

Department of Veterans Affairs

§ 17.1000

(d) *Explanation of benefits (EOB)*—(1) When a claim under the provisions of §§ 17.900 through 17.905 is adjudicated, an EOB will be sent to the beneficiary or guardian and the provider. The EOB provides, at a minimum, the following information:

- (i) Name and address of recipient,
- (ii) Description of services and/or supplies provided,
- (iii) Dates of services or supplies provided,
- (iv) Amount billed,
- (v) Determined allowable amount,
- (vi) To whom payment, if any, was made, and
- (vii) Reasons for denial (if applicable).

(2) [Reserved]

(Authority: 38 U.S.C. 101(2), 1802–1803, 1811–1813, 1821)

(The Office of Management and Budget has approved the information collection requirements in this section under control number 2900–0578)

§ 17.904 Review and appeal process.

For purposes of §§ 17.900 through 17.905, if a health care provider, child, or representative disagrees with a determination concerning provision of health care or with a determination concerning payment, the person or entity may request reconsideration. Such request must be submitted in writing (by facsimile, mail, or hand delivery) within one year of the date of the initial determination to the Health Administration Center (Attention: Chief, Benefit and Provider Services). The request must state why it is believed that 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 sender without further consideration. After reviewing the matter, including any relevant supporting documentation, a benefits advisor will issue a written determination (with a statement of findings and reasons) to the person or entity seeking reconsideration that affirms, reverses, or modifies the previous decision. If the person or entity seeking reconsideration is still dissatisfied, within 90 days of the date of the decision he or she may submit in writing (by fac-

simile, mail, or hand delivery) to the Health Administration Center (Attention: Director) a request for review by the Director, Health Administration Center. The Director will review the claim and any relevant supporting documentation and issue a decision in writing (with a statement of findings and reasons) that affirms, reverses, or modifies the previous decision. An appeal under this section would be considered as filed at the time it was delivered to the VA or at the time it was released for submission to the VA (for example, this could be evidenced by the postmark, if mailed).

NOTE TO § 17.904: The final decision of the Director will inform the claimant of further appellate rights for an appeal to the Board of Veterans' Appeals.

(Authority: 38 U.S.C. 101(2), 1802–1803, 1811–1813, 1821)

(The Office of Management and Budget has approved the information collection requirements in this section under control number 2900–0578)

§ 17.905 Medical records.

Copies of medical records generated outside VA that relate to activities for which VA is asked to provide payment or that VA determines are necessary to adjudicate claims under §§ 17.900 through 17.905 must be provided to VA at no cost.

(Authority: 38 U.S.C. 101(2), 1802–1803, 1811–1813, 1821)

PAYMENT OR REIMBURSEMENT FOR EMERGENCY SERVICES FOR NON-SERVICE-CONNECTED CONDITIONS IN NON-VA FACILITIES

SOURCE: 66 FR 36470, July 12, 2001, unless otherwise noted.

§ 17.1000 Payment or reimbursement for emergency services for non-service-connected conditions in non-VA facilities.

Sections 17.1000 through 17.1008 constitute the requirements under 38 U.S.C. 1725 that govern VA payment or reimbursement for non-VA emergency services furnished to a veteran for non-service-connected conditions.

(Authority: 38 U.S.C. 1725)

§ 17.1001

NOTE TO §17.1000: In cases where a patient is admitted for inpatient care, health care providers furnishing emergency treatment who believe they may have a basis for filing a claim with VA for payment under 38 U.S.C. 1725 should contact VA within 48-hours after admission for emergency treatment. Such contact is not a condition of VA payment. However, the contact will assist the provider in understanding the conditions for payment. The contact may also assist the provider in planning for transfer of the veteran after stabilization.

[66 FR 36470, July 12, 2001, as amended at 68 FR 3404, Jan. 24, 2003]

§ 17.1001 Definitions.

For purposes of §§17.1000 through 17.1008:

(a) The term *health-plan contract* means any of the following:

(1) An insurance policy or contract, medical or hospital service agreement, membership or subscription contract, or similar arrangement under which health services for individuals are provided or the expenses of such services are paid;

(2) An insurance program described in section 1811 of the Social Security Act (42 U.S.C. 1395c) or established by section 1831 of that Act (42 U.S.C. 1395j);

(3) A State plan for medical assistance approved under title XIX of the Social Security Act (42 U.S.C. 1396 *et seq.*);

(4) A workers' compensation law or plan described in section 38 U.S.C. 1729(a)(2)(A); or

(5) A law of a State or political subdivision described in 38 U.S.C. 1729(a)(2)(B) (concerning motor vehicle accidents).

(b) The term *third party* means any of the following:

(1) A Federal entity;

(2) A State or political subdivision of a State;

(3) An employer or an employer's insurance carrier;

(4) An automobile accident reparations insurance carrier; or

(5) A person or entity obligated to provide, or to pay the expenses of, health services under a health-plan contract.

(c) The term *duplicate payment* means payment made, in whole or in part, for

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the same emergency services for which VA reimbursed or made payment.

(d) The term *stabilized* means that no material deterioration of the emergency medical condition is likely, within reasonable medical probability, to occur if the veteran is discharged or transferred to a VA or other Federal facility.

(e) The term *VA medical facility of jurisdiction* means the nearest VA medical facility to where the emergency service was provided.

(Authority: 38 U.S.C. 1725)

§ 17.1002 Substantive conditions for payment or reimbursement.

Payment or reimbursement under 38 U.S.C. 1725 for emergency services may be made only if all of the following conditions are met:

(a) The emergency services were provided in a hospital emergency department or a similar facility held out as providing emergency care to the public;

(b) The claim for payment or reimbursement for the initial evaluation and treatment is for a condition of such a nature that a prudent layperson would have reasonably expected that delay in seeking immediate medical attention would have been hazardous to life or health (this standard would be met if there were an emergency medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that a prudent layperson who possesses an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in placing the health of the individual in serious jeopardy, serious impairment to bodily functions, or serious dysfunction of any bodily organ or part);

(c) A VA or other Federal facility/provider was not feasibly available and an attempt to use them beforehand would not have been considered reasonable by a prudent layperson (as an example, these conditions would be met by evidence establishing that a veteran was brought to a hospital in an ambulance and the ambulance personnel determined that the nearest available appropriate level of care was at a non-VA medical center);