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Medical

Veterans Benefits Administration

Supplement No. 60

Covering period of *Federal Register* issues through March 3, 2011

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Custom Federal Regulations Service™

Supplemental Materials for *Book I*

Code of Federal Regulations
Title 38, Parts 17, 46, 47, 51–53, 58–62, 70, and 200

Medical

Veterans Benefits Administration

Supplement No. 60

3 March 2011

Covering the period of Federal Register issues
through March 3, 2011

When **Book I** was originally prepared, it was current through final regulations published in the *Federal Register* of 15 January 2000. These supplemental materials are designed to keep your regulations up to date. You should file the attached pages immediately, and record the fact that you did so on the *Supplement Filing Record* which is at page I-8 of Book I, *Medical*.

To ensure accuracy and timeliness of your materials, it is important that you follow these simple procedures:

1. Always file your supplemental materials immediately upon receipt.

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FILING INSTRUCTIONS

Book I, Supplement No. 60
March 3, 2011

Remove these old pages	*Add these new pages*	*Section(s) Affected*
Do not file this supplement until you confirm that all prior supplements have been filed		
I-11 to I-26	I-11 to I-26	Book I Contents
17.INDEX-5 to 17.INDEX-6	17.INDEX-5 to 17.INDEX-6	Part 17 Index
17.101-1 to 17.101-2	17.101-1 to 17.101-2	§17.101
17.101-23 to 17.101-26	17.101-23 to 17.101-26	§17.101
17.110-1 to 17.110-2	17.110-1 to 17.110-2	§17.110
17.805-1 to 17.905-1	17.805-1 to 17.905-1	§§17.900, 17.901, 17.902, 17.903, 17.904 & 17.905

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HIGHLIGHTS

Book I, Supplement No. 60
March 3, 2011

Supplement* Highlights *references: Where substantive changes are made in the text of regulations, the paragraphs of *Highlights* sections are cited at the end of the relevant section of text. Thus, if you are reading §17.100, you will see a note at the end of that section which reads: "Supplement *Highlights* references—37(1)." This means that paragraph 1 of the *Highlights* section in Supplement No. 37 contains information about the changes made in §17.100. By keeping and filing the *Highlights* sections, you will have a reference source explaining all substantive changes in the text of the regulations.

Supplement frequency: Beginning 1 January 2000, supplements for this Book I will be issued *every month* during which a final rule addition or modification is made to the parts of Title 38 covered by this book. Supplements will be numbered consecutively as issued.

Modifications in this supplement include the following:

1. On 6 October 2010, the VA published a final rule, effective 18 March 2011, to amend the medical regulations concerning "reasonable charges" for medical care or services provided or furnished by VA to a veteran for a nonservice-connected disability. Change:

- In §17.101, revised paragraphs (a)(2) and (m).

2. On 25 January 2011, the VA published a final rule, effective 24 February 2011, to amend VA adjudication, medical, and vocational rehabilitation and employment regulations to incorporate relevant provisions of the Veterans Benefits Act of 2003. Specifically, this document amends VA regulations regarding herbicide exposure of certain veterans who served in or near the Korean demilitarized zone and regulations regarding spina bifida in their children. Changes in this Book I:

- Revised the heading preceding §17.900;
- In §17.900, added definition of *Veteran with covered service in Korea*;
- In §17.901, revised paragraphs (a), (b), (d)(3) and (d)(4) and revised the Note at the end of the section; and
- In §17.902, revised paragraph (a).

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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.

(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.

(The Office of Management and Budget has approved the information collection requirements in this section under control number 2900-0606.)

(Authority: 38 U.S.C. 101, 501, 1701, 1705, 1710, 1721, 1722, 1729.)

[32 FR 11382, Aug. 5, 1967. Redesignated and amended at 61 FR 21966, 21967, May 13, 1996. Redesignated and amended at 64 FR 22678, April 17, 1999; 65 FR 65908, Nov. 2, 2000; 66 FR 23327, May 8, 2001; 68 FR 22968, Apr. 29, 2003; 68 FR 70715, Dec. 19, 2003; 69 FR 1061, Jan. 7, 2004; 72 FR 68072, Dec. 4, 2007; 75 FR 61623, Oct. 6, 2010]

Supplement *Highlights* references: Book A–34(1). Book I–2(1), 3(1), 17(1), 22(1, 2), 39(1), 60(1).

Reserved

§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 32670, June 9, 2010; 75 FR 32672, June 9, 2010; 75 FR 54030, Sept. 3, 2010; 76 FR 9646, Feb. 22, 2011]

Supplement *Highlights* references: 53(1), 55(1), 57(1).

§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)

Next Section is §17.900

Health Care Benefits for Certain Children of Vietnam Veterans and Veterans with Covered Service in Korea—Spina Bifida and Covered Birth Defects

Source for §§17.900–17.905 — 62 FR 51284, Sept. 30, 1997, unless otherwise indicated.

§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 ca*re 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)

[62 FR 51284, Sept. 30, 1997, as amended at 68 FR 1010, Jan. 8, 2003; 76 FR 4249, Jan. 25, 2011]

Supplement *Highlights* reference: 13(1), 60(2).

§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.

[62 FR 51284, Sept. 30, 1997, as amended at 65 FR 35283, June 2, 2000; 68 FR 1010, Jan. 8, 2003; 76 FR 4249, Jan. 25, 2011]

Supplement *Highlights* reference: 13(1), 60(2).

§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.)

[62 FR 51284, Sept. 30, 1997, as amended at 65 FR 35283, June 2, 2000; 68 FR 1010, Jan. 8, 2003; 76 FR 4249, Jan. 25, 2011]

Supplement *Highlights* reference: 13(1), 60(2).

§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.)

[62 FR 51284, Sept. 30, 1997, as amended at 65 FR 35283, June 2, 2000; 68 FR 1010, Jan. 8, 2003; 76 FR 4249, Jan. 25, 2011]

Supplement *Highlights* reference: 13(1).

§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.)

[62 FR 51284, Sept. 30, 1997, as amended at 68 FR 1010, Jan. 8, 2003; 76 FR 4250, Jan. 25, 2011]

Supplement *Highlights* reference: 13(1).

§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)

[62 FR 51284, Sept. 30, 1997, as amended at 68 FR 1010, Jan. 8, 2003; 76 FR 4250, Jan. 25 2011]

Supplement *Highlights* reference: 13(1).

Next Section is §17.1000