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Veterans Benefits Administration

Supplement No. 66

Covering period of *Federal Register* issues through January 1, 2012

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Code of Federal Regulations
Title 38, Parts 17, 46, 47, 51–53, 58–62, 70, 71, and 200

Medical

Veterans Benefits Administration

Supplement No. 66

5 January 2012

Covering the period of Federal Register issues
through January 1, 2012

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FILING INSTRUCTIONS

Book I, Supplement No. 66
January 5, 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		
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17.INDEX-5 to 17.INDEX-6	17.INDEX-5 to 17.INDEX-6	Part 17 Index
17.38-1 to 17.39-1	17.38-1 to 17.39-1	§17.38
17.110-1 to 17.110-2	17.110-1 to 17.110-2	§17.110
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17.1000-1 to 17.1008-1	17.1000-1 to 17.1008-1	§§17.1001, 17.1002, 17.1005, 17.1006 and 17.1008
59.130-2 to 59.140-1	59.130-2 to 59.140-1	§59.130

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HIGHLIGHTS

Book I, Supplement No. 66
January 5, 2012

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 19 December 2011, the VA published a final rule, effective that same day, to amend its regulation to provide certain health care services to a newborn child of a woman veteran who is receiving maternity care furnished by VA. Change:

- In §17.38, redesignated paragraph (a)(1)(xiv) as (a)(1)(xv) and added new paragraph (a)(1)(xiv).

2. On 20 December 2011, the VA published an interim final rule, effective that same day, to amend its medical regulations concerning the copayment required for certain medications. Change:

- In §17.110, changed "December 31, 2011" to "December 31, 2012" in paragraphs (b)(1)(ii) and (b)(2).

3. On 21 December 2011, the VA published a final rule, effective 20 January 2012, to amend the VA medical regulations concerning emergency hospital care and medical services provided to eligible veterans at non-VA facilities. Changes:

- In §17.120, revised the section heading and introductory text, revised paragraphs (a), (a)(3), (a)(4), (b) and (c);
- Revised §17.121;
- In §17.1001, revised paragraph (d);
- In §17.1002, revised the introductory text and paragraph (c), removed paragraph (d), and redesignated paragraphs (e) through (i) and (d) through (h);
- In §17.1005, revised paragraph (b) and added paragraphs (c) and (d);
- In §17.1006, changed "Fee Service Review Physician or equivalent officer" to "designated VA clinician"; and
- In §17.1008, changed "treatment" to "treatment and any non-emergency treatment that is authorized under § 17.1005(c) of this part".

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§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.

(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) Newborn care, post delivery, for a newborn child for the date of birth plus seven calendar days after the birth of the child when the birth mother is a woman veteran enrolled in VA health care and receiving maternity care furnished by VA or under authorization from VA and the child is delivered either in a VA facility, or in another facility pursuant to a VA authorization for maternity care at VA expense.

(xv) 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 eye-care 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, 1786)

[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, 2011; 76 FR 78571, Dec. 19, 2011]

Supplement *Highlights* references: 37(1). Book I, 9(1), 41(1), 57(1), 61(2), 66(1).

§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). (Authority: 38 U.S.C. 501, 1734)

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

[67 FR 41179, June 17, 2002, as amended at 71 FR 6680, Feb. 9, 2006]

Supplement *Highlights* references: Book I, 10(1), 32(1).

§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, 2012, 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, 2012, the cap will be $960. If the copayment amount increases after December 31, 2012, 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.

(8) Medication for a veteran who is a former prisoner of war.

(9) A veteran who VA determines to be catastrophically disabled, as defined in 38 CFR 17.36(e). (Authority: 38 U.S.C. 501, 1710, 1720D, 1722A, 1730A)

[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; 76 FR 52274, Aug. 22, 2011; 76 FR 78826, Dec. 20, 2011]

Supplement *Highlights* references: 53(1), 55(1), 57(1), 64(1), 66(2).

Payment And Reimbursement of the Expenses of Medical Services Not Previously Authorized

§17.120 Payment or reimbursement for emergency treatment furnished by non-VA providers to certain veterans with service-connected disabilities.

To the extent allowable, payment or reimbursement of the expenses of emergency treatment, not previously authorized, in a private or public (or Federal) hospital not operated by the Department of Veterans Affairs, or of any emergency treatment not previously authorized including transportation (except prosthetic appliances, similar devices, and repairs) will be paid on the basis of a claim timely filed, under the following circumstances:

(a) *For veterans with service connected disabilities.* Emergency treatment not previously authorized was rendered to a veteran in need of such emergency treatment:

(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 States, the District of Columbia, and the Commonwealth of Puerto Rico); or

(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 §17.47(i)(2); and (Authority: 38 U.S.C. 1724, 1728)

(b) *In a medical emergency.* Emergency treatment not previously authorized 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 the patient for use after the emergency condition is stabilized and the patient is discharged) was rendered in a medical emergency of such 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 is met by 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. And,

(c) *When Federal facilities are unavailable.* VA or other Federal facilities that VA has an agreement with to furnish health care services for veterans 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.

[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; 76 FR 79070 Dec. 21, 2011]

Supplement *Highlights* reference: 66(3).

§17.121 Limitations on payment or reimbursement of the costs of emergency treatment not previously authorized.

(a) *Emergency Treatment.* Except as provided in paragraph (b) of this section, VA will not approve claims for payment or reimbursement of the costs of emergency treatment not previously authorized for any period beyond the date on which the medical emergency ended. For this purpose, VA considers that an emergency ends when the designated VA clinician at the VA facility has determined that, based on sound medical judgment, the veteran who received emergency treatment:

(1) Could have been transferred from the non-VA facility to a VA medical center (or other Federal facility that VA has an agreement with to furnish health care services for veterans) for continuation of treatment, or

(2) Could have reported to a VA medical center (or other Federal facility that VA has an agreement with to furnish health care services for veterans) for continuation of treatment.

(b) *Continued non-emergency treatment.* Claims for payment or reimbursement of the costs of emergency treatment not previously authorized may only be approved for continued, non-emergency treatment, if:

(1) The non-VA facility notified VA at the time the veteran could be safely transferred to a VA facility (or other Federal facility that VA has an agreement with to furnish health care services for veterans), and the transfer of the veteran was not accepted; and

(2) The non-VA facility made and documented reasonable attempts to request transfer of the veteran to a VA facility (or to another Federal facility that VA has an agreement with to furnish health care services for veterans), which means the non-VA facility contacted either the VA Transfer Coordinator, Administrative Officer of the Day, or designated staff responsible for accepting transfer of patients, at a local VA (or other Federal facility) and documented such contact in the veteran's progress/physicians' notes, discharge summary, or other applicable medical record.

(c) *Refusal of transfer.* If a stabilized veteran who requires continued non-emergency treatment refuses to be transferred to an available VA facility (or other Federal facility that VA has an agreement with to furnish health care services for veterans), VA will make payment or reimbursement only for the expenses related to the initial evaluation and the emergency treatment furnished to the veteran up to the point of refusal of transfer by the veteran. (Authority: 38 U.S.C. 1724, 1728, 7304)

[49 FR 15548, Apr. 19, 1984. Redesignated at 61 FR 21966, May 13, 1996; as amended at 76 FR 79071, Dec. 21, 2011]

Supplement *Highlights* reference: 66(3).

§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]

Payment or Reimbursement for Emergency Services for Nonservice-Connected Conditions in Non-VA Facilities

Source: 66 Fed. Reg. 36470, July 12, 2001, unless otherwise noted.

Supplement *Highlights* reference: I-4(2), unless otherwise noted.

§17.1000 Payment or reimbursement for emergency services for nonservice-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 nonservice-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]

Supplement *Highlights* reference: 14(1)

§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 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)

[66 FR 36470, July 12, 2001, as amended at 76 FR 79071, Dec. 21, 2011]

Supplement *Highlights* reference: 66(3)

§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 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 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 the nearest available appropriate level of care was at a non-VA medical center);

(d) 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;

(e) The veteran is financially liable to the provider of emergency treatment for that treatment;

(f) 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);

(g) 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

(h) 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; 76 FR 79071, Dec. 21, 2011]

Supplement *Highlights* references: 14(1), 66(3).

§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). 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 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)

§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) Except as provided in paragraph (c) of this section, VA will not approve claims for payment or reimbursement of the costs of emergency treatment not previously authorized for any period beyond the date on which the medical emergency ended. For this purpose, VA considers that an emergency ends when the designated VA clinician at the VA facility has determined that, based on sound medical judgment, a veteran who received emergency treatment:

(1) Could have been transferred from the non-VA facility to a VA medical center (or other Federal facility that VA has an agreement with to furnish health care services for veterans) for continuation of treatment, or

(2) Could have reported to a VA medical center (or other Federal facility that VA has an agreement with to furnish health care services for veterans) for continuation of treatment.

(c) Claims for payment or reimbursement of the costs of emergency treatment not previously authorized may be approved for continued, non-emergency treatment, only if:

(1) The non-VA facility notified VA at the time the veteran could be safely transferred to a VA facility (or other Federal facility that VA has an agreement with to furnish health care services for veterans) and the transfer of the veteran was not accepted, and

(2) The non-VA facility made and documented reasonable attempts to request transfer of the veteran to VA (or to another Federal facility that VA has an agreement with to furnish health care services for veterans), which means the non-VA facility contacted either the VA Transfer Coordinator, Administrative Officer of the Day, or designated staff responsible for accepting transfer of patients at a local VA (or other Federal facility) and documented such contact in the veteran's progress/physicians' notes, discharge summary, or other applicable medical record.

(d) If a stabilized veteran who requires continued non-emergency treatment refuses to be transferred to an available VA facility (or other Federal facility that VA has an agreement with to furnish health care services for veterans), VA will make payment or reimbursement only for the expenses related to the initial evaluation and the emergency treatment furnished to the veteran up to the point of refusal of transfer by the veteran.

[66 FR 36470, July 12, 2001, as amended at 68 FR 3404, Jan. 24, 2003; 76 FR 79071, Dec. 21, 2011]

Supplement *Highlights* references: 14(1), 66(3).

Reserved

§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 designated VA clinician 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)

[66 FR 36470, July 12, 2001, as amended at 76 FR 79072, Dec. 21, 2011]

Supplement *Highlights* reference: 66(3).

§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 and any non-emergency treatment that is authorized under § 17.1005(c) of this part 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 and any non-emergency treatment that is authorized under § 17.1005(c) of this part. 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)

[66 FR 36470, July 12, 2001, as amended at 76 FR 79072, Dec. 21, 2011]

Supplement *Highlights* reference: 66(3).

End of Part 17

(f) The nurse's station must be equipped to receive resident calls through a communication system from resident rooms, toilet and bathing facilities, dining areas, and activity areas.

(g) The State home must have one or more rooms designated for resident dining and activities. These rooms must be:

(1) Well lighted;

(2) Well ventilated; and

(3) Adequately furnished.

(h) The facility management must provide a safe, functional, sanitary, and comfortable environment for the residents, staff and the public. The facility must:

(1) Ensure that water is available to essential areas when there is a loss of normal water supply;

(2) Have adequate outside ventilation by means of windows, or mechanical ventilation, or a combination of the two;

(3) Equip corridors with firmly secured handrails on each side; and

(4) Maintain an effective pest control program so that the facility is free of pests and rodents. (Authority: 38 U.S.C. 101, 501, 1710, 1742, 8105, 8131-8137).

[66 FR 33847, June 26, 2011, as amended at 76 FR 10249, Feb. 24, 2011; 76 FR 70885, Nov. 16, 2011]

Supplement *Highlights* references: 61(1).

Next Section is §59.140

§59.140 Nursing home care requirements.

As a condition for receiving a grant and grant funds for a nursing home facility under this part, States must comply with the requirements of this section.

(a) Resident rooms must be designed and equipped for adequate nursing care, comfort, and privacy of residents. Resident rooms must:

(1) Accommodate no more than four residents;

(2) Have direct access to an exit corridor;

(3) Have at least one window to the outside;

(4) Be equipped with, or located near, toilet and bathing facilities (VA recommends that public toilet facilities also be located near the residents dining and recreational areas);

(5) Be at or above grade level;

(6) Be designed or equipped to ensure full visual privacy for each resident;

(7) Except in private rooms, each bed must have ceiling suspended curtains that extend around the bed to provide total visual privacy in combination with adjacent walls and curtains;

(8) Have a separate bed for each resident of proper size and height for the safety of the resident;

(9) Have a clean, comfortable mattress;

(10) Have bedding appropriate to the weather and climate;

(11) Have functional furniture appropriate to the resident's needs, and

(12) Have individual closet space with clothes racks and shelves accessible to the resident.

(b) Unless determined by VA as necessary to accommodate an increased quality of care for patients, a nursing home project may propose a deviation of no more than 10 percent (more or less) from the following net square footage for the State to be eligible for a grant of 65 percent of the total estimated cost of the project. If the project proposes building more than the following net square footage and VA makes a determination that it is not needed, the cost of the additional net square footage will not be included in the estimated total cost of construction.

Table to Paragraph (b)—Nursing Home

I. Support facilities [allowable square feet (or metric equivalent) per facility for VA participation]:

Administrator	200
Assistant administrator	150
Medical officer, director of nursing or equivalent	150