

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,
58–64, 70, 71, and 200

Medical

Veterans Benefits Administration

Supplement No. 86

Covering period of *Federal Register* issues
through October 1, 2014

Copyright © 2014 Jonathan Publishing

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

Copyright © 2014 Jonathan Publishing

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

Veterans Benefits Administration

Supplement No. 86

5 October 2014

Covering the period of Federal Register issues
through October 1, 2014

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. 86 October 5, 2014

<i>Remove these old pages</i>	<i>Add these new pages</i>	<i>Section(s) Affected</i>
Do not file this supplement until you confirm that all prior supplements have been filed		
I-15 to I-18	I-15 to I-18	Book I Lead Material
17.30-1 to 17.31-1	17.30-1 to 17.31-1	§17.30
17.36-1 to 17.36-8	17.36-1 to 17.36-8	§17.36
17.41-1 to 17.57-1	17.41-1 to 17.57-1	§§17.43, 17.45, 17.47, 17.48, 17.50, 17.52, & 17.57
17.90-1 to 17.98-1	17.90-1 to 17.98-1	§§17.90, 17.93, 17.95, 17.96 & 17.98
17.106-2 to 17.106-5	17.106-2 to 17.106-5	§17.106
17.108-3 to 17.108-4	17.108-3 to 17.108-4	§17.108
17.110-1 to 17.111-6	17.110-1 to 17.111-6	§§17.110 & 17.111
17.142-1 to 17.148-1	17.142-1 to 17.148-1	§17.142
17.150-1 to 17.166-1	17.150-1 to 17.166-1	§§17.150, 17.152, 17.160, 17.161 & 17.163
17.180-1 to 17.190-1	17.180-1 to 17.190-1	§17.180

<i><u>Remove these old pages</u></i>	<i><u>Add these new pages</u></i>	<i><u>Section(s) Affected</u></i>
17.197-1 to 17.200-1	17.197-1 to 17.200-1	§17.197
17.230-1 to 17.240-1	17.230-1 to 17.240-1	§§17.230 & 17.240
17.254-2 to 17.256-1	17.254-2 to 17.256-1	§17.255
17.276-1 to 17.277-1	17.276-1 to 17.277-1	§17.277
17.370-1 to 17.500-1 (this will add 17.400 and 17.410)	17.370-1 to 17.500-1	§§17.400 & 17.410
17.508-1 to 17.509-3	17.508-1 to 17.509-3	§17.509
17.607-2 to 17.610-1	17.607-2 to 17.610-1	§§17.608 & 17.609
17.805-1 to 17.901-1	17.805-1 to 17.901-1	§17.900

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

HIGHLIGHTS

Book I, Supplement No. 86 October 5, 2014

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 12 September 2014, the VA published a final rule effective that same day, to make technical amendments to its medical regulations by updating the statutory authorities identified in certain sections where those statutes have been renumbered or where the authority citation is inaccurate for other technical, nonsubstantive reasons. VA is also amending outdated or incorrect cross-references to other Code of Federal Regulation sections. Changes:

- In §17.30, revised paragraphs (a)(1), (a)(3) and (b),
- In §17.43, revised paragraphs (c) and (d),
- Revised §17.45,
- In §17.47, revised paragraphs (b)(1), (d)(3), (f), (g)(1) and (g)(2),
- Revised §17.50,
- In §17.52, revised paragraphs (a)(1)(v) and (b)(2),
- Revised §17.57,
- In §17.90, revised paragraph (a),
- In §17.93, revised paragraphs (b) and (c)(1),
- Revised §17.95,
- In §17.98, revised paragraph (a),
- In §17.106, revised paragraph (c)(3),
- In §17.142, revised paragraphs (a) and (c),
- In §17.150, revised paragraphs (a) and (b)(4),

- In §17.160, revised paragraph (h),
- In §17.180, revised paragraph (b),
- Revised §17.197,
- In §17.230, revised paragraph (b),
- Revised §17.240, including the section heading,
- In §17.255, revised paragraph (c),
- In §17.509, revised paragraph (a), and
- Revised §17.609

2. On 24 September 2014, the VA published a final rule effective that same day, to implement a statutory mandate that VA provide health care to certain veterans who served at Camp Lejeune, North Carolina, for at least 30 days during the period beginning on January 1, 1957, and ending on December 31, 1987.. Changes:

- In §17.36, revised paragraph (b)(6),
- In §17.108, revised paragraph (e)(2),
- In §17.110, revised paragraph (c)(4),
- In §17.111, revised paragraph (f)(5), and
- Added §17.400.

3. On 24 September 2014, the VA published an interim final rule effective 24 October 2014, to implement statutory authority to provide payment or reimbursement for hospital care and medical services provided to certain veterans' family members who resided at Camp Lejeune, North Carolina, for at least 30 days during the period beginning on January 1, 1957, and ending on December 31, 1987.. Changes:

- Added §17.410.

17.159 Obtaining vehicles for special driver training courses 17.159-1

Dental Services

17.160 Authorization of dental examinations 17.160-1
 17.161 Authorization of outpatient dental treatment 17.161-1
 17.162 Eligibility for Class II dental treatment without rating action 17.162-1
 17.163 Posthospital outpatient dental treatment 17.163-1
 17.164 Patient responsibility in making and keeping dental appointments 17.164-1
 17.165 Emergency outpatient dental treatment..... 17.165-1
 17.166 Dental services for hospital or nursing home patients and domiciled
 members..... 17.166-1
 17.169 VA Dental Insurance Program for veterans and survivors and
 dependents of veterans (VADIP)..... 17.169-1

Autopsies

17.170 Autopsies..... 17.170-1

Veterans Canteen Service

17.180 Delegation of authority 17.180-1

Aid to States for care of Veterans in State Homes

17.190 Recognition of a State home 17.190-1
 17.191 Filing applications..... 17.191-1
 17.192 Approval of annexes and new facilities 17.192-1
 17.193 Prerequisites for payments to State homes 17.193-1
 17.194 Aid for domiciliary care..... 17.194-1

 17.196 Aid for hospital care..... 17.196-1
 17.197 Amount of aid payable 17.197-1
 17.198 Department of Veterans Affairs approval of eligibility required 17.198-1
 17.199 Inspection of recognized State homes..... 17.199-1
 17.200 Audit of State homes..... 17.200-1

Grants to States for Construction or Acquisition of State Home Facilities

17.210 Definitions..... 17.210-1
 17.211 Maximum number of nursing home beds for veterans by State 17.211-1
 17.212 Scope of grants program 17.212-1
 17.213 Applications with respect to projects 17.213-1
 17.214 Disallowance of a grant application and notice of a right to hearing..... 17.214-1
 17.215 Recapture provisions..... 17.215-1
 17.216 General program requirements for construction and acquisition of and

equipment for State home facilities 17.216-1
17.217 Domiciliary and nursing home care program..... 17.217-1
17.218 State home hospital program 17.218-1
17.219 Preapplication phase 17.219-1
17.220 Application phase..... 17.220-1
17.221 Equipment 17.221-1
17.222 General design guidelines and standards 17.222-1

Sharing of Medical Facilities, Equipment, and Information

17.230 Contingency backup to the Department of Defense..... 17.230-1
17.240 Sharing health-care resources 17.240-1
17.241 Sharing medical information services..... 17.241-1
17.242 Coordination of programs with Department of Health and
Human Services 17.242-1

Grants for Exchange of Information

17.250 Scope of the grant program 17.250-1
17.251 The Subcommittee on Academic Affairs..... 17.251-1
17.252 Ex officio member of subcommittee..... 17.252-1
17.253 Applicants for grants 17.253-1
17.254 Applications 17.254-1
17.255 Applications for grants for programs which include
construction projects 17.255-1
17.256 Amended or supplemental applications. 17.256-1
17.257 Awards procedures..... 17.257-1
17.258 Terms and conditions to which awards are subject..... 17.258-1
17.259 Direct costs..... 17.259-1
17.260 Patient care costs to be excluded from direct costs..... 17.260-1
17.261 Indirect costs. 17.261-1
17.262 Authority to approve applications discretionary 17.262-1
17.263 Suspension and termination procedures..... 17.263-1
17.264 Recoupments and releases 17.264-1
17.265 Payments 17.265-1
17.266 Copyrights and patents..... 17.266-1

**Civilian Health and Medical Program of the Department of Veterans Affairs
(CHAMPVA)—Medical Care for Survivors and Dependents of Certain Veterans**

17.270 General provisions 17.270-1
17.271 Eligibility 17.271-1
17.272 Benefit limitations/exclusions..... 17.272-1

17.273 Preauthorization 17.273-1
 17.274 Cost sharing 17.274-1
 17.275 Claim filing deadline..... 17.275-1
 17.276 Appeal/review process 17.276-1
 17.277 Third party liability/medical care cost recovery..... 17.277-1
 17.278 Confidentiality of records 17.278-1

Grants to the Republic of the Philippines

17.350 The program of assistance to the Philippines..... 17.350-1
 17.351 Grants for the replacement and upgrading of equipment at Veterans
 Memorial Medical Center..... 17.351-1
 17.352 Amounts and use of grant funds for the replacement and upgrading of
 equipment 17.352-1
 17.355 Awards procedures..... 17.355-1
 17.362 Acceptance of medical supplies as payment..... 17.362-1
 17.363 Length of stay..... 17.363-1
 17.364 Eligibility determinations..... 17.364-1
 17.365 Admission priorities..... 17.365-1
 17.366 Authorization of emergency admissions 17.366-1
 17.367 Republic of the Philippines to print forms..... 17.367-1
 17.369 Inspections 17.369-1
 17.370 Termination of payments 17.370-1

Hospital Care and Medical Services for Camp Lejeune Veterans and Families

17.400 Hospital care and medical services for Camp Lejeune veterans 17.400-1
 17.410 Hospital care and medical services for Camp Lejeune family members 17.410-1

Confidentiality of Healthcare Quality Assurance Review Records

17.500 General 17.500-1
 17.501 Confidential and privileged documents 17.501-1
 17.502 Applicability of other statutes 17.502-1
 17.503 Improper disclosure..... 17.503-1
 17.504 Disclosure methods..... 17.504-1
 17.505 Disclosure authorities..... 17.505-1
 17.506 Appeal of decision by Veterans Health Administration to
 deny disclosure 17.506-1
 17.507 Employee responsibilities. 17.507-1
 17.508 Access to quality assurance records and documents within the agency..... 17.508-1
 17.509 Authorized disclosure: Non-Department of Veterans Affairs requests. 17.509-1
 17.510 Redisclosure..... 17.510-1
 17.511 Penalties for violations..... 17.511-1

VA Health Professional Scholarship Program

Part 17 — Medical

Authority: 38 U.S.C. 501, 1721, and as noted in specific sections.

Definitions and Active Duty

§17.30 Definitions.

When used in Department of Veterans Affairs medical regulations, each of the following terms shall have the meaning ascribed to it in this section:

(a) *Medical services.* The term *medical services* includes, in addition to medical examination, treatment, and rehabilitative services:

(1) Surgical services, dental services and appliances as authorized in §§17.160 through 17.166, optometric and podiatric services, (in the case of a person otherwise receiving care or services under this chapter) the preventive health care services set forth in 38 U.S.C. 1701(9), noninstitutional extended care, wheelchairs, artificial limbs, trusses and similar appliances, special clothing made necessary by the wearing of prosthetic appliances, and such other supplies or services as are medically determined to be reasonable and necessary. (Authority: 38 U.S.C. 1701(6)(A)(i))

(2) 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 in connection with the veteran's treatment.

(3) Transportation and incidental expenses for any person entitled to such benefits under the provisions of §70.10 of this chapter. (Authority: 38 U.S.C. 1701(6))

(b) *Domiciliary care.* The term *domiciliary care* means the furnishing of a home to a veteran, embracing the furnishing of shelter, food, clothing and other comforts of home, including necessary medical services. The term further includes travel and incidental expenses pursuant to §70.10 of this chapter. (Authority: 38 U.S.C. 1701(4))

[23 FR 6498, Aug. 22, 1958, as amended at 24 FR 8326, Oct. 14, 1959; 30 FR 1787, Feb. 9, 1965; 32 FR 6841, Mar. 4, 1967; 32 FR 13813, Oct. 4, 1967; 33 FR 5298, Apr. 3, 1968; 33 FR 19009, Dec. 20, 1968; 34 FR 9339, June 13, 1969; 36 FR 4782, Mar. 12, 1971; 45 FR 6934, Jan. 31, 1980; 47 FR 58246, Dec. 30, 1982; 49 FR 50029, Dec. 26, 1984; 51 FR 25264, July 10, 1986; 54 FR 14648, Apr. 12, 1989; 61 FR 21965, 21966, May 13, 1996; 62 FR 17072, Apr. 9, 1997; 75 FR 54030, Sept. 3, 2010; 79 FR 54615, Sep. 12, 2014]

Supplement *Highlights* references: 57(1), 86(1).

§17.31 Duty periods defined.

Definitions of duty periods applicable to eligibility for medical benefits are as follows:

(a) *Active military, naval, or air service* includes:

(1) Active duty.

(2) Any period of active duty for training during which the individual was disabled from a disease or injury incurred or aggravated in line of duty.

(3) Any period of inactive duty training during which the individual was disabled from an injury incurred or aggravated in line of duty.

(4) Any period of inactive duty training during which the individual was disabled from an acute myocardial infarction, a cardiac arrest, or a cerebrovascular accident which occurred during such period of inactive duty training.

(b) *Active duty* means:

(1) Full-time duty in the Armed Forces, other than active duty for training.

(2) Full-time duty, other than for training purposes, as a commissioned officer of the Regular or Reserve Corps of the Public Health Service during the following dates:

(i) On or after July 29, 1945;

(ii) Before July 29, 1945, under circumstances affording entitlement to full military benefits; or

(3) Full-time duty as a commissioned officer of the National Oceanic and Atmospheric Administration or its predecessor organizations, the Coast and Geodetic Survey or the Environmental Science Services Administration, during the following dates:

(i) On or after July 29, 1945;

(ii) Before July 29, 1945, under the following circumstances:

(A) While on transfer to one of the Armed Forces;

(B) While, in time of war or national emergency declared by the President, assigned to duty on a project for one of the Armed Forces in an area determined by the Secretary of Defense to be of immediate military hazard; or

(C) In the Philippine Islands on December 7, 1941, and continuously in such islands thereafter; or

(4) Service as a cadet at the U.S. Military, Air Force, or Coast Guard Academy, or as a midshipman at the U.S. Naval Academy.

Enrollment Provisions and Medical Benefits Package**§17.36 Enrollment—provision of hospital and outpatient care to veterans.**

(a) *Enrollment requirement for veterans.*

(1) Except as otherwise provided in §17.37, a veteran must be enrolled in the VA healthcare system as a condition for receiving the “medical benefits package” set forth in §17.38.

Note to paragraph (a)(1): A veteran may apply to be enrolled at any time. (See §17.36(d)(1).)

(2) Except as provided in paragraph (a)(3) of this section, a veteran enrolled under this section and who, if required by law to do so, has agreed to make any applicable copayment is eligible for VA hospital and outpatient care as provided in the “medical benefits package” set forth in §17.38.

Note to paragraph (a)(2): A veteran’s enrollment status will be recognized throughout the United States.

(3) A veteran enrolled based on having a disorder associated with exposure to a toxic substance or radiation, for a disorder associated with service in the Southwest Asia theater of operations during the Gulf War“(the period between August 2, 1990, and November 11, 1998), or any illness associated with service in combat in a war after the Gulf War or during a period of hostility after November 11, 1998, as provided in 38 U.S.C. 1710(e), is eligible for VA care provided in the “medical benefits package” set forth in §17.38 for the disorder.

(b) *Categories of veterans eligible to be enrolled.* The Secretary will determine which categories of veterans are eligible to be enrolled based on the following order of priority:

(1) Veterans with a singular or combined rating of 50 percent or greater based on one or more service-connected disabilities or unemployability.

(2) Veterans with a singular or combined rating of 30 percent or 40 percent based on one or more service-connected disabilities.

(3) Veterans who are former prisoners of war; veterans awarded the Medal of Honor or Purple Heart; veterans with a singular or combined rating of 10 percent or 20 percent based on one or more service-connected disabilities; veterans who were discharged or released from active military service for a disability incurred or aggravated in the line of duty; veterans who receive disability compensation under 38 U.S.C. 1151; veterans whose entitlement to disability compensation is suspended pursuant to 38 U.S.C. 1151, but only to the extent that such veterans’ continuing eligibility for that care is provided for in the judgment or settlement described in 38 U.S.C. 1151; veterans whose entitlement to disability compensation is suspended because of the receipt of military retired pay; and veterans receiving compensation at the 10 percent rating level based on multiple noncompensable service-connected disabilities that clearly interfere with normal employability.

(4) Veterans who receive increased pension based on their need for regular aid and attendance or by reason of being permanently housebound and other veterans who are determined to be catastrophically disabled by the Chief of Staff (or equivalent clinical official) at the VA facility where they were examined.

(5) Veterans not covered by paragraphs (b)(1) through (b)(4) of this section who are determined to be unable to defray the expenses of necessary care under 38 U.S.C. 1722(a).

(6) Veterans of the Mexican border period or of World War I; veterans solely seeking care for a disorder associated with exposure to a toxic substance or radiation, for a disorder associated with service in the Southwest Asia theater of operations during the Gulf War (the period between August 2, 1990, and November 11, 1998), or for any illness associated with service in combat in a war after the Gulf War or during a period of hostility after November 11, 1998, as provided and limited in 38 U.S.C. 1710(e); Camp Lejeune veterans pursuant to §17.400; and veterans with 0 percent service-connected disabilities who are nevertheless compensated, including veterans receiving compensation for inactive tuberculosis.

(7) Veterans who agree to pay to the United States the applicable copayment determined under 38 U.S.C. 1710(f) and 1710(g) if their income for the previous year constitutes “low income” under the geographical income limits established by the U.S. Department of Housing and Urban Development for the fiscal year that ended on September 30 of the previous calendar year. For purposes of this paragraph, VA will determine the income of veterans (to include the income of their spouses and dependents) using the rules in §§3.271, 3.272, 3.273, and 3.276. After determining the veterans’ income and the number of persons in the veterans’ family (including only the spouse and dependent children), VA will compare their income with the current applicable “low-income” income limit for the public housing and section 8 programs in their area that the U.S. Department of Housing and Urban Development publishes pursuant to 42 U.S.C. 1437a(b)(2). If the veteran’s income is below the applicable “low-income” income limits for the area in which the veteran resides, the veteran will be considered to have “low income” for purposes of this paragraph. To avoid a hardship to a veteran, VA may use the projected income for the current year of the veteran, spouse, and dependent children if the projected income is below the “low income” income limit referenced above. This category is further prioritized into the following subcategories:

(i) Noncompensable zero percent service-connected veterans who are in an enrolled status on a specified date announced in a *Federal Register* document promulgated under paragraph (c) of this section and who subsequently do not request disenrollment;

(ii) Nonservice-connected veterans who are in an enrolled status on a specified date announced in a *Federal Register* document promulgated under paragraph (c) of this section and who subsequently do not request disenrollment;

(iii) Noncompensable zero percent service-connected veterans not included in paragraph (b)(7)(i) of this section; and

(iv) Nonservice-connected veterans not included in paragraph (b)(7)(ii) of this section.

(8) Veterans not included in priority category 4 or 7, who are eligible for care only if they agree to pay to the United States the applicable copayment determined under 38 U.S.C. 1710(f) and 1710(g). This category is further prioritized into the following subcategories:

(i) Noncompensable zero percent service-connected veterans who were in an enrolled status on January 17, 2003, or who are moved from a higher priority category or subcategory due to no longer being eligible for inclusion in such priority category or subcategory and who subsequently do not request disenrollment;

(ii) Noncompensable zero percent service-connected veterans not included in paragraph (b)(8)(i) of this section and whose income is not greater than ten percent more than the income that would permit their enrollment in priority category 5 or priority category 7, whichever is higher;

(iii) Nonservice-connected veterans who were in an enrolled status on January 17, 2003, or who are moved from a higher priority category or subcategory due to no longer being eligible for inclusion in such priority category or subcategory and who subsequently do not request disenrollment;

(iv) Nonservice-connected veterans not included in paragraph (b)(8)(iii) of this section and whose income is not greater than ten percent more than the income that would permit their enrollment in priority category 5 or priority category 7, whichever is higher;

(v) Noncompensable zero percent service-connected veterans not included in paragraph (b)(8)(i) or paragraph (b)(8)(ii) of this section; and

(vi) Nonservice-connected veterans not included in paragraph (b)(8)(iii) or paragraph (b)(8)(iv) of this section.

(c) *Federal Register notification of eligible enrollees.*

(1) It is anticipated that each year the Secretary will consider whether to change the categories and subcategories of veterans eligible to be enrolled. The Secretary at any time may revise the categories or subcategories of veterans eligible to be enrolled by amending paragraph (c)(2) of this section. The preamble to a *Federal Register* document announcing which priority categories and subcategories are eligible to be enrolled must specify the projected number of fiscal year applicants for enrollment in each priority category, projected healthcare utilization and expenditures for veterans in each priority category, appropriated funds and other revenue projected to be available for fiscal year enrollees, and projected total expenditures for enrollees by priority category. The determination should include consideration of relevant internal and external factors, e.g., economic changes, changes in medical practices, and waiting times to obtain an appointment for care. Consistent with these criteria, the Secretary will determine which categories of veterans are eligible to be enrolled based on the order of priority specified in paragraph (b) of this section.

(2) Unless changed by a rulemaking document in accordance with paragraph (c)(1) of this section, VA will enroll the priority categories of veterans set forth in §17.36(b) beginning June 15, 2009, except that those veterans in subcategories (v) and (vi) of priority category 8 are not eligible to be enrolled.

(d) *Enrollment and disenrollment process.*

(1) *Application for enrollment.* A veteran may apply to be enrolled in the VA healthcare system at any time. A veteran who wishes to be enrolled must apply by submitting a VA Form 10-10EZ to a VA medical facility or via an Online submission at <https://www.1010ez.med.va.gov/sec/vha/1010ez/>.

(2) *Action on application.* Upon receipt of a completed VA Form 10-10EZ, a VA network or facility director, or the Deputy Under Secretary for Health for Operations and Management or Chief, Health Administration Service or equivalent official at a VA medical facility, or Director, Health Eligibility Center, will accept a veteran as an enrollee upon determining that the veteran is in a priority category eligible to be enrolled as set forth in §17.36(c)(2). Upon determining that a veteran is not in a priority category eligible to be enrolled, the VA network or facility director, or the Deputy Under Secretary for Health for Operations and Management or Chief, Health Administration Service or equivalent official at a VA medical facility, or Director, Health Eligibility Center, will inform the applicant that the applicant is ineligible to be enrolled.

(3) *Placement in enrollment categories.*

(i) Veterans will be placed in priority categories whether or not veterans in that category are eligible to be enrolled.

(ii) A veteran will be placed in the highest priority category or categories for which the veteran qualifies.

(iii) A veteran may be placed in only one priority category, except that a veteran placed in priority category 6 based on a specified disorder or illness will also be placed in priority category 7 or priority category 8, as applicable, if the veteran has previously agreed to pay the applicable copayment, for all matters not covered by priority category 6.

(iv) A veteran who had been enrolled based on inclusion in priority category 5 and became no longer eligible for inclusion in priority category 5 due to failure to submit to VA a current VA Form 10-10EZ will be changed automatically to enrollment based on inclusion in priority category 6 or 8 (or more than one of these categories if the previous principle applies), as applicable, and be considered continuously enrolled. To meet the criteria for priority category 5, a veteran must be eligible for priority category 5 based on the information submitted to VA in a current VA Form 10-10EZ. To be current, after VA has sent a form 10-10EZ to the veteran at the veteran's last known address, the veteran must return the completed form (including signature) to the address on the return envelope within 60 days from the date VA sent the form to the veteran.

(v) Veterans will be disenrolled, and reenrolled, in the order of the priority categories listed with veterans in priority category 1 being the last to be disenrolled and the first to be reenrolled. Similarly, within priority categories 7 and 8, veterans will be disenrolled, and reenrolled, in the order of the priority subcategories listed with veterans in subcategory (i) being the last to be disenrolled and first to be reenrolled.

(4) [Reserved]

(5) *Disenrollment.* A veteran enrolled in the VA health care system under paragraph (d)(2) of this section will be disenrolled only if:

(i) The veteran submits to a VA Medical Center or to the VA Health Eligibility Center, 2957 Clairmont Road, NE., Suite 200, Atlanta, Georgia 30329-1647, a signed and dated document stating that the veteran no longer wishes to be enrolled; or

(ii) A VA network or facility director, or the Deputy Under Secretary for Health for Operations and Management or Chief, Health Administration Service or equivalent official at a VA medical facility, or Director, Health Eligibility Center, determines that the veteran is no longer in a priority category eligible to be enrolled, as set forth in §17.36(c)(2).

(6) *Notification of enrollment status.* Notice of a decision by a VA network or facility director, or the Deputy Under Secretary for Health for Operations and Management or Chief, Health Administration Service or equivalent official at a VA medical facility, or Director, Health Eligibility Center, regarding enrollment status will be provided to the affected veteran by letter and will contain the reasons for the decision. The letter will include an effective date for any changes and a statement regarding appeal rights. The decision will be based on all information available to the decisionmaker, including the information contained in VA Form 10-10EZ.

(e) *Catastrophically disabled.* For purposes of this section, catastrophically disabled means to have a permanent severely disabling injury, disorder, or disease that compromises the ability to carry out the activities of daily living to such a degree that the individual requires personal or mechanical assistance to leave home or bed or requires constant supervision to avoid physical harm to self or others. This definition is met if an individual has been found by the Chief of Staff (or equivalent clinical official) at the VA facility where the individual was examined to have a permanent condition specified in paragraph (e)(1) of this section; to meet permanently one of the conditions specified in paragraph (e)(2) of this section by a clinical evaluation of the patient's medical records that documents that the patient previously met the permanent criteria and continues to meet such criteria (permanently) or would continue to meet such criteria (permanently) without the continuation of on-going treatment; or to meet permanently one of the conditions specified in paragraph (e)(2) of this section by a current medical examination that documents that the patient meets the permanent criteria and will continue to meet such criteria (permanently) or would continue to meet such criteria (permanently) without the continuation of on-going treatment.

(1) Quadriplegia and quadriparesis; paraplegia; legal blindness defined as visual impairment of 20/200 or less visual acuity in the better seeing eye with corrective lenses, or a visual field restriction of 20 degrees or less in the better seeing eye with corrective lenses; persistent vegetative state; or a condition resulting from two of the following procedures, provided the two procedures were not on the same limb:

- (i) Amputation, detachment, or reamputation of or through the hand;
- (ii) Disarticulation, detachment, or reamputation of or through the wrist;
- (iii) Amputation, detachment, or reamputation of the forearm at or through the radius and ulna;
- (iv) Amputation, detachment, or disarticulation of the forearm at or through the elbow;
- (v) Amputation, detachment, or reamputation of the arm at or through the humerus;
- (vi) Disarticulation or detachment of the arm at or through the shoulder;
- (vii) Interthoracoscaphular (forequarter) amputation or detachment;
- (viii) Amputation, detachment, or reamputation of the leg at or through the tibia and fibula;
- (ix) Amputation or detachment of or through the great toe;
- (x) Amputation or detachment of or through the foot;
- (xi) Disarticulation or detachment of the foot at or through the ankle;
- (xii) Amputation or detachment of the foot at or through malleoli of the tibia and fibula;
- (xiii) Amputation or detachment of the lower leg at or through the knee;
- (xiv) Amputation, detachment, or reamputation of the leg at or through the femur;
- (xv) Disarticulation or detachment of the leg at or through the hip; and
- (xvi) Interpelviaabdominal (hindquarter) amputation or detachment.

(2) (i) Dependent in 3 or more Activities of Daily Living (eating, dressing, bathing, toileting, transferring, incontinence of bowel and/or bladder), with at least 3 of the dependencies being permanent with a rating of 1, using the Katz scale.

(ii) A score of 2 or lower on at least 4 of the 13 motor items using the Functional Independence Measure.

(iii) A score of 30 or lower using the Global Assessment of Functioning.

(f) *VA Form 10-10EZ*. Copies of VA Form 10-10EZ are available at any VA medical center and at <https://www.1010ez.med.va.gov/sec/vha/1010ez/>.

(Authority: 38 U.S.C. 101, 501, 1521, 1701, 1705, 1710, 1722)

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

[64 FR 54212, Oct. 6, 1999, as amended at 67 FR 35039, May 17, 2002; 67 FR 62887, Oct. 9, 2002; 68 FR 2672, Jan. 17, 2003; 74 FR 22834, May 15, 2009; 74 FR 48012, Sept. 21, 2009; 75 FR 52628, Aug. 27, 2010; 76 FR 52274, Aug. 22, 2011; 78 FR 72578, Dec. 3, 2013; 79 FR 57414; Sep. 24, 2014]

Supplement Highlights references: 37(1). Book I, 9(1), 12(1), 13(2), 47(2), 51(1), 56(1), 64(1), 85(1), 86(2).

Reserved

Examinations and Observation and Examination**§17.41 Persons eligible for hospital observation and physical examination.**

Hospitalization for observation and physical (including mental) examination may be effected when requested by an authorized official, or when found necessary in examination of the following persons:

(a) Claimants or beneficiaries of VA for purposes of disability compensation, pension, participation in a rehabilitation program under 38 U.S.C. chapter 31, and Government insurance. (38 U.S.C. 1711(a))

(b) Claimants or beneficiaries referred to a diagnostic center for study to determine the clinical identity of an obscure disorder.

(c) Employees of the Department of Veterans Affairs when necessary to determine their mental or physical fitness to perform official duties.

(d) Claimants or beneficiaries of other Federal agencies:

(1) Department of Justice—plaintiffs in Government insurance suits.

(2) United States Civil Service Commission—annuitants or applicants for retirement annuity, and such examinations of prospective appointees as may be requested.

(3) Office of Workers' Compensation Programs—to determine identity, severity, or persistence of disability.

(4) Railroad Retirement Board—applicants for annuity under Public No. 162, 75th Congress.

(5) Other Federal agencies.

(e) Pensioners of nations allied with the United States in World War I and World War II, upon authorization from accredited officials of the respective governments.

[13 FR 7156, Nov. 27, 1948, as amended at 16 FR 12091, Nov. 30, 1951; 19 FR 6716, Oct. 19, 1954; 32 FR 13813, Oct. 4, 1967; 39 FR 32606, Sept. 10, 1974; 49 FR 5616, Feb. 14, 1984. Redesignated and amended at 61 FR 21965, 21966, May 13, 1996]

§17.42 Examinations on an outpatient basis.

Physical examinations on an outpatient basis may be furnished to applicants who have been tentatively determined to be eligible for Department of Veterans Affairs hospital or domiciliary care to determine their need for such care and to the same categories of persons for whom hospitalization for observation and examination may be authorized under §17.41.

[35 FR 6586, Apr. 24, 1970. Redesignated and amended at 61 FR 21965, 21966, May 13, 1996]

Hospital, Domiciliary and Nursing Home Care

§17.43 Persons entitled to hospital or domiciliary care.

Hospital or domiciliary care may be provided:

(a) Not subject to the eligibility provisions of 38 U.S.C. 1710, 1722, and 1729, and 38 CFR 17.44 and 17.45, for:

(1) Persons in the Armed Forces when duly referred with authorization therefor, may be furnished hospital care. Emergency treatment may be rendered, without obtaining formal authorization, to such persons upon their own application, when absent from their commands. Identification of active duty members of the uniformed services will be made by military identification card.

(2) Hospital care may be provided, upon authorization, for beneficiaries of the Public Health Service, Office of Workers' Compensation Programs, and other Federal agencies.

(3) Pensioners of nations allied with the United States in World War I and World War II may be supplied hospital care when duly authorized.

(b) Emergency hospital care may be provided for:

(1) Persons having no eligibility, as a humanitarian service.

(2) Persons admitted because of presumed discharge or retirement from the Armed Forces, but subsequently found to be ineligible as such.

(3) Employees (not potentially eligible as ex-members of the Armed Forces) and members of their families, when residing on reservations of field facilities of the Department of Veterans Affairs, and when they cannot feasibly obtain emergency treatment from private facilities.

(c) Hospital care when incidental to, and to the extent necessary for, the use of a specialized Department of Veterans Affairs medical resource pursuant to a sharing agreement entered into under §17.240, may be authorized for any person designated by the other party to the agreement as a patient to be benefited under the agreement.

(d) The authorization of services under any provision of this section, except services for eligible veterans, is subject to charges as required by §17.102.

[23 FR 6498, Aug. 22, 1958, as amended at 24 FR 8327, Oct. 14, 1959; 32 FR 6841, May 4, 1967; 34 FR 9340, June 13, 1969; 35 FR 6586, Apr. 24, 1970; 39 FR 32606, Sept. 10, 1974. Redesignated and amended at 61 FR 21965, 21966, May 13, 1996. Amended at 64 FR 54218, Oct. 6, 1999; 79 FR 54615, Sep. 12, 2014]

Supplement *Highlights* references: 37(1), 86(1).

§17.44 Hospital care for certain retirees with chronic disability (Executive Orders 10122, 10400 and 11733).

Hospital care may be furnished when beds are available to members or former members of the uniformed services (Army, Navy, Air Force, Marine Corps, Coast Guard, Coast and Geodetic Survey, now National Oceanic and Atmospheric Administration hereinafter referred to as NOAA, and Public Health Service) temporarily or permanently retired for physical disability or receiving disability retirement pay who require hospital care for chronic diseases and who have no eligibility for hospital care under laws governing the Department of Veterans Affairs, or who having eligibility do not elect hospitalization as Department of Veterans Affairs beneficiaries. Care under this section is subject to the following conditions:

(a) Persons defined in this section who are members or former members of the active military, naval, or air service must agree to pay the subsistence rate set by the Secretary of Veterans Affairs, except that no subsistence charge will be made for those persons who are members or former members of the Public Health Service, Coast Guard, Coast and Geodetic Survey now NOAA, and enlisted personnel of the Army, Navy, Marine Corps, and Air Force.

(b) Under this section, the term chronic diseases shall include chronic arthritis, malignancy, psychiatric disorders, poliomyelitis with residuals, neurological disabilities, diseases of the nervous system, severe injuries to the nervous system, including quadriplegia, hemiplegia and paraplegia, tuberculosis, blindness and deafness requiring definitive rehabilitation, disability from major amputation, and other diseases as may be agreed upon from time to time by the Under Secretary for Health and designated officials of the Department of Defense and Department of Health and Human Services. For the purpose of this section, blindness is defined as corrected visual acuity of 20/200 or less in the better eye, or corrected central visual acuity of more than 20/200 if there is a field defect in which the peripheral field has contracted to such an extent that its widest diameter subtends the widest diameter of the field of the better eye at an angle no greater than 20°.

(c) In the case of persons who are former members of the Coast and Geodetic Survey, care may be furnished under this section even though their retirement for disability was from the Environmental Science Services Administration or NOAA.

[34 FR 9340, June 13, 1969, as amended at 39 FR 1841, Jan. 15, 1974; 47 FR 58247, Dec. 30, 1982. Redesignated at 61 FR 21965, May 13, 1996, as amended at 62 FR 17072, Apr. 9, 1997]

§17.45 Hospital care for research purposes.

Subject to §17.102(g), any person who is a bona fide volunteer may be admitted to a Department of Veterans Affairs hospital when the treatment to be rendered is part of an approved Department of Veterans Affairs research project and there are insufficient veteran-patients suitable for the project.

[35 FR 11470, July 17, 1970. Redesignated at 61 FR 21965, May 13, 1996; 79 FR 54615, Sep. 12, 2014]

Supplement *Highlights Reference*: 86(1).

**§17.46 Eligibility for hospital, domiciliary or nursing home care of persons
discharged or released from active military, naval, or air service.**

(a) In furnishing hospital care under 38 U.S.C. 1710(a)(1), VA officials shall:

(1) If the veteran is in immediate need of hospitalization, furnish care at VA facility where the veteran applies or, if that facility is incapable of furnishing care, arrange to admit the veteran to the nearest VA medical center, or Department of Defense hospital with which VA has a sharing agreement under 38 U.S.C. 8111, which is capable of providing the needed care, or if VA or DOD facilities are not available, arrange for care on a contract basis if authorized by 38 U.S.C. 1703 and 38 CFR 17.52; or

(2) If the veteran needs non-immediate hospitalization, schedule the veteran for admission at VA facility where the veteran applies, if the schedule permits, or refer the veteran for admission or scheduling for admission at the nearest VA medical center, or Department of Defense facility with which VA has a sharing agreement under 38 U.S.C. 8111. (Authority: 38 U.S.C. 1703, 1710; §§19011-19012, Pub. L. 99-272)

(b) Domiciliary care may be furnished when needed to:

(1) Any veteran whose annual income does not exceed the maximum annual rate of pension payable to a veteran in need of regular aid and attendance, or

(2) Any veteran who the Secretary determines had no adequate means of support. An additional requirement for eligibility for domiciliary care is the ability of the veteran to perform the following:

- (i) Perform without assistance daily ablutions, such as brushing teeth; bathing; combing hair; body eliminations.
- (ii) Dress self, with a minimum of assistance.
- (iii) Proceed to and return from the dining hall without aid.
- (iv) Feed Self.
- (v) Secure medical attention on an ambulatory basis or by use of personally propelled wheelchair.
- (vi) Have voluntary control over body eliminations or control by use of an appropriate prosthesis.
- (vii) Share in some measure, however slight, in the maintenance and operation of the facility.
- (viii) Make rational and competent decisions as to his or her desire to remain or leave the facility. (Authority 38 U.S.C. 1710(b), sec. 102, Pub. L. 100-322)

[24 FR 8328, Oct. 4, 1959, as amended at 30 FR 1787, Feb. 9, 1965; 32 FR 13813, Oct. 4, 1967; 34 FR 9340, June 13, 1969; 39 FR 1841, Jan. 15, 1974; 45 FR 6935, Jan. 31, 1980; 51 FR 25064, July 10, 1986; 52 FR 11259, Apr. 8, 1987; 53 FR 9627, Mar. 24, 1988; 53 FR 32391, Aug. 25, 1988; 56 FR 5757, Feb. 13, 1991. Redesignated and amended at 61 FR 21965, 21966, May 13, 1996]

§17.47 Considerations applicable in determining eligibility for hospital, nursing home or domiciliary care.

(a) (1) For applicants discharged or released for disability incurred or aggravated in line of duty and who are not in receipt of compensation for service-connected or service-aggravated disability, the official records of the Armed Forces relative to findings of line of duty for its purposes will be accepted in determining eligibility for hospital care. Where the official records of the Armed Forces show a finding of disability not incurred or aggravated in line of duty and evidence is submitted to the Department of Veterans Affairs which permits of a different finding, the decision of the Armed Forces will not be binding upon the Department of Veterans Affairs, which will be free to make its own determination of line of duty incurrence or aggravation upon evidence so submitted. It will be incumbent upon the applicant to present controverting evidence and, until such evidence is presented and a determination favorable to the applicant is made by the Department of Veterans Affairs, the finding of the Armed Forces will control and hospital care will not be authorized. Such controverting evidence, when received from an applicant, will be referred to the adjudicating agency which would have jurisdiction if the applicant was filing claim for pension or disability compensation, and the determination of such agency as to line of duty, which is promptly to be communicated to the head of the field facility receiving the application for hospital care, will govern the facility Director's disapproval or approval of admission, other eligibility requirements having been met. Where the official records of the Armed Forces show that the disability for which a veteran was discharged or released from the Armed Forces under other than dishonorable conditions was incurred or aggravated in the line of duty, such showing will be accepted for the purpose of determining his or her eligibility for hospitalization, notwithstanding the fact that the Department of Veterans Affairs has made a determination in connection with a claim for monetary benefits that the disability was incurred or aggravated not in line of duty.

(2) In those exceptional cases where the official records of the Armed Forces show discharge or release under other than dishonorable conditions because of expiration of period of enlistment or any other reason except disability, but also show a disability incurred or aggravated in line of duty during the said enlistment; and the disability so recorded is considered in medical judgment to be or to have been of such character, duration, and degree as to have justified a discharge or release for disability had the period of enlistment not expired or other reason for discharge or release been given, the Under Secretary for Health, upon consideration of a clear, full statement of circumstances, is authorized to approve admission of the applicant for hospital care, provided other eligibility requirements are met. A typical case of this kind will be one where the applicant was under treatment for the said disability recorded during his or her service at the time discharge or release was given for the reason other than disability.

(b) (1) Under 38 U.S.C. 1710(a)(1), veterans who are receiving disability compensation awarded under §3.362 of this chapter, where a disease, injury or the aggravation of an existing disease or injury occurs as a result of VA examination, medical or surgical treatment, or of hospitalization in a VA health care facility or of participation in a rehabilitation program under 38 U.S.C. ch. 31, under any law administered by VA and not the result of his/her own willful misconduct. Treatment may be provided for the disability for which the compensation is being paid or for any other disability. Treatment under the authority of 38 U.S.C. 1710(a)(1) may not be authorized during any period when disability compensation under §3.362 of this title is not being paid because of the provision of §3.362(a)(2) except to the extent continuing eligibility for

such treatment is provided for in the judgment for settlement described in §3.362(a)(2) of this title. (Authority: 38 U.S.C. 1710(a); sec. 701, Pub. L. 98-160, Pub. L. 99-272)

(2) For purposes of eligibility for domiciliary care, the phrase *no adequate means of support* refers to an applicant for domiciliary care whose annual income exceeds the annual rate of pension for a veteran in receipt of regular aid and attendance, as defined in 38 U.S.C. 1503, but who is able to demonstrate to competent VA medical authority, on the basis of objective evidence, that deficits in health and or functional status render the applicant incapable of pursuing substantially gainful employment, as determined by the Chief of Staff, and who is otherwise without the means to provide adequately for self, or be provided for in the community. (Authority: 38 U.S.C. 1710(a); sec. 701, Pub. L. 98-160, Pub. L. 99-272)

(c) A *disability, disease, or defect* will comprehend any acute, subacute, or chronic disease (or a general medical, tuberculous, or neuropsychiatric type) of any acute, subacute, or chronic surgical condition susceptible of cure or decided improvement by hospital care or any condition which does not require hospital care for an acute or chronic condition but requires domiciliary care. Domiciliary care, as the term implies, is the provision of a home, with such ambulant medical care as is needed. To be provided with domiciliary care, the applicant must consistently have a disability, disease, or defect which is essentially chronic in type and is producing disablement of such degree and probable persistency as will incapacitate from earning a living for a prospective period. (Authority: 38 U.S.C. 1701, 1710)

(d) (1) For purposes of determining eligibility for hospital or nursing home care under §17.47(a), a veteran will be determined unable to defray the expenses of necessary care if the veteran agrees to provide verifiable evidence, as determined by the Secretary, that:

(i) The veteran is eligible to receive medical assistance under a State plan approved under title XIX of the Social Security Act; (Authority: 42 U.S.C. 1396, *et seq.*)

(ii) The veteran is in receipt of pension under 38 U.S.C. 1521; or

(iii) The veteran's attributable income does not exceed \$15,000 if the veteran has no dependents, \$18,000 if the veteran has one dependent, plus \$1,000 for each additional dependent. (Authority: 38 U.S.C. 1722; sec. 19011, Pub. L. 99-272)

(2) For purposes of determining eligibility for hospital or nursing home care under §17.47(c), a veteran will be determined eligible for necessary care if the veteran agrees to provide verifiable evidence, as determined by the Secretary, that: The veteran's attributable income does not exceed \$20,000 if the veteran has no dependents, \$25,000 if the veteran has one dependent, plus \$1,000 for each additional dependent. (Authority: 38 U.S.C. 1722; sec. 19011, Pub. L. 99-272)

(3) Effective on January 1 of each year after calendar year 1986, the amounts set forth in paragraph (d)(1) and (2) of this section shall be increased by the percentage by which the maximum rates of pension were increased under 38 U.S.C. 5312(a), during the preceding year. (Authority: 38 U.S.C. 1722; sec. 19011, Pub. L. 99-272)

(4) Determinations with respect to attributable income made under paragraph (d)(1) and (2) of this section, shall be made in the same manner, including the same sources of income and exclusions from income, as determinations with respect to income are made for determining eligibility for pension under §§3.271 and 3.272 of this title. The term attributable income means income of a veteran for the calendar year preceding application for care,

determined in the same manner as the manner in which a determination is made of the total amount of income by which the rate of pension for such veteran under 38 U.S.C. 1521 would be reduced if such veteran were eligible for pension under that section. (Authority: 38 U.S.C. 1722; sec. 19011, Pub. L. 99-272)

(5) Notwithstanding the attributable income of a veteran, VA may determine that such veteran is not eligible under paragraph (d)(1) and (2) of this section if the corpus of the estate of the veteran is such that under all the circumstances it is reasonable that some part of the corpus of the estate of the veteran be consumed for the veteran's maintenance. The corpus of the estate of a veteran shall be determined in the same manner as determinations are made with respect to the determinations of eligibility for pension under §3.275 of this chapter. The term *corpus of the estate of the veteran* includes the corpus of the estates of the veteran's spouse and dependent children, if any. (Authority: 38 U.S.C. 1722; sec. 19011, Pub. L. 99-272)

(6) In order to avoid hardship VA may determine that a veteran is eligible for care notwithstanding that the veteran does not meet the income requirements established in paragraph (d)(1)(iii) or (d)(2) of this section, if projections of the veteran's income for the year following application for care are substantially below the income requirements established in paragraph (d)(1)(iii) or (d)(2) of this section. (Authority: 38 U.S.C. 1722; sec. 19011, Pub. L. 99-272)

(e) (1) If VA determines that an individual was incorrectly charged a copayment, VA will refund the amount of any copayment actually paid by that individual. (Authority: 38 U.S.C. 501; sec. 19011, Pub. L. 99-272)

(2) In the event a veteran provided inaccurate information on an application and is incorrectly deemed eligible for care under 38 U.S.C. 1710(a)(1) or (a)(2) rather than 38 U.S.C. 1710(a)(3), VA shall retroactively bill the veteran for the applicable copayment. (Authority: 38 U.S.C. 501 and 1710; sec. 19011, Pub. L. 99-272)

(f) If a veteran who receives hospital, nursing home, or outpatient care under 38 U.S.C. 1710(a)(3) by virtue of the veteran's eligibility for hospital care under 38 U.S.C. 1710(a), fails to pay to the United States the amounts agreed to under those sections shall be grounds for determining, in accordance with guidelines promulgated by the Under Secretary for Health, that the veteran is not eligible to receive further care under those sections until such amounts have been paid in full. (Authority: 38 U.S.C. 1710, 1721; sec. 19011, Pub. L. 99-272)

(g) (1) Persons hospitalized who have no service-connected disabilities pursuant to §17.47, and/or persons receiving outpatient medical services pursuant to §17.93 who have no service-connected disabilities who it is believed may be eligible for hospital care and/or medical services, or reimbursement for the expenses of care or services for all or part of the cost thereof by reason of the following:

(i) Membership in a union, fraternal or other organization, or

(ii) Coverage under 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, will not be furnished hospital care or medical services without charge therefore to the extent of the amount for which such parties referred to in paragraphs (g)(1)(i) or (g)(1)(ii) of this section, are, will become, or may be liable. Persons believed entitled to care under any of the plans discussed above will be required to provide such information as the Secretary may require. Provisions of

this paragraph are effective April 7, 1986, except in the case of a health care policy or contract that was entered into before that date, the effective date shall be the day after the plan was modified or renewed or on which there was any change in premium or coverage and will apply only to care and services provided by VA after the date the plan was modified, renewed, or on which there was any change in premium or coverage. (Authority: 38 U.S.C. 1729; sec. 19013, Pub. L. 99-272)

(2) Persons hospitalized for the treatment of nonservice-connected disabilities pursuant to §17.47, or persons receiving outpatient medical services pursuant to §17.93, and who it is believed may be entitled to hospital care and/or medical services or to reimbursement for all or part of the cost thereof from any one or more of the following parties:

- (i) *Workers' Compensation* or employer's liability statutes, State or Federal;
- (ii) By reason of statutory or other relationships with third parties, including those liable for damages because of negligence or other legal wrong;
- (iii) By reason of a statute in a State, or political subdivision of a State;
 - (A) Which requires automobile accident reparations or;
 - (B) Which provides compensation or payment for medical care to victims suffering personal injuries as the result of a crime of personal violence;
- (iv) Right to maintenance and cure in admiralty;

will not be furnished hospital care or medical services without charge therefore to the extent of the amount for which such parties are, will become, or may be liable. Persons believed entitled to care under circumstances described in paragraph (g)(2)(ii) of this section will be required to complete such forms as the Secretary may require, such as a power of attorney and assignment. Notice of this assignment will be mailed promptly to the party or parties believed to be liable. When the amount of charges is ascertained, a bill therefore will be mailed to such party or parties. Persons believed entitled to care under circumstances described in paragraph (g)(2)(i) or (g)(2)(iii) of this section will be required to complete such forms as the Secretary may require. (Authority: 38 U.S.C. 1729, sec. 19013, Pub. L. 99-272)

(h) Within the limits of Department of Veterans Affairs facilities, any veteran who is receiving nursing home care in a hospital under the direct jurisdiction of the Department of Veterans Affairs, may be furnished medical services to correct or treat any nonservice-connected disability of such veteran, in addition to treatment incident to the disability for which the veteran is hospitalized, if the veteran is willing, and such services are reasonably necessary to protect the health of such veteran.

(i) *Participating in a rehabilitation program under 38 U.S.C. chapter 31* refers to any veteran

(1) Who is eligible for and entitled to participate in a rehabilitation program under chapter 31.

- (i) Who is in an extended evaluation period for the purpose of determining feasibility, or

- (ii) For whom a rehabilitation objective has been selected, or
- (iii) Who is pursuing a rehabilitation program, or
- (iv) Who is pursuing a program of independent living, or
- (v) Who is being provided employment assistance under 38 U.S.C. chapter 31, and

(2) Who is medically determined to be in need of hospital care or medical services (including dental) for any of the following reasons:

- (i) Make possible his or her entrance into a rehabilitation program; or
- (ii) Achieve the goals of the veteran's vocational rehabilitation program; or
- (iii) Prevent interruption of a rehabilitation program; or
- (iv) Hasten the return to a rehabilitation program of a veteran in interrupted or leave status; or
- (v) Hasten the return to a rehabilitation program of a veteran placed in discontinued status because of illness, injury or a dental condition; or
- (vi) Secure and adjust to employment during the period of employment assistance; or
- (vii) To enable the veteran to achieve maximum independence in daily living. (Authority: 38 U.S.C. 3104(a)(9); Pub. L. 96-466, sec. 101(a))

(j) Veterans eligible for treatment under chapter 17 of 38 U.S.C. who are alcohol or drug abusers or who are infected with the human immunodeficiency virus (HIV) shall not be discriminated against in admission or treatment by any Department of Veterans Affairs health care facility solely because of their alcohol or drug abuse or dependency or because of their viral infection. This does not preclude the rule of clinical judgment in determining appropriate treatment which takes into account the patient's immune status and/or the infectivity of the HIV or other pathogens (such as tuberculosis, cytomegalovirus, cryptosporidiosis, etc.). Hospital Directors are responsible for assuring that admission criteria of all programs in the medical center do not discriminate solely on the basis of alcohol, drug abuse or infection with human immunodeficiency virus. Quality Assurance Programs should include indicators and monitors for nondiscrimination. (Authority: 38 U.S.C. 7333)

(k) In seeking medical care from VA under 38 U.S.C. 1710 or 1712, a veteran shall furnish such information and evidence as the Secretary may require to establish eligibility. (Authority: 38 U.S.C. 1722; sec. 19011, Pub. L. 99-272)

[32 FR 13813, Oct. 4, 1967, as amended at 64 FR 54218, Oct. 6, 1999; 73 FR 20532, Apr. 16, 2008; 73 FR 65260, Nov. 3, 2008; 79 FR 54615, Sep. 12, 2014]

Editorial Note: For earlier *Federal Register* citations affecting §17.47, see the List of CFR Sections Affected in the Finding Aids section of this volume.

Supplement *Highlights* references: 37(1), 40(1), 86(1).

§17.48 Compensated Work Therapy/Transitional Residences program.

(a) This section sets forth requirements for persons residing in housing under the Compensated Work Therapy/Transitional Residences program.

(b) House managers shall be responsible for coordinating and supervising the day-to-day operations of the facilities. The local VA program coordinator shall select each house manager and may give preference to an individual who is a current or past resident of the facility or the program. A house manager must have the following qualifications:

- (1) A stable, responsible and caring demeanor;
- (2) Leadership qualities including the ability to motivate;
- (3) Effective communication skills including the ability to interact;
- (4) A willingness to accept feedback;
- (5) A willingness to follow a chain of command.

(c) Each resident admitted to the Transitional Residence, except for a house manager, must also be in the Compensated Work Therapy program.

(d) Each resident, except for a house manager, must bi-weekly, in advance, pay a fee to VA for living in the housing. The local VA program coordinator will establish the fee for each resident in accordance with the provisions of paragraph (d)(1) of this section.

(1) The total amount of actual operating expenses of the residence (utilities, maintenance, furnishings, appliances, service equipment, all other operating costs) for the previous fiscal year plus 15 percent of that amount equals the total operating budget for the current fiscal year. The total operating budget is to be divided by the average number of beds occupied during the previous fiscal year and the resulting amount is the average yearly amount per bed. The bi-weekly fee shall equal 1/26th of the average yearly amount per bed, except that a resident shall not, on average, pay more than 30 percent of their gross CWT (Compensated Work Therapy) bi-weekly earnings. The VA program manager shall, bi-annually, conduct a review of the factors in this paragraph for determining resident payments. If he or she determines that the payments are too high or too low by more than 5 percent of the total operating budget, he or she shall recalculate resident payments under the criteria set forth in this paragraph, except that the calculations shall be based on the current fiscal year (actual amounts for the elapsed portion and projected amounts for the remainder).

(2) If the revenues of a residence do not meet the expenses of the residence resulting in an inability to pay actual operating expenses, the medical center of jurisdiction shall provide the funds necessary to return the residence to fiscal solvency in accordance with the provisions of this section.

(e) The length of stay in housing under the Compensated Work Therapy/Transitional Residences program is based on the individual needs of each resident, as determined by consensus of the resident and his/her VA Clinical Treatment team. However, the length of stay should not exceed 12 months. (Authority: 38 U.S.C. 2032)

[51 FR 25066, July 10, 1986, as amended at 61 FR 21966, May 13, 1996; 62 FR 17072, Apr. 9, 1997; redesignated at 67 FR 4668, Jan. 31, 2002; amended at 70 FR 29627, May 24, 2005; 79 FR 54615, Sep. 12, 2014]

Supplement *Highlights* references: 7(1), 28(1), 86(1).

Reserved

§17.49 Priorities for Outpatient Medical Services and Inpatient Hospital Care.

In scheduling appointments for outpatient medical services and admissions for inpatient hospital care, the Under Secretary for Health shall give priority to:

(a) Veterans with service-connected disabilities rated 50 percent or greater based on one or more disabilities or unemployability; and

(b) Veterans needing care for a service-connected disability. (Authority: 38 U.S.C. 101, 501, 1705, 1710.)

[67 FR 4668, Jan. 31, 2002, as amended at 67 FR 58529, Sept. 17, 2002; 69 FR 34074, June 18, 2004]

Supplement *Highlights* references: 7(1), 11(1), 23(3).

Reserved

**Use of Department of Defense, Public Health Service
or Other Federal Hospitals**

§17.50 Use of Department of Defense, Public Health Service or other Federal hospitals with beds allocated to the Department of Veterans Affairs.

Hospital facilities operated by the Department of Defense or the Public Health Service (or any other agency of the United States Government) may be used for the care of Department of Veterans Affairs patients pursuant to agreements between the Department of Veterans Affairs and the department or agency operating the facility. When such an agreement has been entered into and a bed allocation for Department of Veterans Affairs patients has been provided for in a specific hospital covered by the agreement, care may be authorized within the bed allocation for any veteran eligible under 38 U.S.C. 1710 or 38 CFR 17.44. Care in a Federal facility not operated by the Department of Veterans Affairs, however, shall not be authorized for any military retiree whose sole basis for eligibility is under §17.46b, or, except in Alaska and Hawaii, for any retiree of the uniformed services suffering from a chronic disability whose entitlement is under §17.46b, §17.47(b)(2) or §17.47(c)(2) regardless of whether he or she may have dual eligibility under other provisions of §17.47.

[39 FR 1842, Jan. 15, 1974, as amended at 45 FR 6936, Jan. 31, 1980, as amended at 61 FR 21966, May 13, 1996]

§17.51 Emergency use of Department of Defense, Public Health Service or other Federal hospitals.

Hospital care in facilities operated by the Department of Defense or the Public Health Service (or any other agency of the U.S. Government) which do not have beds allocated for the care of Department of Veterans Affairs patients may be authorized subject to the limitations enumerated in §17.50 only in emergency circumstances for any veteran otherwise eligible for hospital care under 38 U.S.C. 1710 or 38 CFR 17.46.

[33 FR 19010, Dec. 20, 1968. Redesignated and amended at 61 FR 21965, 21966, May 13, 1996]

Use of Public or Private Hospitals

§17.52 Hospital care and medical services in non-VA facilities.

(a) When VA facilities or other government facilities are not capable of furnishing economical hospital care or medical services because of geographic inaccessibility or are not capable of furnishing care or services required, VA may contract with non-VA facilities for care in accordance with the provisions of this section. When demand is only for infrequent use, individual authorizations may be used. Care in public or private facilities, however, subject to the provisions of §§17.53, 17.54, 17.55 and 17.56, will only be authorized, whether under a contract or an individual authorization, for:

(1) Hospital care or medical services to a veteran for the treatment of:

- (i) A service-connected disability; or
- (ii) A disability for which a veteran was discharged or released from the active military, naval, or air service or
- (iii) A disability of a veteran who has a total disability permanent in nature from a service-connected disability, or
- (iv) For a disability associated with and held to be aggravating a service-connected disability, or
- (v) For any disability of a veteran participating in a rehabilitation program under 38 U.S.C. ch. 31 and when there is a need for hospital care or medical services for any of the reasons enumerated in §17.47(i). (Authority: 38 U.S.C. 1703, 3104; sec. 101, Pub. L. 96-466; sec. 19012, Pub. L. 99-272)

(2) Medical services for the treatment of any disability of:

- (i) A veteran who has a service-connected disability rated at 50 percent or more,
- (ii) A veteran who has been furnished hospital care, nursing home care, domiciliary care, or medical services, and requires medical services to complete treatment incident to such care or services (each authorization for non-VA treatment needed to complete treatment may continue for up to 12 months, and new authorizations may be issued by VA as needed), and
- (iii) A veteran of the Mexican border period or World War I or who is in receipt of increased pension or additional compensation based on the need for aid and attendance or housebound benefits when it has been determined based on an examination by a physician employed by VA (or, in areas where no such physician is available, by a physician carrying out such function under a contract or fee arrangement), that the medical condition of such veteran precludes appropriate treatment in VA facilities; (Authority: 38 U.S.C. 1703; sec. 19012, Pub. L. 99-272)

(3) Hospital care or medical services for the treatment of medical emergencies which pose a serious threat to the life or health of a veteran receiving hospital care or medical services in a facility over which the Secretary has direct jurisdiction or government facility with

which the Secretary contracts, and for which the facility is not staffed or equipped to perform. and transfer to a public or private hospital which has the necessary staff or equipment is the only feasible means of providing the necessary treatment, until such time following the furnishing of care in the non-VA facility as the veteran can be safely transferred to a VA facility; (Authority: 38 U.S.C. 1703; sec. 19012, Pub. L. 99-272)

(4) Hospital care for women veterans; (Authority: 38 U.S.C. 1703; sec. 19012, Pub. L. 99-272)

(5) Through September 30, 1988, hospital care or medical services that will obviate the need for hospital admission for veterans in the Commonwealth of Puerto Rico, except that the dollar expenditure in Fiscal year 1986 cannot exceed 85% of the Fiscal year 1985 obligations, in Fiscal year 1987 the dollar expenditure cannot exceed 50% of the Fiscal year 1985 obligations and in Fiscal year 1988 the dollar expenditure cannot exceed 25% of the Fiscal year 1985 obligations. (Authority: 38 U.S.C. 1703; sec. 102, Pub. L. 99-166; sec. 19012, Pub. L. 99-272)

(6) Hospital care or medical services that will obviate the need for hospital admission for veterans in Alaska, Hawaii, Virgin Islands and other territories of the United States except that the annually determined hospital patient load and incidence of the furnishing of medical services to veterans hospitalized or treated at the expense of VA in government and non-VA facilities in each such State or territory shall be consistent with the patient load or incidence of the provision of medical services for veterans hospitalized or treated by VA within the 48 contiguous States. (Authority: 38 U.S.C. 1703; sec. 19012, Pub. L. 99-272)

(7) Outpatient dental services and treatment, and related dental appliances, for a veteran who is a former prisoner of war and was detained or interned for a period of not less than 181 days. (Authority: 38 U.S.C. 1703; sec. 19012, Pub. L. 99-272)

(8) Hospital care or medical services for the treatment of medical emergencies which pose a serious threat to the life or health of a veteran which developed during authorized travel to the hospital, or during authorized travel after hospital discharge preventing completion of travel to the originally designated point of return (and this will encompass any other medical services necessitated by the emergency, including extra ambulance or other transportation which may also be furnished at VA expense. (Authority: 38 U.S.C. 1701(5))

(9) Diagnostic services necessary for determination of eligibility for, or of the appropriate course of treatment in connection with, furnishing medical services at independent VA outpatient clinics to obviate the need for hospital admission. (Authority: 38 U.S.C. 1703; sec. 19012, Pub. L. 99-272)

(10) For any disability of a veteran receiving VA contract nursing home care. The veteran is receiving contract nursing home care and requires emergency treatment in non-VA facilities. (Authority: 38 U.S.C. 1703(a))

(11) For completion of evaluation for observation and examination (O&E) purposes, clinic directors or their designees will authorize necessary diagnostic services at non-VA facilities (on an inpatient or outpatient basis) in order to complete requests from VA Regional Offices for O&E of a person to determine eligibility for VA benefits or services.

(b) The Under Secretary for Health shall only furnish care and treatment under paragraph (a) of this section to veterans described in §17.47(d).

(1) To the extent that resources are available and are not otherwise required to assure that VA can furnish needed care and treatment to veterans described in §17.47(a) and (c), and

(2) If the veteran agrees to pay the United States an amount as determined under 38 U.S.C. 1710. (Authority: 38 U.S.C. 1703, 1710 and 1712; sec. 19011-19012, Pub. L. 99-272)

[51 FR 25066, July 10, 1986, as amended at 53 FR 32391, Aug. 25, 1988; 54 FR 53057, Dec. 27, 1989; 58 FR 32446, June 10, 1993. Redesignated and amended at 61 FR 21965, 21966, May 13, 1996; 62 FR 17072, Apr. 9, 1997; 75 FR 78915, Dec. 17, 2010; 77 FR 70895, Nov. 28, 2012; 78 FR 76063, Dec. 16, 2013; 79 FR 54615, Sep. 12, 2014]

Supplement *Highlights* references: 59(1), 74(1), 83(1), 86(1).

§17.53 Limitations on use of public or private hospitals.

The admission of any patient to a private or public hospital at Department of Veterans Affairs expense will only be authorized if a Department of Veterans Affairs medical center or other Federal facility to which the patient would otherwise be eligible for admission is not feasibly available. A Department of Veterans Affairs facility may be considered as not feasibly available when the urgency of the applicant's medical condition, the relative distance of the travel involved, or the nature of the treatment required makes it necessary or economically advisable to use public or private facilities. In those instances where care in public or private hospitals at Department of Veterans Affairs expense is authorized because a Department of Veterans Affairs or other Federal facility was not feasibly available, as defined in this section, the authorization will be continued after admission only for the period of time required to stabilize or improve the patient's condition to the extent that further care is no longer required to satisfy the purpose for which it was initiated.

[39 FR 17223, May 14, 1974, as amended at 47 FR 58248, Dec. 30, 1982. Redesignated at 61 FR 21965, May 13, 1996]

§17.54 Necessity for prior authorization.

(a) The admission of a veteran to a non-Department of Veterans Affairs hospital at Department of Veterans Affairs expense must be authorized in advance. In the case of an emergency which existed at the time of admission, an authorization may be deemed a prior authorization if an application, whether formal or informal, by telephone, telegraph or other communication, made by the veteran or by others in his or her behalf is dispatched to the Department of Veterans Affairs (1) for veterans in the 48 contiguous States and Puerto Rico, within 72 hours after the hour of admission, including in the computation of time Saturday, Sunday and holidays, or (2) for veterans in a noncontiguous State, territory or possession of the United States (not including Puerto Rico) if facilities for dispatch of application as described in this section are not available within the 72-hour period, provided the application was filed within 72 hours after facilities became available.

(b) When an application for admission by a veteran in one of the 48 contiguous States in the United States or in Puerto Rico has been made more than 72 hours after admission, or more than 72 hours after facilities are available in a noncontiguous State, territory of possession of the United States, authorization for continued care at Department of Veterans Affairs expense shall be effective as of the postmark or dispatch date of the application, or the date of any telephone call constituting an informal application.

[42 FR 55212, Oct. 14, 1977. Redesignated at 61 FR 21965, May 13, 1996]

§17.55 Payment for authorized public or private hospital care.

Except as otherwise provided in this section, payment for public or private hospital care authorized under 38 U.S.C. 1703 and 38 CFR 17.52 of this part or under 38 U.S.C. 1728 and 38 CFR 17.120 of this part shall be based on a prospective payment system similar to that used in the Medicare program for paying for similar inpatient hospital services in the community. Payment shall be made using the Health Care Financing Administration (HCFA) PRICER for each diagnosis-related group (DRG) applicable to the episode of care.

(a) Payment shall be made of the full prospective payment amount per discharge, as determined according to the methodology in subparts D and G of 42 CFR part 412, as appropriate.

(b) (1) In the case of a veteran who was transferred to another facility before completion of care, VA shall pay the transferring hospital an amount calculated by the HCFA PRICER for each patient day of care, not to exceed the full DRG rate as provided in paragraph (a) of this section. The hospital that ultimately discharges the patient will receive the full DRG payment.

(2) In the case of a veteran who has transferred from a hospital and/or distinct part unit excluded by Medicare from the DRG-based prospective payment system or from a hospital that does not participate in Medicare, the transferring hospital will receive a payment for each patient day of care not to exceed the amount provided in paragraph (i) of this section.

(c) VA shall pay the providing facility the full DRG-based rate or reasonable cost, without regard to any copayments or deductible required by any Federal law that is not applicable to VA.

(d) If the cost or length of a veteran's care exceeds an applicable threshold amount, as determined by the HCFA PRICER program, VA shall pay, in addition to the amount payable under paragraph (a) of this section, an outlier payment calculated by the HCFA PRICER program, in accordance with subpart F of 42 CFR part 412.

(e) In addition to the amount payable under paragraph (a) of this section, VA shall pay, for each discharge, an amount to cover the non-Federal hospital's capital-related costs, kidney, heart and liver acquisition costs incurred by hospitals with approved transplantation centers, direct costs of medical education, and the costs of qualified nonphysician anesthetists in small rural hospitals. These amounts will be determined by the Under Secretary for Health on an annual basis and published in the "Notices" section of the *Federal Register*.

(f) Payment shall be made only for those services authorized by VA.

(g) Payments made in accordance with this section shall constitute payment in full and the provider or agent for the provider may not impose any additional charge on a veteran or his or her health care insurer for any inpatient services for which payment is made by the VA.

(h) Hospitals of distinct part hospital units excluded from the prospective payment system by Medicare and hospitals that do not participate in Medicare will be paid at the national cost-to-charge ratio times the billed charges that are reasonable, usual, customary, and not in excess of rates or fees the hospital charges the general public for similar services in the community.

(i) A hospital participating in an alternative payment system that has been granted a Federal waiver from the prospective payment system under the provisions of 42 U.S.C. section

1395f(b)(3) or 42 U.S.C. section 1395ww(c) for the purposes of Medicare payment shall not be subject to the payment methodology set forth in this section so long as such Federal waiver remains in effect.

(j) Payments for episodes of hospital care furnished in Alaska that begin during the period starting on the effective date of this section through the 364th day thereafter will be in the amount determined by the HCFA PRICER plus 50 percent of the difference between the amount billed by the hospital and the amount determined by the PRICER. Claims for services provided during that period will be accepted for payment by VA under this paragraph (k) until December 31 of the year following the year in which this section became effective.

(k) Notwithstanding other provisions of this section, VA, for public or private hospital care covered by this section, will pay the lesser of the amount determined under paragraphs (a) through (j) of this section or the amount negotiated with the hospital or its agent. (Authority: 38 USC 513, 1703, 1728; §233 of P. L. 99-576)

[55 FR 42852, Oct. 24, 1990. Redesignated and amended at 61 FR 21965, 21966, May 13, 1996; 62 FR 17072, Apr. 9, 1997; 63 FR 39515, July 23, 1998; 65 FR 66637, Nov. 7, 2000]

Supplement *Highlight* references: Book A-30(1); Book I-2(2).

§17.56 VA payment for inpatient and outpatient health care professional services at non-departmental facilities and other medical charges associated with non-VA outpatient care.

(a) Except for health care professional services provided in the state of Alaska (see paragraph (b) of this section) and except for non-contractual payments for home health services and hospice care, VA will determine the amounts paid under §§17.52 or 17.120 for health care professional services, and all other medical services associated with non-VA outpatient care, using the applicable method in this section:

(1) If a specific amount has been negotiated with a specific provider, VA will pay that amount.

(2) If an amount has not been negotiated under paragraph (a)(1) of this section, VA will pay the lowest of the following amounts:

(i) The applicable Medicare fee schedule or prospective payment system amount (“Medicare rate”) for the period in which the service was provided (without any changes based on the subsequent development of information under Medicare authorities), subject to the following:

(A) In the event of a Medicare waiver, the payment amount will be calculated in accordance with such waiver.

(B) In the absence of a Medicare rate or Medicare waiver, payment will be the VA Fee Schedule amount for the period in which the service was provided. The VA Fee Schedule amount is determined by the authorizing VA medical facility, which ranks all billings (if the facility has had at least eight billings) from non-VA facilities under the corresponding procedure code during the previous fiscal year, with billings ranked from the highest to the lowest. The VA Fee Schedule amount is the charge falling at the 75th percentile. If the authorizing facility has not had at least eight such billings, then this paragraph does not apply.

(ii) The amount negotiated by a repricing agent if the provider is participating within the repricing agent’s network and VA has a contract with that repricing agent. For the purposes of this section, repricing agent means a contractor that seeks to connect VA with discounted rates from non-VA providers as a result of existing contracts that the non-VA provider may have within the commercial health care industry.

(iii) The amount that the provider bills the general public for the same service.

(b) For physician and non-physician professional services rendered in Alaska, VA will pay for services in accordance with a fee schedule that uses the Health Insurance Portability and Accountability Act mandated national standard coding sets. VA will pay a specific amount for each service for which there is a corresponding code. Under the VA Alaska Fee Schedule, the amount paid in Alaska for each code will be 90 percent of the average amount VA actually paid in Alaska for the same services in Fiscal Year (FY) 2003. For services that VA provided less than eight times in Alaska in FY 2003, for services represented by codes established after FY 2003, and for unit-based codes prior to FY 2004, VA will take the Centers for Medicare and Medicaid Services’ rate for each code and multiply it times the average percentage paid by VA in Alaska for Centers for Medicare and Medicaid Services-like codes. VA will increase the amounts on the VA Alaska Fee Schedule annually in accordance with the published national Medicare

17.56-2 §17.56—VA payment for inpatient and outpatient health care professional services **17.56-2**
at non-departmental facilities and other medical charges associated
with non-VA outpatient care

Economic Index (MEI). For those years where the annual average is a negative percentage, the fee schedule will remain the same as the previous year. Payment for non-VA health care professional services in Alaska shall be the lesser of the amount billed or the amount calculated under this subpart.

(c) Payments made by VA to a non-VA facility or provider under this section shall be considered payment in full. Accordingly, the facility or provider or agent for the facility or provider may not impose any additional charge for any services for which payment is made by VA.

(d) In a case where a veteran has paid for emergency treatment for which VA may reimburse the veteran under §17.120, VA will reimburse the amount that the veteran actually paid. Any amounts due to the provider but unpaid by the veteran will be reimbursed to the provider under paragraphs (a) and (b) of this section. (Authority: 38 U.S.C. 1703, 1728)

[63 FR 39515, July 23, 1998, as amended at 65 FR 66637, Nov. 7, 2000; 70 FR 5927, Feb. 4, 2005; 75 FR 78915, Dec. 17, 2010]

Supplement *Highlights* references: Book A–30(1). Book I–2(2), 26(1), 59(1).

17.56-3

§17.56—VA payment for inpatient and outpatient health care professional services at non-departmental facilities and other medical charges associated with non-VA outpatient care

17.56-3

Reserved

Use of Community Nursing Home Care Facilities

§17.57 Use of community nursing homes.

(a) Nursing home care in a contract public or private nursing home facility may be authorized for the following: Any veteran who has been discharged from a hospital under the direct jurisdiction of VA and is currently receiving VA hospital based home health services. (Authority: Pub. L. 99-166) (Authority: 38 U.S.C. 1720, sec. 108, Pub. L. 99-166)

(b) To the extent that resources are available and are not otherwise required to assure that VA can furnish needed care and treatment to veterans described in 38 U.S.C. 1710(a)(1) and (a)(2), the Under Secretary for Health may furnish care under this paragraph to any veteran described in 38 U.S.C. 1710(a)(3) if the veteran agrees to pay the United States an amount as determined in 38 U.S.C. 1710(f). (Authority: 38 U.S.C. 1710, 1720, sec. 19011 Pub. L. 99-272) (Authority: 38 U.S.C. 1720(b))

[51 FR 25067, July 10, 1986. Resdesignated and amended at 61 FR 21965, 21966, May 13, 1996; redesignated at 63 FR 39515, July 23, 1998; 79 FR 54615, Sep. 12, 2014]

Supplement *Highlights* references: 30(1), 86(1).

Next Section is §17.60

§17.98 Mental health services.

(a) Following the death of a veteran, bereavement counseling involving services defined in 38 U.S.C. 1783, may be furnished to persons who were receiving mental health services in connection with treatment of the veteran under 38 U.S.C. 1710, 1712A, or 1717, or 1781, prior to the veteran's death, but may only be furnished in instances where the veteran's death had been unexpected or occurred while the veteran was participating in a VA hospice or similar program. Bereavement counseling may be provided only to assist individuals with the emotional and psychological stress accompanying the veteran's death, and only for a limited period of time, as determined by the Medical Center Director, but not to exceed 60 days. The Medical Center Director may approve a longer period of time when medically indicated.

(b) For purposes of paragraph (a) of this section, an unexpected death is one which occurs when in the course of an illness the provider of care did not or could not have anticipated the timing of the death. Ordinarily, the provider of care can anticipate the patient's death and can inform the patient and family of the immediacy and certainty of death. If that has not taken place, a death can be described as unexpected. (Authority: 38 U.S.C. 1783)

[53 FR 7186, Mar. 7, 1988. Redesignated and amended at 61 FR 21965, 21967, May 13, 1996; 79 FR 54616, Sep. 12, 2014]

Supplement *Highlights* reference: 86(1).

Vocational Training and Healthcare Eligibility Protection for Pension Recipients

§17.90 Medical care for veterans receiving vocational training under 38 U.S.C. chapter 15.

Hospital care, nursing home care and medical services may be provided to any veteran who is participating in a vocational training program under 38 U.S.C. chapter 15.

(a) For purposes of determining eligibility for this medical benefit, the term *participating in a vocational training program under 38 U.S.C. chapter 15* means the same as the term *participating in a rehabilitation program under 38 U.S.C. chapter 31* as defined in §17.47(i). Eligibility for such medical care will continue only while the veteran is participating in the vocational training program.

(b) The term *hospital care and medical services* means class V dental care, priority III medical services, nursing home care and non-VA hospital care and/or fee medical/dental care if VA is unable to provide the required medical care economically at VA or other government facilities because of geographic inaccessibility or because of the unavailability of the required services at VA facilities. (Authority: 38 U.S.C. 1524, 1525, 1516)

[51 FR 19330, May 29, 1986, as amended at 56 FR 3422, Jan. 30, 1991. Redesignated and amended at 61 FR 21965, 21967, May 13, 1996; 79 FR 54615, Sep. 12, 2014]

Supplement *Highlights* reference: 86(1).

§17.91 Protection of health-care eligibility.

Any veteran whose entitlement to VA pension is terminated by reason of income from work or training shall, subject to paragraphs (a) and (b) of this section, retain for 3 years after the termination, the eligibility for hospital care, nursing home care and medical services (not including dental) which the veteran otherwise would have had if the pension had not been terminated as a result of the veteran's receipt of earnings from activity performed for remuneration or gain by the veteran but only if the veteran's annual income from sources other than such earnings would, taken alone, not result in the termination of the veteran's pension.

(a) A veteran who participates in a vocational training program under 38 U.S.C. chapter 15 is eligible for the onetime 3 year retention of hospital care, nursing home care and medical services benefits at any time that the veteran's pension is terminated by reason of income from the veteran's employment.

(b) A veteran who does not participate in a vocational training program under 38 U.S.C. chapter 15 is eligible for the one-time 3 year retention of hospital care and medical services benefits only if the veteran's pension is terminated by reason of income from the veteran's employment during the period February 1, 1985 through January 31, 1989. (Authority: 38 U.S.C. 1524, 1525, 1516)

[51 FR 19330, May 29, 1986. Redesignated at 61 FR 21965, May 13, 1996]

Outpatient Treatment

§17.92 Outpatient care for research purposes.

Subject to the provisions of §17.101, any person who is a bona fide volunteer may be furnished outpatient treatment when the treatment to be rendered is part of an approved Department of Veterans Affairs research project and there are insufficient veteran-patients suitable for the project.

[35 FR 11470, July 17, 1970. Redesignated and amended at 61 FR 21965, 21967, May 13, 1996]

§17.93 Eligibility for outpatient services.

(a) VA shall furnish on an ambulatory or outpatient basis medical services as are needed, to the following applicants under the conditions stated, except that applications for dental treatment must also meet the provisions of §17.161. (Authority: 38 U.S.C. 1710, 1712)

(1) *For compensation and pension examinations.* A compensation and pension examination shall be performed for any veteran who is directed to have such an examination by VA. (Authority: 33 U.S.C. 111 and 501)

(2) *For adjunct treatment.* Subject to the provisions of §§17.36 through 17.38, medical services on an ambulatory or outpatient basis shall be provided to veterans for an adjunct nonservice-connected condition associated with and held to be aggravating a disability from a disease or injury adjudicated as being service-connected.

(b) The term “shall furnish” in this section and 38 U.S.C. 1710(a)(1) and (a)(2) means that, if the veteran is in immediate need of outpatient medical services, VA shall furnish care at the VA facility where the veteran applies. If the needed medical services are not available there, VA shall arrange for care at the nearest VA medical facility or Department of Defense facility (with which VA has a sharing agreement) that can provide the needed care. If VA and Department of Defense facilities are not available, VA shall arrange for care on a fee basis, but only if the veteran is eligible to receive medical services in non-VA facilities under §17.52.

If the veteran is not in immediate need of outpatient medical services, VA shall schedule the veteran for care where the veteran applied, if the schedule there permits, or refer the veteran for scheduling to the nearest VA medical center or Department of Defense facility (with which VA has a sharing agreement).

(c) VA may furnish on an ambulatory or outpatient basis medical services as needed to the following applicants, except that applications for dental treatment must also meet the provisions of §17.123.

(1) *For veterans participating in a rehabilitation program under 38 U.S.C. chapter 31.* Medical services on an ambulatory or outpatient basis may be provided as determined medically necessary for a veteran participating in a rehabilitation program under 38 U.S.C. chapter 31 as defined in §17.47(i).

(2) [Reserved] (Authority: 38 U.S.C. 1710, 1712)

[55 FR 20150, May 15, 1990, as amended at 58 FR 25565, Apr. 27, 1993. Redesignated and amended at 61 FR 21965, 21967, May 13, 1996. Amended at 64 FR 54218, Oct. 6, 1999; 79 FR 54615, Sep. 12, 2014]

Supplement *Highlights* references: 37(1), 86(1).

§17.94 Outpatient medical services for military retirees and other beneficiaries.

Outpatient medical services for military retirees and other beneficiaries for which charges shall be made as required by §17.101. may be authorized for persons properly referred by authorized officials of other Federal agencies for which the Secretary of Veterans Affairs may agree to render such service under the conditions stipulated by the Secretary and pensioners of nations allied with the United States in World War I and World War II when duly authorized.

[32 FR 13815, Oct. 4, 1967, as amended at 45 FR 6937, Jan. 31, 1980; 47 FR 58249, Dec. 30, 1982. Redesignated and amended at 61 FR 21965, 21967, May 13, 1996]

§17.95 Outpatient medical services for Department of Veterans Affairs employees and others in emergencies.

Outpatient medical services for which charges shall be made as required by §17.102 may be authorized for employees of the Department of Veterans Affairs, their families, and the general public in emergencies, subject to conditions stipulated by the Secretary of Veterans Affairs. (Authority: 38 U.S.C. 1784)

[47 FR 58249, Dec. 30, 1982. Redesignated and amended at 61 FR 21965, 21967, May 13, 1996; 79 FR 54615, Sep. 12, 2014]

Supplement *Highlights* reference: 86(1).

§17.96 Medication prescribed by non-VA physicians.

Any prescription, which is not part of authorized Department of Veterans Affairs hospital or outpatient care, for drugs and medicines ordered by a private or non-Department of Veterans Affairs doctor of medicine or doctor of osteopathy duly licensed to practice in the jurisdiction where the prescription is written, shall be filled by a Department of Veterans Affairs pharmacy or a non-VA pharmacy in a state home under contract with VA for filling prescriptions for patients in state homes, provided:

(a) The prescription is for:

(1) A veteran who by reason of being permanently housebound or in need of regular aid and attendance is in receipt of increased compensation under 38 U.S.C. chapter 11, or increased pension under section 3.1(u) (Section 306 Pension) or section 3.1(w) (Improved Pension), of this title, as a veteran of the Mexican Border Period, World War I, World War II, the Korean Conflict, or the Vietnam Era (or, although eligible for such pension, is in receipt of compensation as the greater benefit), or

(2) A veteran in need of regular aid and attendance who was formerly in receipt of increased pension as described in paragraph (a)(1) of this section whose pension has been discontinued solely by reason of excess income, but only so long as such veteran's annual income does not exceed the maximum annual income limitation by more than \$ 1,000, and

(b) The drugs and medicines are prescribed as specific therapy in the treatment of any of the veteran's illnesses or injuries. (Authority: 38 U.S.C. 1706, 1710, 1712(d))

[32 FR 13816, Oct. 4, 1967, as amended at 36 FR 4782, Mar. 12, 1971; 45 FR 6937, Jan. 31, 1980; 47 FR 58249, Dec. 30, 1982. Redesignated at 61 FR 21965, May 13, 1996; 63 FR 37780, July 14, 1998; 68 FR 11977, Mar. 13, 2003; 68 FR 43929, July 25, 2003; 74 FR 44291, Aug. 28, 2009; 79 FR 54615, Sep. 12, 2014]

Supplement *Highlights* references: Book I—19(1), 50(1), 86(1).

Reserved

§17.97 Prescriptions in Alaska, and territories and possessions.

In Alaska and territories and possessions, where there are no Department of Veterans Affairs pharmacies, the expenses of any prescriptions filled by a private pharmacist which otherwise could have been filled by a Department of Veterans Affairs pharmacy under 38 U.S.C. 1712(h), may be reimbursed.

[32 FR 13816, Oct. 4, 1967. Redesignated and amended at 61 FR 21965, 21967, May 13, 1996]

(H) Any exclusive provider organization (EPO) plan.

(I) Any physician hospital organization (PHO) plan.

(J) Any integrated delivery system (IDS) plan.

(K) Any management service organization (MSO) plan.

(L) Any group or individual medical services account.

(M) Any participating provider organization (PPO) plan or any PPO provision or option of any third-party payer plan.

(N) Any Medicare supplemental insurance plan.

(O) Any automobile liability insurance plan.

(P) Any no fault insurance plan, including any personal injury protection plan or medical payments benefit plan for personal injuries arising from the operation of a motor vehicle.

Medicare supplemental insurance plan means an insurance, medical service or health-plan contract primarily for the purpose of supplementing an eligible person's benefit under Medicare. The term has the same meaning as “Medicare supplemental policy” in section 1882(g)(1) of the Social Security Act (42 U.S.C. 1395, *et seq.*) and 42 CFR part 403, subpart B.

No-fault insurance means an insurance contract providing compensation for medical expenses relating to personal injury arising from the operation of a motor vehicle in which the compensation is not premised on who may have been responsible for causing such injury. No-fault insurance includes personal injury protection and medical payments benefits in cases involving personal injuries resulting from operation of a motor vehicle.

Participating provider organization means any arrangement in a third-party payer plan under which coverage is limited to services provided by a select group of providers who are members of the PPO or incentives (for example, reduced copayments) are provided for beneficiaries under the plan to receive health care services from the members of the PPO rather than from other providers who, although authorized to be paid, are not included in the PPO. However, a PPO does not include any organization that is recognized as a health maintenance organization.

Third-party payer means an entity, other than the person who received the medical care or services at issue (first party) and VA who provided the care or services (second party), responsible for the payment of medical expenses on behalf of a person through insurance, agreement or contract. This term includes, but is not limited to the following:

(A) State and local governments that provide such plans other than Medicaid.

(B) Insurance underwriters or carriers.

(C) Private employers or employer groups offering self-insured or partially self-insured medical service or health plans.

(D) Automobile liability insurance underwriter or carrier.

(E) No fault insurance underwriter or carrier.

(F) Workers' compensation program or plan sponsor, underwriter, carrier, or self-insurer.

(G) Any other plan or program that is designed to provide compensation or coverage for expenses incurred by a beneficiary for healthcare services or products.

(H) A third-party administrator.

(b) *Calculating reasonable charges.*

(1) The “reasonable charges” subject to recovery or collection by VA under this section are calculated using the applicable method for such charges established by VA in 38 CFR 17.101.

(2) If the third-party payer's plan includes a requirement for a deductible or copayment by the beneficiary of the plan, VA will recover or collect reasonable charges less that deductible or copayment amount.

(c) *VA's right to recover or collect is exclusive.* The only way for a third-party payer to satisfy its obligation under this section is to pay the VA facility or other authorized representative of the United States. Payment by a third-party payer to the beneficiary does not satisfy the third-party's obligation under this section.

(1) Pursuant to 38 U.S.C. 1729(b)(2), the United States may file a claim or institute and prosecute legal proceedings against a third-party payer to enforce a right of the United States under 38 U.S.C. 1729 and this section. Such filing or proceedings must be instituted within six years after the last day of the provision of the medical care or services for which recovery or collection is sought.

(2) An authorized representative of the United States may compromise, settle or waive a claim of the United States under this section.

(3) The remedies authorized for collection of indebtedness due the United States under 31 U.S.C. 3701, *et seq.*, 28 CFR part 11, 31 CFR parts 900 through 904, and 38 CFR part 1, are available to effect collections under this section.

(4) A third-party payer may not, without the consent of a U.S. Government official authorized to take action under 38 U.S.C. 1729 and this part, offset or reduce any payment due under 38 U.S.C. 1729 or this part on the grounds that the payer considers itself due

a refund from a VA facility. A written request for a refund must be submitted and adjudicated separately from any other claims submitted to the third-party payer under 38 U.S.C. 1729 or this part.

(d) *Assignment of benefits or other submission by beneficiary not necessary.* The obligation of the third-party payer to pay is not dependent upon the beneficiary executing an assignment of benefits to the United States. Nor is the obligation to pay dependent upon any other submission by the beneficiary to the third-party payer, including any claim or appeal. In any case in which VA makes a claim, appeal, representation, or other filing under the authority of this part, any procedural requirement in any third-party payer plan for the beneficiary of such plan to make the claim, appeal, representation, or other filing must be deemed to be satisfied. A copy of the completed VA Form 10-10EZ or VA Form 10-10EZR that includes a veteran's insurance declaration will be provided to payers upon request, in lieu of a claimant's statement or coordination of benefits form.

(e) *Preemption of conflicting State laws and contracts.* Any provision of a law or regulation of a State or political subdivision thereof and any provision of any contract or agreement that purports to establish any requirement on a third-party payer that would have the effect of excluding from coverage or limiting payment for any medical care or services for which payment by the third-party payer under 38 U.S.C. 1729 or this part is required, is preempted by 38 U.S.C. 1729(f) and shall have no force or effect in connection with the third-party payer's obligations under 38 U.S.C. 1729 or this part.

(f) *Impermissible exclusions by third-party payers.*

(1) *Statutory requirement.* Under 38 U.S.C. 1729(f), no provision of any third-party payer's plan having the effect of excluding from coverage or limiting payment for certain care if that care is provided in or through any VA facility shall operate to prevent collection by the United States.

(2) *General rules.* The following are general rules for the administration of 38 U.S.C. 1729 and this part, with examples provided for clarification. The examples provided are not exclusive. A third-party payer may not reduce, offset, or request a refund for payments made to VA under the following conditions:

(i) Express exclusions or limitations in third-party payer plans that are inconsistent with 38 U.S.C. 1729 are inoperative. For example, a provision in a third-party payer's plan that purports to disallow or limit payment for services provided by a government entity or paid for by a government program (or similar exclusion) is not a permissible ground for refusing or reducing third-party payment.

(ii) No objection, precondition or limitation may be asserted that defeats the statutory purpose of collecting from third-party payers. For example, a provision in a third-party payer's plan that purports to disallow or limit payment for services for which the patient has no obligation to pay (or similar exclusion) is not a permissible ground for refusing or reducing third-party payment.

(iii) Third-party payers may not treat claims arising from services provided in or through VA facilities less favorably than they treat claims arising from services provided in other hospitals. For example, no provision of an employer sponsored program or plan that purports to make ineligible for coverage individuals who are eligible to receive VA medical care and services shall be permissible.

(iv) The lack of a participation agreement or the absence of privity of contract between a third-party payer and VA is not a permissible ground for refusing or reducing third-party payment.

(v) A provision in a third-party payer plan, other than a Medicare supplemental plan, that seeks to make Medicare the primary payer and the plan the secondary payer or that would operate to carve out of the plan's coverage an amount equivalent to the Medicare payment that would be made if the services were provided by a provider to whom payment would be made under Part A or Part B of Medicare is not a permissible ground for refusing or reducing payment as the primary payer to VA by the third-party payer unless the provision expressly disallows payment as the primary payer to all providers to whom payment would not be made under Medicare (including payment under Part A, Part B, a Medicare HMO, or a Medicare Advantage plan).

(vi) A third-party payer may not refuse or reduce third-party payment to VA because VA's claim form did not report hospital acquired conditions (HAC) or present on admission conditions (POA). VA is exempt from the Medicare Inpatient prospective payment system and the Medicare rules for reporting POA or HAC information to third-party payers.

(vii) Health Maintenance Organizations (HMOs) may not exclude claims or refuse to certify emergent and urgent services provided within the HMO's service area or otherwise covered non-emergency services provided out of the HMO's service area. In addition, opt-out or point-of-service options available under an HMO plan may not exclude services otherwise payable under 38 U.S.C. 1729 or this part.

(g) *Records.* Pursuant to 38 U.S.C. 1729(h), VA shall make available for inspection and review to representatives of third-party payers, from which the United States seeks payment, recovery, or collection under 38 U.S.C. 1729, appropriate health care records (or copies of such records) of patients. However, the appropriate records will be made available only for the purposes of verifying the care and services which are the subject of the claim(s) for payment under 38 U.S.C. 1729, and for verifying that the care and services met the permissible criteria of the terms and conditions of the third-party payer's plan. Patient care records will not be made available under any other circumstances to any other entity. VA will not make available to a third-party payer any other patient or VA records.

[76 FR 37206, June 24, 2011; 79 FR 54616, Sep. 12, 2014]

Supplement *Highlights* references: 63(1), 86(1)

- (7) A veteran whose entitlement to disability compensation is suspended because of the receipt of military retirement pay.
- (8) A veteran of the Mexican border period or of World War I.
- (9) A military retiree provided care under an interagency agreement as defined in section 113 of Public Law 106-117, 113 Stat. 1545.
- (10) A veteran who VA determines to be unable to defray the expenses of necessary care under 38 U.S.C. 1722(a).
- (11) A veteran who VA determines to be catastrophically disabled, as defined in 38 CFR 17.36(e).
- (12) A veteran receiving care for psychosis or a mental illness other than psychosis pursuant to §17.109.

(e) *Services not subject to copayment requirements for inpatient hospital care or outpatient medical care.* The following are not subject to the copayment requirements under this section:

- (1) Care provided to a veteran for a noncompensable zero percent service-connected disability;
- (2) Care authorized under 38 U.S.C. 1710(e) for Vietnam-era herbicide-exposed veterans, radiation-exposed veterans, Gulf War veterans, post-Gulf War combat-exposed veterans, or Camp Lejeune veterans pursuant to §17.400;
- (3) Special registry examinations (including any follow-up examinations or testing ordered as part of the special registry examination) offered by VA to evaluate possible health risks associated with military service;
- (4) Counseling and care for sexual trauma as authorized under 38 U.S.C. 1720D;
- (5) Compensation and pension examinations requested by the Veterans Benefits Administration;
- (6) Care provided as part of a VA-approved research project authorized by 38 U.S.C. 7303;
- (7) Outpatient dental care provided under 38 U.S.C. 1712;
- (8) Readjustment counseling and related mental health services authorized under 38 U.S.C. 1712A;
- (9) Emergency treatment paid for under 38 U.S.C. 1725 or 1728;

- (10) Care or services authorized under 38 U.S.C. 1720E for certain veterans regarding cancer of the head or neck;
- (11) Publicly announced VA public health initiatives (e.g., health fairs) or an outpatient visit solely consisting of preventive screening and immunizations (e.g. influenza immunization, pneumococcal immunization, hypertension screening, hepatitis C screening, tobacco screening, alcohol screening, hyperlipidemia screening, breast cancer screening, cervical cancer screening, screening for colorectal cancer by fecal occult blood testing, and education about the risks and benefits of prostate cancer screening);
- (12) Weight management counseling (individual and group);
- (13) Smoking cessation counseling (individual and group);
- (14) Laboratory services, flat film radiology services, and electrocardiograms;
- (15) Hospice care; and
- (16) In-home video telehealth care.

(f) *Additional care not subject to outpatient copayment.* Outpatient care is not subject to the outpatient copayment requirements under this section when provided to a veteran during a day for which the veteran is required to make a copayment for extended care services that were provided either directly by VA or obtained for VA by contract. (Authority: 38 U.S.C. 501, 1710, 1730A)

[66 FR 63448, Dec. 6, 2001, as amended at 66 FR 64904, Dec. 14, 2001; 67 FR 21998, May 2, 2002; 68 FR 60854, Oct. 24, 2003; 70 FR 22596, May 2, 2005; 71 FR 2464, Jan. 17, 2006; 73 FR 20532, Apr. 16, 2008; 73 FR 65260, Nov. 3, 2008; 75 FR 54030, Sept. 3, 2010; 76 FR 52274, Aug. 22, 2011; 77 FR 13198, Mar. 6, 2012; 78 FR 28143, May 14, 2013; 79 FR 57414, Sep. 24, 2014]

Supplement *Highlights* references: 21(1), 27(1), 31(1), 40(1), 57(1), 64(1), 68(1), 77(1), 86(2).

§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 July 1, 2010, through December 31, 2014, the copayment amount for veterans in priority categories 2 through 6 of VA's health care system (see §17.36) is \$8.

(ii) 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, 2014, is \$9.

(iii) The copayment amount for all affected veterans for each calendar year after December 31, 2014, 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, 2014, 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, post-Persian Gulf War combat-exposed veterans, or Camp Lejeune veterans pursuant to §17.400.
- (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).
- (10) A veteran receiving care for psychosis or a mental illness other than psychosis pursuant to §17.109. (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 76867, Dec. 31, 2012; 78 FR 28143, May 14, 2013; 78 FR 30768, May 23, 2013; 78 FR 79317, Dec. 30, 2013; 79 FR 57414, Sep. 24, 2014]

Supplement *Highlights* references: 53(1), 55(1), 57(1), 64(1), 66(2), 74(4), 77(1), 83(3), 86(2).

§17.111 Copayments for Extended care services.

(a) *General.* This section sets forth requirements regarding copayments for extended care services provided to veterans by VA (either directly by VA or paid for by VA).

(b) *Copayments.*

(1) Unless exempted under paragraph (f) of this section, as a condition of receiving extended care services from VA, a veteran must agree to pay VA and is obligated to pay VA a copayment as specified by this section. A veteran has no obligation to pay a copayment for the first 21 days of extended care services that VA provided the veteran in any 12-month period (the 12-month period begins on the date that VA first provided extended care services to the veteran). However, for each day that extended care services are provided beyond the first 21 days, a veteran is obligated to pay VA the copayment amount set forth below to the extent the veteran has available resources. Available resources are based on monthly calculations, as determined under paragraph (d) of this section. The following sets forth the extended care services provided by VA and the corresponding copayment amount per day:

- (i) Adult day health care—\$15.
- (ii) Domiciliary care—\$5.
- (iii) Institutional respite care—\$97.
- (iv) Institutional geriatric evaluation—\$97.
- (v) Non-institutional geriatric evaluation—\$15.
- (vi) Non-institutional respite care—\$15.
- (vii) Nursing home care—\$97.

(2) For purposes of counting the number of days for which a veteran is obligated to make a copayment under this section, VA will count each day that adult day health care, non-institutional geriatric evaluation, and non-institutional respite care are provided and will count each full day and partial day for each inpatient stay except for the day of discharge.

(c) *Definitions.* For purposes of this section:

(1) *Adult day health care* is a therapeutic outpatient care program that provides medical services, rehabilitation, therapeutic activities, socialization, nutrition and transportation services to disabled veterans in a congregate setting.

(2) *Domiciliary care* is defined in §17.30(b).

(3) *Extended care services* means adult day health care, domiciliary care, institutional geriatric evaluation, noninstitutional geriatric evaluation, nursing home care, institutional respite care, and noninstitutional respite care.

(4) *Geriatric evaluation* is a specialized, diagnostic/consultative service provided by an interdisciplinary team that is for the purpose of providing a comprehensive assessment, care plan, and extended care service recommendations.

(5) *Institutional* means a setting in a hospital, domiciliary, or nursing home of overnight stays of one or more days.

(6) *Noninstitutional* means a service that does not include an overnight stay.

(7) *Nursing home care* means the accommodation of convalescents or other persons who are not acutely ill and not in need of hospital care, but who require nursing care and related medical services, if such nursing care and medical services are prescribed by, or are performed under the general direction of, persons duly licensed to provide such care (nursing services must be provided 24 hours a day). Such term includes services furnished in skilled nursing care facilities. Such term excludes hospice care.

(8) *Respite care* means care which is of limited duration, is furnished on an intermittent basis to a veteran who is suffering from a chronic illness and who resides primarily at home, and is furnished for the purpose of helping the veteran to continue residing primarily at home. (Respite providers temporarily replace the caregivers to provide services ranging from supervision to skilled care needs.)

(d) *Effect of the veteran's financial resources on obligation to pay copayment.*

(1) A veteran is obligated to pay the copayment to the extent the veteran and the veteran's spouse have available resources. For veterans who have been receiving extended care services for 180 days or less, their available resources are the sum of the income of the veteran and the veteran's spouse, minus the sum of the veterans allowance, the spousal allowance, and expenses. For veterans who have been receiving extended care services for 181 days or more, their available resources are the sum of the value of the liquid assets, the fixed assets, and the income of the veteran and the veteran's spouse, minus the sum of the veterans allowance, the spousal allowance, the spousal resource protection amount, and (but only if the veteran—has a spouse or dependents residing in the community who is not institutionalized) expenses. When a veteran is legally separated from a spouse, available resources do not include spousal income, expenses, and assets or a spousal allowance.

(2) For purposes of determining available resources under this section:

(i) *Income* means current income (including, but not limited to, wages and income from a business (minus business expenses), bonuses, tips, severance pay, accrued benefits, cash gifts, inheritance amounts, interest income, standard dividend income from non tax deferred annuities, retirement income, pension income, unemployment payments, worker's compensation payments, black lung payments, tort settlement payments, social security payments, court mandated payments, payments from VA or any other Federal programs, and any other income). The amount of current income will be stated in frequency of receipt, *e.g.*, per week, per month.

(ii) *Expenses* means basic subsistence expenses, including current expenses for the following: rent/mortgage for primary residence; vehicle payment for one vehicle; food for veteran, veteran's spouse, and veteran's dependents; education for veteran, veteran's spouse, and veteran's dependents; court-ordered payments of veteran or veteran's

spouse (*e.g.*, alimony, child-support); and including the average monthly expenses during the past year for the following: utilities and insurance for the primary residence; out-of-pocket medical care costs not otherwise covered by health insurance; health insurance premiums for the veteran, veteran's spouse, and veteran's dependents; and taxes paid on income and personal property.

(iii) *Fixed Assets* means:

(A) Real property and other non-liquid assets; except that this does not include:

(1) Burial plots;

(2) A residence if the residence is:

(i) The primary residence of the veteran and the veteran is receiving only noninstitutional extended care service; or

(ii) The primary residence of the veteran's spouse or the veteran's dependents (if the veteran does not have a spouse) if the veteran is receiving institutional extended care service.

(3) A vehicle if the vehicle is:

(i) The vehicle of the veteran and the veteran is receiving only noninstitutional extended care service; or

(ii) The vehicle of the veteran's spouse or the veteran's dependents (if the veteran does not have a spouse) if the veteran is receiving institutional extended care service.

(B) [Reserved]

(iv) *Liquid assets* means cash, stocks, dividends received from IRA, 401K's and other tax deferred annuities, bonds, mutual funds, retirement accounts (*e.g.*, IRA, 401Ks, annuities), art, rare coins, stamp collections, and collectibles of the veteran, spouse, and dependents. This includes household and personal items (*e.g.*, furniture, clothing, and jewelry) except when the veteran's spouse or dependents are living in the community.

(v) *Spousal allowance* is an allowance of \$20 per day that is included only if the spouse resides in the community (not institutionalized).

(vi) *Spousal resource protection* amount means the value of liquid assets but not to exceed \$89,280 if the spouse is residing in the community (not institutionalized).

(vii) *Veterans allowance* is an allowance of \$20 per day.

(3) The maximum amount of a copayment for any month equals the copayment amount specified in paragraph (b)(1) of this section multiplied by the number of days in the month. The copayment for any month may be less than the amount specified in paragraph (b)(1)

of this section if the veteran provides information in accordance with this section to establish that the copayment should be reduced or eliminated.

(e) *Requirement to submit information.*

(1) Unless exempted under paragraph (f) of this section, a veteran must submit to a VA medical facility a completed VA Form 10-10EC and documentation requested by the Form at the following times:

(i) At the time of initial request for an episode of extended care services;

(ii) At the time of request for extended care services after a break in provision of extended care services for more than 30 days; and

(iii) Each year at the time of submission to VA of VA Form 10-10EZ.

(2) When there are changes that might change the copayment obligation (i.e., changes regarding marital status, fixed assets, liquid assets, expenses, income (when received), or whether the veteran has a spouse or dependents residing in the community), the veteran must report those changes to a VA medical facility within 10 days of the change.

(f) *Veterans and care that are not subject to the copayment requirements.* The following veterans and care are not subject to the copayment requirements of this section:

(1) A veteran with a compensable service-connected disability.

(2) A veteran whose annual income (determined under 38 U.S.C. 1503) is less than the amount in effect under 38 U.S.C. 1521(b).

(3) Care for a veteran's noncompensable zero percent service-connected disability.

(4) An episode of extended care services that began on or before November 30, 1999.

(5) Care authorized under 38 U.S.C. 1710(e) for Vietnam-era herbicide-exposed veterans, radiation-exposed veterans, Persian Gulf War veterans, post-Persian Gulf War combat-exposed veterans, or Camp Lejeune veterans pursuant to §17.400.

(6) Care for treatment of sexual trauma as authorized under 38 U.S.C. 1720D.

(7) Care or services authorized under 38 U.S.C. 1720E for certain veterans regarding cancer of the head or neck.

(8) A veteran who VA determines to be catastrophically disabled, as defined in 38 CFR 17.36(e), is exempt from copayments for adult day health care, non-institutional respite care, and non-institutional geriatric care.

(9) A veteran receiving care for psychosis or a mental illness other than psychosis pursuant to §17.109.

(g) VA Form 10-10EC.

[Note: Form 10-10EC will be found on the next three pages.]

(Authority: 38 U.S.C. 101(28), 501, 1701(7), 1710, 1710B, 1720B, 1720D, 1722A)

[67 FR 35040, May 17, 2002, as amended at 69 FR 39846, July 1, 2004; 76 FR 52274, Aug. 22, 2011; 78 FR 28143, May 14, 2013; 79 FR 57414, Sep. 24, 2014]

Supplement *Highlights* references: 9(1), 24(1), 64(1), 77(1), 86(2).

Application for Extended Services, VAF 10-10EC:

<http://www.va.gov/vaforms/medical/pdf/10-10EC.pdf>

§17.142 Authority to approve sharing agreements, contracts for scarce medical specialist services and contracts for other medical services.

The Under Secretary for Health is delegated authority to enter into

(a) Sharing agreements authorized under 38 U.S.C. 8153 and §17.240;

(b) Contracts with schools and colleges of medicine, osteopathy, dentistry, podiatry, optometry, and nursing, clinics, and any other group or individual capable of furnishing such services to provide scarce medical specialist services at Department of Veterans Affairs health care facilities (including, but not limited to, services of physicians, dentists, podiatrists, optometrists, nurses, physicians' assistants, expanded function dental auxiliaries, technicians, and other medical support personnel); and

(c) When a sharing agreement or contract for scarce medical specialist services is not warranted, contracts authorized under the provisions of 38 U.S.C. 8153 for medical and ancillary services. The authority under this section generally will be exercised by approval of proposed contracts or agreements negotiated at the health care facility level. Such approval, however, will not be necessary in the case of any purchase order or individual authorization for which authority has been delegated in 48 CFR 801.670-3. All such contracts and agreements will be negotiated pursuant to 48 CFR chapters 1 and 8. (Authority: 38 U.S.C. 512, 7409, 8153)

[45 FR 6938, Jan. 31, 1980. Redesignated at 61 FR 21966, May 13, 1996, as amended at 62 FR 17072, Apr. 9, 1997; 79 FR 54616, Sep. 12, 2014]

Supplement *Highlights* reference: 86(1).

Next Section is §17.148

Prosthetic, Sensory, and Rehabilitative Aids

§17.148 Service dogs.

(a) *Definitions.* For the purposes of this section:

Service dogs are guide or service dogs prescribed for a disabled veteran under this section.

(b) *Clinical requirements.* VA will provide benefits under this section to a veteran with a service dog only if:

(1) The veteran is diagnosed as having a visual, hearing, or substantial mobility impairment; and

(2) The VA clinical team that is treating the veteran for such impairment determines based upon medical judgment that it is optimal for the veteran to manage the impairment and live independently through the assistance of a trained service dog. Note: If other means (such as technological devices or rehabilitative therapy) will provide the same level of independence, then VA will not authorize benefits under this section.

(3) For the purposes of this section, substantial mobility impairment means a spinal cord injury or dysfunction or other chronic impairment that substantially limits mobility. A chronic impairment that substantially limits mobility includes but is not limited to a traumatic brain injury that compromises a veteran's ability to make appropriate decisions based on environmental cues (i.e., traffic lights or dangerous obstacles) or a seizure disorder that causes a veteran to become immobile during and after a seizure event.

(c) *Recognized service dogs.* VA will recognize, for the purpose of paying benefits under this section, the following service dogs:

(1) The dog and veteran must have successfully completed a training program offered by an organization accredited by Assistance Dogs International or the International Guide Dog Federation, or both (for dogs that perform both service- and guide-dog assistance). The veteran must provide to VA a certificate showing successful completion issued by the accredited organization that provided such program.

(2) Dogs obtained before September 5, 2012 will be recognized if a guide or service dog training organization in existence before September 5, 2012 certifies that the veteran and dog, as a team, successfully completed, no later than September 5, 2013, a training program offered by that training organization. The veteran must provide to VA a certificate showing successful completion issued by the organization that provided such program. Alternatively, the veteran and dog will be recognized if they comply with paragraph (c)(1) of this section.

§17.150 Prosthetic and similar appliances.

Artificial limbs, braces, orthopedic shoes, hearing aids, wheelchairs, medical accessories, similar appliances including invalid lifts and therapeutic and rehabilitative devices, and special clothing made necessary by the wearing of such appliances, may be purchased, made or repaired for any veteran upon a determination of feasibility and medical need, provided:

(a) *As part of outpatient care.* The appliances or repairs are a necessary part of outpatient care for which the veteran is eligible under 38 U.S.C. 1710 and 38 CFR 17.93 (or a necessary part of outpatient care authorized under §17.94) or

(b) *As part of hospital care.* The appliances or repairs are a necessary part of inpatient care for any service-connected disability or any nonservice-connected disability, if:

- (1) The nonservice-connected disability is associated with an aggravating a service-connected disability, or
- (2) The nonservice-connected disability is one for which hospital admission was authorized, or
- (3) The nonservice-connected disability is associated with and aggravating a nonservice-connected disability for which hospital admission was authorized or
- (4) The nonservice-connected disability is one for which treatment may be authorized under the provisions of §17.47(h), or

(c) *As part of domiciliary care.* The appliances or repairs are necessary for continued domiciliary care, or are necessary to treat a member's service-connected disability, or nonservice-connected disability associated with and aggravating a service-connected disability, or

(d) *As part of nursing home care.* The appliances or repairs are a necessary part of nursing home care furnished in facilities under the direct and exclusive jurisdiction of the Department of Veterans Affairs.

[32 FR 13816, Oct. 4, 1967, as amended at 33 FR 12315, Aug. 31, 1968; 34 FR 9341, June 13, 1969; 35 FR 17948, Nov. 21, 1970; 54 FR 34983, Aug. 23, 1989. Redesignated and amended at 61 FR 21966, 21968, May 13, 1996; 79 FR 54616, Sep. 12, 2014]

Supplement *Highlights* reference: 86(1).

§17.151 Invalid lifts for recipients of aid and attendance allowance or special monthly compensation.

An invalid lift may be furnished if:

(a) The applicant is a veteran who is receiving (1) special monthly compensation (including special monthly compensation based on the need for aid and attendance) under the provisions of 38 U.S.C. 1114(r), or (2) comparable compensation benefits at the rates prescribed under 38 U.S.C. 1134, or (3) increased pension based on the need for aid and attendance or a greater compensation benefit rather than aid and attendance pension to which he or she has been adjudicated to be presently eligible; and

(b) The veteran has loss, or loss of use, of both lower extremities and at least one upper extremity (loss of use may result from paralysis or other impairment to muscle power and includes all cases in which the veteran cannot use his or her extremities or is medically prohibited from doing so because of a serious disease or disability); and

(c) The veteran has been medically determined incapable of moving himself or herself from his or her bed to a wheelchair, or from his or her wheelchair to his or her bed, without the aid of an attendant, because of the disability involving the use of his or her extremities; and

(d) An invalid lift would be a feasible means by which the veteran could accomplish the necessary maneuvers between bed and wheelchair, and is medically determined necessary.

[33 FR 12315, Aug. 31, 1968, as amended at 36 FR 3117, Feb. 13, 1971; 54 FR 34983, Aug. 23, 1989. Redesignated at 61 FR 21966, May 13, 1996]

§17.152 Devices to assist in overcoming the handicap of deafness.

Devices for assisting in overcoming the handicap of deafness (including telecaptioning television decoders) may be furnished to any veteran who is profoundly deaf (rated 80% or more disabled for hearing impairment by the Department of Veterans Affairs) and is entitled to compensation on account of such hearing impairment. (Authority: 38 U.S.C. 1717(c))

[53 FR 46607, Nov. 18, 1988. Redesignated at 61 FR 21966, May 13, 1996; 79 FR 54616, Sep. 12, 2014]

Supplement *Highlights* reference: 86(1).

§17.153 Training in the use of appliances.

Beneficiaries supplied prosthetic and similar appliances will be additionally entitled to fitting and training in the use of the appliances. Such training will usually be given in Department of Veterans Affairs facilities and by Department of Veterans Affairs employees, but may be obtained under contract if determined necessary.

[26 FR 5871, June 30, 1961. Redesignated at 61 FR 21966, May 13, 1996]

§17.154 Equipment for blind veterans.

VA may furnish mechanical and/or electronic equipment considered necessary as aids to overcoming the handicap of blindness to blind veterans entitled to disability compensation for a service-connected disability. (Authority: 38 U.S.C. 1714)

[26 FR 5872, June 30, 1961. Redesignated at 61 FR 21966, May 13, 1996; as amended at 77 FR 54382, Sep. 5, 2012]

Automotive Equipment and Driver Training

§17.155 Minimum standards of safety and quality for automotive adaptive equipment.

(a) The Under Secretary for Health or designee is authorized to develop and establish minimum standards of safety and quality for adaptive equipment provided under 38 U.S.C. chapter 39.

(b) In the performance of this function, the following considerations will apply:

(1) Minimum standards of safety and quality will be developed and promulgated for basic adaptive equipment specifically designed to facilitate operation and use of standard passenger motor vehicles by persons who have specified types of disablement and for the installation of such equipment.

(2) In those instances where custom-built adaptive equipment is designed and installed to meet the peculiar needs of uniquely disabled persons and where the incidence of probable usage is not such as to justify development of formal standards, such equipment will be inspected and, if in order, approved for use by a qualified designee of the Under Secretary for Health.

(3) Adaptive equipment, available to the general public, which is manufactured under standards of safety imposed by a Federal agency having authority to establish the same, shall be deemed to meet required standards for use as adaptive equipment. These include such items as automatic transmissions, power brakes, power steering and other automotive options.

(c) For those items where specific Department of Veterans Affairs standards of safety and quality have not as yet been developed, or where such standards are otherwise provided as with custom-designed or factory option items, authorization of suitable adaptive equipment will not be delayed. Approval of such adaptive equipment, however, shall be subject to the judgment of designated certifying officials that it meets implicit standards of safety and quality adopted by the industry or as later developed by the Department of Veterans Affairs.

[40 FR 8819, Mar. 3, 1975. Redesignated at 61 FR 21966, May 13, 1996, as amended at 62 FR 17072, Apr. 9, 1997]

§17.156 Eligibility for automobile adaptive equipment.

Automobile adaptive equipment may be authorized if the Under Secretary for Health or designee determines that such equipment is deemed necessary to insure that the eligible person will be able to operate the automobile or other conveyance in a manner consistent with such person's safety and so as to satisfy the applicable standards of licensure established by the State of such person's residency or other proper licensing authority.

(a) Persons eligible for adaptive equipment are:

(1) Veterans who are entitled to receive compensation for the loss or permanent loss of use of one or both feet; or the loss or permanent loss of use of one or both hands; or ankylosis of one or both knees, or one of both hips if the disability is the result of injury incurred or disease contracted in or aggravated by active military, naval or air service.

(2) Members of the Armed Forces serving on active duty who are suffering from any disability described in paragraph (a)(1) of this section incurred or contracted during or aggravated by active military service are eligible to receive automobile adaptive equipment.

(b) Payment or reimbursement of reasonable costs for the repair, replacement, or reinstallation of adaptive equipment deemed necessary for the operation of the automobile may be authorized by the Under Secretary for Health or designee. (Authority: 38 U.S.C. 3902)

[53 FR 46607, Nov. 18, 1988. Redesignated at 61 FR 21966, May 13, 1996, as amended at 62 FR 17072, Apr. 9, 1997]

§17.157 Definition—adaptive equipment.

The term, adaptive equipment, means equipment which must be part of or added to a conveyance manufactured for sale to the general public to make it safe for use by the claimant, and enable that person to meet the applicable standards of licensure. Adaptive equipment includes any term specified by the Under Secretary for Health or designee as ordinarily necessary for any of the classes of losses or combination of such losses specified in §17.156 of this part, or as deemed necessary in an individual case. Adaptive equipment includes, but is not limited to, a basic automatic transmission, power steering, power brakes, power window lifts, power seats, air-conditioning equipment when necessary for the health and safety of the veteran, and special equipment necessary to assist the eligible person into or out of the automobile or other conveyance, regardless of whether the automobile or other conveyance is to be operated by the eligible person or is to be operated for such person by another person; and any modification of the interior space of the automobile or other conveyance if needed because of the physical condition of such person in order for such person to enter or operate the vehicle. (Authority: 38 U.S.C. 3901, 3902)

[53 FR 46608, Nov. 18, 1988. Redesignated and amended at 61 FR 21966, 21968, May 13, 1996]

§17.158 Limitations on assistance.

(a) An eligible person shall not be entitled to adaptive equipment for more than two automobiles or other conveyances at any one time or during any four-year period except when due to circumstances beyond control of such person, one of the automobiles or conveyances for which adaptive equipment was provided during the applicable four-year period is no longer available for the use of such person.

(1) Circumstances beyond the control of the eligible person are those where the vehicle was lost due to fire, theft, accident, court action, or when repairs are so costly as to be prohibitive or a different vehicle is required due to a change in the eligible person's physical condition.

(2) For purposes of paragraph (a)(1) of this section, an eligible person shall be deemed to have access to and use of an automobile or other conveyance for which the Department of Veterans Affairs has provided adaptive equipment if that person has sold, given or transferred the vehicle to a spouse, family member or other person residing in the same household as the eligible person, or to a business owned by such person. (Authority: 38 U.S.C. 3903)

(b) Eligible persons may be reimbursed for the actual cost of adaptive equipment subject to a dollar amount for specific items established from time to time by the Under Secretary for Health. (Authority: 38 U.S.C. 3902)

(c) Reimbursement for a repair to an item of adaptive equipment is limited to the current vehicles of record and only to the basic components authorized as automobile adaptive equipment. Reimbursable amounts for repairs are limited to the cost of parts and labor based on the amounts published in generally acceptable commercial estimating guides for domestic automobiles. (Authority: 38 U.S.C. 3902)

[53 FR 46608, Nov. 18, 1988. Redesignated and amended at 61 FR 21966, 21968, May 13, 1996]

§17.159 Obtaining vehicles for special driver training courses.

The Secretary may obtain by purchase, lease, gift or otherwise, any automobile, motor vehicle, or other conveyance deemed necessary to conduct special driver training courses at Department of Veterans Affairs health care facilities. The Secretary may sell, assign, transfer or convey any such automobile, vehicle or conveyance to which the Department of Veterans Affairs holds title for such price or under such terms deemed appropriate by the Secretary. Any proceeds received from such disposition shall be credited to the applicable Department of Veterans Affairs appropriation. (Authority: 38 U.S.C. 3903(e)(3))

[45 FR 6939, Jan. 31, 1980. Redesignated at 54 FR 46607, Nov. 18, 1988, and further redesignated at 61 FR 21966, May 13, 1996]

Dental Services

§17.160 Authorization of dental examinations.

When a detailed report of dental examination is essential for a determination of eligibility for benefits, dental examinations may be authorized for the following classes of claimants or beneficiaries:

(a) Those having a dental disability adjudicated as incurred or aggravated in active military, naval, or air service or those requiring examination to determine whether the dental disability is service connected.

(b) Those having disability from disease or injury other than dental, adjudicated as incurred or aggravated in active military, naval, or air service but with an associated dental condition that is considered to be aggravating the basic service-connected disorder.

(c) Those for whom a dental examination is ordered as a part of a general physical examination.

(d) Those requiring dental examination during hospital, nursing home, or domiciliary care.

(e) Those held to have suffered dental injury or aggravation of an existing dental injury, as the result of examination, hospitalization, or medical or surgical (including dental) treatment that had been awarded.

(f) Veterans who are participating in a rehabilitation program under 38 U.S.C. chapter 31 are entitled to such dental services as are professionally determined necessary for any of the reasons enumerated in §17.47(g). (Authority: 38 U.S.C. 1712(b); ch. 31)

(g) Those for whom a special dental examination is authorized by the Under Secretary for Health or the Assistant Chief Medical Director for Dentistry.

(h) Persons defined in §17.93.

[13 FR 7162, Nov. 27, 1948, as amended at 21 FR 10388, Dec. 28, 1956; 23 FR 6503, Aug. 22, 1958; 27 FR 11424, Nov. 20, 1962; 29 FR 1463, Jan. 29, 1964; 30 FR 1789, Feb. 9, 1965; 32 FR 13817, Oct. 4, 1967; 33 FR 5300, Apr. 3, 1968; 35 FR 6586, Apr. 24 1970; 49 FR 5617, Feb. 14, 1984. Redesignated and amended at 61 FR 21966, 21968, May 13, 1996; 79 FR 54616, Sep. 12, 2014]

Supplement *Highlights* reference: 86(1).

§17.161 Authorization of outpatient dental treatment.

Outpatient dental treatment may be authorized by the Chief, Dental Service, for beneficiaries defined in 38 U.S.C. 1712(b) and 38 CFR 17.93 to the extent prescribed and in accordance with the applicable classification and provisions set forth in this section.

(a) *Class I.* Those having a service-connected compensable dental disability or condition, may be authorized any dental treatment indicated as reasonably necessary to maintain oral health and masticatory function. There is no time limitation for making application for treatment and no restriction as to the number of repeat episodes of treatment.

(b) *Class II.*

(1) (i) Those having a service-connected noncompensable dental condition or disability shown to have been in existence at time of discharge or release from active service, which took place after September 30, 1981, may be authorized any treatment indicated as reasonably necessary for the one-time correction of the service-connected noncompensable condition, but only if:

(A) They served on active duty during the Persian Gulf War and were discharged or released, under conditions other than dishonorable, from a period of active military, naval, or air service of not less than 90 days, or they were discharged or released under conditions other than dishonorable, from any other period of active military, naval, or air service of not less than 180 days;

(B) Application for treatment is made within 180 days after such discharge or release.

(C) The certificate of discharge or release does not bear a certification that the veteran was provided, within the 90-day period immediately before such discharge or release, a complete dental examination (including dental X-rays) and all appropriate dental treatment indicated by the examination to be needed, and

(D) Department of Veterans Affairs dental examination is completed within six months after discharge or release, unless delayed through no fault of the veteran.

(ii) Those veterans discharged from their final period of service after August 12, 1981, who had reentered active military service within 90 days after the date of a discharge or release from a prior period of active military service, may apply for treatment of service-connected noncompensable dental conditions relating to any such periods of service within 180 days from the date of their final discharge or release.

(iii) If a disqualifying discharge or release has been corrected by competent authority, application may be made within 180 days after the date of correction.

(2) (i) Those having a service-connected noncompensable dental condition or disability shown to have been in existence at time of discharge or release from active service, which took place before October 1, 1981, may be authorized any treatment indicated as reasonably necessary for the one-time correction of the service-connected noncompensable condition, but only if:

(A) They were discharged or released, under conditions other than dishonorable, from a period of active military, naval or air service of not less than 180 days.

(B) Application for treatment is made within one year after such discharge or release.

(C) Department of Veterans Affairs dental examination is completed within 14 months after discharge or release, unless delayed through no fault of the veteran.

(ii) Those veterans discharged from their final period of service before August 13, 1981, who had reentered active military service within one year from the date of a prior discharge or release, may apply for treatment of service-connected noncompensable dental conditions relating to any such prior periods of service within one year of their final discharge or release.

(iii) If a disqualifying discharge or release has been corrected by competent authority, application may be made within one year after the date of correction. (Authority: 38 U.S.C. 1712)

(c) *Class II(a)*. Those having a service-connected noncompensable dental condition or disability adjudicated as resulting from combat wounds or service trauma may be authorized any treatment indicated as reasonably necessary for the correction of such service-connected noncompensable condition or disability. (Authority: 38 U.S.C. 501; 1712(a)(1)(C))

(d) *Class II(b)*. Certain homeless and other enrolled veterans eligible for a one-time course of dental care under 38 U.S.C. 2062. (Authority: 38 U.S.C. 2062; 38 U.S.C. 1712(a)(1)(H))

(e) *Class II(c)*. Those who were prisoners of war, as determined by the concerned military service department, may be authorized any needed outpatient dental treatment. (Authority: Pub. L. 100-322; Pub. L. 108-170; 38 U.S.C. 1712(a)(1)(F))

(f) *Class IIR (Retroactive)*. Any veteran who had made prior application for and received dental treatment from the Department of Veterans Affairs for noncompensable dental conditions, but was denied replacement of missing teeth which were lost during any period of service prior to his/her last period of service may be authorized such previously denied benefits under the following conditions:

(1) Application for such retroactive benefits is made within one year of April 5, 1983.

(2) Existing Department of Veterans Affairs records reflect the prior denial of the claim.

All Class IIR (Retroactive) treatment authorized will be completed on a fee basis status. (Authority: 38 U.S.C. 1712)

(g) *Class III*. Those having a dental condition professionally determined to be aggravating disability from an associated service-connected condition or disability may be authorized dental treatment for only those dental conditions which, in sound professional judgment, are having a direct and material detrimental effect upon the associated basic condition or disability.

(h) *Class IV.* Those whose service-connected disabilities are rated at 100% by schedular evaluation or who are entitled to the 100% rate by reason of individual unemployability may be authorized any needed dental treatment. (Authority: 38 U.S.C. 1712)

(i) *Class V.* A veteran who is participating in a rehabilitation program under 38 U.S.C. chapter 31 may be authorized such dental services as are professionally determined necessary for any of the reasons enumerated in §17.47(g). (Authority: 38 U.S.C. 1712(b); chapter 31)

(j) *Class VI.* Any veterans scheduled for admission or otherwise receiving care and services under chapter 17 of 38 U.S.C. may receive outpatient dental care which is medically necessary, i.e., is for dental condition clinically determined to be complicating a medical condition currently under treatment. (Authority: 38 U.S.C. 1712)

[20 FR 9505, Dec. 20, 1955, as amended at 26 FR 11214, Nov. 28, 1961; 27 FR 11424, Nov. 20, 1962; 29 FR 18219, Dec. 23, 1964; 32 FR 13817, Oct. 4, 1967; 33 FR 5300, Apr. 3, 1968; 45 FR 47680, July 16, 1980; 48 FR 16681, Apr. 19, 1983; 49 FR 5617, Feb. 14, 1984; 54 FR 25449, June 15, 1989; 57 FR 4367, Feb. 5, 1992; 57 FR 41701, Sept. 11, 1992. Redesignated and amended at 61 FR 21965, 21968, May 13, 1996; 73 FR 58876, Oct. 8, 2008; 75 FR 54030, Sept. 3, 2010; 79 FR 54616, Sep. 12, 2014]

Supplement *Highlights* references: 43(1), 57(1), 86(1).

§17.162 Eligibility for Class II dental treatment without rating action.

When an application has been made for class II dental treatment under §17.161(b), the applicant may be deemed eligible and dental treatment authorized on a one-time basis without rating action if:

(a) The examination to determine the need for dental care has been accomplished within the specified time limit after date of discharge or release unless delayed through no fault of the veteran, and sound dental judgment warrants a conclusion the condition originated in or was aggravated during service and the condition existed at the time of discharge or release from active service, and (Authority: 38 U.S.C. 1712)

(b) The treatment will not involve replacement of a missing tooth noted at the time of Department of Veterans Affairs examination except:

(1) In conjunction with authorized extraction replacement, or

(2) When a determination can be made on the basis of sound professional judgment that a tooth was extracted or lost on active duty.

(c) Individuals whose entire tour of duty consisted of active or inactive duty for training shall not be eligible for treatment under this section.

[37 FR 6847, Apr. 5, 1972, as amended at 48 FR 16682, Apr. 19, 1983. Redesignated and amended at 61 FR 21966, 21968, May 13, 1996]

§17.163 Posthospital outpatient dental treatment.

The Chief, Dental Service may authorize outpatient dental care which is reasonably necessary to complete treatment of a nonservice-connected dental condition which was begun while the veteran was receiving Department of Veterans Affairs authorized hospital care. (Authority: 38 U.S.C. 1712(a)(1)(E))

[45 FR 6939, Jan. 31, 1980. Redesignated at 61 FR 21966, May 13, 1996; 79 FR 54616, Sep. 12, 2014]

§17.164 Patient responsibility in making and keeping dental appointments.

Any veteran eligible for dental treatment on a one-time completion basis only and who has not received such treatment within 3 years after filing the application shall be presumed to have abandoned the claim for dental treatment.

[45 FR 6939, Jan. 31, 1980. Redesignated at 61 FR 21966, May 13, 1996]

§17.165 Emergency outpatient dental treatment.

When outpatient emergency dental care is provided, as a humanitarian service, to individuals who have no established eligibility for outpatient dental care, the treatment will be restricted to the alleviation of pain or extreme discomfort, or the remediation of a dental condition which is determined to be endangering life or health. The provision of emergency treatment to persons found ineligible for dental care will not entitle the applicant to further dental treatment. Individuals provided emergency dental care who are found to be ineligible for such care will be billed. (Authority: 38 U.S.C. 501)

[50 FR 14704, Apr. 15, 1985; 50 FR 21604, May 28, 1985. Redesignated at 61 FR 21966, May 13, 1996]

§17.166 Dental services for hospital or nursing home patients and domiciled members.

Persons receiving hospital, nursing home, or domiciliary care pursuant to the provisions of §§17.46 and 17.47, will be furnished such dental services as are professionally determined necessary to the patients' or members' overall hospital, nursing home, or domiciliary care.

[30 FR 1790, Feb. 9, 1965. Redesignated at 61 FR 21966, May 13, 1996]

Next Section is §17.170

Veterans Canteen Service**§17.180 Delegation of authority.**

In connection with the Veterans Canteen Service, the Under Secretary for Health is hereby delegated authority as follows:

(a) To exercise the powers and functions of the Secretary with respect to the maintenance and operation of the Veterans Canteen Service.

(b) To designate the Assistant Chief Medical Director for Administration to administer the overall operation of the Veterans Canteen Service and to designate selected employees of the Veterans Canteen Service to perform the functions described in the enabling statute, 38 U.S.C. ch. 78, so as to effectively maintain and operate the Veterans Canteen Service.

[20 FR 337, Jan. 14, 1955, as amended at 36 FR 23386, Dec. 9, 1971; 45 FR 6939, Jan. 31, 1980. Redesignated at 61 FR 21966, May 13, 1996, as amended at 62 FR 17072, Apr. 9, 1997; 79 FR 54616, Sep. 12, 2014]

Supplement *Highlights* reference: 86(1).

Next Section is §17.190

Aid to States for Care of Veterans in State Homes

Note: Sections 17.190 through 17.200 do not apply to nursing home care in State homes. The provisions for nursing home care in State homes are set forth in 38 CFR part 51.

§17.190 Recognition of a State home.

A State-operated facility which provides hospital or domiciliary care to veterans must be formally recognized by the Secretary as a State home before Federal aid payments can be made for the care of such veterans. Any agency of a State (exclusive of a territory or possession) responsible for the maintenance or administration of a State home may apply for recognition by the Department of Veterans Affairs for the purpose of receiving aid for the care of veterans in such State home. A State home may be recognized if: (Authority: 38 U.S.C. 501, 1741)

(a) The State home is a facility which exists primarily for the accommodation of veterans incapable of earning a living and who are in need of domiciliary, and

(b) The majority of such veterans who are domiciliary members in the home are veterans who may be included in the computation of the amount of aid payable from the Department of Veterans Affairs, and

(c) The personnel, building and other facilities and improvements at the home are devoted primarily to the care of veterans.

[35 FR 3166, Feb. 19, 1970, as amended at 45 FR 6939, Jan. 31, 1980. Redesignated and amended at 61 FR 21966, 21968, May 13, 1996; amended at 65 FR 968, Jan. 6, 2000; 72 FR 18128, Apr. 11, 2007]

Supplement *Highlights* reference: 37(1)

§17.197 Amount of aid payable.

The amount of aid payable to a recognized State home shall be at the per diem rates established by 38 U.S.C. 1741(a)(1)(A) for domiciliary care; and sec. 1741(a)(1)(B) for hospital care. In no case shall the payments made with respect to any veteran exceed one-half of the cost of the veteran's care in the State home. VA will publish the actual per diem rates, whenever they change, in a *Federal Register* notice. (Authority: 38 U.S.C. 1741)

[50 FR 32568, Aug. 13, 1985. Redesignated at 61 FR 21966, May 13, 1996. Amended at 65 FR 968, Jan. 6, 2000; 79 FR 54616, Sep. 12, 2014]

Supplement *Highlights* reference: 86(1).

§17.198 Department of Veterans Affairs approval of eligibility required.

Federal aid will be paid only for the care of veterans whose separate eligibility for hospital or domiciliary care has been approved by the Department of Veterans Affairs. To obtain such approval, State homes will complete a Department of Veterans Affairs application form for each veteran for the type of care to be provided and submit it to the Department of Veterans Affairs office of jurisdiction for determination of eligibility. Payments shall be made only from the date the Department of Veterans Affairs office of jurisdiction receives such application; however, if such request is received by the Department of Veterans Affairs office of jurisdiction within 10 days after the beginning of the care of such veteran for which he or she is determined to be eligible, payment shall be made on account of such veteran from the date care began. (Authority: 38 U.S.C. 1743)

[85 FR 3167, Feb. 19, 1970, as amended at 45 FR 6940, Jan. 31, 1980. Redesignated at 61 FR 21966, May 13, 1996. Amended at 65 FR 968, Jan. 6, 2000]

§17.199 Inspection of recognized State homes.

Representatives of the Department of Veterans Affairs may inspect any State home at such times as are deemed necessary. Such inspections shall be concerned with the physical plant; records relating to admissions, discharges and occupancy; fiscal records; and all other areas of interest necessary to a determination of compliance with applicable laws and regulations relating to the payment of Federal aid. The authority to inspect carries with it no authority over the management or control of any State home. (Authority: 38 U.S.C. 1742)

[30 FR 221, Jan. 8, 1965, as amended at 35 FR 3167, Feb. 19, 1970. Redesignated at 61 FR 21966, May 13, 1996]

§17.200 Audit of State homes.

The State must comply with the Single Audit Act of 1984 (part 41 of this chapter). (Authority: 31 U.S.C. 7501-7507)

[52 FR 23825, June 25, 1987. Redesignated at 61 FR 21966, May 13, 1996]

Next Section is §17.230

Sharing of Medical Facilities, Equipment, and Information

§17.230 Contingency backup to the Department of Defense.

(a) *Priority care to active duty personnel.* The Secretary, during and/or immediately following a period of war or national emergency declared by the Congress or the President that involves the use of United States Armed Forces in armed conflict, is authorized to furnish hospital care, nursing home care, and medical services to members of the Armed Forces on active duty. The Secretary may give higher priority in the furnishing of such care and services in VA facilities to members of the Armed Forces on active duty than to any other group of persons eligible for such care and services with the exception of veterans with service-connected disabilities. (Authority: 38 U.S.C. 8111A, Pub. L. 97-174)

(b) *Contract authority.* During a period in which the Secretary is authorized to furnish care and services to members of the Armed Forces under paragraph (a) of this section, the Secretary, to the extent authorized by the President and subject to the availability of appropriations or reimbursements, may authorize VA facilities to enter into contracts with private facilities for the provision during such period of hospital care and medical services for certain veterans. These veterans include only those who are receiving hospital care under 38 U.S.C. 1710 or, in emergencies, for those who are eligible for treatment under that section, or who are receiving care under 38 U.S.C. 1710(g). This authorization pertains only to circumstances in which VA facilities are not capable of furnishing or continuing to furnish the care or services required because of the furnishing of care and services to members of the Armed Forces. (Authority: 38 U.S.C. 8111A) (Authority: Sec. 501 and 1720(a) of Title 38, U.S.C.)

[49 FR 5617, Feb. 14, 1984. Redesignated at 61 FR 21966, May 13, 1996; 79 FR 54616, Sep. 12, 2014]

Supplement Highlights reference: 86(1).

Next Section is §17.240

§17.240 Sharing health-care resources.

Subject to such terms and conditions as the Under Secretary for Health shall prescribe, agreements may be entered into for sharing medical resources between Department health-care facilities and any health-care provider, or other entity or individual with geographical limitations determined by the Under Secretary for Health, provided:

(a) The agreement will achieve one of the following purposes:

(1) It will secure the use of a health-care resource which otherwise might not be feasibly available by providing for the mutual use or exchange of use of health-care resources when such an agreement will obviate the need for a similar resource to be installed or provided at a facility operated by the Department of Veterans Affairs, or

(2) It will secure effective use of Department of Veterans Affairs health-care resources by providing for the mutual use or exchange of use, of health-care resources in a facility operated by the Department of Veterans Affairs, which have been justified on the basis of veterans' care, but which are not utilized to their maximum effective capacity; and

(b) The agreement is determined to be in the best interest of the prevailing standards of the Department of Veterans Affairs Medical Program; and

(c) The agreement provides for reciprocal reimbursement based on a charge which covers the full cost of the use of health-care resources, incidental hospital care or other needed services, supplies used, and normal depreciation and amortization costs of equipment.

(d) Reimbursement for medical care rendered to an individual who is entitled to hospital or medical services (Medicare) under subchapter XVIII of chapter 7 of title 42 U.S.C., and who has no entitlement to medical care from the Department of Veterans Affairs, will be made to such facility, or if the contract or agreement so provides to the community health care facility which is party to the agreement, in accordance with:

(1) Rates prescribed by the Secretary of Health and Human Services, after consultation with the Secretary of Veterans Affairs, and

(2) Procedures jointly prescribed by the Secretary of Health and Human Services and the Secretary of Veterans Affairs to assure reasonable quality of care and service and efficient and economical utilization of resources. (Authority: 38 U.S.C. 8153)

[32 FR 6841, May 4 1967, as amended at 35 FR 18198, Nov. 28, 1970; 39 FR 1846, Jan. 15, 1974; 45 FR 6940, Jan. 31, 1980; 47 FR 58250, Dec. 30, 1982; 54 FR 34983, Aug. 23, 1989. Redesignated at 61 FR 21966, May 13, 1996, as amended at 62 FR 17072, Apr. 9, 1997; 79 FR 54616, Sep. 12, 2014]

Supplement *Highlights* reference: 86(1).

Order 11246 (30 FR 12319) and any implementing regulations the Secretary of Labor may promulgate.

[33 FR 6011, Apr. 19, 1968, as amended at 36 FR 320, Jan. 9, 1971; 42 FR 54804, Oct. 11, 1977. Redesignated and amended at 61 FR 21966, 21969, May 13, 1996]

§17.255 Applications for grants for programs which include construction projects.

In addition to the documents and evidence required by §17.254, any application for a grant for the construction of any facility, structure or system which is part of an exchange of information program shall include the following:

(a) Each application shall include complete descriptions, maps, and surveys of the construction site, and documentary evidence and explanations showing ownership, and

(b) Each application shall include complete plans and specifications for the construction project, and where applicable, sufficient explanations of technical applications so that they may be understood by the layman, and

(c) Each application shall contain assurance that the rates of pay for laborers and mechanics engaged in construction activities will not be less than the prevailing local wage rates for similar work as determined in accordance with the provisions of 40 U.S.C. 3141-3144, 3146, and 3147.

[33 FR 6012, Apr. 19, 1968. Redesignated and amended at 61 FR 21966, 21969, May 13, 1996; 79 FR 54616, Sep. 12, 2014]

Supplement *Highlights* reference: 86(1).

§17.256 Amended or supplemental applications.

An amended application, or an application for a supplemental grant, may be considered either before or after final action has been taken on the original application. Amended applications and applications for supplemental grants shall be subject to the same terms, conditions and requirements necessary for original applications.

[33 FR 6012, Apr. 19, 1968. Redesignated at 61 FR 21966, May 13, 1996]

§17.276 Appeal/review process.

Notice of the initial determination regarding payment of CHAMPVA benefits will be provided to the beneficiary on a CHAMPVA Explanation of Benefits (EOB) form. The EOB form is generated by the CHAMPVA automated payment processing system. If a beneficiary disagrees with the determination concerning covered services or calculation of benefits, he or she may request reconsideration. Such requests must be submitted to the Center in writing within one year of the date of the initial determination. The request must state why the beneficiary believes the decision is in error and must include any new and relevant information not previously considered. Any request for reconsideration that does not identify the reason for dispute will be returned to the claimant without further consideration. After reviewing the claim and any relevant supporting documentation, a CHAMPVA benefits advisor will issue a written determination to the beneficiary that affirms, reverses or modifies the previous decision. If the beneficiary is still dissatisfied, within 90 days of the date of the decision he or she may make a written request for review by the Director, Health Administration Center, or his or her designee. The Director, Health Administration Center, or his or her designee will review the claim, and any relevant supporting documentation, and issue a decision in writing that affirms, reverses or modifies the previous decision. The decision of the Director, Health Administration Center, or his or her designee with respect to benefit coverage and computation of benefits is final. (Authority: 38 U.S.C. 501, 1781)

Note to §17.276: Denial of CHAMPVA benefits based on legal eligibility requirements may be appealed to the Board of Veterans' Appeals in accordance with 38 CFR part 20. Medical determinations are not appealable to the Board. 38 CFR 20.101.

[63 FR 48102, Sept. 9, 1998, as amended at 73 FR 65553, Nov. 4, 2008]

Supplement *Highlights* references: 31(1), 44(1).

§17.277 Third-party liability/Medicare cost recovery.

The Center will actively pursue third-party liability/medical care cost recovery in accordance with applicable law. (Authority: 42 U.S.C. 2651; 38 U.S.C. 501, 1781)

[63 FR 48102, Sept. 9, 1998, as amended at 73 FR 65553, Nov. 4, 2008; 79 FR 54616, Sep. 12, 2014]

Supplement *Highlights* references: 31(1), 44(1), 86(1).

§17.370 Termination of payments.

Payments may be terminated if the U.S. Department of Veterans Affairs determines the Veterans Memorial Medical Center has not replaced and upgraded as needed equipment during the period in which the agreements cited in §17.50 are in effect or has not rehabilitated the existing physical plant and facilities to place the medical center on a sound and effective operating basis, or has not maintained the medical center in a well-equipped and effective operating condition. Payments, however, will not be stopped unless the Veterans Memorial Medical Center has been given at least 60 days advance written notice of intent to stop payments. (Authority: 38 U.S.C. 1732)

[33 FR 5301, Apr. 3, 1968, as amended at 47 FR 58251, Dec. 30, 1982]

Next Section is §17.500

§ 17.400 Hospital care and medical services for Camp Lejeune veterans.

(a) *General.* In accordance with this section, VA will provide hospital care and medical services to Camp Lejeune veterans. Camp Lejeune veterans will be enrolled pursuant to § 17.36(b)(6).

(b) *Definitions.* For the purposes of this section:

Camp Lejeune means any area within the borders of the U.S. Marine Corps Base Camp Lejeune or Marine Corps Air Station New River, North Carolina.

Camp Lejeune veteran means any veteran who served at Camp Lejeune on active duty, as defined in 38 U.S.C. 101(21), in the Armed Forces for at least 30 (consecutive or nonconsecutive) days during the period beginning on January 1, 1957, and ending on December 31, 1987. A veteran served at Camp Lejeune if he or she was stationed at Camp Lejeune, or traveled to Camp Lejeune as part of his or her professional duties.

(c) *Limitations.* For a Camp Lejeune veteran, VA will assume that illnesses or conditions listed in paragraph (d)(1)(i) through (xv) of this section are attributable to the veteran's active duty in the Armed Forces unless it is clinically determined, under VA clinical practice guidelines, that such an illness or condition is not attributable to the veteran's service.

(d) *Copayments.*

(1) *Exemption.* Camp Lejeune veterans are not subject to copayment requirements for hospital care and medical services provided on or after August 6, 2012, for the following illnesses and conditions:

- (i) Esophageal cancer;
- (ii) Lung cancer;
- (iii) Breast cancer;
- (iv) Bladder cancer;
- (v) Kidney cancer;
- (vi) Leukemia;
- (vii) Multiple myeloma;
- (viii) Myelodysplastic syndromes;
- (ix) Renal toxicity;
- (x) Hepatic steatosis;
- (xi) Female infertility;
- (xii) Miscarriage;

- (xiii) Scleroderma;
- (xiv) Neurobehavioral effects; and
- (xv) Non-Hodgkin's Lymphoma.

(2) *Retroactive Exemption.* VA will reimburse Camp Lejeune veterans for any copayments paid to VA for hospital care and medical services provided for one of the illnesses or conditions listed in paragraph (d)(1) of this section, if the following are true:

(i) The veteran requested Camp Lejeune veteran status no later than September 24, 2016; and

(ii) VA provided the hospital care or medical services to the Camp Lejeune veteran on or after August 6, 2012. (Authority: 38 U.S.C. 1710.)

[79 FR 57414, Sep. 24, 2014]

Supplement *Highlights* reference: 86(2).

§ 17.410 Hospital care and medical services for Camp Lejeune family members.

(a) *General.* In accordance with this section and subject to the availability of funds appropriated for such purpose, VA will provide payment or reimbursement for certain hospital care and medical services furnished to Camp Lejeune family members by non-VA health care providers.

(b) *Definitions.* For the purposes of this section:

Camp Lejeune has the meaning set forth in § 17.400(b).

Camp Lejeune family member means an individual who:

(i) Resided at Camp Lejeune (or was in utero while his or her mother either resided at Camp Lejeune or served at Camp Lejeune under § 17.400(b)) for at least 30 (consecutive or nonconsecutive) days during the period beginning on January 1, 1957, and ending on December 31, 1987; and

(ii) Meets one of the following criteria:

(A) Is related to a Camp Lejeune veteran by birth;

(B) Was married to a Camp Lejeune veteran; or

(C) Was a legal dependent of a Camp Lejeune veteran.

Camp Lejeune veteran has the meaning set forth in § 17.400(b).

Health-plan contract has the meaning set forth in § 17.1001(a).

Third party has the meaning set forth in § 17.1001(b).

(c) *Application.* An individual may apply for benefits under this section by completing and submitting an application form.

(d) *Payment or reimbursement of certain medical care and hospital services.* VA will provide payment or reimbursement for hospital care and medical services provided to a Camp Lejeune family member by a non-VA provider if all of the following are true:

(1) The Camp Lejeune family member or provider of care or services has submitted a timely claim for payment or reimbursement, which means:

(i) For hospital care and medical services provided before the date that the application discussed in paragraph (c) of this section was received by VA, the hospital care and medical services must have been provided no more than 2 years prior to the date that VA receives the application but not prior to March 26, 2013, and the claim for payment or reimbursement must be received by VA no more than 60 days after VA approves the application;

(ii) For hospital care and medical services provided on or after the date that the application discussed in paragraph (c) of this section was received by VA, the claim for

payment or reimbursement must be received by VA no more than 2 years after the later of either the date of discharge from a hospital or the date that medical services were rendered;

(2) The Camp Lejeune family member's treating physician certifies that the claimed hospital care or medical services were provided for an illness or condition listed in § 17.400(d)(1), and provides information about any co-morbidities, risk factors, or other exposures that may have contributed to the illness or condition;

(3) VA makes the clinical finding, under VA clinical practice guidelines, that the illness or condition did not result from a cause other than the residence of the family member at Camp Lejeune;

(4) VA would be authorized to provide the claimed hospital care or medical services to a veteran under VA's medical benefits package in § 17.38;

(5) The Camp Lejeune family member or hospital care or medical service provider has exhausted without success all claims and remedies reasonably available to the family member or provider against a third party, including health-plan contracts; and

(6) Funds were appropriated to implement 38 U.S.C. 1787 in a sufficient amount to permit payment or reimbursement.

(e) *Payment or reimbursement amounts.* Payments or reimbursements under this section will be in amounts determined in accordance with this paragraph (e).

(1) If a third party is partially liable for the claimed hospital care or medical services, then VA will pay or reimburse the lesser of the amount for which the Camp Lejeune family member remains personally liable or the amount for which VA would pay for such care under §§ 17.55 and 17.56.

(2) If VA is the sole payer for hospital care and medical services, then VA will pay or reimburse in accordance with §§ 17.55 and 17.56, as applicable. (Authority: 38 U.S.C. 1787)

[79 FR 57414, Sep. 24, 2014]

Supplement *Highlights* reference: 86(3).

Confidentiality of Healthcare: Quality Assurance Review Records

Authority: 38 U.S.C. 5705.

Source: §§17.500-17.511 appear at 59 FR 53355, Oct. 24, 1994,
unless otherwise noted.

§17.500 General.

(a) Section 5705, title 38, United States Code was enacted to protect the integrity of the VA's medical quality assurance program by making confidential and privileged certain records and documents generated by this program and information contained therein. Disclosure of quality assurance records and documents made confidential and privileged by 38 U.S.C. 5705 and the regulations in §§17.500 through 17.511 may only be made in accordance with the provisions of 38 U.S.C. 5705 and those regulations.

(b) The purpose of the regulations in §§17.500 through 17.511 is to specify and provide for the limited disclosure of those quality assurance documents which are confidential under the provisions of 38 U.S.C. 5705.

(c) For purposes of the regulations in §§17.500 through 17.511, the VA's medical quality assurance program consists of systematic healthcare reviews carried out by or for VA for the purpose of improving the quality of medical care or improving the utilization of healthcare resources in VA medical facilities. These review activities may involve continuous or periodic data collection and may relate to either the structure, process, or outcome of health care provided in the VA.

(d) Nothing in the regulations in §§17.500 through 17.511 shall be construed as authority to withhold any record or document from a committee or subcommittee of either House of Congress or any joint committee or subcommittee of Congress, if such record or document pertains to any matter within the jurisdiction of such committee or joint committee.

(e) The regulations in §§17.500 through 17.511 do not waive the sovereign immunity of the United States, and do not waive the confidentiality provisions and disclosure restrictions of 38 U.S.C. 5705. (Authority: 38 U.S.C. 5705)

§17.508 Access to quality assurance records and documents within the agency.

(a) Access to confidential and privileged quality assurance records and documents within the Department pursuant to this section is restricted to VA employees (including consultants and contractors of VA) who have a need for such information to perform their government duties or contractual responsibilities and who are authorized access by the VA medical facility Director, Regional Director, the Under Secretary for Health, or their designees or by the regulations in §§17.500 through 17.511.

(b) To foster continuous quality improvement, practitioners on VA rolls, whether paid or not, will have access to confidential and privileged quality assurance records and documents relating to evaluation of the care they provided.

(c) Any quality assurance record or document, whether confidential and privileged or not, may be provided to the General Counsel or any attorney within the Office of General Counsel, wherever located. These documents may also be provided to a Department of Justice (DOJ) attorney who is investigating a claim or potential claim against the VA or who is preparing for litigation involving the VA. If necessary, such a record or document may be removed from the VA medical facility to the site where the General Counsel or any attorney within the Office of General Counsel or the DOJ attorney is conducting an investigation or preparing for litigation.

(d) Any quality assurance record or document or the information contained therein, whether confidential and privileged or not, will be provided to the Department of Veterans Affairs Office of Inspector General upon request. A written request is not required.

(e) To the extent practicable, documents accessed under paragraph (b) of this section will not include the identity of peer reviewers. Reasonable efforts will be made to edit documents so as to protect the identities of reviewers, but the inability to completely do so will not bar access under paragraph (b).

(f) No individual shall be permitted access to confidential and privileged quality assurance records and documents identified in §17.501 unless such individual has been informed of the penalties for unauthorized disclosure. Any misuse of confidential and privileged quality assurance records or documents shall be reported to the appropriate VHA official, e.g., Service Chief, Medical Center Director.

(g) In general, confidential and privileged quality assurance records and documents will be maintained for a minimum of 3 years and may be held longer if needed for research studies or quality assurance or legal purposes. (Authority: 38 U.S.C. 5705)

§17.509 Authorized disclosure: Non-Department of Veterans Affairs requests.

(a) Requests for confidential and privileged quality assurance records and documents from organizations or individuals outside VA must be made to the Department and must specify the nature and content of the information requested, to whom the information should be transmitted or disclosed, and the purpose listed in paragraphs (b) through (j) of this section for which the information requested will be used. In addition, the requestor will specify to the extent possible the beginning and final dates of the period for which disclosure or access is requested. The request must be in writing and signed by the requestor. Except as specified in paragraphs (b) and (c) of this section, these requests should be forwarded to the Director of the facility in possession of the records or documents for response. The procedures outlined in 38 U.S.C. 5701, 5 U.S.C. 552 and 552a, and 38 CFR 1.500 through 1.582 will be followed where applicable.

(b) Disclosure shall be made to Federal agencies upon their written request to permit VA's participation in healthcare programs including healthcare delivery, research, planning, and related activities with the requesting agencies. Any Federal agency may apply to the Under Secretary for Health for approval. If the VA decides to participate in the healthcare program with the requestor, the requesting agency will enter into an agreement with VA to ensure that the agency and its staff will ensure the confidentiality of any quality assurance records or documents shared with the agency.

(c) Qualified persons or organizations, including academic institutions, engaged in healthcare program activities shall, upon request to and approval by the Under Secretary for Health, Regional Director, medical facility Director, or their designees, have access to confidential and privileged medical quality assurance records and documents to permit VA participation in a healthcare activity with the requestor provided that no records or documents are removed from the VA facility in possession of the records.

(d) When a request under paragraphs (b) or (c) of this section concerns access for research purposes, the request, together with the research plan or protocol, shall first be submitted to and approved by an appropriate VA medical facility Research and Development Committee and then approved by the Director of the VA medical facility. The VA medical facility staff together with the qualified person(s) conducting the research shall be responsible for the preservation of the anonymity of the patients, clients, and providers and shall not disseminate any records or documents which identify such individuals directly or indirectly without the individual's consent. This applies to the handling of data or information as well as reporting or publication of findings. These requirements are in addition to other applicable protections for the research.

(e) Individually identified patient medical record information which is protected by another statute as provided in §17.502 may not be disclosed to a non-VA person or organization, including disclosures for research purposes under paragraph (d), except as provided in that statute.

(f) Under paragraph (b), the Under Secretary for Health or designee or under paragraph (c), the Under Secretary for Health, Regional Director, medical facility Director, or their designees may approve a written request if it meets the following criteria:

- (1) Participation by VA will benefit VA patient care; or
- (2) Participation by VA will enhance VA medical research; or
- (3) Participation by VA will enhance VA health services research; or

- (4) Participation by VA will enhance VA healthcare planning or program development activities; or
- (5) Participation by VA will enhance related VA healthcare program activities; and
- (6) Access to the record by the requester is required for VA to participate in a healthcare program with the requester.

(g) Protected quality assurance records or documents, including records pertaining to a specific individual, will for purposes authorized under law be disclosed to a civil or criminal law enforcement governmental agency or instrumentality charged under applicable law with the protection of public health or safety, including state licensing and disciplinary agencies, if a written request for such records or documents is received from an official of such an organization. The request must state the purpose authorized by law for which the records will be used. The Under Secretary for Health, Regional Director, medical facility Director, or their designees will determine the extent to which the information is disclosable.

(h) Federal agencies charged with protecting the public health and welfare, federal and private agencies which engage in various monitoring and quality control activities, agencies responsible for licensure of individual health care facilities or programs, and similar organizations will be provided confidential and privileged quality assurance records and documents if a written request for such records or documents is received from an official of such an organization. The request must state the purpose for which the records will be used. The Under Secretary for Health, Regional Director, medical facility Director, or their designees will determine the extent to which the information is disclosable.

(i) JCAHO (Joint Commission on Accreditation of Healthcare Organizations) survey teams and similar national accreditation agencies or boards and other organizations requested by VA to assess the effectiveness of quality assurance program activities or to consult regarding these programs are entitled to disclosure of confidential and privileged quality assurance documents with the following qualifications:

(1) Accreditation agencies which are charged with assessing all aspects of medical facility patient care, e.g., JCAHO, may have access to all confidential and privileged quality assurance records and documents.

(2) Accreditation agencies charged with more narrowly focused review (e.g., College of American Pathologists, American Association of Blood Banks, Nuclear Regulatory Commission, etc.) may have access only to such confidential and privileged records and documents as are relevant to their respective focus.

(j) Confidential and privileged quality assurance records and documents shall be released to the General Accounting Office if such records or documents pertain to any matter within its jurisdiction.

(k) Confidential and privileged quality assurance records and documents shall be released to both VA and non-VA healthcare personnel upon request to the extent necessary to meet a medical emergency affecting the health or safety of any individual.

(l) For any disclosure made under paragraphs (a) through (i) of this section, the name of and other identifying information regarding any individual VA patient, employee, or other

individual associated with VA shall be deleted from any confidential and privileged quality assurance record or document before any disclosure under these quality assurance regulations in §§17.500 through 17.511 is made, if disclosure of such name and identifying information would constitute a clearly unwarranted invasion of personal privacy.

(m) Disclosure of the confidential and privileged quality assurance records and documents identified in §17.501 will not be made to any individual or agency until that individual or agency has been informed of the penalties for unauthorized disclosure or redisclosure. (Authority: 38 U.S.C. 5705)

[59 FR 26210, Oct. 24, 1994; as amended at 79 FR 54616, Sep. 12, 2014]

Supplement *Highlights* reference: 86(1).

(d) *Location for service.* VA reserves the right to make final decisions on the location for service obligation. A participant who receives a scholarship as a full-time student must be willing to relocate to another geographic location to carry out his or her service obligation according to the participant's mobility agreement. A participant who received a scholarship as a part-time student may be allowed to serve the period of obligated service at the health care facility where the individual was assigned when the scholarship was authorized, if there is a vacant position which will satisfy the individual's mobility agreement at that facility. (Authority: 38 U.S.C. 7616(a))

(e) *Creditability of advanced clinical training.* No period of advanced clinical training will be credited toward satisfying the period of obligated service incurred under the Scholarship Program. (Authority: 38 U.S.C. 7616(b)(3)(A)(ii))

[47 FR 10810, Mar. 12, 1982, as amended at 48 FR 37400, Aug. 18, 1983; 54 FR 28675, July 7, 1989; 78 FR 51070, Aug. 20, 2013]

Supplement *Highlight* Reference(s): 79(1)

§17.608 Deferment of obligated service.

(a) *Request for deferment.* A participant receiving a degree from a school of medicine, osteopathy, dentistry, optometry, or podiatry, may request deferment of obligated service to complete an approved program of advanced clinical training. The Secretary may defer the beginning date of the obligated service to allow the participant to complete the advanced clinical training program. The period of this deferment will be the time designated for the specialty training. (Authority: 38 U.S.C. 7616(b)(3)(A)(i))

(b) *Deferment requirements.* Any participant whose period of obligated service is deferred shall be required to take all or part of the advanced clinical training in an accredited program in an educational institution having an Affiliation Agreement with a Department of Veterans Affairs health care facility, and such training will be undertaken in a Department of Veterans Affairs health-care facility. (Authority: 38 U.S.C. 7616(b)(4))

(c) *Additional service obligation.* A participant who has requested and received deferment for approved advanced clinical training may, at the time of approval of such deferment and at the discretion of the Secretary and upon the recommendation of the Under Secretary for Health, incur an additional period of obligated service:

(1) At the rate of one-half of a calendar year for each year of approved clinical training (or a proportionate ratio thereof) if the training is in a specialty determined to be necessary to meet health care requirements of the Veterans Health Administration; Department of Veterans Affairs; or

(2) At the rate of three-quarters of a calendar year for each year of approved graduate training (or a proportionate ratio thereof) if the training is in a medical specialty determined not to be necessary to meet the health care requirements of the Veterans Health Administration. Specialties necessary to meet the health care requirements of the Veterans Health Administration will be prescribed periodically by the Secretary when, and if, this provision for an additional period of obligated service is to be used. (Authority: 38 U.S.C. 7616(b)(4)(B))

(d) *Altering deferment.* Before altering the length or type of approved advanced clinical training for which the period of obligated service was deferred under paragraphs (a) or (b) of this section, the participant must request and obtain the Secretary's written approval of the alteration. (Authority: 38 U.S.C. 7633)

(e) *Beginning of service after deferment.* Any participant whose period of obligated service has been deferred under paragraph (a) or (b) of this section must begin the obligated service effective on the date of appointment under title 38 in full-time clinical practice in an assignment or location in a Department of Veterans Affairs health care facility as determined by the Secretary. The assignment will be made by the Secretary within 120 days prior to or no later than 30 days following the completion of the requested graduate training for which the deferment was granted. Travel and relocation regulations will apply. (Authority: 38 U.S.C. 7616(b)(2))

[47 FR 10810, Mar. 12, 1982; 47 FR 13523, Mar. 31, 1982, as amended at 54 FR 28675, July 7, 1989; 61 FR 21969, May 13, 1996; 79 FR 54616, Sep. 12, 2014]

Supplement *Highlights* reference: 86(1).

§17.609 Pay during period of obligated service.

The initial appointment of physicians for obligated service will be made in a grade commensurate with qualifications as determined in 38 U.S.C. 7404(b). A physician serving a period of obligated service is not eligible for incentive special pay during the first three years of such obligated service. A physician may be paid primary special pay at the discretion of the Secretary upon the recommendation of the Under Secretary for Health. (Authority: 38 U.S.C. 7431-7433)

[47 FR 10810, Mar. 12, 1982, as amended at 54 FR 28676, July 7, 1989; 61 FR 21969, May 13, 1996; 79 FR 54616, Sep. 12, 2014]

Supplement *Highlights* reference: 86(1).

§17.610 Failure to comply with terms and conditions of participation.

(a) If a participant, other than one described in paragraph (b) of this section fails to accept payment or instructs the school not to accept payment of the scholarship provided by the Secretary, the participant must, in addition to any service or other obligation incurred under the contract, pay to the United States the amount of \$1,500 liquidated damages. Payment of this amount must be made within 90 days of the date on which the participant fails to accept payment of the scholarship award or instructs the school not to accept payment. (Authority: 38 U.S.C. 7617(a))

(b) If a participant:

- (1) Fails to maintain an acceptable level of academic standing;
- (2) Is dismissed from the school for disciplinary reasons;
- (3) Voluntarily terminates the course of study or program for which the scholarship was awarded including in the case of a full-time student, a reduction of course load from full-time to part-time before completing the course of study or program;
- (4) Fails to become licensed to practice in the discipline for which the degree program prepared the participant, if applicable, in a State within 1 year from the date such person becomes eligible to apply for State licensure; or (Authority: 38 U.S.C. 7617(b)(4))
- (5) Is a part-time student and fails to maintain employment in a permanent assignment in a VA health care facility while enrolled in the course of training being pursued; the participant must instead of performing any service obligation, pay to the United States an amount equal to all scholarship funds awarded under the written contract executed in accordance with §17.602. Payment of this amount must be made within 1 year from the date academic training terminates unless a longer period is necessary to avoid hardship. No interest will be charged on any part of this indebtedness. (Authority: 38 U.S.C. 7617(b))

(c) Participants who breach their contracts by failing to begin or complete their service obligation (for any reason) other than as provided for under paragraph (b) of this section are liable to repay the amount of all scholarship funds paid to them and to the school on their behalf, plus interest, multiplied by three, minus months of service obligation satisfied, as determined by the following formula:

$$A = 3 * \phi * [(t-s) / t]$$

in which:

“A” is the amount the United States is entitled to recover;

“ ϕ ” is the sum of the amounts paid to or on behalf of the applicant and the interest on such amounts which would be payable if, at the time the amounts were paid, they were loans bearing interest at the maximum legal prevailing rate, as determined by the Treasurer of the United States;

“t” is the total number of months in the applicant’s period of obligated service;
and

“s” is the number of months of the period of obligated service served by the participant.

§17.805 Additional terms of loans.

In the operation of each residence established with the assistance of the loan, the recipient must agree to the following:

- (a) The use of alcohol or any illegal drugs in the residence will be prohibited;
- (b) Any resident who violates the prohibition of alcohol or any illegal drugs will be expelled from the residence;
- (c) The cost of maintaining the residence, including fees for rent and utilities, will be paid by residents;
- (d) The residents will, through a majority vote of the residents, otherwise establish policies governing the conditions of the residence, including the manner in which applications for residence are approved;
- (e) The residence will be operated solely as a residence for not less than six veterans.
(Authority: Sec. 8 of Pub. L. 102-54, 105 Stat. 271, 38 U.S.C. 501)

Next Section is §17.900

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

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

§17.900 Definitions.

For purposes of §§17.900 through 17.905:

Approved health care provider means a health care provider currently approved by the Center for Medicare and Medicaid Services (CMS), Department of Defense TRICARE Program, Civilian Health and Medical Program of the Department of Veterans Affairs (CHAMPVA), Joint Commission on Accreditation of Health Care Organizations (JCAHO), or currently approved for providing health care under a license or certificate issued by a governmental entity with jurisdiction. An entity or individual will be deemed to be an approved health care provider only when acting within the scope of the approval, license, or certificate.

Child for purposes of spina bifida means the same as *individual* as defined at §3.814(c)(3) or §3.815(c)(2) of this title and for purposes of covered birth defects means the same as *individual* as defined at §3.815(c)(2) of this title.

Covered birth defect means the same as defined at §3.815(c)(3) of this title and also includes complications or medical conditions that are associated with the covered birth defect(s) according to the scientific literature.

Habilitative and rehabilitative care means such professional, counseling, and guidance services and such treatment programs (other than vocational training under 38 U.S.C. 1804 or 1814) as are necessary to develop, maintain, or restore, to the maximum extent practicable, the functioning of a disabled person.

Health care means home care, hospital care, nursing home care, outpatient care, preventive care, habilitative and rehabilitative care, case management, and respite care; and includes the training of appropriate members of a child's family or household in the care of the child; and the provision of such pharmaceuticals, supplies (including continence-related supplies such as catheters, pads, and diapers), equipment (including durable medical equipment), devices, appliances, assistive technology, direct transportation costs to and from approved health care providers (including any necessary costs for meals and lodging en route, and accompaniment by an attendant or attendants), and other materials as the Secretary determines necessary.

Health care provider means any entity or individual that furnishes health care, including specialized clinics, health care plans, insurers, organizations, and institutions.

Home care means medical care, habilitative and rehabilitative care, preventive health services, and health-related services furnished to a child in the child's home or other place of residence.

Hospital care means care and treatment furnished to a child who has been admitted to a hospital as a patient.

Nursing home care means care and treatment furnished to a child who has been admitted to a nursing home as a resident.

Outpatient care means care and treatment, including preventive health services, furnished to a child other than hospital care or nursing home care.

Preventive care means care and treatment furnished to prevent disability or illness, including periodic examinations, immunizations, patient health education, and such other services as the Secretary determines necessary to provide effective and economical preventive health care.

Respite care means care furnished by an approved health care provider on an intermittent basis for a limited period to an individual who resides primarily in a private residence when such care will help the individual continue residing in such private residence.

Spina bifida means all forms and manifestations of spina bifida except spina bifida occulta (this includes complications or medical conditions that are associated with spina bifida according to the scientific literature).

Veteran with covered service in Korea for purposes of spina bifida means the same as defined at §3.814(c)(2) of this title.

Vietnam veteran for purposes of spina bifida means the same as defined at §3.814(c)(1) or §3.815(c)(1) of this title and for purposes of covered birth defects means the same as defined at §3.815(c)(1) of this title. (Authority: 38 U.S.C. 101(2), 1802-1803, 1811-1813, 1821, 1831)

[62 FR 51284, Sept. 30, 1997, as amended at 68 FR 1010, Jan. 8, 2003; 76 FR 4249, Jan. 25, 2011; 79 FR 54616, Sep. 12, 2014]

Supplement *Highlights* reference: 13(1), 60(2), 86(1).

§17.901 Provision of health care.

(a) *Spina bifida.* VA will provide a Vietnam veteran or veteran with covered service in Korea's child who has been determined under §3.814 or §3.815 of this title to suffer from spina bifida with health care as the Secretary determines is needed. VA may inform spina bifida patients, parents, or guardians that health care may be available at not-for-profit charitable entities.

(b) *Covered birth defects.* VA will provide a woman Vietnam veteran's child who has been determined under §3.815 of this title to suffer from covered birth defects (other than spina bifida) with such health care as the Secretary determines is needed by the child for the covered birth defects. However, if VA has determined for a particular covered birth defect that §3.815(a)(2) of this title applies (concerning affirmative evidence of cause other than the mother's service during the Vietnam era), no benefits or assistance will be provided under this section with respect to that particular birth defect.

(c) *Providers of care.* Health care provided under this section will be provided directly by VA, by contract with an approved health care provider, or by other arrangement with an approved health care provider.

(d) *Submission of information.* For purposes of §§17.900 through 17.905:

- (1) The telephone number of the Health Administration Center is 888/820-1756;
- (2) The facsimile number of the Health Administration Center is 303/331-7807;
- (3) The hand-delivery address of the Health Administration Center is 3773 Cherry Creek Drive North, Denver, CO 80246; and
- (4) The mailing address of the Health Administration Center for claims submitted pursuant to either paragraph (a) or (b) of this section is P.O. Box 469065, Denver, CO 80246-9065. (Authority: 38 U.S.C. 101(2), 1802-1803, 1811-1813, 1831)

Note to §17.901: Under this program, beneficiaries with spina bifida will receive comprehensive care through the Department of Veterans Affairs. However, the health care benefits available under this section to children with other covered birth defects are not comprehensive, and VA will furnish them only health care services that are related to their covered birth defects. With respect to covered children suffering from spina bifida, VA is the exclusive payer for services paid under 17.900 through 17.905, regardless of any third party insurer, Medicare, Medicaid, health plan, or any other plan or program providing health care coverage. As to children with other covered birth defects, any third party insurer, Medicare, Medicaid, health plan, or any other plan or program providing health care coverage would be responsible according to its provisions for payment for health care not relating to the covered birth defects.

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

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