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## **Medical**

Book I

Title 38, Parts 17, 46, 47, 51–53,  
58–64, 70, 71, and 200

Supplement No. 96

Covering period of *Federal Register* issues  
through November 1, 2015

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**GENERAL INSTRUCTIONS**

Custom Federal Regulations Service™

**Supplemental Materials for *Book I***

**Code of Federal Regulations**

**Title 38, Parts 17, 46, 47, 51–53, 58–64, 70, 71, and 200**

***Medical***

**Supplement No. 96**

5 November 2015

Covering the period of Federal Register issues  
through November 1, 2015

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. 96  
November 5, 2015**

*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**

17.1530-1 to 17.1540-1

17.1530-1 to 17.1540-1

§17.1535

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

## HIGHLIGHTS

### Book I, Supplement No. 96 November 5, 2015

**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 29 October 2015, the VA published a final rule effective that same day, to amend the its medical regulations implementing section 101 of the Veterans Access, Choice, and Accountability Act of 2014, which directed VA to establish a program to furnish hospital care and medical services through eligible non-VA health care providers to eligible veterans who either cannot be seen within the wait-time goals of the Veterans Health Administration or who qualify based on their place of residence. This final rule responds to public comments and amends the regulations to modify payment rates under the Program. Changes:

- In §17.1535, redesignated paragraph (a)(3) as (a)(5), and added new paragraphs (a)(3) and (a)(4).



**§ 17.1530 Eligible entities and providers.**

(a) *General.* An entity or provider is eligible to deliver care under the Veterans Choice Program if, in accordance with paragraph (c) of this section, it is accessible to the veteran and is an entity or provider identified in section 101(a)(1)(B) of the Veterans Access, Choice, and Accountability Act of 2014 and is either:

(1) Not a part of, or an employee of, VA; or

(2) If the provider is an employee of VA, is not acting within the scope of such employment while providing hospital care or medical services through the Veterans Choice Program.

(b) *Agreement.* An entity or provider must enter into an agreement with VA to provide non-VA hospital care or medical services to eligible veterans through one of the following types of agreements: contracts, intergovernmental agreements, or provider agreements. Each form of agreement must be executed by a duly authorized Department official.

(c) *Accessibility.* An entity or provider may only furnish hospital care or medical services to an eligible veteran if the entity or provider is accessible to the eligible veteran. VA will determine accessibility by considering the following factors:

(1) The length of time the eligible veteran would have to wait to receive hospital care or medical services from the entity or provider;

(2) The qualifications of the entity or provider to furnish the hospital care or medical services to the eligible veteran; and

(3) The distance between the eligible veteran's residence and the entity or provider.

(d) *Requirements for health care providers.* To be eligible to furnish care or services under the Veterans Choice Program, a health care provider must maintain at least the same or similar credentials and licenses as those required of VA's health care providers, as determined by the Secretary. The agreement reached under paragraph (b) of this section will clarify these requirements. Eligible health care providers must submit verification of such licenses and credentials maintained by the provider to VA at least once per 12-month period. Any entities that are eligible to provide care through the Program must ensure that any of their providers furnishing care and services through the Program meet these standards. An eligible entity may submit this information on behalf of its providers.

(Authority: Sec. 101, Pub. L. 113-146, 128 Stat. 1754) (The information collection requirements have been submitted to the Office of Management and Budget and are pending OMB approval.)

[79 FR 65586, Nov. 5, 2014]

**Supplement *Highlights* references:** 88(2).

**§ 17.1535 Payment rates and methodologies.**

(a) *Payment rates.* Payment rates will be negotiated and set forth in an agreement between the Secretary and an eligible entity or provider.

(1) Except as otherwise provided in this section, payment rates may not exceed the rates paid by the United States to a provider of services (as defined in section 1861(u) of the Social Security Act (42 U.S.C. 1395x(u)) or a supplier (as defined in section 1861(d) of such Act (42 U.S.C. 1395x(d)) under the Medicare program under title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.) for the same care or services. These rates are known as the “Medicare Fee Schedule” for VA purposes.

(2) For eligible entities or providers in highly rural areas, the Secretary may enter into an agreement that includes a rate greater than the rate defined paragraph (a)(1) of this section for hospital care or medical services, so long as such rate is still determined by VA to be fair and reasonable. The term “highly rural area” means an area located in a county that has fewer than seven individuals residing in that county per square mile.

(3) For eligible entities or providers in Alaska, the Secretary may enter into agreements at rates established under §§ 17.55(j) and 17.56(b).

(4) For eligible entities or providers in a State with an All-Payer Model Agreement under the Social Security Act that became effective on January 1, 2014, payment rates will be calculated based on the payment rates under such agreement.

(5) When there are no available rates as described in paragraph (a)(1) of this section, the Secretary shall, to the extent consistent with the Veterans Access, Choice, and Accountability Act of 2014, follow the process and methodology outlined in §§17.55 and 17.56 and pay the resulting rate.

(b) *Payment responsibilities.* Responsibility for payments will be as follows.

(1) For a nonservice-connected disability, as that term is defined at §3.1(l) of this chapter, a health-care plan of an eligible veteran is primarily responsible, to the extent such care or services is covered by the health-care plan, for paying the eligible entity or provider for such hospital care or medical services as are authorized under §§17.1500 through 17.1540 and furnished to an eligible veteran. VA shall be responsible for promptly paying only for costs of the VA-authorized service not covered by such health-care plan, including a payment made by the veteran, except that such payment may not exceed the rate determined for such care or services pursuant to paragraph (a) of this section.

(2) For hospital care or medical services furnished for a service-connected disability, as that term is defined at §3.1(k) of this chapter, or pursuant to 38 U.S.C. 1710(e), 1720D, or 1720E, VA is solely responsible for paying the eligible entity or provider for such hospital care or medical services as are authorized under §§17.1500 through 17.1540 and furnished to an eligible veteran.

(c) *Authorized care.* VA will only pay for an episode of care for hospital care or medical services authorized by VA. The eligible entity or provider must contact VA to receive authorization prior to providing any hospital care or medical services the eligible non-VA entity or provider believes are necessary that are not identified in the authorization VA submits to the eligible entity or provider. VA will only pay for the hospital care or medical services that are furnished by an eligible entity or provider. There must be an actual encounter with a health care provider, who is either an employee of an entity in an agreement with VA or who is furnishing care through an agreement the health care provider has entered into with VA, and such encounter must occur after an election is made by an eligible veteran.

(Authority: Secs. 101, 105, Pub. L. 113-146, 128 Stat. 1754)

[79 FR 65587, Nov. 5, 2014; as amended at 80 FR 66429, Oct. 29, 2015]

**Supplement *Highlights* references:** 88(2), 96(1).

**§ 17.1540 Claims processing system.**

(a) There is established within the Chief Business Office of the Veterans Health Administration a nationwide claims processing system for processing and paying bills or claims for authorized hospital care and medical services furnished to eligible veterans under §§17.1500 through 17.1540.

(b) The Chief Business Office is responsible for overseeing the implementation and maintenance of such system.

(c) The claims processing system will receive requests for payment from eligible entities and providers for hospital care or medical services furnished to eligible veterans. The claims processing system will provide accurate, timely payments for claims received in accordance with §§17.1500 through 17.1540.

(Authority: Secs. 101, 105, Pub. L. 113-146, 128 Stat. 1754)

[79 FR 65587, Nov. 5, 2014]

**Supplement *Highlights* references:** 88(2).