§ 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 for the veteran must provide 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 2900–0219)

[68 FR 1010, Jan. 8, 2003, as amended at 76 FR 4250, Jan. 25, 2011; 81 FR 19891, Apr. 6, 2016]

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)
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.


§ 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 3923(a)(2) of the Social Security Act (42 U.S.C. 1396); or
(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 that VA has an agreement with to furnish health care services for veterans.
(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 treatment (including medical services, professional services, ambulance services, ancillary care and medication (including a short course of medication related to and necessary for the treatment of the emergency condition that is provided directly to or prescribed for the patient for use after the emergency condition is stabilized and the patient is discharged)) will 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 that VA has an agreement with to furnish health care services for veterans was not feasibly available and an attempt to use them beforehand