

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.

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(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 10-10EZ-R 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