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Medical

Veterans Benefits Administration

Supplement No. 70

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

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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, 71, and 200

Medical

Veterans Benefits Administration

Supplement No. 70

5 June 2012

Covering the period of Federal Register issues
through June 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.

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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new regulations), and occasionally old pages will be removed without addition of any new material (reflecting rescinded regulations)—in these cases the word *None* will appear in the appropriate column.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. 70
June 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		
17.110-1 to 17.110-2	17.110-1 to 17.110-2	§17.110
51.110-1 to 51.120-1	51.110-1 to 51.120-1	§51.110

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

HIGHLIGHTS

Book I, Supplement No. 70
June 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 3 May 2012 the VA published a final rule effective 4 June 2012, to update the reference to the required resident assessment tool for State homes that receive per diem from VA for providing nursing home care to veterans. It requires State nursing homes receiving per diem from VA to use the most recent version of the Centers for Medicare and Medicaid Services (CMS) Resident Assessment Instrument/Minimum Data Set (MDS), which is version 3.0. Change:

- In §51.110, revised paragraph (b)(1)(i).

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§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; 77 FR 28259, May 14, 2012]

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

§51.110 Resident assessment.

The facility management must conduct initially, annually and as required by a change in the resident's condition a comprehensive, accurate, standardized, reproducible assessment of each resident's functional capacity.

(a) *Admission orders*. At the time each resident is admitted, the facility management must have physician orders for the resident's immediate care and a medical assessment, including a medical history and physical examination, within a time frame appropriate to the resident's condition, not to exceed 72 hours after admission, except when an examination was performed within five days before admission and the findings were recorded in the medical record on admission.

(b) *Comprehensive assessments*.

(1) The facility management must make a comprehensive assessment of a resident's needs:

(i) Using the Centers for Medicare and Medicaid Services (CMS) Resident Assessment Instrument Minimum Data Set, Version 3.0; and

(ii) Describing the resident's capability to perform daily life functions, strengths, performances, needs as well as significant impairments in functional capacity.

(2) *Frequency*. Assessments must be conducted:

(i) No later than 14 days after the date of admission;

(ii) Promptly after a significant change in the resident's physical, mental, or social condition; and

(iii) In no case less often than once every 12 months.

(3) *Review of assessments*. The nursing facility management must examine each resident no less than once every 3 months, and as appropriate, revise the resident's assessment to assure the continued accuracy of the assessment.

(4) *Use*. The results of the assessment are used to develop, review, and revise the resident's individualized comprehensive plan of care, under paragraph (d) of this section.

(c) *Accuracy of assessments*.

(1) *Coordination*:

(i) Each assessment must be conducted or coordinated with the appropriate participation of health professionals.

(ii) Each assessment must be conducted or coordinated by a registered nurse that signs and certifies the completion of the assessment.

(2) *Certification*. Each person who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment.

(d) *Submission of assessments*. Each assessment (initial, annual, change in condition, and quarterly) using the Centers for Medicare and Medicaid Services (CMS) Resident Assessment Instrument Minimum Data Set, Version 2.0 must be submitted electronically to VA at the IP address provided by VA to the State within 30 days after completion of the assessment document.

(e) *Comprehensive care plans*.

(1) The facility management must develop an individualized comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's physical, mental, and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the following:

(i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §51.120; and

(ii) Any services that would otherwise be required under §51.120 of this part but are not provided due to the resident's exercise of rights under §51.70, including the right to refuse treatment under §51.70(b)(4) of this part.

(2) A comprehensive care plan must be:

(i) Developed within 7 calendar days after completion of the comprehensive assessment;

(ii) Prepared by an interdisciplinary team, that includes the primary physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and

(iii) Periodically reviewed and revised by a team of qualified persons after each assessment.

(3) The services provided or arranged by the facility must:

(i) Meet professional standards of quality; and

(ii) Be provided by qualified persons in accordance with each resident's written plan of care.

(f) *Discharge summary*. Prior to discharging a resident, the facility management must prepare a discharge summary that includes:

(1) A recapitulation of the resident's stay;

(2) A summary of the resident's status at the time of the discharge to include items in paragraph (b)(2) of this section; and

(3) A post-discharge plan of care that is developed with the participation of the resident and his or her family, which will assist the resident to adjust to his or her new living environment. (Authority: 38 U.S.C. 101, 501, 1710, 1741-1743)

(The Office of Management and Budget has approved the information collection requirements in this section under control number 2900-0160.)

[65 FR 968, Jan. 6, 2000, as amended at 74 FR 19434, Apr. 29, 2009; 77 FR 26184, May 3, 2012]

Supplement *Highlights* references: 47(1), 70(1).

Next Section is §51.120

§51.120 Quality of care.

Each resident must receive and the facility management must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.

(a) *Reporting of Sentinel Events*.

(1) *Definition*. A sentinel event is an adverse event that results in the loss of life or limb or permanent loss of function.

(2) Examples of sentinel events are as follows:

(i) Any resident death, paralysis, coma or other major permanent loss of function associated with a medication error; or

(ii) Any suicide of a resident, including suicides following elopement (unauthorized departure) from the facility; or

(iii) Any elopement of a resident from the facility resulting in a death or a major permanent loss of function; or

(iv) Any procedure or clinical intervention, including restraints, that result in death or a major permanent loss of function; or

(v) Assault, homicide or other crime resulting in patient death or major permanent loss of function; or

(vi) A patient fall that results in death or major permanent loss of function as a direct result of the injuries sustained in the fall.

(3) The facility management must report sentinel events to the director of VA medical center of jurisdiction within 24 hours of identification. The VA medical center of jurisdiction must report sentinel events by calling VA Network Director (10N 1-22) and Chief Consultant, Geriatrics and Extended Care Strategic Healthcare Group (114) within 24 hours of notification.

(4) The facility management must establish a mechanism to review and analyze a sentinel event resulting in a written report no later than 10 working days following the event. The purpose of the review and analysis of a sentinel event is to prevent injuries to residents, visitors, and personnel, and to manage those injuries that do occur and to minimize the negative consequences to the injured individuals and facility.

(b) *Activities of daily living*. Based on the comprehensive assessment of a resident, the facility management must ensure that:

(1) A resident's abilities in activities of daily living do not diminish unless circumstances of the individual's clinical condition demonstrate that diminution was unavoidable. This includes the resident's ability to:

(i) Bathe, dress, and groom;

(ii) Transfer and ambulate;

(iii) Toilet;