service is to be used.

(Authority: 38 U.S.C. 7616(b)(4)(B))

(d) *Altering deferment*. Before altering the length or type of approved advanced clinical training for which the period of obligated service was deferred under paragraphs (a) or (b) of this section, the participant must request and obtain the Secretary's written approval of the alteration.

(Authority: 38 U.S.C. 7633)

(e) *Beginning of service after deferment*. Any participant whose period of obligated service has been deferred under paragraph (a) or (b) of this section must begin the obligated service effective on the date of appointment under title 38 in full-time clinical practice in an assignment or location in a Department of Veterans Affairs health care facility as determined by the Secretary. The assignment will be made by the Secretary within 120 days prior to or no later than 30 days following the completion of the requested graduate training for which the deferment was granted. Travel and relocation regulations will apply.

(Authority: 38 U.S.C. 7616(b)(2))

[47 FR 10810, Mar. 12, 1982; 47 FR 13523, Mar. 31, 1982, as amended at 54 FR 28675, July 7, 1989; 61 FR 21969, May 13, 1996]

§ 17.609 Pay during period of obligated service.

The initial appointment of physicians for obligated service will be made in a grade commensurate with qualifications as determined in section 7404(b)(1) of title 38 U.S.C. A physician serving a period of obligated service is not eligible for incentive special pay during the first three years of such obligated service. A physician may be paid primary special pay at the discretion of the Secretary upon the recommendation of the Under Secretary for Health.

(Authority: Pub. L. 96–330, Sec. 202; 38 U.S.C. 7431–7440)

[47 FR 10810, Mar. 12, 1982, as amended at 54 FR 28676, July 7, 1989; 61 FR 21969, May 13, 1996]

§ 17.610 Failure to comply with terms and conditions of participation.

(a) If a participant, other than one described in paragraph (b) of this section fails to accept payment or instructs the school not to accept payment of the scholarship provided by the Secretary, the participant must, in addition to any service or other obligation incurred under the contract, pay to the United States the amount of $1,500 liquidated damages. Payment of this amount must be made within 90 days of the date on which the participant fails to accept payment of the scholarship award or instructs the school not to accept payment.

(Authority: 38 U.S.C. 7617(a))

(b) If a participant:

(1) Fails to maintain an acceptable level of academic standing;

(2) Is dismissed from the school for disciplinary reasons;

(3) Voluntarily terminates the course of study or program for which the scholarship was awarded including in the case of a full-time student, a reduction of course load from full-time to part-time before completing the course of study or program;

(4) Fails to become licensed to practice in the discipline for which the degree program prepared the participant, if applicable, in a State within 1 year from the date such person becomes eligible to apply for State licensure; or

(Authority: 38 U.S.C. 7617(b)(4))

(5) Is a part-time student and fails to maintain employment in a permanent assignment in a VA health care facility while enrolled in the course of training being pursued; the participant must instead of performing any service obligation, pay to the United States an amount equal to all scholarship funds awarded under the written contract executed in accordance with § 17.602. Payment of this amount must be made within 1 year from the date academic training terminates unless a longer period is necessary to avoid hardship. No interest will be charged on any part of this indebtedness.

(Authority: 38 U.S.C. 7617(b))

(c) Participants who breach their contracts by failing to begin or complete their service obligation (for any reason) other than as provided for under paragraph (b) of this section are liable to repay the amount of all scholarship funds paid to them and to the school on their behalf, plus interest, multiplied by three, minus months of service obligation satisfied, as determined by the following formula:

$$A = 3\Phi \left(\frac{t-s}{t}\right)$$

in which:

'A' is the amount the United States is entitled to recover;

'φ' is the sum of the amounts paid to or on behalf of the applicant and the interest on such amounts which would be payable if, at the time the amounts were paid, they were loans bearing interest at the maximum legal prevailing rate, as determined by the Treasurer of the United States;

't' is the total number of months in the applicant's period of obligated service; and

's' is the number of months of the period of obligated service served by the participant.

The amount which the United States is entitled to recover shall be paid within 1 year of the date on which the applicant failed to begin or complete the period of obligated service, as determined by the Secretary.

(Authority: 38 U.S.C. 7617(c)(1)(2))

(Approved by the Office of Management and Budget under control number 2900–0352)

[47 FR 10810, Mar. 12, 1982; 47 FR 13523, Mar. 31, 1982, as amended at 48 FR 37400, Aug. 18, 1983; 54 FR 28676, July 7, 1989; 54 FR 46611, Nov. 6, 1989; 61 FR 24237, May 14, 1996]

§ 17.611 Bankruptcy.

Any payment obligation incurred may not be discharged in bankruptcy under title 11 U.S.C. until 5 years after the date on which the payment obligation is due.

(Authority: 38 U.S.C. 7634(c))

[47 FR 10810, Mar. 12, 1982]

§ 17.612 Cancellation, waiver, or suspension of obligation.

(a) Any obligation of a participant for service or payment will be canceled upon the death of the participant.

(Authority: 38 U.S.C. 7634(a))

(b)(1) A participant may seek a waiver or suspension of the service or payment obligation incurred under this program by written request to the Secretary setting forth the basis, circumstances, and causes which support the requested action. The Secretary may approve an initial request for a suspension for a period of up to 1 year. A renewal of this suspension may also be granted.

(2) The Secretary may waive or suspend any service or payment obligation incurred by a participant whenever compliance by the participant (i) is impossible, due to circumstances beyond the control of the participant or (ii) whenever the Secretary concludes that a waiver or suspension of compliance would be in the best interest of the Department of Veterans Affairs.

(Authority: 38 U.S.C. 7634(b))

(c) Compliance by a participant with a service or payment obligation will be considered impossible due to circumstances beyond the control of the participant if the Secretary determines, on the basis of such information and documentation as may be required, that the participant suffers from a physical or mental disability resulting in permanent inability to perform the service or other activities which would be necessary to comply with the obligation.

(Authority: 38 U.S.C. 7634(b))

(d) Waivers or suspensions of service or payment obligations, when not related to paragraph (c) of this section, and when considered in the best interest of the Department of Veterans Affairs, will be determined by the Secretary on an individual basis.

(Authority: 38 U.S.C. 7634(b))

[47 FR 10810, Mar. 12, 1982]

TRANSITIONAL HOUSING LOAN PROGRAM

SOURCE: 59 FR 49579, Sept. 29, 1994, unless otherwise noted.

§ 17.800 Purpose.

The purpose of the Transitional Housing Loan Program regulations is to establish application provisions and selection criteria for loans to non-profit organizations for use in initial start-up costs for transitional housing for veterans who are in (or have recently been in) a program for the treatment of substance abuse. This program is intended to increase the amount of transitional housing available for such veterans who need a period of supportive housing to encourage sobriety maintenance and reestablishment of social and community relationships.

§ 17.801 Definitions.

(a) *Applicant:* A non-profit organization making application for a loan under this program.

(b) *Non-profit organization:* A secular or religious organization, no part of the net earnings of which may inure to the benefit of any member, founder, contributor, or individual. The organization must include a voluntary board and must either maintain or designate an entity to maintain an accounting system which is operated in accordance with generally accepted accounting principles. If not named in, or approved under Title 38 U.S.C. (United States Code), Section 5902, a non-profit organization must provide VA with documentation which demonstrates approval as a non-profit organization under Internal Revenue Code, Section 501.c(3).

(c) *Recipient:* A non-profit organization which has received a loan from VA under this program.

(d) *Veteran:* A person who served in the active military, naval, or air service, and who was discharged or released therefrom under conditions other than dishonorable.

(Authority: Sec. 8 of Pub. L. 102–54, 105 Stat 271, 38 U.S.C. 501)

§ 17.802 Application provisions.

(a) To obtain a loan under these Transitional Housing Loan Program regulations, an application must be

submitted by the applicant in the form prescribed by VA in the application package. The completed application package must be submitted to the Deputy Associate Director for Psychiatric Rehabilitation Services, (302/111C), VA Medical Center, 100 Emancipation Drive, Hampton, VA 23667. An application package may be obtained by writing to the proceeding address or telephoning (804) 722–9961 x3628. (This is not a toll-free number)

(b) The application package includes exhibits to be prepared and submitted, including:

(1) Information concerning the applicant's income, assets, liabilities and credit history,

(2) Information for VA to verify the applicant's financial information,

(3) Identification of the official(s) authorized to make financial transactions on behalf of the applicant,

(4) Information concerning:

(i) The history, purpose and composition of the applicant,

(ii) The applicant's involvement with recovering substance abusers, including:

(A) Type of services provided,

(B) Number of persons served,

(C) Dates during which each type of service was provided,

(D) Names of at least two references of government or community groups whom the organization has worked with in assisting substance abusers,

(iii) The applicant's plan for the provision of transitional housing to veterans including:

(A) Means of identifying and screening potential residents,

(B) Number of occupants intended to live in the residence for which the loan assistance is requested,

(C) Residence operating policies addressing structure for democratic self-government, expulsion policies for non-payment, alcohol or illegal drug use or disruptive behavior,

(D) Type of technical assistance available to residents in the event of house management problems,

(E) Anticipated cost of maintaining the residence, including rent and utilities,

(F) Anticipated charge, per veteran, for residing in the residence,

(G) Anticipated means of collecting rent and utilities payments from residents,

(H) A description of the housing unit for which the loan is sought to support, including location, type of neighborhood, brief floor plan description, etc., and why this residence was selected for this endeavor.

(iv) The applicant's plans for use of the loan proceeds.

(Authority: Sec. 8 of Pub. L. 102–54, 105 Stat. 271, 38 U.S.C. 501)

§ 17.803 Order of consideration.

Loan applications will be considered on a first-come-first-serve basis, subject to availability of funds for loans and awards will be made on a first-come-first-serve basis to applicants who meet the criteria for receiving a loan. If no funds are available for loans, applications will be retained in the order of receipt for consideration as funds become available.

(Authority: Sec. 8 of Pub. L. 102–54, 105 Stat. 271, 38 U.S.C. 501)

§ 17.804 Loan approval criteria.

Upon consideration of the application package, loan approval will be based on the following:

(a) Favorable financial history and status,

(1) A minimum of a two-year credit history,

(2) No open liens, judgments, and no unpaid collection accounts,

(3) No more than two instances where payments were ever delinquent beyond 60 days,

(4) Net ratio: (monthly expenses divided by monthly cash flow) that does not exceed 40%,

(5) Gross ratio: (total indebtedness divided by gross annual cash flow) that does not exceed 35%,

(6) At least two favorable credit references,

(b) Demonstrated ability to successfully address the needs of substance abusers as determined by a minimum of one year of successful experience in providing services, such as, provision of housing, vocational training, structured job seeking assistance, organized relapse prevention services, or similar

activity. Such experience would involve at least twenty-five substance abusers, and would be experience which could be verified by VA inquiries of government or community groups with whom the applicant has worked in providing these services.

(c) An acceptable plan for operating a residence designed to meet the conditions of a loan under this program, which will include:

(1) Measures to ensure that residents are eligible for residency, *i.e.*, are veterans, are in (or have recently been in) a program for the treatment of substance abuse, are financially able to pay their share of costs of maintaining the residence, and agree to abide by house rules and rent/utilities payment provisions,

(2) Adequate rent/utilities collections to cover cost of maintaining the residence,

(3) Policies that ensure democratic self-run government, including expulsion policies, and

(4) Available technical assistance to residents in the event of house management problems.

(d) Selection of a suitable housing unit for use as a transitional residence in a neighborhood with no known illegal drug activity, and with adequate living space for number of veterans planned for residence (at least one large bedroom for every three veterans, at least one bathroom for every four veterans, adequate common space for entire household)

(e) Agreements, signed by an official authorized to bind the recipient, which include:

(1) The loan payment schedule in accordance with the requirements of Pub. L. 102–54, with the interest rate being the same as the rate the VA is charged to borrow these funds from the U.S. Department of Treasury and with a penalty of 4% of the amount due for each failure to pay an installment by the date specified in the loan agreement involved, and

(2) The applicant's intent to use proceeds of loan only to cover initial startup costs associated with the residence, such as security deposit, furnishings, household supplies, and any other initial startup costs.

(Authority: Sec. 8 of Pub. L. 102–54, 105 Stat. 271, 38 U.S.C. 501)

§ 17.805 Additional terms of loans.

In the operation of each residence established with the assistance of the loan, the recipient must agree to the following:

(a) The use of alcohol or any illegal drugs in the residence will be prohibited;

(b) Any resident who violates the prohibition of alcohol or any illegal drugs will be expelled from the residence;

(c) The cost of maintaining the residence, including fees for rent and utilities, will be paid by residents;

(d) The residents will, through a majority vote of the residents, otherwise establish policies governing the conditions of the residence, including the manner in which applications for residence are approved;

(e) The residence will be operated solely as a residence for not less than six veterans.

(Authority: Sec. 8 of Pub. L. 102–54, 105 Stat. 271, 38 U.S.C. 501)

HEALTH CARE BENEFITS FOR CERTAIN CHILDREN OF VIETNAM VETERANS AND VETERANS WITH COVERED SERVICE IN KOREA—SPINA BIFIDA AND COVERED BIRTH DEFECTS

SOURCE: 68 FR 1010, Jan. 8, 2003, unless otherwise noted.

§ 17.900 Definitions.

For purposes of §§ 17.900 through 17.905—

Approved health care provider means a health care provider currently approved by the Center for Medicare and Medicaid Services (CMS), Department of Defense TRICARE Program, Civilian Health and Medical Program of the Department of Veterans Affairs (CHAMPVA), Joint Commission on Accreditation of Health Care Organizations (JCAHO), or currently approved for providing health care under a license or certificate issued by a governmental entity with jurisdiction. An entity or individual will be deemed to be an approved health care provider only

when acting within the scope of the approval, license, or certificate.

Child for purposes of spina bifida means the same as *individual* as defined at § 3.814(c)(2) or § 3.815(c)(2) of this title and for purposes of covered birth defects means the same as *individual* as defined at § 3.815(c)(2) of this title.

Covered birth defect means the same as defined at § 3.815(c)(3) of this title and also includes complications or medical conditions that are associated with the covered birth defect(s) according to the scientific literature.

Habilitative and rehabilitative care means such professional, counseling, and guidance services and such treatment programs (other than vocational training under 38 U.S.C. 1804 or 1814) as are necessary to develop, maintain, or restore, to the maximum extent practicable, the functioning of a disabled person.

Health care means home care, hospital care, nursing home care, outpatient care, preventive care, habilitative and rehabilitative care, case management, and respite care; and includes the training of appropriate members of a child's family or household in the care of the child; and the provision of such pharmaceuticals, supplies (including continence-related supplies such as catheters, pads, and diapers), equipment (including durable medical equipment), devices, appliances, assistive technology, direct transportation costs to and from approved health care providers (including any necessary costs for meals and lodging en route, and accompaniment by an attendant or attendants), and other materials as the Secretary determines necessary.

Health care provider means any entity or individual that furnishes health care, including specialized clinics, health care plans, insurers, organizations, and institutions.

Home care means medical care, habilitative and rehabilitative care, preventive health services, and health-related services furnished to a child in the child's home or other place of residence.

Hospital care means care and treatment furnished to a child who has been admitted to a hospital as a patient.

Nursing home care means care and treatment furnished to a child who has been admitted to a nursing home as a resident.

Outpatient care means care and treatment, including preventive health services, furnished to a child other than hospital care or nursing home care.

Preventive care means care and treatment furnished to prevent disability or illness, including periodic examinations, immunizations, patient health education, and such other services as the Secretary determines necessary to provide effective and economical preventive health care.

Respite care means care furnished by an approved health care provider on an intermittent basis for a limited period to an individual who resides primarily in a private residence when such care will help the individual continue residing in such private residence.

Spina bifida means all forms and manifestations of spina bifida except spina bifida occulta (this includes complications or medical conditions that are associated with spina bifida according to the scientific literature).

Veteran with covered service in Korea for purposes of spina bifida means the same as defined at § 3.814(c)(2) of this title.

Vietnam veteran for purposes of spina bifida means the same as defined at § 3.814(c)(1) or § 3.815(c)(1) of this title and for purposes of covered birth defects means the same as defined at § 3.815(c)(1) of this title.

(Authority: 38 U.S.C. 101(2), 1802–1803, 1811–1813, 1821, 1831)

[68 FR 1010, Jan. 8, 2003, as amended at 76 FR 4249, Jan. 25, 2011]

§ 17.901 Provision of health care.

(a) *Spina bifida.* VA will provide a Vietnam veteran or veteran with covered service in Korea's child who has been determined under § 3.814 or § 3.815 of this title to suffer from spina bifida with health care as the Secretary determines is needed. VA may inform spina bifida patients, parents, or guardians that health care may be available at not-for-profit charitable entities.

(b) *Covered birth defects.* VA will provide a woman Vietnam veteran's child who has been determined under § 3.815 of this title to suffer from covered

birth defects (other than spina bifida) with such health care as the Secretary determines is needed by the child for the covered birth defects. However, if VA has determined for a particular covered birth defect that § 3.815(a)(2) of this title applies (concerning affirmative evidence of cause other than the mother's service during the Vietnam era), no benefits or assistance will be provided under this section with respect to that particular birth defect.

(c) *Providers of care*. Health care provided under this section will be provided directly by VA, by contract with an approved health care provider, or by other arrangement with an approved health care provider.

(d) *Submission of information*. For purposes of §§ 17.900 through 17.905:

(1) The telephone number of the Health Administration Center is (888) 820–1756;

(2) The facsimile number of the Health Administration Center is (303) 331–7807;

(3) The hand-delivery address of the Health Administration Center is 3773 Cherry Creek Drive North, Denver, CO 80246; and

(4) The mailing address of the Health Administration Center for claims submitted pursuant to either paragraph (a) or (b) of this section is P.O. Box 469065, Denver, CO 80246–9065.

(Authority: 38 U.S.C. 101(2), 1802–1803, 1811–1813, 1831)

NOTE TO § 17.901: Under this program, beneficiaries with spina bifida will receive comprehensive care through the Department of Veterans Affairs. However, the health care benefits available under this section to children with other covered birth defects are not comprehensive, and VA will furnish them only health care services that are related to their covered birth defects. With respect to covered children suffering from spina bifida, VA is the exclusive payer for services paid under 17.900 through 17.905, regardless of any third party insurer, Medicare, Medicaid, health plan, or any other plan or program providing health care coverage. As to children with other covered birth defects, any third party insurer, Medicare, Medicaid, health plan, or any other plan or program providing health care coverage would be responsible according to its provisions for payment for health care not relating to the covered birth defects.

[68 FR 1010, Jan. 8, 2003, as amended at 76 FR 4249, Jan. 25, 2011]

§ 17.902 Preauthorization.

(a) Preauthorization from a customer service representative of the Health Administration Center is required for the following services or benefits under §§ 17.900 through 17.905: rental or purchase of durable medical equipment with a total rental or purchase price in excess of $300, respectively; transplantation services; mental health services; training; substance abuse treatment; dental services; and travel (other than mileage at the General Services Administration rate for privately owned automobiles). Authorization will only be given in spina bifida cases where there is a demonstrated medical need. In cases of other covered birth defects, authorization will only be given where there is a demonstrated medical need related to the covered birth defects. Requests for provision of health care requiring preauthorization shall be made to the Health Administration Center and may be made by telephone, facsimile, mail, or hand delivery. The application must contain the following:

(1) Name of child,

(2) Child's Social Security number,

(3) Name of veteran,

(4) Veteran's Social Security number,

(5) Type of service requested,

(6) Medical justification,

(7) Estimated cost, and

(8) Name, address, and telephone number of provider.

(b) Notwithstanding the provisions of paragraph (a) of this section, preauthorization is not required for a condition for which failure to receive immediate treatment poses a serious threat to life or health. Such emergency care should be reported by telephone to the Health Administration Center within 72 hours of the emergency.

(Authority: 38 U.S.C. 101(2), 1802–1803, 1811–1813, 1831)

(The Office of Management and Budget has approved the information collection requirements in this section under control number 2900–0578)

[68 FR 1010, Jan. 8, 2003, as amended at 76 FR 4249, Jan. 25, 2011]

§ 17.903 Payment.

(a)(1) Payment for services or benefits under §§ 17.900 through 17.905 will be

determined utilizing the same payment methodologies as provided for under the Civilian Health and Medical Program of the Department of Veterans Affairs (CHAMPVA) (see § 17.270).

(2) As a condition of payment, the services must have occurred:

(i) For spina bifida, on or after October 1, 1997, and must have occurred on or after the date the child was determined eligible for benefits under § 3.814 of this title.

(ii) For covered birth defects, on or after December 1, 2001, and must have occurred on or after the date the child was determined eligible for benefits under § 3.815 of this title.

(3) Claims from approved health care providers must be filed with the Health Administration Center in writing (facsimile, mail, hand delivery, or electronically) no later than:

(i) One year after the date of service; or

(ii) In the case of inpatient care, one year after the date of discharge; or

(iii) In the case of retroactive approval for health care, 180 days following beneficiary notification of eligibility.

(4) Claims for health care provided under the provisions of §§ 17.900 through 17.905 must contain, as appropriate, the information set forth in paragraphs (a)(4)(i) through (a)(4)(v) of this section.

(i) Patient identification information:

(A) Full name,

(B) Address,

(C) Date of birth, and

(D) Social Security number.

(ii) Provider identification information (inpatient and outpatient services):

(A) Full name and address (such as hospital or physician),

(B) Remittance address,

(C) Address where services were rendered,

(D) Individual provider's professional status (M.D., Ph.D., R.N., etc.), and

(E) Provider tax identification number (TIN) or Social Security number.

(iii) Patient treatment information (long-term care or institutional services):

(A) Dates of service (specific and inclusive),

(B) Summary level itemization (by revenue code),

(C) Dates of service for all absences from a hospital or other approved institution during a period for which inpatient benefits are being claimed,

(D) Principal diagnosis established, after study, to be chiefly responsible for causing the patient's hospitalization,

(E) All secondary diagnoses,

(F) All procedures performed,

(G) Discharge status of the patient, and

(H) Institution's Medicare provider number.

(iv) Patient treatment information for all other health care providers and ancillary outpatient services such as durable medical equipment, medical requisites, and independent laboratories:

(A) Diagnosis,

(B) Procedure code for each procedure, service, or supply for each date of service, and

(C) Individual billed charge for each procedure, service, or supply for each date of service.

(v) Prescription drugs and medicines and pharmacy supplies:

(A) Name and address of pharmacy where drug was dispensed,

(B) Name of drug,

(C) National Drug Code (NDC) for drug provided,

(D) Strength,

(E) Quantity,

(F) Date dispensed,

(G) Pharmacy receipt for each drug dispensed (including billed charge), and

(H) Diagnosis for which each drug is prescribed.

(b) Health care payment will be provided in accordance with the provisions of §§ 17.900 through 17.905. However, the following are specifically excluded from payment:

(1) Care as part of a grant study or research program,

(2) Care considered experimental or investigational,

(3) Drugs not approved by the U.S. Food and Drug Administration for commercial marketing,

(4) Services, procedures, or supplies for which the beneficiary has no legal obligation to pay, such as services obtained at a health fair,

(5) Services provided outside the scope of the provider's license or certification, and

(6) Services rendered by providers suspended or sanctioned by a Federal agency.

(c) Payments made in accordance with the provisions of §§ 17.900 through 17.905 shall constitute payment in full. Accordingly, the health care provider or agent for the health care provider may not impose any additional charge for any services for which payment is made by VA.

(d) *Explanation of benefits (EOB)*—(1) When a claim under the provisions of §§ 17.900 through 17.905 is adjudicated, an EOB will be sent to the beneficiary or guardian and the provider. The EOB provides, at a minimum, the following information:

(i) Name and address of recipient,

(ii) Description of services and/or supplies provided,

(iii) Dates of services or supplies provided,

(iv) Amount billed,

(v) Determined allowable amount,

(vi) To whom payment, if any, was made, and

(vii) Reasons for denial (if applicable).

(2) [Reserved]

(Authority: 38 U.S.C. 101(2), 1802–1803, 1811–1813, 1831)

(The Office of Management and Budget has approved the information collection requirements in this section under control number 2900–0578)

[68 FR 1010, Jan. 8, 2003, as amended at 76 FR 4249, Jan. 25, 2011]

§ 17.904 Review and appeal process.

For purposes of §§ 17.900 through 17.905, if a health care provider, child, or representative disagrees with a determination concerning provision of health care or with a determination concerning payment, the person or entity may request reconsideration. Such request must be submitted in writing (by facsimile, mail, or hand delivery) within one year of the date of the initial determination to the Health Administration Center (Attention: Chief, Benefit and Provider Services). The request must state why it is believed that the decision is in error and must include any new and relevant information not previously considered. Any request for reconsideration that does not identify the reason for dispute will be returned to the sender without further consideration. After reviewing the matter, including any relevant supporting documentation, a benefits advisor will issue a written determination (with a statement of findings and reasons) to the person or entity seeking reconsideration that affirms, reverses, or modifies the previous decision. If the person or entity seeking reconsideration is still dissatisfied, within 90 days of the date of the decision he or she may submit in writing (by facsimile, mail, or hand delivery) to the Health Administration Center (Attention: Director) a request for review by the Director, Health Administration Center. The Director will review the claim and any relevant supporting documentation and issue a decision in writing (with a statement of findings and reasons) that affirms, reverses, or modifies the previous decision. An appeal under this section would be considered as filed at the time it was delivered to the VA or at the time it was released for submission to the VA (for example, this could be evidenced by the postmark, if mailed).

NOTE TO § 17.904: The final decision of the Director will inform the claimant of further appellate rights for an appeal to the Board of Veterans' Appeals.

(Authority: 38 U.S.C. 101(2), 1802–1803, 1811–1813, 1831)

(The Office of Management and Budget has approved the information collection requirements in this section under control number 2900–0578)

[68 FR 1010, Jan. 8, 2003, as amended at 76 FR 4250, Jan. 25, 2011]

§ 17.905 Medical records.

Copies of medical records generated outside VA that relate to activities for which VA is asked to provide payment or that VA determines are necessary to adjudicate claims under §§ 17.900 through 17.905 must be provided to VA at no cost.

(Authority: 38 U.S.C. 101(2), 1802–1803, 1811–1813, 1831)

[68 FR 1010, Jan. 8, 2003, as amended at 76 FR 4250, Jan. 25, 2011]

PAYMENT OR REIMBURSEMENT FOR EMERGENCY SERVICES FOR NON-SERVICE-CONNECTED CONDITIONS IN NON-VA FACILITIES

SOURCE: 66 FR 36470, July 12, 2001, unless otherwise noted.

§ 17.1000 Payment or reimbursement for emergency services for non-service-connected conditions in non-VA facilities.

Sections 17.1000 through 17.1008 constitute the requirements under 38 U.S.C. 1725 that govern VA payment or reimbursement for non-VA emergency services furnished to a veteran for non-service-connected conditions.

(Authority: 38 U.S.C. 1725)

NOTE TO § 17.1000: In cases where a patient is admitted for inpatient care, health care providers furnishing emergency treatment who believe they may have a basis for filing a claim with VA for payment under 38 U.S.C. 1725 should contact VA within 48-hours after admission for emergency treatment. Such contact is not a condition of VA payment. However, the contact will assist the provider in understanding the conditions for payment. The contact may also assist the provider in planning for transfer of the veteran after stabilization.

[66 FR 36470, July 12, 2001, as amended at 68 FR 3404, Jan. 24, 2003]

§ 17.1001 Definitions.

For purposes of §§ 17.1000 through 17.1008:

(a) The term *health-plan contract* means any of the following:

(1) An insurance policy or contract, medical or hospital service agreement, membership or subscription contract, or similar arrangement under which health services for individuals are provided or the expenses of such services are paid;

(2) An insurance program described in section 1811 of the Social Security Act (42 U.S.C. 1395c) or established by section 1831 of that Act (42 U.S.C. 1395j);

(3) A State plan for medical assistance approved under title XIX of the Social Security Act (42 U.S.C. 1396 *et seq.*);

(4) A workers' compensation law or plan described in section 38 U.S.C. 1729(a)(2)(A); or

(5) A law of a State or political subdivision described in 38 U.S.C. 1729(a)(2)(B) (concerning motor vehicle accidents).

(b) The term *third party* means any of the following:

(1) A Federal entity;

(2) A State or political subdivision of a State;

(3) An employer or an employer's insurance carrier;

(4) An automobile accident reparations insurance carrier; or

(5) A person or entity obligated to provide, or to pay the expenses of, health services under a health-plan contract.

(c) The term *duplicate payment* means payment made, in whole or in part, for the same emergency services for which VA reimbursed or made payment.

(d) The term *stabilized* means that no material deterioration of the emergency medical condition is likely, within reasonable medical probability, to occur if the veteran is discharged or transferred to a VA or other Federal facility.

(e) The term *VA medical facility of jurisdiction* means the nearest VA medical facility to where the emergency service was provided.

(Authority: 38 U.S.C. 1725)

§ 17.1002 Substantive conditions for payment or reimbursement.

Payment or reimbursement under 38 U.S.C. 1725 for emergency services may be made only if all of the following conditions are met:

(a) The emergency services were provided in a hospital emergency department or a similar facility held out as providing emergency care to the public;

(b) The claim for payment or reimbursement for the initial evaluation and treatment is for a condition of such a nature that a prudent layperson would have reasonably expected that delay in seeking immediate medical attention would have been hazardous to life or health (this standard would be met if there were an emergency medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that a prudent layperson who possesses an average knowledge of health and medicine

could reasonably expect the absence of immediate medical attention to result in placing the health of the individual in serious jeopardy, serious impairment to bodily functions, or serious dysfunction of any bodily organ or part);

(c) A VA or other Federal facility/provider was not feasibly available and an attempt to use them beforehand would not have been considered reasonable by a prudent layperson (as an example, these conditions would be met by evidence establishing that a veteran was brought to a hospital in an ambulance and the ambulance personnel determined that the nearest available appropriate level of care was at a non-VA medical center);

(d) The claim for payment or reimbursement for any medical care beyond the initial emergency evaluation and treatment is for a continued medical emergency of such a nature that the veteran could not have been safely discharged or transferred to a VA or other Federal facility (the medical emergency lasts only until the time the veteran becomes stabilized);

(e) At the time the emergency treatment was furnished, the veteran was enrolled in the VA health care system and had received medical services under authority of 38 U.S.C. chapter 17 within the 24-month period preceding the furnishing of such emergency treatment;

(f) The veteran is financially liable to the provider of emergency treatment for that treatment;

(g) The veteran has no coverage under a health-plan contract for payment or reimbursement, in whole or in part, for the emergency treatment (this condition cannot be met if the veteran has coverage under a health-plan contract but payment is barred because of a failure by the veteran or the provider to comply with the provisions of that health-plan contract, e.g., failure to submit a bill or medical records within specified time limits, or failure to exhaust appeals of the denial of payment);

(h) If the condition for which the emergency treatment was furnished was caused by an accident or work-related injury, the claimant has exhausted without success all claims and remedies reasonably available to the veteran or provider against a third party for payment of such treatment; and the veteran has no contractual or legal recourse against a third party that could reasonably be pursued for the purpose of extinguishing, in whole or in part, the veteran's liability to the provider; and

(i) The veteran is not eligible for reimbursement under 38 U.S.C. 1728 for the emergency treatment provided (38 U.S.C. 1728 authorizes VA payment or reimbursement for emergency treatment to a limited group of veterans, primarily those who receive emergency treatment for a service-connected disability).

(Authority: 38 U.S.C. 1725)

[66 FR 36470, July 12, 2001, as amended at 68 FR 3404, Jan. 24, 2003]

§ 17.1003 Emergency transportation.

Notwithstanding the provisions of § 17.1002, payment or reimbursement under 38 U.S.C. 1725 for ambulance services, including air ambulance services, may be made for transporting a veteran to a facility only if the following conditions are met:

(a) Payment or reimbursement is authorized under 38 U.S.C. 1725 for emergency treatment provided at such facility (or payment or reimbursement could have been authorized under 38 U.S.C. 1725 for emergency treatment if death had not occurred before emergency treatment could be provided);

(b) The veteran is financially liable to the provider of the emergency transportation;

(c) The veteran has no coverage under a health-plan contract for reimbursement or payment, in whole or in part, for the emergency transportation or any emergency treatment authorized under 38 U.S.C. 1728 (this condition is not met if the veteran has coverage under a health-plan contract but payment is barred because of a failure by the veteran or the provider to comply with the provisions of that health-plan contract); and

(d) If the condition for which the emergency transportation was furnished was caused by an accident or work-related injury, the claimant has exhausted without success all claims

and remedies reasonably available to the veteran or provider against a third party for payment of such transportation; and the veteran has no contractual or legal recourse against a third party that could reasonably be pursued for the purpose of extinguishing, in whole or in part, the veteran's liability to the provider.

(Authority: 38 U.S.C. 1725)

§ 17.1004 Filing claims.

(a) A claimant for payment or reimbursement under 38 U.S.C. 1725 must be the entity that furnished the treatment, the veteran who paid for the treatment, or the person or organization that paid for such treatment on behalf of the veteran.

(b) To obtain payment or reimbursement for emergency treatment under 38 U.S.C. 1725, a claimant must submit to the VA medical facility of jurisdiction a completed standard billing form (such as a UB92 or a HCFA 1500). Where the form used does not contain a false claims notice, the completed form must also be accompanied by a signed, written statement declaring that ''I hereby certify that this claim meets all of the conditions for payment by VA for emergency medical services under 38 CFR 17.1002 (except for paragraph (e)) and 17.1003. I am aware that 38 U.S.C. 6102(b) provides that one who obtains payment without being entitled to it and with intent to defraud the United States shall be fined in accordance with title 18, United States Code, or imprisoned not more than one year, or both.''

NOTE TO § 17.1004(b): These regulations regarding payment or reimbursement for emergency services for nonservice-connected conditions in non-VA facilities also can be found on the internet at *http://www.va.gov/health/elig*.

(c) Notwithstanding the provisions of paragraph (b) of this section, no specific form is required for a claimant (or duly authorized representative) to claim payment or reimbursement for emergency transportation charges under 38 U.S.C. 1725. The claimant need only submit a signed and dated request for such payment or reimbursement to the VA medical facility of jurisdiction, together with a bill showing the services provided and charges for which the veteran is personally liable and a signed statement explaining who requested such transportation services and why they were necessary.

(d) To receive payment or reimbursement for emergency services, a claimant must file a claim within 90 days after the latest of the following:

(1) July 19, 2001.

(2) The date that the veteran was discharged from the facility that furnished the emergency treatment;

(3) The date of death, but only if the death occurred during transportation to a facility for emergency treatment or if the death occurred during the stay in the facility that included the provision of the emergency treatment; or

(4) The date the veteran finally exhausted, without success, action to obtain payment or reimbursement for the treatment from a third party.

(e) If after reviewing a claim the decisionmaker determines that additional information is needed to make a determination regarding the claim, such official will contact the claimant in writing and request additional information. The additional information must be submitted to the decisionmaker within 30 days of receipt of the request or the claim will be treated as abandoned, except that if the claimant within the 30-day period requests in writing additional time, the time period for submission of the information may be extended as reasonably necessary for the requested information to be obtained.

(Authority: 38 U.S.C. 1725)

[66 FR 36470, July 12, 2001, as amended at 68 FR 3404, Jan. 24, 2003]

§ 17.1005 Payment limitations.

(a) Payment or reimbursement for emergency treatment under 38 U.S.C. 1725 shall be the lesser of the amount for which the veteran is personally liable or 70 percent of the amount under the applicable Medicare fee schedule for such treatment.

(b) Reimbursement or payment for emergency treatment may be made only for the period from the beginning of the initial evaluation treatment until such time as the veteran could be safely discharged or transferred to a

VA facility or other Federal facility. For purposes of payment or reimbursement under 38 U.S.C. 1725, VA deems it safe for the veteran to be transferred once the veteran has become stabilized.

(Authority: 38 U.S.C. 1725)

[66 FR 36470, July 12, 2001, as amended at 68 FR 3404, Jan. 24, 2003]

§ 17.1006 Decisionmakers.

The Chief of the Health Administration Service or an equivalent official at the VA medical facility of jurisdiction will make all determinations regarding payment or reimbursement under 38 U.S.C. 1725, except that the Fee Service Review Physician or equivalent officer at the VA medical facility of jurisdiction will make determinations regarding § 17.1002(b), (c), and (d). Any decision denying a benefit must be in writing and inform the claimant of VA reconsideration and appeal rights.

(Authority: 38 U.S.C. 1725)

§ 17.1007 Independent right of recovery.

(a) VA has the right to recover its payment under this section when, and to the extent that, a third party makes payment for all or part of the same emergency treatment for which VA reimbursed or made payment under this section.

(1) Under 38 U.S.C. 1725(d)(4), the veteran (or the veteran's personal representative, successor, dependents, or survivors) or claimant shall ensure that the Secretary is promptly notified of any payment received from any third party for emergency treatment furnished to the veteran. The veteran (or the veteran's personal representative, successor, dependents, or survivors) or claimant shall immediately forward all documents relating to such payment, cooperate with the Secretary in the investigation of such payment and assist the Secretary in enforcing the United States' right to recover any payment made and accepted under this section. The required notification and submission of documentation must be provided by the veteran or claimant to the VA medical facility of jurisdiction within three working days of receipt of notice of the duplicate payment.

(2) If the Chief Financial Officer or equivalent official at the VA medical facility of jurisdiction concludes that payment from a third party was made for all or part of the same emergency treatment for which VA reimbursed or made payment under this section, such VA official shall, except as provided in paragraph (c) of this section, initiate action to collect or recover the amount of the duplicate payment in the same manner as for any other debt owed the United States.

(b)(1) Any amount paid by the United States to the veteran (or the veteran's personal representative, successor, dependents, or survivors) or to any other person or organization paying for such treatment shall constitute a lien in favor of the United States against any recovery the payee subsequently receives from a third party for the same treatment.

(2) Any amount paid by the United States, and accepted by the provider that furnished the veteran's emergency treatment, shall constitute a lien against any subsequent amount the provider receives from a third party for the same emergency treatment for which the United States made payment.

(c) If it is determined that a duplicate payment was made, the Chief Financial Officer or equivalent official at the VA medical facility of jurisdiction may waive recovery of a VA payment made under this section to a veteran upon determining that the veteran has substantially complied with the provisions of paragraph (a)(1) of this section and that actions to recover the payment would not be cost-effective or would conflict with other litigative interests of the United States.

(Authority: 38 U.S.C. 1725)

§ 17.1008 Balance billing prohibited.

Payment by VA under 38 U.S.C. 1725 on behalf of a veteran to a provider of emergency treatment shall, unless rejected and refunded by the provider within 30 days of receipt, extinguish all liability on the part of the veteran for that emergency treatment. Neither the absence of a contract or agreement between VA and the provider nor any provision of a contract, agreement, or assignment to the contrary shall operate

to modify, limit, or negate this requirement.

(Authority: 38 U.S.C. 1725)