Custom Federal Regulations Service™

This is supplemental material for Book I of your set of Federal Regulations

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

Medical

Veterans Benefits Administration

Supplement No. 69

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

Need Assistance?

Questions concerning **MISSING SUPPLEMENTS**, need for **ADDITIONAL BOOKS**, and other **DISTRIBUTION LIST** issues for this loose-leaf service should be directed to:

Department of Veterans Affairs
Veterans Benefits Administration
Administration
Mail Code: 20M33
810 Vermont Avenue, N.W.
Washington DC 20420
Telephone: 202/273-7588
Fax: 202/275-5947
E-mail: coarms@vba.va.gov

Questions concerning the **FILING INSTRUCTIONS** for this loose-leaf service, or the reporting of **SUBSTANTIVE ERRORS** in the text, may be directed to:

Jonathan Publishing
660 Laurel Street, B-103
Baton Rouge LA 70802
Telephone: 225-205-5873
Fax: 702-993-6003
E-mail: info@jonpub.com

GENERAL INSTRUCTIONS

Custom Federal Regulations Service™

Supplemental Materials for *Book I*

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

Medical

Veterans Benefits Administration

Supplement No. 69

5 May 2012

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

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.

2. Before filing, always check the Supplement Filing Record (page I-8) to be sure that all prior supplements have been filed. If you are missing any supplements, contact the Veterans Benefits Administration at the address listed on page I-2.

3. After filing, enter the relevant information on the Supplement Filing Record sheet (page I-8)—the date filed, name/initials of filer, and date through which the *Federal Register* is covered.

4. If as a result of a failure to file, or an undelivered supplement, you have more than one supplement to file at a time, be certain to file them in chronological order, lower number first.

5. Always retain the filing instructions (simply insert them at the back of the book) as a backup record of filing and for reference in case of a filing error.

6. Be certain that you *permanently discard* any pages indicated for removal in the filing instructions in order to avoid confusion later.

To execute the filing instructions, simply remove *and throw away* the pages listed under *Remove These Old Pages,* and replace them in each case with the corresponding pages from this supplement listed under *Add These New Pages*. Occasionally new pages will be added without removal of any old material (reflecting new regulations), and occasionally old pages will be removed without addition of any new material (reflecting rescinded regulations)—in these cases the word *None* will appear in the appropriate column.

FILING INSTRUCTIONS

Book I, Supplement No. 69
May 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		
17.1000-1 to 17.1006-1	17.1000-1 to 17.1006-1	§§17.1001, 17.1002, 17.1004 & 17.1005

Be sure to complete the *Supplement Filing Record* (page I-9) when you have finished filing this material.

HIGHLIGHTS

Book I, Supplement No. 69
May 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 20 April 2012, the VA published a final rule, effective 21 May 2012, to amend its "Payment or Reimbursement for Emergency Services for Nonservice-Connected Conditions in Non-VA Facilities" regulations to conform with a statutory change that expanded veterans' eligibility for reimbursement. Changes:

- In §17.1001, removed paragraph (a)(5);
- In §17.1002, revised paragraph (g);
- In §17.1004, removed paragraph (d)(1), redesignated paragraphs (d)(2) to (d)(4) as (d)(1) to (d)(3), and added paragraph (f); and
- In §17.1005, added paragraphs (e) and (f).

☼

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

(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; 77 FR 23617, Apr. 20, 2012]

Supplement *Highlights* references: 66(3), 69(1).

§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, 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; 77 FR 23617, Apr. 20, 2012]

Supplement *Highlights* references: 14(1), 66(3), 69(1).

§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) The date that the veteran was discharged from the facility that furnished the emergency treatment;

(2) 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

(3) 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)

(f) Notwithstanding paragraph (d) of this section, VA will provide retroactive payment or reimbursement for emergency treatment received by the veteran on or after July 19, 2001, but more than 90 days before May 21, 2012, if the claimant files a claim for reimbursement no later than 1 year after May 21, 2012.

(The Office of Management and Budget has approved the information collection requirements in this section under control number 2900-0620.)

[66 FR 36470, July 12, 2001, as amended at 77 FR 23617, Apr. 20, 2012]

Supplement *Highlights* reference: 69(1).

§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.

(e) If an eligible veteran under § 17.1002 has contractual or legal recourse against a third party that would only partially extinguish the veteran's liability to the provider of emergency treatment, then:

(1) VA will be the secondary payer;

(2) Subject to the limitations of this section, VA will pay the difference between the amount VA would have paid under this section for the cost of the emergency treatment and the amount paid (or payable) by the third party; and

(3) The provider will consider the combined payment under paragraph (c)(2) of this section as payment in full and extinguish the veteran's liability to the provider.

(f) VA will not reimburse a claimant under this section for any deductible, copayment or similar payment that the veteran owes the third party.

[66 FR 36470, July 12, 2001, as amended at 68 FR 3404, Jan. 24, 2003; 76 FR 79071, Dec. 21, 2011; 77 FR 23618, Apr. 20, 2012]

Supplement *Highlights* references: 14(1), 66(3), 69(1).

§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).