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(This book contains parts 0 to 17)

Part

CHAPTER I—Department of Veterans Affairs 0

CHAPTER I—DEPARTMENT OF VETERANS AFFAIRS

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PART 0—VALUES, STANDARDS OF ETHICAL CONDUCT, AND RELATED RESPONSIBILITIES

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AUTHORITY: 5 U.S.C. 301; 38 U.S.C. 501; see sections 201, 301, and 502(a) of E.O. 12674, 54 FR 15159, 3 CFR, 1989 Comp., p. 215 as modified by E.O. 12731, 55 FR 42547, 3 CFR, 1990 Comp., p. 306.

SOURCE: 31 FR 5828, Apr. 15, 1966, unless otherwise noted.

Subpart A—Core Values, Characteristics, and Customer Experience Principles of the Department

SOURCE: 77 FR 41275, July 13, 2012, unless otherwise noted.

§ 0.600 General.

This section describes the Core Values, Characteristics, and Customer Experience Principles that serve as internal guidelines for employees of the Department of Veterans Affairs (VA). These Core Values, Characteristics, and Customer Experience Principles define VA employees, articulate what VA stands for, and underscore its moral obligation to veterans, their families, and other beneficiaries. They are intended to establish one overarching set of guidelines that apply to all VA Administrations and staff offices, confirming the values already instilled in many VA employees and enforcing their commitment to provide the best experience possible to veterans, servicemembers, their families, caregivers, and survivors.

[84 FR 22710, May 20, 2019]

§ 0.601 Core Values.

VA's Core Values define VA employees. They describe the organization's culture and character, and serve as the foundation for the way VA employees should interact with each other, as well as with people outside the organization. They also serve as a common bond between all employees regardless of their grade, specialty area, or location. These Core Values are Integrity, Commitment, Advocacy, Respect, and Excellence. Together, the first letters of the Core Values spell ''I CARE,'' and VA employees should adopt this motto and these Core Values in their day-to-day operations.

(a) *Integrity*. VA employees will act with high moral principle, adhere to the highest professional standards, and maintain the trust and confidence of all with whom they engage.

(b) *Commitment*. VA employees will work diligently to serve veterans and other beneficiaries, be driven by an earnest belief in VA's mission, and fulfill their individual responsibilities and organizational responsibilities.

(c) *Advocacy*. VA employees will be truly veteran-centric by identifying, fully considering, and appropriately advancing the interests of veterans and other beneficiaries.

(d) *Respect*. VA employees will treat all those they serve and with whom they work with dignity and respect, and they will show respect to earn it.

(e) *Excellence*. VA employees will strive for the highest quality and continuous improvement, and be thoughtful and decisive in leadership, accountable for their actions, willing to admit mistakes, and rigorous in correcting them.

§ 0.602 Core Characteristics.

While Core Values define VA employees, the Core Characteristics define what VA stands for and what VA strives to be as an organization. These are aspirational goals that VA wants

its employees, veterans, and the American people to associate with the Department and with its workforce. These Core characteristics describe the traits all VA organizations should possess and demonstrate, and they identify the qualities needed to successfully accomplish today's missions and also support the ongoing transformation to a 21st Century VA. These characteristics are:

(a) *Trustworthy*. VA earns the trust of those it serves, every day, through the actions of its employees. They provide care, benefits, and services with compassion, dependability, effectiveness, and transparency.

(b) *Accessible*. VA engages and welcomes veterans and other beneficiaries, facilitating their use of the entire array of its services. Each interaction will be positive and productive.

(c) *Quality*. VA provides the highest standard of care and services to veterans and beneficiaries while managing the cost of its programs and being efficient stewards of all resources entrusted to it by the American people. VA is a model of unrivalled excellence due to employees who are empowered, trusted by their leaders, and respected for their competence and dedication.

(d) *Innovative*. VA prizes curiosity and initiative, encourages creative contributions from all employees, seeks continuous improvement, and adapts to remain at the forefront in knowledge, proficiency, and capability to deliver the highest standard of care and services to all of the people it serves.

(e) *Agile*. VA anticipates and adapts quickly to current challenges and new requirements by continuously assessing the environment in which it operates and devising solutions to better serve veterans, other beneficiaries, and Service members.

(f) *Integrated*. VA links care and services across the Department; other federal, state, and local agencies; partners; and Veterans Services Organizations to provide useful and understandable programs to veterans and other beneficiaries. VA's relationship with the Department of Defense is unique, and VA will nurture it for the benefit of veterans and Service members.

§ 0.603 Customer Experience principles.

VA will provide the best customer experience in its delivery of care, benefits, and memorial services to veterans, servicemembers, their families, caregivers, and survivors. The delivery of exceptional customer experience is the responsibility of all VA employees and will be guided by VA's Core Values and Characteristics. Customer experience is the product of interactions between an organization and a customer over the duration of their relationship. VA measures these interactions through Ease, Effectiveness, and Emotion, all of which impact the overall trust the customer has in the organization.

(a) *Ease*. VA will make access to VA care, benefits, and memorial services smooth and easy.

(b) *Effectiveness*. VA will deliver care, benefits, and memorial services to the customer's satisfaction.

(c) *Emotion*. VA will deliver care, benefits, and memorial services in a manner that makes customers feel honored and valued in their interactions with VA. VA will use customer experience data and insights in strategy development and decision-making to ensure that the voice of veterans, servicemembers, their families, caregivers, and survivors inform how VA delivers care, benefits, and memorial services.

[84 FR 22710, May 20, 2019]

Subpart B—General Provisions

SOURCE: Redesignated at 77 FR 41275, July 13, 2012, unless otherwise noted.

§ 0.735–1 Agency ethics officials.

(a) *Designated Agency Ethics Official (DAEO)*. The Assistant General Counsel (023) is the designated agency ethics official (DAEO) for the Department of Veterans Affairs. The Deputy Assistant General Counsel (023C) is the alternate DAEO, who is designated to act in the DAEO's absence. The DAEO has primary responsibility for the administration, coordination, and management of the VA ethics program, pursuant to 5 CFR 2638.201–204.

(b) *Deputy ethics officials.* (1) The Regional Counsel are deputy ethics officials. They have been delegated the authority to act for the DAEO within their jurisdiction, under the DAEO's supervision, pursuant to 5 CFR 2638.204.

(2) The alternate DAEO, the DAEO's staff, and staff in the Offices of Regional Counsel, may also act as deputy ethics officials pursuant to delegations of one or more of the DAEO's duties from the DAEO or the Regional Counsel.

[58 FR 61813, Nov. 23, 1993. Redesignated at 61 FR 11309, Mar. 20, 1996]

§ 0.735–2 Government-wide standards.

For government-wide standards of ethical conduct and related responsibilities for Federal employees, see 5 CFR Part 735 and Chapter XVI.

[61 FR 11309, Mar. 20, 1996. Redesignated at 63 FR 33579, June 19, 1998]

Subpart C—Standards of Ethical Conduct and Related Responsibilities of Employees

SOURCE: 58 FR 61814, Nov. 23, 1993, unless otherwise noted. Redesignated at 77 FR 41275, July 13, 2012.

§ 0.735–10 Cross-reference to employee ethical and other conduct standards and financial disclosure regulations.

Employees of the Department of Veterans Affairs (VA) should refer to the executive branch-wide Standards of Ethical Conduct at 5 CFR part 2635, the executive branch-wide Employee Responsibilities and Conduct at 5 CFR part 735, and the executive branch-wide financial disclosure regulation at 5 CFR part 2634.

§ 0.735–11 Other conduct on the job.

Relationship with beneficiaries and claimants. Employees are expected to be helpful to beneficiaries, patients and claimants, but:

(a) An employee shall not procure intoxicants or drugs for, or attempt to sell intoxicants or drugs to, patients or members, or give or attempt to give intoxicants or drugs to them unless officially prescribed for medical use;

(b) An employee shall not abuse patients, members, or other beneficiaries, whether or not provoked.

§ 0.735–12 Standards of conduct in special areas.

(a) *Safety.* (1) Employees will observe safety instructions, signs, and normal safety practices and precautions, including the use of protective clothing and equipment.

(2) An employee shall report each work-connected injury, accident or disease he or she suffers.

(b) *Furnishing testimony.* Employees will furnish information and testify freely and honestly in cases respecting employment and disciplinary matters. Refusal to testify, concealment of material facts, or willfully inaccurate testimony in connection with an investigation or hearing may be ground for disciplinary action. An employee, however, will not be required to give testimony against himself or herself in any matter in which there is indication that he or she may be or is involved in a violation of law wherein there is a possibility of self-incrimination.

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AUTHORITY: 38 U.S.C. 501(a), and as noted in specific sections.

DEPARTMENT OF VETERANS AFFAIRS OFFICIAL SEAL AND DISTINGUISHING FLAG

§ 1.9 Description, use, and display of VA seal and flag.

(a) *General*. This section describes the official seal and distinguishing flag of the of the Department of Veterans Affairs, and prescribes the rules for their custody and use.

(b) *Definitions*. (1) *VA* means all organizational units of the Department of Veterans Affairs.

(2) *Embossed seal* means an image of the official seal made on paper or other medium by using an embosser with a negative and positive die to create a raised impression.

(3) *Official seal* means the original(s) of the VA seal showing the exact form, content, and colors thereof.

(4) *Replica* means a copy of the official seal displaying the identical form, content, and colors thereof.

(5) *Reproduction* means a copy of the official seal displaying the identical form and content, reproduced in only one color.

(6) *Secretary* means the Secretary of Veterans Affairs.

(7) *Deputy Secretary* means the Deputy Secretary of Veterans Affairs.

(c) *Custody of official seal and distinguishing flags*. The Secretary or designee shall:

(1) Have custody of:

(i) The official seal and prototypes thereof, and masters, molds, dies, and other means of producing replicas, reproductions, and embossing seals and

(ii) Production, inventory, and loan records relating to items specified in paragraph (c)(1)(i) of this section, and

(2) Have custody of distinguishing flags, and be responsible for production, inventory, and loan records thereof.

(d) *Official Seal*—(1) *Description of official seal*. The Department of Veterans Affairs prescribes as its official seal, of which judicial notice shall be taken pursuant to 38 U.S.C. 302, the imprint illustrated below:

(i) The official seal includes an American eagle clutching a cord in its talons. The cord binds a 13-star U.S. flag and a 50-star U.S. flag. In the field over the eagle is a pentagon formation of stars, with one point down. The words Department of Veterans Affairs and United States of America surround the eagle, stars, and flags. A rope motif makes up the outermost ring of the seal.

(ii) The eagle represents the eternal vigilance of all our nation's veterans. The stars represent the five branches of military service. The crossed flags represent our nation's history. The gold cord that binds the two flags, which is shown clutched in the eagle's talons is symbolic of those who have fallen in the defense of liberty. Each of the various individual items placed together in the seal is a salute to the past, present, and future.

(iii) The colors used in the configuration are gold, brown, blue, white, silver, yellow, black, and red.

(iv) The colors are derived from the American flag and from nature. By invoking this symbolism, the color scheme represents the Nation's commitment to its veterans.

(2) *Use of the official seal, replicas, reproductions, and embossing seals.* (i) The Secretary or designees are authorized to affix replicas, reproductions, and embossed seals to appropriate documents, certifications, and other material for all purposes as authorized by this section.

(ii) Replicas may be used only for:

(A) Display in or adjacent to VA facilities, in Department auditoriums, presentation rooms, hearing rooms, lobbies, and public document rooms.

(B) Offices of senior officials.

(C) Official VA distinguishing flags, adopted and utilized pursuant to paragraph (e)(2) of this section.

(D) Official awards, certificates, medals, and plaques.

(E) Motion picture film, video tape, and other audiovisual media prepared by or for VA and attributed thereto.

(F) Official prestige publications which represent the achievements or mission of VA.

(G) For other similar official purposes.

(H) For such other purposes as will tend to advance the aims, purposes and mission of the Department of Veterans Affairs as determined by the Secretary or Deputy Secretary.

(iii) Reproductions may be used only on:

(A) VA letterhead stationery.

(B) Official VA identification cards and security credentials.

(C) Business cards for VA employees.

(D) Official VA signs.

(E) Official publications or graphics issued by and attributed to VA, or joint statements of VA with one or more Federal agencies, State or local governments, or foreign governments.

(F) Official awards, certificates, and medals.

(G) Motion picture film, video tape, and other audiovisual media prepared by and for VA and attributed thereto.

(H) For other similar official purposes.

(I) For such other purposes as will tend to advance the aims, purposes and mission of the Department of Veterans Affairs as determined by the Secretary or Deputy Secretary.

(iv) Use of the official seal and embossed seals:

(A) Embossed seals may be used only on VA legal documents, including interagency or intergovernmental agreements with States, foreign patent applications, and similar official documents.

(B) The official seal may be used only for those purposes related to the conduct of Departmental affairs in furtherance of the VA mission.

(e) *Distinguishing flag.* (1) Description of distinguishing flag.

(i) The base or field of the flag shall be blue and a replica of the official seal shall appear on both sides thereof.

(ii) A Class 1 flag shall be of nylon banner, measure 4′4″ on the hoist by 5′6″ on the fly, exclusive of heading and hems, and be fringed on three edges with nylon fringe, 2½″ wide.

(iii) A Class 2 flag shall be of nylon banner, measure 3′ on the hoist by 5′ on the fly, exclusive of heading and hems, and be fringed on three edges with nylon fringe, 2½″ wide.

(iv) Each flag shall be manufactured in accordance with Department of Veterans Affairs Specification X–497G. The replica of the official seal shall be screen printed or embroidered on both sides.

(2) Use of distinguishing flag. (i) VA distinguishing flags may be used only:

(A) In the offices of the Secretary, Deputy Secretary, Assistant Secretaries, Deputy Assistant Secretaries and heads of field locations designated below:

(*1*) Regional Offices.

(*2*) Medical Centers and Outpatient Clinics.

(*3*) Domiciliaries.

(*4*) Marketing Centers and Supply Depots.

(*5*) Data Processing Centers.

(*6*) National Cemetery Offices.

(*7*) Other locations as designated by the Deputy Assistant Secretary for Administration.

(B) At official VA ceremonies.

(C) In Department auditoriums, official presentation rooms, hearing

rooms, lobbies, public document rooms, and in non-VA facilities in connection with events or displays sponsored by VA, and public appearances of VA officials.

(D) On or in front of VA installation buildings.

(E) Other such official VA purposes or purposes as will tend to advance the aims, purposes and mission of the Department of Veterans Affairs as determined by the Deputy Assistant Secretary for Administration.

(f) *Unauthorized uses of the seal and flag.* (1) The official seal, replicas, reproductions, embossed seals, and the distinguished flag shall not be used, except as authorized by the Secretary or Deputy Secretary, in connection with:

(i) Contractor-operated facilities.

(ii) Souvenir or novelty items.

(iii) Toys or commercial gifts or premiums.

(iv) Letterhead design, except on official Departmental stationery.

(v) Matchbook covers, calendars and similar items.

(vi) Civilian clothing or equipment.

(vii) Any article which may disparage the seal or flag or reflect unfavorably upon VA.

(viii) Any manner which implies Departmental endorsement of commercial products or services, or of the commercial user's policies or activities.

(2) Penalties for unauthorized use. Any person who uses the distinguishing flag, or the official seal, replicas, reproductions or embossed seals in a manner inconsistent with this section shall be subject to the penalty provisions of 18 U.S.C. 506, 701, or 1017, providing penalties for their wrongful use, as applicable.

(Authority: 38 U.S.C. 302, 38 U.S.C. 501)

[55 FR 49518, Nov. 29, 1990]

THE UNITED STATES FLAG FOR BURIAL PURPOSES

§ 1.10 Eligibility for and disposition of the United States flag for burial purposes.

(a) *Eligibility for burial flags*—(1) *Persons eligible.* (i) A veteran of any war, of Mexican border service, or of service after January 31, 1955, discharged or released from active duty under conditions other than dishonorable. (For the purpose of this section, the term *Mexican border service* means active military, naval, or air service during the period beginning on January 1, 1911, and ending on April 5, 1917, in Mexico, on the borders thereof, or in the waters adjacent thereto.)

(ii) A peacetime veteran discharged or released, before June 27, 1950, from the active military, naval, or air service, under conditions other than dishonorable, after serving at least one enlistment, or for a disability incurred or aggravated in line of duty.

(iii) Any person who has died while in military or naval service of the United States after May 27, 1941. This subdivision authorizes and requires the furnishing of a flag only where the military or naval service does not furnish a flag immediately. The only cases wherein a flag is not supplied immediately are those of persons whose remains are interred outside the continental limits of the United States, or whose remains are not recovered or are recovered and not identified.

(iv) Any person who served in the organized military forces of the Commonwealth of the Philippines while such forces were in the service of the Armed Forces of the United States pursuant to the military order of the President of the United States, dated July 26, 1941, including among such military forces organized guerrilla forces under commanders appointed, designated, or subsequently recognized by the Commander in Chief, Southwest Pacific Area, or other competent authority in the Army of the United States, and who dies after separation from such service under conditions other than dishonorable, on or after April 25, 1951.

(Authority: 38 U.S.C. 107(a))

(v) Any deceased member or former member of the Selected Reserve (as described in section 10143 of title 10) who is not otherwise eligible for a flag under this section or section 1482(a) of title 10 and who:

(A) Completed at least one enlistment as a member of the Selected Reserve or, in the case of an officer, completed the period of initial obligated service as a member of the Selected Reserve;

(B) Was discharged before completion of the person's initial enlistment as a member of the Selected Reserve or, in the case of an officer, period of initial obligated service as a member of the Selected Reserve, for a disability incurred or aggravated in the line of duty; or

(C) Died while a member of the Selected Reserve.

(Authority: 38 U.S.C. 2301(f)(1))

(b) *Disposition of burial flags.* (1) When a flag is actually used to drape the casket of a deceased veteran, it must be delivered to the next of kin following interment. Where the flag is not claimed by the next of kin it may be given upon request to a close friend or associate of the deceased veteran. Such action will constitute final and conclusive determination of rights under this section. (38 U.S.C. 2301)

(2) The phrase *next of kin* for the purpose of disposing of the flag used for burial purposes is defined as follows, with preference to entitlement in the order listed:

(i) Widow or widower.

(ii) Children, according to age (minor child may be issued a flag on application signed by guardian).

(iii) Parents, including adoptive, stepparents, and foster parents.

(iv) Brothers or sisters, including brothers or sisters of the halfblood.

(v) Uncles or aunts.

(vi) Nephews or nieces.

(vii) Others—cousins, grandparents, etc. (but not in-laws).

(3) The phrase *close friend or associate* for the purpose of disposing of the burial flag means any person who because of his or her relationship with the deceased veteran arranged for the burial or assisted in the burial arrangements. In the absence of a person falling in either of these categories, any person who establishes by evidence that he or she was a close friend or associate of the veteran may be furnished the burial flag. Where more than one request for the burial flag is received and each is accompanied by satisfactory evidence of relationship or association, the head of the field facility having jurisdiction of the burial flag quota will determine which applicant is the one most equitably entitled to the burial flag.

(Authority: 72 Stat. 1114, 1169, as amended; 38 U.S.C. 501, 2301)

[13 FR 6999, Nov. 27, 1948, as amended at 20 FR 8350, Nov. 8, 1955; 24 FR 10106, Dec. 15, 1959; 31 FR 4959, Mar. 26, 1966; 42 FR 27245, May 27, 1977; 66 FR 27598, May 18, 2001]

QUARTERS FOR DEPARTMENT OF VETERANS AFFAIRS EMPLOYEES OVERSEAS

§ 1.11 Quarters for Department of Veterans Affairs employees in Government-owned or –rented buildings overseas.

Pursuant to the provisions of 5 U.S.C. 5912, a U.S. citizen employee of the Department of Veterans Affairs permanently stationed in a foreign country may be furnished, without cost to him or her, living quarters, including heat, fuel, and light, in a Government-owned or –rented building. When in the interest of the service and when administratively feasible, an agreement may be entered into by the Under Secretary for Benefits or designee with another Federal agency, which is authorized to furnish quarters, to provide such quarters for Department of Veterans Affairs employees under the provisions of 31 U.S.C. 686. Quarters provided will be in lieu of any living quarters allowance to which the employee may otherwise be entitled.

(Authority: 72 Stat. 1114; 38 U.S.C. 501)

[33 FR 362, Jan. 10, 1968]

PROGRAM EVALUATION

§ 1.15 Standards for program evaluation.

(a) The Department of Veterans Affairs will evaluate all programs authorized under title 38 U.S.C. These evaluations will be conducted so as to determine each program's effectiveness in achieving its stated goals and in achieving such goals in relation to their cost. In addition, these evaluations will determine each program's impact on related programs and its structure and mechanism for delivery of services. All programs will be evaluated on a continuing basis and all evaluations will be conducted by Department of Veterans Affairs staff assigned

to an organizational entity other than those responsible for program administration. These evaluations will be conducted with sufficient frequency to allow for an assessment of the continued effectiveness of the programs.

(b) The program evaluation will be designed to determine if the existing program supports the intent of the law. A program evaluation must identify goals and objectives that support this intent, contain a method to measure fulfillment of the objectives, ascertain the degree to which goals and objectives are met, and report the findings and conclusions to Congress, as well as make them available to the public.

(c) The goals must be clear, specific, and measurable. To be clear they must be readily understood, free from doubt or confusion, and specific goals must be explicitly set forth. They must be measurable by objective means. These means can include use of existing record systems, observations, and information from other sources.

(d) All program evaluations require a detailed evaluation plan. The evaluation plan must clearly state the objectives of the program evaluation, the methodology to be used, resources to be committed, and a timetable of major phases.

(e) Each program evaluation must be objective. It must report the accomplishments as well as the shortcomings of the program in an unbiased way. The program evaluation must have findings that give decision-makers information which is of a level of detail and importance to enable decisions to be made affecting either direction or operation. The information in the program evaluation must be timely, and must contain information of sufficient currency that decisions based on the data in the evaluation can be made with a high degree of confidence in the data.

(f) Each program evaluation requires a systematic research design to collect the data necessary to measure the objectives. This research design should conform to the following:

(1) *Rationale*. The research design for each evaluation should contain a specific rationale and should be structured to determine possible cause and effect relationships.

(2) *Relevancy*. It must deal with issues currently existing within the program, within the Department, and within the environment in which the program operates.

(3) *Validity*. The degree of statistical validity should be assessed within the research design. Alternatives include an assessment of cost of data collection vs. results necessary to support decisions.

(4) *Reliability*. Use of the same research design by others should yield the same findings.

(g) The final program evaluation report will be reviewed for comments and concurrence by relevant organizations within the Department of Veterans Affairs, but in no case should this review unreasonably delay the results of the evaluation. Where disagreement exists, the dissenting organization's position should be summarized for a decision by the Secretary.

(h) The final program evaluation report will be forwarded, with approved recommendations, to the concerned organization. An action plan to accomplish the approved recommendations will be forwarded for evaluation by the evaluating entity.

(i) Program evaluation results should be integrated to the maximum extent possible into Department of Veterans Affairs plans and budget submissions to ensure continuity with other Department of Veterans Affairs management processes.

(Authority: 38 U.S.C. 527)

[47 FR 53735, Nov. 29, 1982, as amended at 54 FR 34980, Aug. 23, 1989]

§ 1.17 Evaluation of studies relating to health effects of radiation exposure.

(a) From time to time, the Secretary shall publish evaluations of scientific or medical studies relating to the adverse health effects of exposure to ionizing radiation in the ''Notices'' section of the FEDERAL REGISTER.

(b) Factors to be considered in evaluating scientific studies include:

(1) Whether the study's findings are statistically significant and replicable.

(2) Whether the study and its findings have withstood peer review.

(3) Whether the study methodology has been sufficiently described to permit replication of the study.

(4) Whether the study's findings are applicable to the veteran population of interest.

(5) The views of the appropriate panel of the Scientific Council of the Veterans' Advisory Committee on Environmental Hazards.

(c) When the Secretary determines, based on the evaluation of scientific or medical studies and after receiving the advice of the Veterans' Advisory Committee on Environmental Hazards and applying the reasonable doubt doctrine as set forth in paragraph (d)(1) of this section, that a significant statistical association exists between any disease and exposure to ionizing radiation, § 3.311 of this chapter shall be amended to provide guidelines for the establishment of service connection.

(d)(1) For purposes of paragraph (c) of this section a *significant statistical association* shall be deemed to exist when the relative weights of valid positive and negative studies permit the conclusion that it is at least as likely as not that the purported relationship between exposure to ionizing radiation and a specific adverse health effect exists.

(2) For purposes of this paragraph a valid study is one which:

(i) Has adequately described the study design and methods of data collection, verification and analysis;

(ii) Is reasonably free of biases, such as selection, observation and participation biases; however, if biases exist, the investigator has acknowledged them and so stated the study's conclusions that the biases do not intrude upon those conclusions; and

(iii) Has satisfactorily accounted for known confounding factors.

(3) For purposes of this paragraph a valid positive study is one which satisfies the criteria in paragraph (d)(2) of this section and whose findings are statistically significant at a probability level of .05 or less with proper accounting for multiple comparisons and subgroup analyses.

(4) For purposes of this paragraph a valid negative study is one which satisfies the criteria in paragraph (d)(2) of this section and has sufficient statistical power to detect an association between exposure to ionizing radiation and a specific adverse health effect if such an association were to exist.

(e) For purposes of assessing the relative weights of valid positive and negative studies, other studies affecting epidemiological assessments including case series, correlational studies and studies with insufficient statistical power as well as key mechanistic and animal studies which are found to have particular relevance to an effect on human organ systems may also be considered.

(f) Notwithstanding the provisions of paragraph (d) of this section, a *significant statistical association* may be deemed to exist between exposure to ionizing radiation and a specific disease if, in the Secretary's judgment, scientific and medical evidence on the whole supports such a decision.

(Authority: 38 U.S.C. 501; Pub. L. 98–542, as amended by Pub. L. 102–4)

[54 FR 40391, Oct. 2, 1989; 54 FR 46187, Nov. 1, 1989; 75 FR 17859, Apr. 8, 2010]

§ 1.18 Guidelines for establishing presumptions of service connection for former prisoners of war.

(a) *Purpose*. The Secretary of Veterans Affairs will establish presumptions of service connection for former prisoners of war when necessary to prevent denials of benefits in significant numbers of meritorious claims.

(b) *Standard*. The Secretary may establish a presumption of service connection for a disease when the Secretary finds that there is at least limited/suggestive evidence that an increased risk of such disease is associated with service involving detention or internment as a prisoner of war and an association between such detention or internment and the disease is biologically plausible.

(1) *Definition*. The phrase ''limited/suggestive evidence'' refers to evidence of a sound scientific or medical nature that is reasonably suggestive of an association between prisoner-of-war experience and the disease, even though the evidence may be limited because matters such as chance, bias, and confounding could not be ruled out with confidence or because the relatively small size of the affected population restricts the data available for study.

(2) *Examples*. ''Limited/suggestive evidence'' may be found where one high-quality study detects a statistically significant association between the prisoner-of-war experience and disease, even though other studies may be inconclusive. It also may be satisfied where several smaller studies detect an association that is consistent in magnitude and direction. These examples are not exhaustive.

(c) *Duration of detention or internment*. In establishing a presumption of service connection under paragraph (b) of this section, the Secretary may, based on sound scientific or medical evidence, specify a minimum duration of detention or internment necessary for application of the presumption.

(d) *Association*. The requirement in paragraph (b) of this section that an increased risk of disease be ''associated'' with prisoner-of-war service may be satisfied by evidence that demonstrates either a statistical association or a causal association.

(e) *Evidence*. In making determinations under paragraph (b) of this section, the Secretary will consider, to the extent feasible:

(1) Evidence regarding the increased incidence of disease in former prisoners of war;

(2) Evidence regarding the health effects of circumstances or hardships similar to those experienced by prisoners of war (such as malnutrition, torture, physical abuse, or psychological stress);

(3) Evidence regarding the duration of exposure to circumstances or hardships experienced by prisoners of war that is associated with particular health effects; and

(4) Any other sound scientific or medical evidence the Secretary considers relevant.

(f) *Evaluation of studies*. In evaluating any study for the purposes of this section, the Secretary will consider:

(1) The degree to which the study's findings are statistically significant;

(2) The degree to which any conclusions drawn from the study data have withstood peer review;

(3) Whether the methodology used to obtain the data can be replicated;

(4) The degree to which the data may be affected by chance, bias, or confounding factors; and

(5) The degree to which the data may be relevant to the experience of prisoners of war in view of similarities or differences in the circumstances of the study population.

(g) *Contracts for Scientific Review and Analysis*. To assist in making determinations under this section, the Secretary may contract with an appropriate expert body to review and summarize the scientific evidence, and assess the strength thereof, concerning the association between detention or internment as a prisoner of war and the occurrence of any disease, or for any other purpose relevant to the Secretary's determinations.

(Authority: 38 U.S.C. 501(a), 1110)

[69 FR 60089, Oct. 7, 2004]

REFERRALS OF INFORMATION REGARDING CRIMINAL VIOLATIONS

§ 1.200 Purpose.

This subpart establishes a duty upon and sets forth the mechanism for VA employees to report information about actual or possible criminal violations to appropriate law enforcement entities.

(Authority: 5 U.S.C. App. 3, 38 U.S.C. 902)

[68 FR 17550, Apr. 10, 2003]

§ 1.201 Employee's duty to report.

All VA employees with knowledge or information about actual or possible violations of criminal law related to VA programs, operations, facilities, contracts, or information technology systems shall immediately report such knowledge or information to their supervisor, any management official, or directly to the Office of Inspector General.

(Authority: 5 U.S.C. App. 3, 38 U.S.C. 902)

[68 FR 17550, Apr. 10, 2003]

§ 1.203 Information to be reported to VA Police.

Information about actual or possible violations of criminal laws related to VA programs, operations, facilities, or involving VA employees, where the violation of criminal law occurs on VA

premises, will be reported by VA management officials to the VA police component with responsibility for the VA station or facility in question. If there is no VA police component with jurisdiction over the offense, the information will be reported to Federal, state or local law enforcement officials, as appropriate.

(Authority: 38 U.S.C. 902)

[68 FR 17550, Apr. 10, 2003]

§ 1.204 Information to be reported to the Office of Inspector General.

Criminal matters involving felonies will also be immediately referred to the Office of Inspector General, Office of Investigations. VA management officials with information about possible criminal matters involving felonies will ensure and be responsible for prompt referrals to the OIG. Examples of felonies include but are not limited to, theft of Government property over $1000, false claims, false statements, drug offenses, crimes involving information technology systems and serious crimes against the person, *i.e.*, homicides, armed robbery, rape, aggravated assault and serious physical abuse of a VA patient.

(Authority: 5 U.S.C. App. 3)

[68 FR 17550, Apr. 10, 2003]

§ 1.205 Notification to the Attorney General or United States Attorney's Office.

VA police and/or the OIG, whichever has primary responsibility within VA for investigation of the offense in question, will be responsible for notifying the appropriate United States Attorney's Office, pursuant to 28 U.S.C. 535.

(Authority: 5 U.S.C. App. 3, 38 U.S.C. 902)

[68 FR 17550, Apr. 10, 2003]

SECURITY AND LAW ENFORCEMENT AT DEPARTMENT OF VETERANS AFFAIRS FACILITIES

§ 1.218 Security and law enforcement at VA facilities.

(a) *Authority and rules of conduct.* Pursuant to 38 U.S.C. 901, the following rules and regulations apply at all property under the charge and control of VA (and not under the charge and control of the General Services Administration) and to all persons entering in or on such property. The head of the facility is charged with the responsibility for the enforcement of these rules and regulations and shall cause these rules and regulations to be posted in a conspicuous place on the property.

(1) *Closing property to public.* The head of the facility, or designee, shall establish visiting hours for the convenience of the public and shall establish specific hours for the transaction of business with the public. The property shall be closed to the public during other than the hours so established. In emergency situations, the property shall be closed to the public when reasonably necessary to ensure the orderly conduct of Government business. The decision to close a property during an emergency shall be made by the head of the facility or designee. The head of the facility or designee shall have authority to designate areas within a facility as closed to the public.

(2) *Recording presence.* Admission to property during periods when such property is closed to the public will be limited to persons authorized by the head of the facility or designee. Such persons may be required to sign a register and/or display identification documents when requested to do so by VA police, or other authorized individual. No person, without authorization, shall enter upon or remain on such property while the property is closed. Failure to leave such premises by unauthorized persons shall constitute an offense under this paragraph.

(3) *Preservation of property.* The improper disposal of rubbish on property; the spitting on the property; the creation of any hazard on property to persons or things; the throwing of articles of any kind from a building; the climbing upon the roof or any part of the building, without permission; or the willful destruction, damage, or removal of Government property or any part thereof, without authorization, is prohibited. The destruction, mutilation, defacement, injury, or removal of any monument, gravestone, or other structure within the limits of any national cemetery is prohibited.

(4) *Conformity with signs and emergency conditions.* The head of the facility, or designee, shall have authority to post signs of a prohibitory and directory nature. Persons, in and on property, shall comply with such signs of a prohibitory or directory nature, and during emergencies, with the direction of police authorities and other authorized officials. Tampering with, destruction, marring, or removal of such posted signs is prohibited.

(5) *Disturbances.* Conduct on property which creates loud or unusual noise; which unreasonably obstructs the usual use of entrances, foyers, lobbies, corridors, offices, elevators, stairways, or parking lots; which otherwise impedes or disrupts the performance of official duties by Government employees; which prevents one from obtaining medical or other services provided on the property in a timely manner; or the use of loud, abusive, or otherwise improper language; or unwarranted loitering, sleeping, or assembly is prohibited. In addition to measures designed to secure voluntary terminations of violations of this paragraph the head of the facility or designee may cause the issuance of orders for persons who are creating a disturbance to depart the property. Failure to leave the premises when so ordered constitutes a further disturbance within the meaning of this rule, and the offender is subject to arrest and removal from the premises.

(6) *Gambling.* Participating in games for money or for tangible or intangible things, or the operating of gambling devices, the conduct of a lottery or pool, or the selling or purchasing of numbers tickets, in or on property is prohibited.

(7) *Alcoholic beverages and narcotics.* Operating a motor vehicle on property by a person under the influence of alcoholic beverages, narcotic drugs, hallucinogens, marijuana, barbiturates, or amphetamines is prohibited. Entering property under the influence of any narcotic drug, hallucinogen, marijuana, barbiturate, amphetamine, or alcoholic beverage (unless prescribed by a physician) is prohibited. The use on property of any narcotic drug, hallucinogen, marijuana, barbiturate, or amphetamine (unless prescribed by a physician) is prohibited. The introduction or possession of alcoholic beverages or any narcotic drug, hallucinogen, marijuana, barbiturate, and amphetamine on property is prohibited, except for liquor or drugs prescribed for use by medical authority for medical purposes. Provided such possession is consistent with the laws of the State in which the facility is located, liquor may be used and maintained in quarters assigned to employees as their normal abode, and away from the abode with the written consent of the head of the facility which specifies a special occasion for use and limits the area and period for the authorized use.

(8) *Soliciting, vending, and debt collection.* Soliciting alms and contributions, commercial soliciting and vending of all kinds, displaying or distributing commercial advertising, or collecting private debts in or on property is prohibited. This rule does not apply to (i) national or local drives for funds for welfare, health, or other purposes as authorized under Executive Order 12353, Charitable Fund Raising (March 23, 1982), as amended by Executive Order 12404 (February 10, 1983), and regulations issued by the Office of Personnel Management implementing these Executive Orders; (ii) concessions or personal notices posted by employees on authorized bulletin boards; and (iii) solicitation of labor organization membership or dues under 5 U.S.C. chapter 71.

(9) *Distribution of handbills.* The distributing of materials such as pamphlets, handbills, and/or flyers, and the displaying of placards or posting of materials on bulletin boards or elsewhere on property is prohibited, except as authorized by the head of the facility or designee or when such distributions or displays are conducted as part of authorized Government activities.

(10) *Photographs for news, advertising, or commercial purposes.* Photographs for advertising or commercial purposes may be taken only with the written consent of the head of the facility or designee. Photographs for news purposes may be taken at entrances, lobbies, foyers, or in other places designated by the head of the facility or designee.

(11) *Animals.* (i) Service animals, as defined in paragraph (a)(11)(viii) of this section, are permitted on VA property when those animals accompany individuals with disabilities and are trained for that purpose. A service animal shall be under the control of the person with the disability or an alternate handler at all times while on VA property. A service animal shall have a harness, leash, or other tether, unless either the handler is unable because of a disability to use a harness, leash, or other tether, or the use of a harness, leash, or other tether would interfere with the service animal's safe, effective performance of work or tasks, in which case the service animal must be otherwise under the handler's control (*e.g.*, voice control, signals, or other effective means). VA is not responsible for the care or supervision of a service animal. Service animal presence on VA property is subject to the same terms, conditions, and regulations as generally govern admission of the public to the property.

(ii) A service animal will be denied access to VA property or removed from VA property if:

(A) The animal is not under the control of the individual with a disability or an alternate handler;

(B) The animal is not housebroken. The animal must be trained to eliminate its waste in an outdoor area; or

(C) The animal otherwise poses a risk to the health or safety of people or other service animals. In determining whether an animal poses a risk to the health or safety of people or other service animals, VA will make an individualized assessment based on objective indications to ascertain the severity of the risk. Such indications include but are not limited to:

(*1*) External signs of aggression from the service animal, such as growling, biting or snapping, baring its teeth, lunging; or

(*2*) External signs of parasites on the service animal (*e.g.* fleas, ticks), or other external signs of disease or bad health (*e.g.* diarrhea or vomiting).

(iii) Service animals will be restricted from accessing certain areas of VA property under the control of the Veterans Health Administration (VHA properties) to ensure patient care, patient safety, or infection control standards are not compromised. Such areas include but are not limited to:

(A) Operating rooms and surgical suites;

(B) Areas where invasive procedures are being performed;

(C) Acute inpatient hospital settings when the presence of the service animal is not part of a documented treatment plan;

(D) Decontamination, sterile processing, and sterile storage areas;

(E) Food preparation areas (not to include public food service areas); and

(F) Any areas where personal protective clothing must be worn or barrier protective measures must be taken to enter.

(iv) Service animals will be restricted from accessing certain areas of VA property under the control of the National Cemetery Administration (NCA properties) to ensure that public safety, facilities and grounds care, and maintenance control are not compromised. Such areas include but are not limited to:

(A) Open interment areas, except as approved to observe an individual interment or inurnment.

(B) Construction or maintenance sites; and

(C) Grounds keeping and storage facilities.

(v) If a service animal is denied access to VA property or removed from VA property in accordance with (a)(11)(ii) of this section, or restricted from accessing certain VA property in accordance with paragraphs (a)(11)(iii) and (iv) of this section, then VA will give the individual with a disability the opportunity to obtain services without having the service animal on VA property.

(vi) Unless paragraph (a)(11)(vii) of this section applies, an individual with a disability must not be required to provide documentation, such as proof that an animal has been certified, trained, or licensed as a service animal, to gain access to VA property accompanied by the service animal. However, an individual may be asked if the animal is required because of a disability, and what work or task the animal has been trained to perform.

(vii) An individual with a disability, if such individual will be accompanied by the service animal while receiving treatment in a VHA residential program, must provide VA with documentation that confirms the service animal has had a current rabies vaccine as determined by state and local public health requirements, and current core canine vaccines as dictated by local veterinary practice standards (*e.g.* distemper, parvovirus, and adenovirus-2).

(viii) A service animal means any dog that is individually trained to do work or perform tasks for the benefit of an individual with a disability, including a physical, sensory, psychiatric, intellectual, or other mental disability. Other species of animals, whether wild or domestic, trained or untrained, are not service animals for the purposes of this definition. The work or tasks performed by a service animal must be directly related to the individual's disability. The crime deterrent effects of an animal's presence and the provision of emotional support, well-being, comfort, or companionship do not constitute work or tasks for the purposes of this definition. Service dogs in training are not considered service animals. This definition applies regardless of whether VA is providing benefits to support a service dog under 38 CFR 17.148.

(ix) Generally, animals other than service animals (''non-service animals'') are not permitted to be present on VA property, and any individual with a non-service animal must remove it. However, a VA facility head or designee may permit certain non-service animals to be present on VA property for the following reasons:

(A) Animals may be permitted to be present on VA property for law enforcement purposes;

(B) Animals under the control of the VA Office of Research and Development may be permitted to be present on VA property;

(C) Animal-assisted therapy (AAT) animals may be permitted to be present on VHA property when the presence of such animals would not compromise patient care, patient safety, or infection control standards. AAT is a goal-directed clinical intervention, as provided or facilitated by a VA therapist or VA clinician, that incorporates the use of an animal into the treatment regimen of a patient. Any AAT animal present on VHA property must facilitate achievement of patient-specific treatment goals, as documented in the patient's treatment plan. AAT animals must be up to date with all core vaccinations or immunizations, prophylactic parasite control medications, and regular health screenings as determined necessary by a licensed veterinarian consistent with local veterinary practice standards. Proof of compliance with these requirements must be documented and accessible in the area(s) where patients receive AAT.

(D) Animal-assisted activity (AAA) animals may be permitted to be present on VHA property when the presence of such animals would not compromise patient care, patient safety, or infection control standards. AAA involves animals in activities to provide patients with casual opportunities for motivational, educational, recreational, and/or therapeutic benefits. AAA is not a goal-directed clinical intervention that must be provided or facilitated by a VA therapist or clinician, and therefore is not necessarily incorporated into the treatment regimen of a patient or documented in the patient's medical record as treatment. AAA animals must be up to date with all core vaccinations or immunizations, prophylactic parasite control medications, and regular health screenings as determined necessary by a licensed veterinarian consistent with local veterinary practice standards. Proof of compliance with these requirements must be documented and accessible in the area(s) where patients may participate in AAA.

(E) Animals participating in a VA Community Living Center (CLC) residential animal program or a Mental Health Residential Rehabilitation Treatment Program (MHRRTP) may be permitted to be present on VHA property, when the presence of such animals would not compromise patient care, patient safety, or infection control standards. A residential animal program in a VA CLC or a MHRRTP is a program that uses the presence of

animals to create a more homelike environment to foster comfort for veterans, while also stimulating a sense of purpose, familiarity, and belonging. Any VA CLC or MHRRTP residential animal present on VHA property must facilitate achievement of therapeutic outcomes (such as described above), as documented in patient treatment plans. Residential animals in a VA CLC or MHRRTP must be up to date with all core vaccinations and immunizations, prophylactic parasite control medications, and regular health screenings as determined necessary by a licensed veterinarian consistent with local veterinary practice standards. Proof of compliance with these requirements must be documented and accessible in the VA CLC or MHRRTP.

(F) Animals may be present on NCA property for ceremonial purposes during committal services, interments, and other memorials, if the presence of such animals would not compromise public safety, facilities and grounds care, and maintenance control standards.

(x) For purposes of this section, a disability means, with respect to an individual, a physical or mental impairment that substantially limits one or more major life activities of the individual; a record of such an impairment; or being regarded as having such an impairment.

(12) *Vehicular and pedestrian traffic.* Drivers of all vehicles in or on property shall drive in a careful and safe manner at all times and shall comply with the signals and directions of police and all posted traffic signs. The blocking of entrances, driveways, walks, loading platforms, or fire hydrants in or on property is prohibited; parking in unauthorized locations or in locations reserved for other persons or contrary to the direction of posted signs is prohibited. Creating excessive noise on hospital or cemetery premises by muffler cut out, the excessive use of a horn, or other means is prohibited. Operation of a vehicle in a reckless or unsafe manner, drag racing, bumping, overriding curbs, or leaving the roadway is prohibited.

(13) *Weapons and explosives.* No person while on property shall carry firearms, other dangerous or deadly weapons, or explosives, either openly or concealed, except for official purposes.

(14) *Demonstrations.* (i) All visitors are expected to observe proper standards of decorum and decency while on VA property. Toward this end, any service, ceremony, or demonstration, except as authorized by the head of the facility or designee, is prohibited. Jogging, bicycling, sledding and other forms of physical recreation on cemetery grounds is prohibited.

(ii) For the purpose of the prohibition expressed in this paragraph, unauthorized demonstrations or services shall be defined as, but not limited to, picketing, or similar conduct on VA property; any oration or similar conduct to assembled groups of people, unless the oration is part of an authorized service; the display of any placards, banners, or foreign flags on VA property unless approved by the head of the facility or designee; disorderly conduct such as fighting, threatening, violent, or tumultuous behavior, unreasonable noise or coarse utterance, gesture or display or the use of abusive language to any person present; and partisan activities, *i.e.*, those involving commentary or actions in support of, or in opposition to, or attempting to influence, any current policy of the Government of the United States, or any private group, association, or enterprise.

(15) *Key security.* The head of the facility of designee, will determine which employees, by virtue of their duties, shall have access to keys or barrier-card keys which operate locks to rooms or areas on the property. The unauthorized possession, manufacture, and/or use of such keys or barrier cards is prohibited. The surreptitious opening or attempted opening of locks or card-operated barrier mechanisms is prohibited.

(16) *Sexual misconduct.* Any act of sexual gratification on VA property involving two or more persons, who do not reside in quarters on the property, is prohibited. Acts of prostitution or solicitation for acts of prostitution on VA property is prohibited. For the purposes of this paragraph, an act of prostitution is defined as the performance or the offer or agreement to perform any sexual act for money or payment.

(b) *Schedule of offenses and penalties.* Conduct in violation of the rules and regulations set forth in paragraph (a) of this section subjects an offender to arrest and removal from the premises. Whomever shall be found guilty of violating these rules and regulations while on any property under the charge and control of VA is subject to a fine as stated in the schedule set forth herein or, if appropriate, the payment of fixed sum in lieu of appearance (forfeiture of collateral) as may be provided for in rules of the United States District Court. Violations included in the schedule of offenses and penalties may also subject an offender to a term of imprisonment of not more than six months, as may be determined appropriate by a magistrate or judge of the United States District Court:

(1) Improper disposal of rubbish on property, $200.

(2) Spitting on property, $25.

(3) Throwing of articles from a building or the unauthorized climbing upon any part of a building, $50.

(4) Willful destruction, damage, or removal of Government property without authorization, $500.

(5) Defacement, destruction, mutilation or injury to, or removal, or disturbance of, gravemarker or headstone, $500.

(6) Failure to comply with signs of a directive and restrictive nature posted for safety purposes, $50.

(7) Tampering with, removal, marring, or destruction of posted signs, $150.

(8) Entry into areas posted as closed to the public or others (trespass), $50.

(9) Unauthorized demonstration or service in a national cemetery or on other VA property, $250.

(10) Creating a disturbance during a burial ceremony, $250.

(11) Disorderly conduct which creates loud, boisterous, and unusual noise, or which obstructs the normal use of entrances, exits, foyers, offices, corridors, elevators, and stairways or which tends to impede or prevent the normal operation of a service or operation of the facility, $250.

(12) Failure to depart premises by unauthorized persons, $50.

(13) Unauthorized loitering, sleeping or assembly on property, $50.

(14) Gambling-participating in games of chance for monetary gain or personal property; the operation of gambling devices, a pool or lottery; or the taking or giving of bets, $200.

(15) Operation of a vehicle under the influence of alcoholic beverages or nonprescribed narcotic drugs, hallucinogens, marijuana, barbiturates, or amphetamines, $500.

(16) Entering premises under the influence of alcoholic beverages or narcotic drugs, hallucinogens, marijuana, barbiturates or amphetamines, $200.

(17) Unauthorized use on property of alcoholic beverages or narcotic drugs, hallucinogens, marijuana, barbiturates, or amphetamines, $300.

(18) Unauthorized introduction on VA controlled property of alcoholic beverages or narcotic drugs, hallucinogens, marijuana, barbiturates, or amphetamines or the unauthorized giving of same to a patient or beneficiary, $500.

(19) Unauthorized solicitation of alms and contributions on premises, $50.

(20) Commercial soliciting or vending, or the collection of private debts on property, $50.

(21) Distribution of pamphlets, handbills, and flyers, $25.

(22) Display of placards or posting of material on property, $25.

(23) Unauthorized photography on premises, $50.

(24) Failure to comply with traffic directions of VA police, $25.

(25) Parking in spaces posted as reserved for physically disabled persons, $50.

(26) Parking in no-parking areas, lanes, or crosswalks so posted or marked by yellow borders or yellow stripes, $25.

(27) Parking in emergency vehicle spaces, areas and lanes bordered in red or posted as EMERGENCY VEHICLES ONLY or FIRE LANE, or parking within 15 feet of a fire hydrant, $50.

(28) Parking within an intersection or blocking a posted vehicle entrance or posted exit lane, $25.

(29) Parking in spaces posted as reserved or in excess of a posted time limit, $15.

(30) Failing to come to a complete stop at a STOP sign, $25.

(31) Failing to yield to a pedestrian in a marked and posted crosswalk, $25.

(32) Driving in the wrong direction on a posted one-way street, $25.

(33) Operation of a vehicle in a reckless or unsafe manner, too fast for conditions, drag racing, overriding curbs, or leaving the roadway, $100.

(34) Exceeding posted speed limits:

(i) By up to 10 mph, $25.

(ii) By up to 20 mph, $50.

(iii) By over 20 mph, $100.

(35) Creating excessive noise in a hospital or cemetery zone by muffler cut out, excessive use of a horn, or other means, $50.

(36) Failure to yield right of way to other vehicles, $50.

(37) Possession of firearms, carried either openly or concealed, whether loaded or unloaded (except by Federal or State law enforcement officers on official business, $500.

(38) Introduction or possession of explosives, or explosive devices which fire a projectile, ammunition, or combustibles, $500.

(39) Possession of knives which exceed a blade length of 3 inches; switchblade knives; any of the variety of hatchets, clubs and hand-held weapons; or brass knuckles, $300.

(40) The unauthorized possession of any of the variety of incapacitating liquid or gas-emitting weapons, $200.

(41) Unauthorized possession, manufacture, or use of keys or barrier card-type keys to rooms or areas on the property, $200.

(42) The surreptitious opening, or attempted opening, of locks or card-operated barrier mechanisms on property, $500.

(43) Soliciting for, or the act of, prostitution, $250.

(44) Any unlawful sexual activity, $250.

(45) Jogging, bicycling, sledding or any recreational physical activity conducted on cemetery grounds, $50.

(c) *Enforcement procedures.* (1) VA administration directors will issue policies and operating procedures governing the proper exercise of arrest and other law enforcement actions, and limiting the carrying and use of weapons by VA police officers. VA police officers found qualified under respective VA administration directives and duly appointed heads of facilities for the purposes of 38 U.S.C. 902(b)(1), will enforce these rules and regulations and other Federal laws on VA property in accordance with the policies and operating procedures issued by respective VA administration directors and under the direction of the head of the facility.

(2) VA administration directors will prescribe training for VA police officers of the scope and duration necessary to assure the proper exercise of the law enforcement and arrest authority vested in them and to assure their abilities in the safe handling of situations involving patients and the public in general. VA police officers will successfully complete prescribed training in law enforcement procedures and the safe handling of patients as a condition of their retention of statutory law enforcement and arrest authority.

(3) Nothing contained in the rules and regulations set forth in paragraph (a) of this section shall be construed to abrogate any other Federal laws or regulations, including assimilated offenses under 18 U.S.C. 13, or any State or local laws and regulations applicable to the area in which the property is situated.

[50 FR 29226, July 18, 1985, as amended at 80 FR 49162, Aug. 17, 2015]

§ 1.220 On-site activities by pharmaceutical company representatives at VA medical facilities.

(a) *Scope.* This rule governs on-site, in-person promotional activities, including educational activities, by pharmaceutical company representatives at VA medical facilities. It does not apply to the distribution of information and materials through other means.

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

Criteria-for-use means clinical criteria developed by the Department of Veterans Affairs (VA) at a National level that describe how certain drugs may be used. VA's criteria-for-use are available to the public at www.pbm.va.gov. Exceptions may be applied at the local level for operational reasons.

Drug or drugs means:

(1) Articles recognized in the official United States Pharmacopoeia, official Homeopathic Pharmacopoeia of the

United States, official National Formulary, or any supplement to any of them;

(2) Articles intended for use in the diagnosis, cure, mitigation, treatment, or prevention of disease in man or other animals;

(3) Articles (other than food) intended to affect the structure or any function of the body of man or other animals; and

(4) Articles intended for use as a component of any article specified in paragraphs (1), (2), or (3) of this definition.

Drug-related supplies means supplies related to the use of a drug, such as test strips or testing devices, inhalers, spacers, insulin syringes, and tablet splitters.

New molecular entity refers to a drug product containing an active ingredient that has never before received U.S. Food and Drug Administration approval.

Non-promotable drugs are drugs designated by VA as non-promotable on *http://www.pbm.va.gov*. A list of the drugs or drug-related supplies classified by VA as non-promotable may be requested by contacting the VA medical facility's Chief of Pharmacy Services.

Non-VANF drugs or drug-related supplies means drugs or drug-related supplies that do not appear on the VANF.

Pharmaceutical company representative means any individual employed by or contracted to represent a pharmaceutical manufacturer or retailer.

VA medical facility means any property under the charge and control of VA used to provide medical benefits, including Community-Based Outpatient Clinics and similar facilities.

VA National Formulary (VANF) drugs and/or drug-related supplies means any drug or drug-related supply that appears on the VA National Formulary (VANF). The VANF is available at *www.pbm.va.gov*, or may be requested by contacting the VA medical facility's Chief of Pharmacy Services.

Veterans Integrated Service Network (VISN) means one of the networks of VA medical facilities located in a particular region as designated by VA.

(c) *Promotion of drugs and drug-related supplies*. Notwithstanding §1.218(a)(8), VA will allow promotion of VANF drugs and drug-related supplies, and non-VANF drugs and drug-related supplies with criteria-for-use, on-site and in-person at VA medical facilities if all of the following are true:

(1) Drugs or drug-related supplies are discussed, displayed and represented accurately;

(2) The promotion has significant educational value and does not inappropriately divert VA staff from other activities that VA staff would otherwise perform during duty hours, including patient care and other educational activities; and

(3) The drug or drug-related supply has not been classified by VA as non-promotable.

(d) *Promotion of non-VANF drugs and drug-related supplies without criteria-for-use*. Non-VANF drugs and drug-related supplies without criteria-for-use may be promoted only if the requirements of paragraphs (c)(1) through (3) of this section are met and the promotion is specifically permitted by the VISN Pharmacist Executive, or Chief of Pharmacy Services, or designee.

(e) *Promotion of a new molecular entity*. A new molecular entity may be promoted only if the requirements of paragraphs (c)(1) through (3) of this section are met and the promotion is specifically permitted by the VISN Pharmacist Executive, or Chief of Pharmacy Services, or designee. Such permission will be automatically revoked if the new molecular entity is subsequently designated non-promotable. Such permission must be reconsidered if the new molecular entity is denied VANF status.

(f) *Educational programs and associated materials*. For purposes of this section, an educational program is a pre-scheduled event or meeting during which a pharmaceutical company representative provides information about a drug or drug-related supply. All educational programs and associated materials must receive prior approval from the person at the VA medical facility to whom such approval authority has been delegated under local policy, usually the Chief of Pharmacy Services. All materials associated with a proposed educational program must be provided at least 60 days before the

proposed date of the educational program or distribution of associated materials, unless VA agrees in an individual case to a different date, so that a determination of their suitability can be made. The approval authority will deem suitable any educational program and associated materials if it is part of a risk evaluation and mitigation strategy or other duty imposed by the Food and Drug Administration. Otherwise, educational programs and associated materials will be deemed suitable if the approval authority determines that they conform to the following requirements:

(1) Industry sponsorship must be disclosed in the introductory remarks and in the announcement brochure. Sponsorship includes any contribution, whether in the form of staple goods, personnel, or financing, intended to support the educational program.

(2) If industry-sponsored and non-sponsored sources of data or other analytical information exist for FDA-approved uses of a particular drug, a direct comparison between the two sources must be disclosed in the introductory remarks and in the announcement brochure.

(3) The educational program does not solicit protected health information or patient participation in pharmaceutical company-sponsored programs, except as may be required by Federal laws and regulations such as an educational program that is part of a risk evaluation and mitigation strategy required by the Food and Drug Administration.

(4) Patient educational materials must not contain the name or logo of the pharmaceutical manufacturer or be used for promotion of a specific medication, unless the VA Pharmacy Benefits Management Service determines that the logo or name is inconspicuous and legal requirements (e.g., trademark requirements) make their removal impractical. However, this requirement does not apply to labeling required by the Food and Drug Administration.

(5) Educational programs and associated materials regarding a drug, drug-related supply, or a new therapeutic indication for a drug that is already on the VANF but has not yet been reviewed by VA, must be submitted by the pharmaceutical company or pharmaceutical company representative to the VA medical facility's Chief of Pharmacy Services or designee.

(6) Educational programs and associated materials focusing primarily on non-VANF drugs or drug-related supplies without criteria-for-use are permitted only if those drugs or drug-related supplies may be promoted under paragraph (d) of this section.

(g) *Providing gifts, drugs or other promotional items to VA employees or facilities*—(1) *General.* No pharmaceutical company representative may give, and no VA employee may receive, any item (including but not limited to promotional materials, continuing education materials, textbooks, entertainment, and gratuities) that exceeds the value permissible for acceptance under government ethical rules (5 CFR 2635.204(a)). However, such items may be donated to a medical center library or individual department for use by all employees, in accordance with medical center policy. Gifts in support of VA staff official travel may be accepted by the Department subject to advance legal review in accordance with 31 U.S.C. 1353, 41 CFR part 304, and VA policy regarding such gifts.

(2) *Samples of drugs and drug-related supplies.* Pharmaceutical company representatives must submit samples of drugs and drug-related supplies for approval to the person at the medical facility to whom such responsibility is delegated under local policy, usually the Director. All usage information pertaining to these drugs or drug-related supplies must be forwarded to the VISN Pharmacist Executive or VISN Formulary Committee. All samples of drugs or drug-related supplies must be delivered to the Office of the Chief of Pharmacy Services for proper storage, documentation and dispensing. Drug or drug-related supply samples may not be provided to VA staff for their personal use.

(3) *Donations of food.* Pharmaceutical company representatives may not provide food items of any type or any value to VA staff (including volunteers and without compensation employees)

or bring food items into VA medical facilities for use by non-VA staff (e.g., employees of affiliates).

(h) *Conduct of pharmaceutical company representatives.* In addition to the other provisions in this section, pharmaceutical company representatives must conform to the following:

(1) *Contacts must be by appointment only.* In order to minimize the potential for disruption of patient care activities, a pharmaceutical company representative must schedule an appointment before each visit. Access to VA medical facilities by a pharmaceutical company representative without an appointment is not permitted under any circumstances. VA medical facilities may develop a list of individuals or departments that may not be called-on by pharmaceutical company representatives. A pharmaceutical company representative must not attempt to make appointments with, or leave any materials for, individuals or departments on the list. The list may be obtained at the VA medical facility office of the Chief of Pharmacy Services. A pharmaceutical company representative visiting a VA medical facility for a scheduled appointment may not leave promotional materials for, or initiate requests for meetings with, other VA staff; however, pharmaceutical company representatives may respond to requests initiated by VA staff during the visit.

(2) *Paging VA employees.* A pharmaceutical company representative may not use the public address (paging) system to locate any VA employee. Contacts using the electronic paging system (beepers) are permissible only if specifically requested by the VA employee.

(3) *Marketing to students.* Pharmaceutical company representatives are prohibited from marketing to medical, pharmacy, nursing and other health profession students, including residents. Exceptions may be permitted when approved by, and conducted in the presence of, the staff member providing clinical supervision.

(4) *Attendance at conferences.* A pharmaceutical company representative may not attend a medical center conference where information regarding individual patients is discussed or presented.

(5) *Patient care areas.* Pharmaceutical company representatives generally may not wait for scheduled appointments or make presentations in patient-care areas, but may briefly travel through them, when necessary, to meet in a staff member's office. Patient-care areas include, but are not limited to:

(i) Patient rooms and ward areas where patients may be encountered;

(ii) Clinic examination rooms;

(iii) Nurses stations;

(iv) Intensive care units;

(v) Operating room suites;

(vi) Urgent care centers;

(vii) Emergency rooms (but not staff offices that may be located in them); or

(viii) Ambulatory treatment centers.

(6) *Distribution of materials.* Pharmaceutical company representatives may only distribute materials on-site at the time and location of a scheduled appointment or educational program. In no circumstances may materials be left in patient care areas.

(i) *Non-compliance.* (1) *General.* The visiting privileges of a pharmaceutical company representative or multiple representatives may be limited, suspended, or revoked by the written order of the Director of the VA medical center of jurisdiction if the Director determines the pharmaceutical company representative(s) failed to comply with the requirements of this section.

(2) *Notice of interim action.* The Director will notify the pharmaceutical company representative of the non-compliance and of the Director's interim action under paragraph (i)(4) of this section. The Director will also notify the supervisor of the pharmaceutical company representative(s) if there have been multiple instances of misconduct. The notice will offer 30 days to provide a response; however, the interim action will be enforced effective the date of the notice.

(3) *Final written order.* At the end of the 30-day period for a response, or after the Director receives a timely response, the Director will issue to the pharmaceutical company representative and supervisor a final written order either confirming the action taken as indicated in the notice, or specifying another action to be taken

under paragraph (i)(4) of this section. The written order may also state that the Director has determined that no further action is required. Any final written order issued by the Director shall include a summary of the circumstances of the violation, a listing of the specific provisions of this section that the pharmaceutical company representative(s) violated, and the bases for the Director's determination regarding the appropriate action. Notice concerning a final written order suspending or permanently revoking the visiting privileges of multiple pharmaceutical company representatives shall include specific notice concerning the right to review of the Director's order by the Under Secretary for Health.

(4) *Actions*. Actions that may be imposed under this section include limitation, suspension, or permanent revocation of visiting privileges at one or more VA medical facilities. In determining the appropriate action, the Director shall consider the requirements of this section, the circumstances of the improper conduct, any prior acts of misconduct by the same pharmaceutical company representative, any response submitted by the pharmaceutical company representative or their supervisor under paragraph (i)(2) of this section, and any prior written orders issued or other actions taken with respect to similar acts of misconduct.

(5) *Review*. The pharmaceutical company may request the Under Secretary's review within 30 days of the date of the Director's final written order by submitting a written request to the Director. The Director shall forward the initial notice, any response, the final written order, and the request for review to the Under Secretary for a final VA decision. VA will enforce the Director's final written order while it is under review by the Under Secretary. The Director will provide the individual who made the request written notice of the Under Secretary's decision.

(Authority: 38 U.S.C. 501)

[77 FR 13007, Mar. 5, 2012]

PARKING FEES AT VA MEDICAL FACILITIES

§ 1.300 Purpose.

Sections 1.300 through 1.303 prescribe policies and procedures for establishing parking fees for the use of Department of Veterans Affairs controlled parking spaces at VA medical facilities.

(Authority: 38 U.S.C. 501, 8109)

[53 FR 25490, July 7, 1988]

§ 1.301 Definitions.

As used in §§1.300 through 1.303 of this title:

(a) *Secretary* means the Secretary of Veterans Affairs.

(b) *Eligible person* means any individual to whom the Secretary is authorized to furnish medical examination or treatment.

(c) *Garage* means a structure or part of a structure in which vehicles may be parked.

(d) *Medical facility* means any facility or part thereof which is under the jurisdiction of the Secretary for the provision of health-care services, including any necessary buildings and structures, garage or parking facility.

(e) *Parking facilities* includes all surface and garage parking spaces at a VA medical facility.

(f) *Volunteer worker* means an individual who performs services, without compensation, under the auspices of VA Voluntary Service (VAVS) at a VA medical facility, for the benefit of veterans receiving care at that medical facility.

(Authority: 38 U.S.C. 8109)

[53 FR 25490, July 7, 1988]

§ 1.302 Applicability and scope.

(a) The provisions of §§1.300 through 1.303 apply to VA medical facility parking facilities in the United States, its territories and possessions, and the Commonwealth of Puerto Rico, and to such parking facilities for the use of VA medical facilities jointly shared by VA and another Federal agency when the facility is operated by the VA. Sections 1.300 through 1.303 apply to all users of those parking facilities. Fees shall be assessed and collected at medical facilities where parking garages

are constructed, acquired, or altered at a cost exceeding $500,000 (or, in the case of acquisition by lease, $100,000 per year). The Secretary, in the exercise of official discretion, may also determine that parking fees shall be charged at any other VA medical facility.

(b) All fees established shall be reasonable under the circumstances and shall cover all parking facilities used in connection with such VA medical facility.

(Authority: 38 U.S.C. 8109)

[53 FR 25490, July 7, 1988]

§ 1.303 Policy.

(a) *General.* Parking spaces at VA medical facilities shall only be provided under the following conditions:

(1) VA and its employees shall not be liable for any damages to vehicles (or their contents) parked in VA parking facilities, unless such damages are directly caused by such employees acting in the course of their VA employment.

(2) Parking facilities at VA medical facilities shall only be made available at each medical facility for such periods and under such terms as prescribed by the facility director, consistent with §§ 1.300 through 1.303.

(3) VA will limit parking facilities at VA medical facilities to the minimum necessary, and administer those parking facilities in full compliance with ridesharing regulations and Federal laws.

(b) *Fees.* (1) As provided in § 1.302, VA will assess VA employees, contractor employees, tenant employees, visitors, and other individuals having business at a VA medical facility where VA parking facilities are available, a parking fee for the use of that parking facility. All parking fees shall be set at a rate which shall be equivalent to one-half of the appropriate fair rental value (*i.e.*, monthly, weekly, daily, hourly) for the use of equivalent commercial space in the vicinity of the medical facility, subject to the terms and conditions stated in paragraph (a) of this section. Fair rental value shall include an allowance for the costs of management of the parking facilities. The Secretary will determine the fair market rental value through use of generally accepted appraisal techniques. If the appraisal establishes that there is no comparable commercial rate because of the absence of commercial parking facilities within a two-mile radius of the medical facility, then the rate established shall be not less than the lowest rate charged for parking at the VA medical facility with the lowest established parking fees. Rates established shall be reviewed biannually by the Secretary to reflect any increase or decrease in value as determined by appraisal updating.

(2) No parking fees shall be established or collected for parking facilities used by or for vehicles of the following:

(i) Volunteer workers in connection with such workers performing services for the benefit of veterans receiving care at the medical facility;

(ii) A veteran or an eligible person in connection with such veteran or eligible person receiving examination or treatment;

(iii) An individual transporting a veteran or eligible person seeking examination or treatment; and

(iv) Federal Government employees using Government owned or leased or private vehicles for official business.

(Authority: 38 U.S.C. 8109)

[53 FR 25490, July 7, 1988]

RELEASE OF INFORMATION FROM DEPARTMENT OF VETERANS AFFAIRS (VA) RECORDS RELATING TO DRUG ABUSE, ALCOHOLISM OR ALCOHOL ABUSE, INFECTION WITH THE HUMAN IMMUNODEFICIENCY VIRUS (HIV), OR SICKLE CELL ANEMIA

NOTE: Sections 1.460 through 1.499 of this part concern the confidentiality of information relating to drug abuse, alcoholism or alcohol abuse, infection with the human immunodeficiency virus, or sickle cell anemia in VA records and are applicable in combination with other regulations pertaining to the release of information from VA records. Sections 1.500 through 1.527, Title 38, Code of Federal Regulations, implement the provisions of 38 U.S.C. §§ 5701 and 5702. Sections 1.550 through 1.559 implement the provisions of 5 U.S.C. § 552 (The Freedom of Information Act). Sections 1.575 through 1.584 implement the provisions of 5 U.S.C. § 552a (The Privacy Act of 1974).

The provisions of §§ 1.460 through 1.499 of this part pertain to any program or activity,

including education, treatment, rehabilitation or research, which relates to drug abuse, alcoholism or alcohol abuse, infection with the human immunodeficiency virus, or sickle cell anemia. The statutory authority for the drug abuse provisions and alcoholism or alcohol abuse provisions of §§1.460 through 1.499 is Sec. 111 of Pub. L. 94–581, the Veterans Omnibus Health Care Act of 1976 (38 U.S.C. §§7331 through 7334), the authority for the human immunodeficiency virus provisions is Sec. 121 of Pub. L. 100–322, the Veterans' Benefits and Services Act of 1988 (38 U.S.C. §7332); the authority for the sickle cell anemia provisions is Sec. 109 of Pub. L. 93–82, the Veterans Health Care Expansion Act of 1973 (38 U.S.C. §§1751–1754).

AUTHORITY: 38 U.S.C. 1751–1754 and 7331–7334.

SOURCE: 60 FR 63929, Dec. 13, 1995, unless otherwise noted.

§ 1.460 Definitions.

For purposes of §§1.460 through 1.499 of this part, the following definitions apply:

Agreement. The term ''agreement'' means a document that a VA health care facility develops in collaboration with an Organ Procurement Organization, eye bank or tissue bank with written, detailed responsibilities and obligations of the parties with regard to identifying potential donors and facilitating the donation process.

Alcohol abuse. The term ''alcohol abuse'' means the use of an alcoholic beverage which impairs the physical, mental, emotional, or social well-being of the user.

Contractor. The term ''contractor'' means a person who provides services to VA such as data processing, dosage preparation, laboratory analyses or medical or other professional services. Each contractor shall be required to enter into a written agreement subjecting such contractor to the provisions of §§1.460 through 1.499 of this part; 38 U.S.C. 5701 and 7332; and 5 U.S.C. 552a and 38 CFR 1.576(g).

Deceased. The term ''deceased'' means death established by either neurological criteria (brain death) or cardiopulmonary criteria (cardiac death). Brain death is the irreversible cessation of all brain function. Cardiac death is the irreversible cessation of circulatory and respiratory function. In both cases, ''irreversible'' means that function will not resume spontaneously and will not be restarted artificially.

Decision-making capacity. The term ''decision-making capacity'' has the same meaning set forth in 38 CFR 17.32(a).

Diagnosis. The term ''diagnosis'' means any reference to an individual's alcohol or drug abuse or to a condition which is identified as having been caused by that abuse or any reference to sickle cell anemia or infection with the human immunodeficiency virus which is made for the purpose of treatment or referral for treatment. A diagnosis prepared for the purpose of treatment or referral for treatment but which is not so used is covered by §§1.460 through 1.499 of this part. These regulations do not apply to a diagnosis of drug overdose or alcohol intoxication which clearly shows that the individual involved is not an alcohol or drug abuser (e.g., involuntary ingestion of alcohol or drugs or reaction to a prescribed dosage of one or more drugs).

Disclose or disclosure. The term ''disclose'' or ''disclosure'' means a communication of patient identifying information, the affirmative verification of another person's communication of patient identifying information, or the communication of any information from the record of a patient who has been identified.

Drug abuse. The term ''drug abuse'' means the use of a psychoactive substance for other than medicinal purposes which impairs the physical, mental, emotional, or social well-being of the user.

Eye bank and tissue bank. The term ''eye bank and tissue bank'' means an ''establishment'' as defined in 21 CFR 1271.3, pursuant to section 361 of the Public Health Service Act (42 U.S.C. 264) that has a valid, current registration with the Federal Food and Drug Administration (FDA) as required under 21 CFR part 1271.

Individual. The term ''individual'' means a veteran, as defined in 38 U.S.C. 101(2), or a dependent of a veteran, as defined in 38 U.S.C. 101(3) and (4)(A).

Infection with the human immunodeficiency virus (HIV). The term ''infection with the human immunodeficiency

virus (HIV)'' means the presence of laboratory evidence for human immunodeficiency virus infection. The term does not include negative results from the testing of an individual for the presence of the virus or antibodies to the virus, or such testing of an individual where the results are negative.

Informant. The term ''informant'' means an individual who is a patient or employee or who becomes a patient or employee at the request of a law enforcement agency or official and who at the request of a law enforcement agency or official observes one or more patients or employees for the purpose of reporting the information obtained to the law enforcement agency or official.

Near death. The term ''near death'' means that in the clinical judgment of the patient's health care provider based on defined clinical triggers, the patient's death is imminent.

Organ Procurement Organization. The term ''Organ Procurement Organization'' (OPO) means an organization that performs or coordinates the procurement, preservation, and transportation of organs and maintains a system of locating prospective recipients for available organs.

Patient. The term ''patient'' means any individual or subject who has been given a diagnosis or treatment for drug abuse, alcoholism or alcohol abuse, infection with the human immunodeficiency virus, or sickle cell anemia and includes any individual who, after arrest on a criminal charge, is interviewed and/or tested in connection with drug abuse, alcoholism or alcohol abuse, infection with the human immunodeficiency virus, or sickle cell anemia in order to determine that individual's eligibility to participate in a treatment or rehabilitation program if the result of such testing is positive. The term ''patient'' includes an individual who has been diagnosed or treated for alcoholism, drug abuse, HIV infection, or sickle cell anemia for purposes of participation in a VA program or activity relating to those four conditions, including a program or activity consisting of treatment, rehabilitation, education, training, evaluation, or research. For the purpose of infection with the human immunodeficiency virus or sickle cell anemia, the term ''patient'' includes one tested positive for the disease even if no treatment is provided, offered, or requested. The term does not include a patient who has tested negative for the disease.

Patient identifying information. The term ''patient identifying information'' means the name, address, social security number, fingerprints, photograph, or similar information by which the identity of a patient can be determined with reasonable accuracy and speed either directly or by reference to other publicly available information. The term does not include a number assigned to a patient by a treatment program, if that number does not consist of, or contain numbers (such as social security, or driver's license number) which could be used to identify a patient with reasonable accuracy and speed from sources external to the treatment program.

Person. The term ''person'' means an individual, partnership, corporation, Federal, State or local government agency, or any other legal entity.

Practitioner. The term ''practitioner'' has the same meaning set forth in 38 CFR 17.32(a).

Procurement organization. The term ''procurement organization'' means an organ procurement organization, eye bank, and/or tissue bank as defined in this section.

Records. The term ''records'' means any information received, obtained or maintained, whether recorded or not, by an employee or contractor of VA, for the purpose of seeking or performing VA program or activity functions relating to drug abuse, alcoholism, tests for or infection with the human immunodeficiency virus, or sickle cell anemia regarding an identifiable patient. A program or activity function relating to drug abuse, alcoholism, infection with the human immunodeficiency virus, or sickle cell anemia includes evaluation, treatment, education, training, rehabilitation, research, or referral for one of these conditions. Sections 1.460 through 1.499 of this part apply to a primary or other diagnosis, or other information which identifies, or could reasonably be expected to identify, a patient as having

a drug or alcohol abuse condition, infection with the human immunodeficiency virus, or sickle cell anemia (e.g., alcoholic psychosis, drug dependence), but only if such diagnosis or information is received, obtained or maintained for the purpose of seeking or performing one of the above program or activity functions. Sections 1.460 through 1.499 of this part do not apply if such diagnosis or other information is not received, obtained or maintained for the purpose of seeking or performing a function or activity relating to drug abuse, alcoholism, infection with the human immunodeficiency virus, or sickle cell anemia for the patient in question. Whenever such diagnosis or other information, not originally received or obtained for the purpose of obtaining or providing one of the above program or activity functions, is subsequently used in connection with such program or activity functions, those original entries become a ''record'' and §§ 1.460 through 1.499 of this part thereafter apply to those entries. Segregability: these regulations do not apply to records or information contained therein, the disclosure of which (the circumstances surrounding the disclosure having been considered) could not reasonably be expected to disclose the fact that a patient has been connected with a VA program or activity function relating to drug abuse, alcoholism, infection with the human immunodeficiency virus, or sickle cell anemia.

(1) The following are examples of instances whereby records or information related to alcoholism or drug abuse are covered by the provisions of §§ 1.460 through 1.499 of this part:

(i) A patient with alcoholic delirium tremens is admitted for detoxification. The patient is offered treatment in a VA alcohol rehabilitation program which he declines.

(ii) A patient who is diagnosed as a drug abuser applies for and is provided VA drug rehabilitation treatment.

(iii) While undergoing treatment for an unrelated medical condition, a patient discusses with the physician his use and abuse of alcohol. The physician offers VA alcohol rehabilitation treatment which is declined by the patient.

(2) The following are examples of instances whereby records or information related to alcoholism or drug abuse are not covered by the provisions of §§ 1.460 through 1.499 of this part:

(i) A patient with alcoholic delirium tremens is admitted for detoxification, treated and released with no counseling or treatment for the underlying condition of alcoholism.

(ii) While undergoing treatment for an unrelated medical condition, a patient informs the physician of a history of drug abuse fifteen years earlier with no ingestion of drugs since. The history and diagnosis of drug abuse is documented in the hospital summary and no treatment is sought by the patient or offered or provided by VA during the current period of treatment.

(iii) While undergoing treatment for injuries sustained in an accident, a patient's medical record is documented to support the judgment of the physician to prescribe certain alternate medications in order to avoid possible drug interactions in view of the patient's enrollment and treatment in a non-VA methadone maintenance program. The patient states that continued treatment and follow-up will be obtained from private physicians and VA treatment for the drug abuse is not sought by the patient nor provided or offered by the staff.

(iv) A patient is admitted to the emergency room suffering from a possible drug overdose. The patient is treated and released; a history and diagnosis of drug abuse may be documented in the hospital summary. The patient is not offered treatment for the underlying conditions of drug abuse, nor is treatment sought by the patient for that condition.

Surrogate. The term ''surrogate'' has the same meaning set forth in 38 CFR 17.32(a).

Third party payer. The term ''third party payer'' means a person who pays, or agrees to pay, for diagnosis or treatment furnished to a patient on the basis of a contractual relationship with the patient or a member of his or her family or on the basis of the patient's eligibility for Federal, State, or local governmental benefits.

Treatment. The term ''treatment'' means the management and care of a

patient for drug abuse, alcoholism or alcohol abuse, or the diagnosis, management and care of a patient for infection with the human immunodeficiency virus, or sickle cell anemia, or a condition which is identified as having been caused by one or more of these conditions, in order to reduce or eliminate the adverse effects upon the patient. The term does not include negative test results for the human immunodeficiency virus, antibodies to the virus, or sickle cell anemia, or such testing of an individual where the results are negative.

Undercover agent. The term ''undercover agent'' means an officer of any Federal, State, or local law enforcement agency who becomes a patient or employee for the purpose of investigating a suspected violation of law or who pursues that purpose after becoming a patient or becoming employed for other purposes.

VHA health care facilty. The term ''VHA health care facility'' means a VA medical center, VA emergency room, VA nursing home or other facility as defined in 38 U.S.C. 1701(3).

(Authority: 38 U.S.C. 7332, 7334)

[60 FR 63929, Dec. 13, 1995, as amended at 72 FR 48241, Aug. 23, 2007; 73 FR 65260, Nov. 3, 2008; 76 FR 6696, Feb. 8, 2011; 82 FR 14822, Mar. 23, 2017]

§ 1.461 Applicability.

(a) *General*—(1) *Restrictions on disclosure*. The restrictions on disclosure in these regulations apply to any information whether or not recorded, which:

(i) Would identify a patient as an alcohol or drug abuser, an individual who tested positive for or is infected with the human immunodeficiency virus (HIV), hereafter referred to as HIV, or an individual who tested positive for or has sickle cell anemia, either directly, by reference to other publicly available information, or through verification of such an identification by another person; and

(ii) Is provided or obtained for the purpose of treating alcohol or drug abuse, infection with the HIV, or sickle cell anemia, making a diagnosis for that treatment, or making a referral for that treatment as well as for education, training, evaluation, rehabilitation and research program or activity purposes.

(2) *Restriction on use*. The restriction on use of information to initiate or substantiate any criminal charges against a patient or to conduct any criminal investigation of a patient applies to any information, whether or not recorded, which is maintained for the purpose of treating drug abuse, alcoholism or alcohol abuse, infection with the HIV, or sickle cell anemia, making a diagnosis for that treatment, or making a referral for that treatment as well as for education, training, evaluation, rehabilitation, and research program or activity purposes.

(b) *Period covered as affecting applicability*. The provisions of §§ 1.460 through 1.499 of this part apply to records of identity, diagnosis, prognosis, or treatment pertaining to any given individual maintained over any period of time which, irrespective of when it begins, does not end before March 21, 1972, in the case of diagnosis or treatment for drug abuse; or before May 14, 1974, in the case of diagnosis or treatment for alcoholism or alcohol abuse; or before September 1, 1973, in the case of testing, diagnosis or treatment of sickle cell anemia; or before May 20, 1988, in the case of testing, diagnosis or treatment for an infection with the HIV.

(c) *Exceptions*—(1) *Department of Veterans Affairs and Armed Forces*. The restrictions on disclosure in §§ 1.460 through 1.499 of this part do not apply to communications of information between or among those components of VA who have a need for the information in connection with their duties in the provision of health care, adjudication of benefits, or in carrying out administrative responsibilities related to those functions, including personnel of the Office of the Inspector General who are conducting audits, evaluations, healthcare inspections, or non-patient investigations, or between such components and the Armed Forces. Information obtained by VA components under these circumstances may be disclosed outside of VA to prosecute or investigate a non-patient only in accordance with § 1.495 of this part. Similarly, the restrictions on disclosure in §§ 1.460 through 1.499 of this part do not apply

to communications of information to the Department of Justice or U.S. Attorneys who are providing support in civil litigation or possible litigation involving VA.

(2) *Contractor*. The restrictions on disclosure in §§1.460 through 1.499 of this part do not apply to communications between VA and a contractor of information needed by the contractor to provide his or her services.

(3) *Crimes on VA premises or against VA personnel*. The restrictions on disclosure and use in §§1.460 through 1.499 of this part do not apply to communications from VA personnel to law enforcement officers which:

(i) Are directly related to a patient's commission of a crime on the premises of the facility or against personnel of VA or to a threat to commit such a crime; and

(ii) Are limited to the circumstances of the incident, including the patient status of the individual committing or threatening to commit the crime, that individual's name and address to the extent authorized by 38 U.S.C. 5701(f)(2), and that individual's last known whereabouts.

(4) *Undercover agents and informants*. (i) Except as specifically authorized by a court order granted under §1.495 of this part, VA may not knowingly employ, or admit as a patient, any undercover agent or informant in any VA drug abuse, alcoholism or alcohol abuse, HIV infection, or sickle cell anemia treatment program.

(ii) No information obtained by an undercover agent or informant, whether or not that undercover agent or informant is placed in a VA drug abuse, alcoholism or alcohol abuse, HIV infection, or sickle cell anemia treatment program pursuant to an authorizing court order, may be used to criminally investigate or prosecute any patient unless authorized pursuant to the provisions of §1.494 of this part.

(iii) The enrollment of an undercover agent or informant in a treatment unit shall not be deemed a violation of this section if the enrollment is solely for the purpose of enabling the individual to obtain treatment for drug or alcohol abuse, HIV infection, or sickle cell anemia.

(d) *Applicability to recipients of information*—(1) *Restriction on use of information*. In the absence of a proper §1.494 court order, the restriction on the use of any information subject to §§1.460 through 1.499 of this part to initiate or substantiate any criminal charges against a patient or to conduct any criminal investigation of a patient applies to any person who obtains that information from VA, regardless of the status of the person obtaining the information or of whether the information was obtained in accordance with §§1.460 through 1.499 of this part. This restriction on use bars, among other things, the introduction of that information as evidence in a criminal proceeding and any other use of the information to investigate or prosecute a patient with respect to a suspected crime. Information obtained by undercover agents or informants (see paragraph (c) of this section) or through patient access (see §1.469 of this part) is subject to the restriction on use.

(2) *Restrictions on disclosures—third-party payers and others*. The restrictions on disclosure in §§1.460 through 1.499 of this part apply to third-party payers and persons who, pursuant to a consent, receive patient records directly from VA and who are notified of the restrictions on redisclosure of the records in accordance with §1.476 of this part.

(Authority: 38 U.S.C. 7332(e) and 7334)

[60 FR 63929, Dec. 13, 1995, as amended at 76 FR 65135, Oct. 20, 2011; 82 FR 14822, Mar. 23, 2017]

§ 1.462 Confidentiality restrictions.

(a) *General*. The patient records to which §§1.460 through 1.499 of this part apply may be disclosed or used only as permitted by these regulations and may not otherwise be disclosed or used in any civil, criminal, administrative, or legislative proceedings conducted by any Federal, State, or local authority. Any disclosure made under these regulations must be limited to that information which is necessary to carry out the purpose of the disclosure.

(b) *Unconditional compliance required*. The restrictions on disclosure and use in §§1.460 through 1.499 of this part apply whether the person seeking the information already has it, has other

means of obtaining it, is a law enforcement or other official, has obtained a subpoena, or asserts any other justification for a disclosure or use which is not permitted by §§1.460 through 1.499 of this part. These provisions do not prohibit VA from acting accordingly when there is no disclosure of information.

(c) *Acknowledging the presence of patients: responding to requests.* (1) The presence of an identified patient in a VA facility for the treatment or other VA program activity relating to drug abuse, alcoholism or alcohol abuse, infection with the HIV, or sickle cell anemia may be acknowledged only if the patient's written consent is obtained in accordance with §1.475 of this part or if an authorizing court order is entered in accordance with §§1.490 through 1.499 of this part. Acknowledgment of the presence of an identified patient in a facility is permitted if the acknowledgment does not reveal that the patient is being treated for or is otherwise involved in a VA program or activity concerning drug abuse, alcoholism or alcohol abuse, infection with the HIV, or sickle cell anemia.

(2) Any answer to a request for a disclosure of patient records which is not permissible under §§1.460 through 1.499 of this part must be made in a way that will not affirmatively reveal that an identified individual has been, or is being diagnosed or treated for drug abuse, alcoholism or alcohol abuse, infection with the HIV, or sickle cell anemia. These regulations do not restrict a disclosure that an identified individual is not and never has been a patient.

(Authority: 38 U.S.C. 7334)

§1.463 Criminal penalty for violations.

Under 38 U.S.C. 7332(g), any person who violates any provision of this statute or §§1.460 through 1.499 of this part shall be fined not more than $5,000 in the case of a first offense, and not more than $20,000 for a subsequent offense.

(Authority: 38 U.S.C. 7332(g))

§1.464 Minor patients.

(a) *Definition of minor.* As used in §§1.460 through 1.499 of this part the term ''minor'' means a person who has not attained the age of majority specified in the applicable State law, or if no age of majority is specified in the applicable State law, the age of eighteen years.

(b) *State law not requiring parental consent to treatment.* If a minor patient acting alone has the legal capacity under the applicable State law to apply for and obtain treatment for drug abuse, alcoholism or alcohol abuse, infection with the HIV, or sickle cell anemia, any written consent for disclosure authorized under §1.475 of this part may be given only by the minor patient. This restriction includes, but is not limited to, any disclosure of patient identifying information to the parent or guardian of a minor patient for the purpose of obtaining financial reimbursement. Sections 1.460 through 1.499 of this part do not prohibit a VA facility from refusing to provide nonemergent treatment to an otherwise ineligible minor patient until the minor patient consents to the disclosure necessary to obtain reimbursement for services from a third party payer.

(c) *State law requiring parental consent to treatment.* (1) Where State law requires consent of a parent, guardian, or other person for a minor to obtain treatment for drug abuse, alcoholism or alcohol abuse, infection with the HIV, or sickle cell anemia, any written consent for disclosure authorized under §1.475 of this part must be given by both the minor and his or her parent, guardian, or other person authorized under State law to act in the minor's behalf.

(2) Where State law requires parental consent to treatment, the fact of a minor's application for treatment may be communicated to the minor's parent, guardian, or other person authorized under State law to act in the minor's behalf only if:

(i) The minor has given written consent to the disclosure in accordance with §1.475 of this part; or

(ii) The minor lacks the capacity to make a rational choice regarding such consent as judged by the appropriate VA facility director under paragraph (d) of this section.

(d) *Minor applicant for service lacks capacity for rational choice.* Facts relevant

to reducing a threat to the life or physical well being of the applicant or any other individual may be disclosed to the parent, guardian, or other person authorized under State law to act in the minor's behalf if the appropriate VA facility director judges that:

(1) A minor applicant for services lacks capacity because of extreme youth or mental or physical condition to make a rational decision on whether to consent to a disclosure under § 1.475 of this part to his or her parent, guardian, or other person authorized under State law to act in the minor's behalf, and

(2) The applicant's situation poses a substantial threat to the life or physical well-being of the applicant or any other individual which may be reduced by communicating relevant facts to the minor's parent, guardian, or other person authorized under State law to act in the minor's behalf.

(Authority: 38 U.S.C. 7334)

§ 1.465 Incompetent and deceased patients.

(a) *Incompetent patients other than minors.* In the case of a patient who has been adjudicated as lacking the capacity, for any reason other than insufficient age, to manage his or her own affairs, any consent which is required under §§ 1.460 through 1.499 of this part may be given by a court appointed legal guardian.

(b) *Deceased patients*—(1) *Vital statistics.* Sec. 1.460 through 1.499 of this part do not restrict the disclosure of patient identifying information relating to the cause of death of a patient under laws requiring the collection of death or other vital statistics or permitting inquiry into the cause of death.

(2) *Consent by personal representative.* Any other disclosure of information identifying a deceased patient as being treated for drug abuse, alcoholism or alcohol abuse, infection with the HIV, or sickle cell anemia is subject to §§ 1.460 through 1.499 of this part. If a written consent to the disclosure is required, the Under Secretary for Health or designee may, upon the prior written request of the next of kin, executor/executrix, administrator/administratrix, or other personal representative of such deceased patient, disclose the contents of such records, only if the Under Secretary for Health or designee determines such disclosure is necessary to obtain survivorship benefits for the deceased patient's survivor. This would include not only VA benefits, but also payments by the Social Security Administration, Worker's Compensation Boards or Commissions, or other Federal, State, or local government agencies, or nongovernment entities, such as life insurance companies.

(3) *Information related to sickle cell anemia.* Information related to sickle cell anemia may be released to a blood relative of a deceased veteran for medical follow-up or family planning purposes.

(Authority: 38 U.S.C. 7332(b)(3))

§ 1.466 Security for records.

(a) Written records which are subject to §§ 1.460 through 1.499 of this part must be maintained in a secure room, locked file cabinet, safe or other similar container when not in use. Access to information stored in computers will be limited to authorized VA employees who have a need for the information in performing their duties. These security precautions shall be consistent with the Privacy Act of 1974 (5 U.S.C. 552a).

(b) Each VA facility shall adopt in writing procedures related to the access to and use of records which are subject to §§ 1.460 through 1.499 of this part.

(Authority: 38 U.S.C. 7334)

§ 1.467 Restrictions on the use of identification cards and public signs.

(a) No facility may require any patient to carry on their person while away from the facility premises any card or other object which would identify the patient as a participant in any VA drug abuse, alcoholism or alcohol abuse, HIV infection, or sickle cell anemia treatment program. A facility may require patients to use or carry cards or other identification objects on the premises of a facility. Patients may not be required to wear clothing or colored identification bracelets or display objects openly to all facility staff or others which would identify them as

being treated for drug or alcohol abuse, HIV infection, or sickle cell anemia.

(b) Treatment locations should not be identified by signs that would identify individuals entering or exiting these locations as patients enrolled in a drug or alcohol abuse, HIV infection, or sickle cell anemia program or activity.

(Authority: 38 U.S.C. 7334)

§ 1.468 Relationship to Federal statutes protecting research subjects against compulsory disclosure of their identity.

(a) *Research privilege description.* There may be concurrent coverage of patient identifying information by the provisions of §§ 1.460 through 1.499 of this part and by administrative action taken under Sec. 303(a) of the Public Health Service Act (42 U.S.C. 241(d) and the implementing regulations at 42 CFR Part 2a); or Sec. 502(c) of the Controlled Substances Act (21 U.S.C. 872(c) and the implementing regulations at 21 CFR 1316.21). These ''research privilege'' statutes confer on the Secretary of Health and Human Services and on the Attorney General, respectively, the power to authorize researchers conducting certain types of research to withhold from all persons not connected with the research the names and other identifying information concerning individuals who are the subjects of the research.

(b) *Effect of concurrent coverage.* Sections 1.460 through 1.499 of this part restrict the disclosure and use of information about patients, while administrative action taken under the research privilege statutes and implementing regulations protects a person engaged in applicable research from being compelled to disclose any identifying characteristics of the individuals who are the subjects of that research. The issuance under §§ 1.490 through 1.499 of this part of a court order authorizing a disclosure of information about a patient does not affect an exercise of authority under these research privilege statutes. However, the research privilege granted under 21 CFR 291.505(g) to treatment programs using methadone for maintenance treatment does not protect from compulsory disclosure any information which is permitted to be disclosed under those regulations. Thus, if a court order entered in accordance with §§ 1.490 through 1.499 of this part authorizes a VA facility to disclose certain information about its patients, the facility may not invoke the research privilege under 21 CFR 291.505(g) as a defense to a subpoena for that information.

(Authority: 38 U.S.C. 7334)

§ 1.469 Patient access and restrictions on use.

(a) *Patient access not prohibited.* Sections 1.460 through 1.499 of this part do not prohibit a facility from giving a patient access to his or her own records, including the opportunity to inspect and copy any records that VA maintains about the patient, subject to the provisions of the Privacy Act (5 U.S.C. 552a(d)(1)) and 38 CFR 1.577. If the patient is accompanied, giving access to the patient and the accompanying person will require a written consent by the patient which is provided in accordance with § 1.475 of this part.

(b) *Restrictions on use of information.* Information obtained by patient access to patient record is subject to the restriction on use of this information to initiate or substantiate any criminal charges against the patient or to conduct any criminal investigation of the patient as provided for under § 1.461(d)(1) of this part.

(Authority: 38 U.S.C. 7334)

§§ 1.470–1.474 [Reserved]

DISCLOSURES WITH PATIENT'S CONSENT

§ 1.475 Form of written consent.

(a) *Required elements.* A written consent to a disclosure under §§ 1.460 through 1.499 of this part must include:

(1) The name of the facility permitted to make the disclosure (such a designation does not preclude the release of records from other VA health care facilities unless a restriction is stated on the consent).

(2) The name or title of the individual or the name of the organization to which disclosure is to be made.

(3) The name of the patient.

(4) The purpose of the disclosure.

(5) How much and what kind of information is to be disclosed.

(6) The signature of the patient and, when required for a patient who is a minor, the signature of a person authorized to give consent under § 1.464 of this part; or, when required for a patient who is incompetent or deceased, the signature of a person authorized to sign under § 1.465 of this part in lieu of the patient.

(7) The date on which the consent is signed.

(8) A statement that the consent is subject to revocation at any time except to the extent that the facility which is to make the disclosure has already acted in reliance on it. Acting in reliance includes the provision of treatment services in reliance on a valid consent to disclose information to a third party payer.

(9) The date, event, or condition upon which the consent will expire if not revoked before. This date, event, or condition must ensure that the consent will last no longer than reasonably necessary to serve the purpose for which it is given.

(b) *Expired, deficient, or false consent.* A disclosure may not be made on the basis of a consent which:

(1) Has expired;

(2) On its face substantially fails to conform to any of the requirements set forth in paragraph (a) of this section;

(3) Is known to have been revoked; or

(4) Is known, or through a reasonable effort could be known, by responsible personnel of VA to be materially false.

(c) *Notification of deficient consent.* Other than the patient, no person or entity may be advised that a special consent is required in order to disclose information relating to an individual participating in a drug abuse, alcoholism or alcohol abuse, HIV, or sickle cell anemia program or activity. Where a person or entity presents VA with an insufficient written consent for information protected by 38 U.S.C. 7332, VA must, in the process of obtaining a legally sufficient consent, correspond only with the patient whose records are involved, or the legal guardian of an incompetent patient or next of kin of a deceased patient, and not with any other person.

(d) It is not necessary to use any particular form to establish a consent referred to in paragraph (a) of this section, however, VA Form 10–5345, titled Request for and Consent to Release of Medical Records Protected by 38 U.S.C. 7332, may be used for such purpose.

(Authority: 38 U.S.C. 7332(a)(2) and (b)(1))

§ 1.476 Prohibition on redisclosure.

Each disclosure under §§ 1.460 through 1.499 of this part made with the patient's written consent must be accompanied by a written statement similar to the following:

> This information has been disclosed to you from records protected by Federal confidentiality rules (38 CFR Part 1). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 38 CFR Part 1. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient or patient with sickle cell anemia or HIV infection.

(Authority: 38 U.S.C. 7334)

§ 1.477 Disclosures permitted with written consent.

If a patient consents to a disclosure of his or her records under § 1.475 of this part, a facility may disclose those records in accordance with that consent to any individual or organization named in the consent, except that disclosures to central registries and in connection with criminal justice referrals must meet the requirements of §§ 1.478 and 1.479 of this part, respectively.

(Authority: 38 U.S.C. 7332(b)(1))

§ 1.478 Disclosures to prevent multiple enrollments in detoxification and maintenance treatment programs; not applicable to records relating to sickle cell anemia or infection with the human immunodeficiency virus.

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

(1) *Central registry* means an organization which obtains from two or more member programs patient identifying information about individuals applying for maintenance treatment or detoxification treatment for the purpose of

avoiding an individual's concurrent enrollment in more than one program.

(2) *Detoxification treatment* means the dispensing of a narcotic drug in decreasing doses to an individual in order to reduce or eliminate adverse physiological or psychological effects incident to withdrawal from the sustained use of a narcotic drug.

(3) *Maintenance treatment* means the dispensing of a narcotic drug in the treatment of an individual for dependence upon heroin or other morphine-like drugs.

(4) *Member program* means a non-VA detoxification treatment or maintenance treatment program which reports patient identifying information to a central registry and which is in the same State as that central registry or is not more than 125 miles from any border of the State in which the central registry is located.

(b) *Restrictions on disclosure.* VA may disclose patient records to a central registry which is located in the same State or is not more than 125 miles from any border of the State or to any non-VA detoxification or maintenance treatment program not more than 200 miles away for the purpose of preventing the multiple enrollment of a patient only if:

(1) The disclosure is made when:

(i) The patient is accepted for treatment;

(ii) The type or dosage of the drug is changed; or

(iii) The treatment is interrupted, resumed or terminated.

(2) The disclosure is limited to:

(i) Patient identifying information;

(ii) Type and dosage of the drug; and

(iii) Relevant dates.

(3) The disclosure is made with the patient's written consent meeting the requirements of § 1.475 of this part, except that:

(i) The consent must list the name and address of each central registry and each known non-VA detoxification or maintenance treatment program to which a disclosure will be made; and

(ii) The consent may authorize a disclosure to any non-VA detoxification or maintenance treatment program established within 200 miles after the consent is given without naming any such program.

(c) *Use of information limited to prevention of multiple enrollments.* A central registry and any non-VA detoxification or maintenance treatment program to which information is disclosed to prevent multiple enrollments may not redisclose or use patient identifying information for any purpose other than the prevention of multiple enrollments unless authorized by a court order under §§ 1.490 through 1.499 of this part.

(Authority: 38 U.S.C. 7334)

§ 1.479 Disclosures to elements of the criminal justice system which have referred patients.

(a) VA may disclose information about a patient from records covered by §§ 1.460 through 1.499 of this part to those persons within the criminal justice system which have made participation in a VA treatment program a condition of the disposition of any criminal proceedings against the patient or of the patient's parole or other release from custody if:

(1) The disclosure is made only to those individuals within the criminal justice system who have a need for the information in connection with their duty to monitor the patient's progress (e.g., a prosecuting attorney who is withholding charges against the patient, a court granting pretrial or posttrial release, probation or parole officers responsible for supervision of the patient); and

(2) The patient has signed a written consent as a condition of admission to the treatment program meeting the requirements of § 1.475 of this part (except paragraph (a)(8) which is inconsistent with the revocation provisions of paragraph (c) of this section) and the requirements of paragraphs (b) and (c) of this section.

(b) *Duration of consent.* The written consent must state the period during which it remains in effect. This period must be reasonable, taking into account:

(1) The anticipated length of the treatment recognizing that revocation of consent may not generally be effected while treatment is ongoing;

(2) The type of criminal proceeding involved, the need for the information in connection with the final disposition

of that proceeding, and when the final disposition will occur; and

(3) Such other factors as the facility, the patient, and the person(s) who will receive the disclosure consider pertinent.

(c) *Revocation of consent.* The written consent must state that it is revocable upon the passage of a specified amount of time or the occurrence of a specified, ascertainable event. The time or occurrence upon which consent becomes revocable may be no earlier than the individual's completion of the treatment program and no later than the final disposition of the conditional release or other action in connection with which consent was given.

(d) *Restrictions on redisclosure and use.* A person who receives patient information under this section may redisclose and use it only to carry out that person's official duties with regard to the patient's conditional release or other action in connection with which the consent was given, including parole.

(Authority: 38 U.S.C. 7334)

§§ 1.480–1.482 [Reserved]

DISCLOSURES WITHOUT PATIENT CONSENT

§ 1.483 Disclosure of information to participate in state prescription drug monitoring programs.

Information covered by §§ 1.460 through 1.499 of this part may be disclosed to State Prescription Drug Monitoring Programs pursuant to the limitations set forth in § 1.515 of this part.

[78 FR 9592, Feb. 11, 2013]

§ 1.484 Disclosure of medical information to the surrogate of a patient who lacks decision-making capacity.

A VA medical practitioner may disclose the content of any record of the identity, diagnosis, prognosis, or treatment of a patient that is maintained in connection with the performance of any VA program or activity relating to drug abuse, alcoholism or alcohol abuse, infection with the human immunodeficiency virus, or sickle cell anemia to a surrogate of the patient who is the subject of such record if:

(a) The patient lacks decision-making capacity; and

(b) The practitioner deems the content of the given record necessary for the surrogate to make an informed decision regarding the patient's treatment.

(Authority: 38 U.S.C. 7331, 7332)

[76 FR 6696, Feb. 8, 2011]

§ 1.485 Medical emergencies.

(a) *General rule.* Under the procedures required by paragraph (c) of this section, patient identifying information from records covered by §§ 1.460 through 1.499 of this part may be disclosed to medical personnel who have a need for information about a patient for the purpose of treating a condition which poses an immediate threat to the health of any individual and which requires immediate medical intervention.

(b) *Special rule.* Patient identifying information may be disclosed to medical personnel of the Food and Drug Administration (FDA) who assert a reason to believe that the health of any individual may be threatened by an error in the manufacture, labeling, or sale of a product under FDA jurisdiction, and that the information will be used for the exclusive purpose of notifying patients or their physicians of potential dangers.

(c) *Procedures.* Immediately following disclosure, any VA employee making an oral disclosure under authority of this section shall make an accounting of the disclosure in accordance with the Privacy Act (5 U.S.C. 552a(c) and 38 CFR 1.576(c)) and document the disclosure in the patient's records setting forth in writing:

(1) The name and address of the medical personnel to whom disclosure was made and their affiliation with any health care facility;

(2) The name of the individual making the disclosure;

(3) The date and time of the disclosure;

(4) The nature of the emergency (or error, if the report was to FDA);

(5) The information disclosed; and

(6) The authority for making the disclosure (§ 1.485 of this part).

(Authority: 38 U.S.C. 7332(b)(2)(A))

§ 1.485a Eye, organ and tissue donation.

A VHA health care facility may disclose the individually-identified medical record information of an individual covered by §§ 1.460 through 1.499 of this part to an authorized representative of a procurement organization for the purpose of facilitating determination of whether the individual is a suitable potential organ, eye, or tissue donor if:

(a) The individual is currently an inpatient in a VHA health care facility;

(b) The individual is, in the clinical judgment of the individual's primary health care provider, near death or deceased;

(c) The VHA health care facility has a signed agreement with the procurement organization in accordance with the applicable requirements of the United States Department of Health and Human Services (HHS); and

(d) The VHA health care facility has confirmed with HHS that it has certified or recertified the organ procurement organization as provided in the applicable HHS regulations. VA medical centers must verify annually in January of each calendar year with the Food and Drug Administration (FDA) that an eye bank or tissue bank has complied with the FDA registration requirements of 21 CFR part 1271 and that the registration status is active before permitting an eye bank or tissue bank to receive protected health information.

(Authority: 38 U.S.C. 5701(k), 7332(b)(2)(E))

[72 FR 48242, Aug. 23, 2007, as amended at 73 FR 65260, Nov. 3, 2008]

§ 1.486 Disclosure of information related to infection with the human immunodeficiency virus to public health authorities.

(a) In the case of any record which is maintained in connection with the performance of any program or activity relating to infection with the HIV, information may be disclosed to a Federal, State, or local public health authority, charged under Federal or State law with the protection of the public health, and to which Federal or State law requires disclosure of such record, if a qualified representative of such authority has made a written request that such record be provided as required pursuant to such law for a purpose authorized by such law. In the case of a State law, such law must, in order for VA to be able to release patient name and address information in accordance with 38 U.S.C. 5701(f)(2), provide for a penalty or fine or other sanction to be assessed against those individuals who are subject to the jurisdiction of the public health authority but fail to comply with the reporting requirements.

(b) A person to whom a record is disclosed under this section may not redisclose or use such record for a purpose other than that for which the disclosure was made.

(Authority: 38 U.S.C. 7332(b)(2)(C))

§ 1.487 Disclosure of information related to infection with the human immunodeficiency virus to the spouse or sexual partner of the patient.

(a) Subject to paragraph (b) of this section, a physician or a professional counselor may disclose information or records indicating that a patient is infected with the HIV if the disclosure is made to the spouse of the patient, or to an individual whom the patient has, during the process of professional counseling or of testing to determine whether the patient is infected with such virus, identified as being a sexual partner of such patient.

(b) A disclosure under this section may be made only if the physician or counselor, after making reasonable efforts to counsel and encourage the patient to provide the information to the spouse or sexual partner, reasonably believes that the patient will not provide the information to the spouse or sexual partner and that the disclosure is necessary to protect the health of the spouse or sexual partner.

(c) A disclosure under this section may be made by a physician or counselor other than the physician or counselor referred to in paragraph (b) of this section if such physician or counselor is unavailable by reason of extended absence or termination of employment to make the disclosure.

(Authority: 38 U.S.C. 7332(b))

§ 1.488 Research activities.

Subject to the provisions of 38 U.S.C. 5701, 38 CFR 1.500–1.527, the Privacy Act (5 U.S.C. 552a), 38 CFR 1.575–1.584 and the following paragraphs, patient medical record information covered by §§ 1.460 through 1.499 of this part may be disclosed for the purpose of conducting scientific research.

(a) Information in individually identifiable form may be disclosed from records covered by §§ 1.460 through 1.499 of this part for the purpose of conducting scientific research if the Under Secretary for Health or designee makes a determination that the recipient of the patient identifying information:

(1) Is qualified to conduct the research.

(2) Has a research protocol under which the information:

(i) Will be maintained in accordance with the security requirements of § 1.466 of this part (or more stringent requirements); and

(ii) Will not be redisclosed except as permitted under paragraph (b) of this section.

(3) Has furnished a written statement that the research protocol has been reviewed by an independent group of three or more individuals who found that the rights of patients would be adequately protected and that the potential benefits of the research outweigh any potential risks to patient confidentiality posed by the disclosure of records.

(b) A person conducting research may disclose information obtained under paragraph (a) of this section only back to VA and may not identify any individual patient in any report of that research or otherwise disclose patient identities.

(Authority: 38 U.S.C. 7332(b)(2)(B))

§ 1.489 Audit and evaluation activities.

Subject to the provisions of 38 U.S.C. 5701, 38 CFR 1.500–1.527, the Privacy Act (5 U.S.C. 552a), 38 CFR 1.575–1.584, and the following paragraphs, patient medical records covered by §§ 1.460 through 1.499 of this part may be disclosed outside VA for the purposes of conducting audit and evaluation activities.

(a) *Records not copies.* If patient records covered by §§ 1.460 through 1.499 of this part are not copied, patient identifying information may be disclosed in the course of a review of records on VA facility premises to any person who agrees in writing to comply with the limitations on redisclosure and use in paragraph (d) of this section and:

(1) Where audit or evaluation functions are performed by a State or Federal governmental agency on behalf of VA; or

(2) Who is determined by the VA facility director to be qualified to conduct the audit or evaluation activities.

(b) *Copying of records.* Records containing patient identifying information may be copied by any person who:

(1) Agrees in writing to:

(i) Maintain the patient identifying information in accordance with the security requirements provided in § 1.466 of this part (or more stringent requirements);

(ii) Destroy all the patient identifying information upon completion of the audit or evaluation; and

(iii) Comply with the limitations on disclosure and use in paragraph (d) of this section.

(2) The VA medical facility director determines to be qualified to conduct the audit or evaluation activities.

(c) *Congressional oversight.* Records subject to §§ 1.460 through 1.499 of this part upon written request may be released to congressional committees or subcommittees for program oversight and evaluation if such records pertain to any matter within the jurisdiction of such committee or subcommittee.

(d) *Limitation on disclosure and use.* Records containing patient identifying information disclosed under this section may be disclosed only back to VA and used only to carry out an audit or evaluation purpose, or, to investigate or prosecute criminal or other activities as authorized by a court order entered under § 1.494 of this part.

(Authority: 38 U.S.C. 7332(b)(2)(B))

COURT ORDERS AUTHORIZING DISCLOSURES AND USE

§ 1.490 Legal effect of order.

The records to which §§ 1.460 through 1.499 of this part apply may be disclosed if authorized by an appropriate

order of a court of competent jurisdiction granted after application showing good cause therefore. In assessing good cause the court is statutorily required to weigh the public interest and the need for disclosure against the injury to the patient or subject, to the physician-patient relationship, and to the treatment services. Upon the granting of such order, the court, in determining the extent to which any disclosure of all or any part of any record is necessary, is required by statute to impose appropriate safeguards against unauthorized disclosure. An order of a court of competent jurisdiction to produce records subject to §§1.460 through 1.499 of this part will not be sufficient unless the order reflects that the court has complied with the requirements of 38 U.S.C. 7332(b)(2)(D). Such an order from a Federal court compels disclosure. However, such an order from a State court only acts to authorize the Secretary to exercise discretion pursuant to 38 U.S.C. 5701(b)(5) and 38 CFR 1.511 to disclose such records. It does not compel disclosure.

(Authority: 38 U.S.C. 7332(b)(2)(D))

§ 1.491 Confidential communications.

(a) A court order under §§1.490 through 1.499 of this part may authorize disclosure of confidential communications made by a patient to a treatment program in the course of diagnosis, treatment, or referral for treatment only if:

(1) The disclosure is necessary to protect against an existing threat to life or of serious bodily injury, including circumstances which constitute suspected child abuse and neglect and verbal threats against third parties;

(2) The disclosure is necessary in connection with investigation or prosecution of an extremely serious crime, such as one which directly threatens loss of life or serious bodily injury, including homicide, rape, kidnapping, armed robbery, assault with a deadly weapon, or child abuse and neglect; or

(3) The disclosure is in connection with litigation or an administrative proceeding in which the patient offers testimony or other evidence pertaining to the content of the confidential communications.

(b) [Reserved]

(Authority: 38 U.S.C. 7334)

§ 1.492 Order not applicable to records disclosed without consent to researchers, auditors and evaluators.

A court order under §§1.460 through 1.499 of this part may not authorize qualified personnel, who have received patient identifying information from VA without consent for the purpose of conducting research, audit or evaluation, to disclose that information or use it to conduct any criminal investigation or prosecution of a patient. However, a court order under §1.495 of this part may authorize disclosure and use of records to investigate or prosecute VA personnel.

(Authority: 38 U.S.C. 7334)

§ 1.493 Procedures and criteria for orders authorizing disclosures for noncriminal purposes.

(a) *Application.* An order authorizing the disclosure of patient records covered by §§1.460 through 1.499 of this part for purposes other than criminal investigation or prosecution may be applied for by any person having a legally recognized interest in the disclosure which is sought. The application may be filed separately or as part of a pending civil action in which it appears that the patient records are needed to provide evidence. An application must use a fictitious name, such as John Doe, to refer to any patient and may not contain or otherwise disclose any patient identifying information unless the patient is the applicant or has given a written consent (meeting the requirements of §1.475 of this part) to disclosure or the court has ordered the record of the proceeding sealed from public scrutiny.

(b) *Notice.* The patient and VA facility from whom disclosure is sought must be given:

(1) Adequate notice in a manner which will not disclose patient identifying information to other persons; and

(2) An opportunity to file a written response to the application, or to appear in person, for the limited purpose of providing evidence on whether the statutory and regulatory criteria for the issuance of the court order are met.

(c) *Review of evidence: Conduct of hearing.* Any oral argument, review of evidence, or hearing on the application must be held in the judge's chambers or in some manner which ensures that patient identifying information is not disclosed to anyone other than a party to the proceeding, the patient, or VA, unless the patient requests an open hearing in a manner which meets the written consent requirements of § 1.475 of this part. The proceeding may include an examination by the judge of the patient records referred to in the application.

(d) *Criteria for entry of order.* An order under this section may be entered only if the court determines that good cause exists. To make this determination the court must find that:

(1) Other ways of obtaining the information are not available or would not be effective; and

(2) The public interest and need for the disclosure outweigh the potential injury to the patient, the physician-patient relationship and the treatment services.

(e) *Content of order.* An order authorizing a disclosure must:

(1) Limit disclosure to those parts of the patient's record which are essential to fulfill the objective of the order;

(2) Limit disclosure to those persons whose need for information is the basis for the order; and

(3) Include such other measures as are necessary to limit disclosure for the protection of the patient, the physician-patient relationship and the treatment services; for example, sealing from public scrutiny the record of any proceeding for which disclosure of a patient's record has been ordered.

(Authority: 38 U.S.C. 7334)

§ 1.494 Procedures and criteria for orders authorizing disclosure and use of records to criminally investigate or prosecute patients.

(a) *Application.* An order authorizing the disclosure or use of patient records covered by §§ 1.460 through 1.499 of this part to criminally investigate or prosecute a patient may be applied for by VA or by any person conducting investigative or prosecutorial activities with respect to the enforcement of criminal laws. The application may be filed separately, as part of an application for a subpoena or other compulsory process, or in a pending criminal action. An application must use a fictitious name such as John Doe, to refer to any patient and may not contain or otherwise disclose patient identifying information unless the court has ordered the record of the proceeding sealed from public scrutiny.

(b) *Notice and hearing.* Unless an order under § 1.495 of this part is sought with an order under this section, VA must be given:

(1) Adequate notice (in a manner which will not disclose patient identifying information to third parties) of an application by a person performing a law enforcement function;

(2) An opportunity to appear and be heard for the limited purpose of providing evidence on the statutory and regulatory criteria for the issuance of the court order; and

(3) An opportunity to be represented by counsel.

(c) *Review of evidence: Conduct of hearings.* Any oral argument, review of evidence, or hearing on the application shall be held in the judge's chambers or in some other manner which ensures that patient identifying information is not disclosed to anyone other than a party to the proceedings, the patient, or VA. The proceeding may include an examination by the judge of the patient records referred to in the application.

(d) *Criteria.* A court may authorize the disclosure and use of patient records for the purpose of conducting a criminal investigation or prosecution of a patient only if the court finds that all of the following criteria are met:

(1) The crime involved is extremely serious, such as one which causes or directly threatens loss of life or serious bodily injury including, but not limited to, homicide, rape, kidnapping, armed robbery, assault with a deadly weapon, and child abuse and neglect.

(2) There is a reasonable likelihood that the records will disclose information of substantial value in the investigation or prosecution.

(3) Other ways of obtaining the information are not available or would not be effective.

(4) The potential injury to the patient, to the physician-patient relationship and to the ability of VA to provide services to other patients is outweighed by the public interest and the need for the disclosure.

(5) If the applicant is a person performing a law enforcement function, VA has been represented by counsel independent of the applicant.

(e) *Content of order.* Any order authorizing a disclosure or use of patient records under this section must:

(1) Limit disclosure and use to those parts of the patient's record which are essential to fulfill the objective of the order;

(2) Limit disclosure to those law enforcement and prosecutorial officials who are responsible for, or are conducting, the investigation or prosecution, and limit their use of the records to investigation and prosecution of extremely serious crime or suspected crime specified in the applications; and

(3) Include such other measures as are necessary to limit disclosure and use to the fulfillment on only that public interest and need found by the court.

(Authority: 38 U.S.C. 7332(c))

§ 1.495 Procedures and criteria for orders authorizing disclosure and use of records to investigate or prosecute VA or employees of VA.

(a) *Application.* (1) An order authorizing the disclosure or use of patient records covered by §§ 1.460 through 1.499 of this part to criminally or administratively investigate or prosecute VA (or employees or agents of VA) may be applied for by an administrative, regulatory, supervisory, investigative, law enforcement, or prosecutorial agency having jurisdiction over VA activities.

(2) The application may be filed separately or as part of a pending civil or criminal action against VA (or agents or employees of VA) in which it appears that the patient records are needed to provide material evidence. The application must use a fictitious name, such as John Doe, to refer to any patient and may not contain or otherwise disclose any patient identifying information unless the court has ordered the record of the proceeding sealed from public scrutiny or the patient has given a written consent (meeting the requirements of § 1.475 of this part) to that disclosure.

(b) *Notice not required.* An application under this section may, in the discretion of the court, be granted without notice. Although no express notice is required to VA or to any patient whose records are to be disclosed, upon implementation of an order so granted VA or the patient must be afforded an opportunity to seek revocation or amendment of that order, limited to the presentation of evidence on the statutory and regulatory criteria for the issuance of the court order.

(c) *Requirements for order.* An order under this section must be entered in accordance with, and comply with the requirements of, § 1.493(d) and (e) of this part.

(d) *Limitations on disclosure and use of patient identifying information.* (1) An order entered under this section must require the deletion of patient identifying information from any documents made available to the public.

(2) No information obtained under this section may be used to conduct any investigation or prosecution of a patient, or be used as the basis for an application for an order under § 1.494 of this part.

(Authority: 38 U.S.C. 7334)

§ 1.496 Orders authorizing the use of undercover agents and informants to criminally investigate employees or agents of VA.

(a) *Application.* A court order authorizing the placement of an undercover agent or informant in a VA drug or alcohol abuse, HIV infection, or sickle cell anemia treatment program as an employee or patient may be applied for by any law enforcement or prosecutorial agency which has reason to believe that employees or agents of the VA treatment program are engaged in criminal misconduct.

(b) *Notice.* The VA facility director must be given adequate notice of the application and an opportunity to appear and be heard (for the limited purpose of providing evidence on the statutory and regulatory criteria for the issuance of the court order), unless the application asserts a belief that:

(1) The VA facility director is involved in the criminal activities to be investigated by the undercover agent or informant; or

(2) The VA facility director will intentionally or unintentionally disclose the proposed placement of an undercover agent or informant to the employees or agents who are suspected of criminal activities.

(c) *Criteria.* An order under this section may be entered only if the court determines that good cause exists. To make this determination the court must find:

(1) There is reason to believe that an employee or agent of a VA treatment program is engaged in criminal activity;

(2) Other ways of obtaining evidence of this criminal activity are not available or would not be effective; and

(3) The public interest and need for the placement of an undercover agent or informant in the VA treatment program outweigh the potential injury to patients of the program, physician-patient relationships and the treatment services.

(d) *Content of order.* An order authorizing the placement of an undercover agent or informant in a VA treatment program must:

(1) Specifically authorize the placement of an undercover agent or an informant;

(2) Limit the total period of the placement to six months;

(3) Prohibit the undercover agent or informant from disclosing any patient identifying information obtained from the placement except as necessary to criminally investigate or prosecute employees or agents of the VA treatment program; and

(4) Include any other measures which are appropriate to limit any potential disruption of the program by the placement and any potential for a real or apparent breach of patient confidentiality; for example, sealing from public scrutiny the record of any proceeding for which disclosure of a patient's record has been ordered.

(e) *Limitation on use of information.* No information obtained by an undercover agent or informant placed under this section may be used to criminally investigate or prosecute any patient or as the basis for an application for an order under § 1.494 of this part.

(Authority: 38 U.S.C. 7334)

§§ 1.497–1.499 [Reserved]

RELEASE OF INFORMATION FROM DEPARTMENT OF VETERANS AFFAIRS CLAIMANT RECORDS

NOTE: Sections 1.500 through 1.527 concern the availability and release of information from files, records, reports, and other papers and documents in Department of Veterans Affairs custody pertaining to claims under any of the laws administered by the Department of Veterans Affairs. As to the release of information from Department of Veterans Affairs records other than claimant records, see §§ 1.550 through 1.558. Sections 1.500 through 1.526 implement the provisions of 38 U.S.C. 5701, 5702.

[32 FR 10848, July 25, 1967]

AUTHORITY: Sections 1.500 to 1.527 issued under 72 Stat. 1114, 1236, as amended; 38 U.S.C. 501, 5701.

§ 1.500 General.

(a) Files, records, reports, and other papers and documents pertaining to any claim filed with the Department of Veterans Affairs, whether pending or adjudicated, and the names and addresses of present or former personnel of the armed services, and their dependents, in the possession of the Department of Veterans Affairs, will be deemed confidential and privileged, and no disclosure therefrom will be made except in the circumstances and under the conditions set forth in §§ 1.501 through 1.526.

(b) A claimant may not have access to or custody of official Department of Veterans Affairs records concerning himself or herself nor may a claimant inspect records concerning himself or herself. Disclosure of information from Department of Veterans Affairs records to a claimant or his or her duly authorized agent or representative may be made, however, under the provisions of §§ 1.501 through 1.526.

(c) Each administration, staff office, and field facility head will designate an employee(s) who will be responsible for initial action on (granting or denying) requests to inspect or obtain information from or copies of records under

their jurisdiction and within the purview of §§ 1.501 through 1.526 unless the regulations in this part currently contain such designations. The request should be made to the office concerned (having jurisdiction of the record desired) or, if not known, to the Director or Veterans Assistance Officer in the nearest VA regional office, or to the VA Central Office, 810 Vermont Avenue NW., Washington, DC 20420. Personal contacts should normally be made during the regular duty hours of the office concerned, which are 8 a.m. to 4:30 p.m., Monday through Friday, for VA Central Office and most field facilities. Any legal question arising in a field facility concerning the release of information will be referred to the appropriate Regional Counsel for disposition as contemplated by § 13.401 of this chapter. In central office such legal questions will be referred to the General Counsel. Any administrative question will be referred through administrative channels to the appropriate administration or staff office head.

(d) Upon denial of a request under paragraph (c) of this section, the responsible Department of Veterans Affairs official or designated employee will inform the requester in writing of the denial and advise him or her that he or she may appeal the denial. The requester will also be furnished the title and address of the Department of Veterans Affairs official to whom the appeal should be addressed. (See § 1.527.) In each instance of denial of a request, the denial will be made a matter of record and the record will contain a citation to the specific provision of Department of Veterans Affairs regulations upon which the denial is based.

[24 FR 8174, Oct. 8, 1959, as amended at 32 FR 10848, July 25, 1967; 38 FR 15601, June 14, 1973]

§ 1.501 Release of information by the Secretary.

The Secretary of Veterans Affairs or the Deputy Secretary may release information, statistics, or reports to individuals or organizations when in the Secretary's or Deputy Secretary's judgment such release would serve a useful purpose.

[32 FR 10848, July 25, 1967, as amended at 54 FR 34980, Aug. 23, 1989]

§ 1.502 Disclosure of the amount of monetary benefits.

The monthly rate of pension, compensation, dependency and indemnity compensation, retirement pay, subsistence allowance, or educational assistance allowance of any beneficiary shall be made known to any person who applies for such information.

[32 FR 10848, July 25, 1967]

§ 1.503 Disclosure of information to a veteran or his or her duly authorized representative as to matters concerning the veteran alone.

Information may be disclosed to a veteran or his or her duly authorized representative as to matters concerning himself or herself alone when such disclosure would not be injurious to the physical or mental health of the veteran. If the veteran be deceased, matters concerning him or her may be disclosed to his widow, children, or next of kin if such disclosure will not be injurious to the physical or mental health of the person in whose behalf information is sought or cause repugnance or resentment toward the decedent.

[13 FR 6999, Nov. 27, 1948]

§ 1.504 Disclosure of information to a widow, child, or other claimant.

Information may be disclosed to a widow, widower, child, or other dependent parent or other claimant, or the duly authorized representative of any of these persons as to matters concerning such person alone when such disclosure will not be injurious to the physical or mental health of the person to whom the inquiry relates. If the person concerning whom the information is sought is deceased, matters concerning such person may be disclosed to the next of kin if the disclosures will not be injurious to the physical or mental health of the person in whose behalf the information is sought or cause repugnance or resentment toward the decedent.

[13 FR 6999, Nov. 27, 1948, as amended at 54 FR 34980, Aug. 23, 1989]

§ 1.505 Genealogy.

Information of a genealogical nature when its disclosure will not be detrimental to the memory of the veteran and not prejudicial, so far as may be apparent, to the interests of any living person or to the interests of the Government may be released by the Department of Veterans Affairs or in the case of inactive records may be released by the Archivist of the United States if in the Archivist's custody.

[13 FR 6999, Nov. 27, 1948]

§ 1.506 Disclosure of records to Federal Government departments, State unemployment compensation agencies, and the Office of Servicemembers' Group Life Insurance.

(a) All records or documents required for official purposes by any department or other agency of the U.S. Government or any state unemployment compensation agency acting in an official capacity for the Department of Veterans Affairs shall be furnished in response to an official request, written, or oral, from such department or agency. If the requesting department or agency does not indicate the purpose for which the records or documents are requested and there is doubt as to whether they are to be used for official purposes, the requesting department or agency will be asked to specify the purpose for which they are to be used.

(b) The Under Secretary for Benefits, Director of Insurance Service, or designee of either in Central Office, is authorized to release information to OSGLI (Office of Servicemembers' Group Life Insurance) for the purpose of aiding in the settlement of a particular insurance case.

[33 FR 2994, Feb. 15, 1968]

§ 1.507 Disclosures to members of Congress.

Members of Congress shall be furnished in their official capacity in any case such information contained in the Department of Veterans Affairs files as may be requested for official use. However, in any unusual case, the request will be presented to the Secretary, Deputy Secretary, or staff or administration head for personal action. When the requested information is of a type which may not be furnished a claimant, the member of Congress shall be advised that the information is furnished to him or her confidentially in his official capacity and should be so treated by him or her. (See 38 U.S.C. 5701.) Information concerning the beneficiary designation of a United States Government Life Insurance or National Service Life Insurance policy is deemed confidential and privileged and during the insured's lifetime shall not be disclosed to anyone other than the insured or his or her duly appointed fiduciary unless the insured or the fiduciary authorizes the release of such information.

[32 FR 10848, July 25, 1967]

§ 1.508 Disclosure in cases where claimants are charged with or convicted of criminal offenses.

(a) Where incompetent claimants are charged with, or convicted of, offenses other than those growing out of their relationship with the Department of Veterans Affairs and in which it is desired to disclose information from the files and records of the Department of Veterans Affairs, the Regional Counsel, Under Secretary for Benefits, Veterans Benefits Administration, or the General Counsel if the General Counsel deems it necessary and proper, may disclose to the court having jurisdiction so much of the information from the files and records of the Department of Veterans Affairs relating to the mental condition of such beneficiaries, the same to be available as evidence, as may be necessary to show the mental condition of the accused and the time of its onset. This provision, however, does not alter the general procedure for handling offenses growing out of relations with the Department of Veterans Affairs.

(b) When desired by a U.S. district court, the Regional Counsel or the General Counsel may supply information as to whether any person charged with crime served in the military or naval service of the United States and whether the Department of Veterans Affairs has a file on such person. If the file is desired either by the court or by the prosecution or defense, it may be

produced only in accord with §§ 1.501 through 1.526.

[21 FR 10375, Dec. 28, 1956, as amended at 32 FR 10848, July 25, 1967; 54 FR 34980, Aug. 23, 1989]

§ 1.509 Disclosure to courts in proceedings in the nature of an inquest.

The Under Secretary for Benefits, Veterans Benefits Administration, Regional Counsels, and facility heads are authorized to make disclosures to courts of competent jurisdiction of such files, records, reports, and other documents as are necessary and proper evidence in proceedings in the nature of an inquest into the mental competency of claimants and other proceedings incident to the appointment and discharge of guardians, curators, or conservators to any court having jurisdiction of such fiduciaries in all matters of appointment, discharge, or accounting in such courts.

[32 FR 10848, July 25, 1967]

§ 1.510 Disclosure to insurance companies cooperating with the Department of Justice in the defense of insurance suits against the United States.

Copies of records from the files of the Department of Veterans Affairs will, in the event of litigation involving commercial insurance policies issued by an insurance company cooperating with the Department of Justice in defense of insurance suits against the United States, be furnished to such companies without charge, provided the claimant or his or her duly authorized representative has authorized the release of the information contained in such records. If the release of information is not authorized in writing by the claimant or his or her duly authorized representative, information contained in the files may be furnished to such company if to withhold same would tend to permit the accomplishment of a fraud or miscarriage of justice. However, before such information may be released without the consent of the claimant, the request therefor must be accompanied by an affidavit of the representative of the insurance company, setting forth that litigation is pending, the character of the suit, and the purpose for which the information desired is to be used. If such information is to be used adversely to the claimant, the affidavit must set forth facts from which it may be determined by the General Counsel or Regional Counsel whether the furnishing of the information is necessary to prevent the perpetration of a fraud or other injustice. The averments contained in such affidavit should be considered in connection with the facts shown by the claimant's file, and, if such consideration shows the disclosure of the record is necessary and proper to prevent a fraud or other injustice, information as to the contents thereof may be furnished to the insurance company or copies of the records may be furnished to the court, workmen's compensation, or similar board in which the litigation is pending upon receipt of a subpoena duces tecum addressed to the Secretary of Veterans Affairs, or the head of the office in which the records desired are located. In the event the subpoena requires the production of the file, as distinguished from the copies of the records, no expense to the Department of Veterans Affairs may be involved in complying therewith, and arrangements must be made with the representative of the insurance company causing the issuance of the subpoena to insure submission of the file to the court without expense to the Department of Veterans Affairs.

[32 FR 10848, July 25, 1967]

§ 1.511 Disclosure of claimant records in connection with judicial proceedings generally.

(a)(1) Where a suit (or legal proceeding) has been threatened or instituted against the Government, or a prosecution against a claimant has been instituted or is being contemplated, the request of the claimant or his or her duly authorized representative for information, documents, reports, etc., shall be acted upon by the General Counsel in Central Office, or the Regional Counsel for the field facility, who shall determine the action to be taken with respect thereto. Where the records have been sent to the Department of Justice in connection with any such suit (or legal proceeding), the request will be referred to the Department of Justice, Washington, DC,

through the office of the General Counsel, for attention. Where the records have been sent to an Assistant U.S. Attorney, the request will be referred by the appropriate Regional Counsel to the Assistant U.S. Attorney. In all other cases where copies of documents or records are desired by or on behalf of parties to a suit (or legal proceeding), whether in a Federal court or any other, such copies shall be disclosed as provided in paragraphs (b) and (c) of this section where the request is accompanied by court process, or paragraph (e) of this section where the request is not accompanied by court process. A court process, such as a court order or subpoena duces tecum should be addressed to either the Secretary of Veterans Affairs or to the head of the field facility at which the records desired are located. The determination as to the action to be taken upon any request for the disclosure of claimant records received in this class of cases shall be made by the component having jurisdiction over the subject matter in Central Office, or the division having jurisdiction over the subject matter in the field facility, except in those cases in which representatives of the component or division have determined that the records desired are to be used adversely to the claimant, in which event the process will be referred to the General Counsel in Central Office or to the Regional Counsel for the field facility for disposition.

(2) Where a claim under the provisions of the Federal Tort Claims Act has been filed, or where such a claim can reasonably be anticipated, no information, documents, reports, etc., will be disclosed except through the Regional Counsel having jurisdiction, who will limit the disclosure of information to that which would be available under discovery proceedings, if the matter were in litigation. Any other information may be disclosed only after concurrence in such disclosure is provided by the General Counsel.

(b) *Disclosures in response to Federal court process*—(1) *Court order*. Except for drug and alcohol abuse, human immunodeficiency virus and sickle cell anemia treatment records, which are protected under 38 U.S.C. 7332, where the records sought are maintained in a VA Privacy Act system of records, and are retrieved by the name or other personal identifier of a living claimant who is a citizen of the United States or an alien lawfully admitted for permanent residence, a Federal court order is the process necessary for the disclosure of such records. Upon receipt of a Federal court order directing disclosure of claimant records, such records will be disclosed. Disclosure of records protected under 38 U.S.C. 7332 will be made in accordance with provisions of paragraph (g) of this section.

(2) *Subpoena*. Except for drug and alcohol abuse, human immunodeficiency virus and sickle cell anemia treatment records, which are protected under 38 U.S.C. 7332, where the records sought are maintained in a VA Privacy Act system of records, and are retrieved by the name or other personal identifier of a claimant, a subpoena is not sufficient authority for the disclosure of such records and such records will not be disclosed, unless the claimant is deceased, or either is not a citizen of the United States, or is an alien not lawfully admitted for permanent residence. Where one of these exceptions applies, upon receipt of a Federal court subpoena, such records will be disclosed. Additionally, where the subpoena is accompanied by authorization from the claimant, disclosure will be made. Regarding the disclosure of medical records pertaining to drug and alcohol abuse, human immunodeficiency virus and sickle cell anemia treatment, a subpoena is insufficient for such disclosure. Specific provisions for the disclosure of these records are set forth in paragraph (g) of this section.

(3) A disclosure of records in response to the receipt of a Federal court process will be made to those individuals designated in the process to receive such records, or to the court from which the process issued. Where original records are produced, they must remain at all times in the custody of a representative of the Department of Veterans Affairs, and, if offered and received in evidence, permission should be obtained to substitute a copy so that the original may remain intact in the record. Where a court process is issued by or on behalf of a party litigant other than the United States,

such party litigant must prepay the costs of copies in accordance with fees prescribed by §1.526(i) and any other costs incident to producing the records.

(c) *Disclosures in response to state or local court process*—(1) *State or local court order*. Except for drug and alcohol abuse, human immunodeficiency virus and sickle cell anemia treatment records, which are protected under 38 U.S.C. 7332, where the records sought are maintained in a VA Privacy Act system of records, and are retrieved by the name or other personal identifier of a living claimant who is a citizen of the United States or an alien lawfully admitted for permanent residence, a State or local court order is the process necessary for disclosure of such records. Upon receipt of a State or local court order directing disclosure of claimant records, disclosure of such records will be made in accordance with the provisions set forth in paragraph (c)(3) of this section. Disclosure of records protected under 38 U.S.C. 7332 will be made in accordance with provisions of paragraph (g) of this section.

(2) *State or local court subpoena*. Except for drug and alcohol abuse, human immunodeficiency virus and sickle cell anemia treatment records, which are protected under 38 U.S.C. 7332, where the records sought are maintained in a VA Privacy Act system of records, and are retrieved by the name or other personal identifier of a claimant, a subpoena is not sufficient authority for disclosure of such records and such records will not be disclosed unless the claimant is deceased, or, either is not a citizen of the United States, or is an alien not lawfully admitted for permanent residence. Where one of these exceptions applies, upon receipt of a State or local court subpoena directing disclosure of claimant records, disclosure of such records will be made in accordance with the provisions set forth in paragraph (c)(3), of this section. Regarding the disclosure of 7332 records, a subpoena is insufficient for such disclosure. Specific provisions for the disclosure of these records are set forth in paragraph (g) of this section.

(3) Where the disclosure provisions of paragraph (c) (1) or (2) of this section apply, disclosure will be made as follows:

(i) When the process presented is accompanied by authority from the claimant; or,

(ii) In the absence of claimant disclosure authority, the Regional Counsel having jurisdiction must determine whether the disclosure of the records is necessary to prevent the perpetration of fraud or other injustice in the matter in question. To make such a determination, the Regional Counsel may require such additional documentation, e.g., affidavit, letter of explanation, or such other documentation which would detail the need for such disclosure, set forth the character of the pending suit, and the purpose for which the documents or records sought are to be used as evidence. The claimant's record may also be considered in the making of such determination. Where a court process is received, and the Regional Counsel finds that additional documentation will be needed to make the foregoing determination, the Regional Counsel, or other employee having reasonable knowledge of the requirements of this regulation, shall contact the person causing the issuance of such court process, and advise that person of the need for additional documentation. Where a court appearance is appropriate, and the Regional Counsel has found that there is an insufficient basis upon which to warrant a disclosure of the requested information, the Regional Counsel, or other employee having reasonable knowledge of the requirement of this regulation and having consulted with the Regional Counsel, shall appear in court and advise the court that VA records are confidential and privileged and may be disclosed only in accordance with applicable Federal regulations, and to further advise the court of such regulatory requirements and how they have not been satisified. Where indicated, the Regional Counsel will take appropriate action to have the matter of disclosure of the affected records removed to Federal court.

(4) Any disclosure of records in response to the receipt of State or local court process will be made to those individuals designated in the process to receive such records, or to the court

from which such process issued. Payment of the fees as prescribed by § 1.526(i), as well as any other cost incident to producing the records, must first be deposited with the Department of Veterans Affairs by the party who caused the process to be issued. The original records must remain at all times in the custody of a representative of the Department of Veterans Affairs, and, if there is an offer and admission of any record or document contained therein, permission should be obtained to substitute a copy so that the original may remain intact in the record.

(d) Notice requirements where disclosures are made pursuant to court process. Whenever a disclosure of Privacy Act protected records is made in response to the process of a Federal, State, or local court, the custodian of the records disclosed will make reasonable efforts to notify the subject of such records that such subject's records were disclosed to another person under compulsory legal process. Such notice should be accomplished when the process compelling disclosure becomes a matter of public record. Generally, a notice sent to the last known address of the subject would be sufficient to comply with this requirement.

(e) Disclosures in response to requests when not accompanied by court process. Requests received from attorneys or others for copies of records for use in suits in which the Government is not involved, not accompanied by a court process, will be handled by the component or division having jurisdiction over the subject matter. If the request can be complied with under § 1.503 or § 1.504, and under the Privacy Act (to the extent that such records are protected by the Privacy Act), the records requested will be disclosed upon receipt of the required fee. If, however, the records cannot be furnished under such authority, the applicant will be advised of the procedure to obtain copies of records as set forth in paragraphs (b) and (c) of this section.

(f) Suits by or against the Secretary under 38 U.S.C. 3720. Records pertaining to the loan guaranteed, insured, or made by the Department of Veterans Affairs may be made available by the General Counsel or the Regional Counsel subject to the usual rules of evidence, and where authorized under the Privacy Act, after clearance with the Department of Justice or U.S. Attorney if appropriate.

(g) Disclosure of drug abuse, alcohol abuse, human immunodeficiency virus and sickle cell anemia treatment or related records under court process. Disclosure of these types of records, which are protected from unauthorized disclosure under 38 U.S.C. 7332, may be made only in response to an appropriate order of a court of competent jurisdiction granted after application showing good cause therefore. In assessing good cause the court is required to weigh the public interest and the need for disclosure against the injury to the patient or subject, to the physician-patient relationship, and to the treatment services. The court, in determining the extent to which any disclosure of all or any part of any record is necessary, shall impose appropriate safeguards against unauthorized disclosure. As to a Federal court order satisfying the requirements of this paragraph, the records will be disclosed as provided in such order. As to a State or local court order satisfying the requirements of this subsection, the disclosure of the records involved is conditioned upon satisfying the provisions set forth in paragraph (c)(3) of this section. If the aforementioned section is satisfied, and a disclosure of records is to be forthcoming, the records will be disclosed as provided in the court order.

(Authority: 5 U.S.C. 552; 5 U.S.C. 552a; 38 U.S.C. 5701 and 38 U.S.C. 7332)

[56 FR 15833, Apr. 18, 1991]

§ 1.512 Disclosure of loan guaranty information.

(a) The disclosure of records or information contained in loan guaranty files is governed by the Freedom of Information Act, 5 U.S.C. 552; the Privacy Act, 5 U.S.C. 552a; the confidentiality provisions of 38 U.S.C. 5701, and the provisions of 38 CFR 1.500–1.584. In addition, the release of names and addresses and the release of certificates of reasonable value, appraisal reports, property inspection reports, or reports

of inspection on individual water supply and sewage disposal systems shall be governed by paragraphs (b), (c), (d), and (e) of this section.

(b)(1) Upon request, any person is entitled to obtain copies of certificates of reasonable value, appraisal reports, property inspection reports, or reports of inspection on individual water supply and sewage disposal systems provided that the individual identifiers of the veteran-purchaser(s) or dependents are deleted prior to release of such documents. However, individual identifiers may be disclosed in accordance with paragraph (b)(2) of this section. The address of the property being appraised or inspected shall not be considered an individual identifier.

(Authority: 38 U.S.C. 5701(a), (c))

(2) Individual identifiers of veteran purchasers or dependents may be disclosed when disclosure is made to the following:

(i) The individual purchasing the property;

(ii) The current owner of the property;

(iii) The individual that requested the appraisal or report;

(iv) A person or entity which is considering making a loan to an individual with respect to the property concerned; or

(v) An attorney, real estate broker, or any other agent representing any of these persons.

(Authority: 38 U.S.C. 5701(c), (h)(2)(D))

(c)(1) The Secretary may release the name, address, or both, and may release other information relating to the identity of an applicant for or recipient of a Department of Veterans Affairs-guaranteed, insured, or direct loan, specially adapted housing grant, loan to finance acquisition of Department of Veterans Affairs-owned property, release of liability, or substitution of entitlement to credit reporting agencies, companies or individuals extending credit, depository institutions, insurance companies, investors, lenders, employers, landlords, utility companies and governmental agencies for any of the purposes specified in paragraph (c)(2) of this section.

(2) A release may be made under paragraph (c)(1) of this section:

(i) To enable such parties to provide the Department of Veterans Affairs with data which assists in determining the creditworthiness, credit capacity, income or financial resources of the applicant for or recipient of loan guaranty administered benefits, or verifying whether any such data previously received is accurate; or

(ii) To enable the Secretary to offer for sale or other disposition any loan or installment sale contract.

(Authority: 38 U.S.C. 5701(h)(2)(A), (B), (C))

(d) Upon request, the Secretary may release information relating to the individual's loan transaction to credit reporting agencies, companies or individuals extending credit, depository institutions, insurance companies, investors, lenders, employers, landlords, utility companies and governmental agencies where necessary in connection with a transfer of information on the status of a Department of Veterans Affairs loan account to persons or organizations proposing to extend credit or render services or other benefits to the borrower in order that the person or organization may determine whether to extend credit or render services or other benefits to the borrower. Such releases shall be made only if the person or organization seeking the information furnishes the individual's name, address or other information necessary to identify the individual.

(Authority: 38 U.S.C. 5701(e), (h)(2)(A) and (D))

(e) The Secretary shall maintain information in the loan guaranty file consisting of the date, notice and purpose of each disclosure, and the name and address of the person to whom the disclosure is made from the loan guaranty files.

(Authority: 38 U.S.C. 5701(h)(2)(D), 5 U.S.C. 552a(c))

[47 FR 11279, Mar. 16, 1982]

§ 1.513 Disclosure of information contained in Armed Forces service and related medical records in Department of Veterans Affairs custody.

(a) *Service records.* Information received by the Department of Veterans Affairs from the Departments of the Army, Navy, Air Force, and the Department of Transportation relative to the military or naval service of a claimant is furnished solely for the official use of the Department of Veterans Affairs but such information may be disclosed under the limitations contained in §§ 1.501 through 1.526.

(b) *Medical records.* Information contained in the medical records (including clinical records and social data) may be released under the following conditions:

(1) Complete transcript of résumé or medical records on request to:

(i) The Department of the Army.

(ii) The Department of the Navy (including naval aviation and United States Marine Corps).

(iii) The Department of the Air Force.

(iv) The Department of Transportation (Coast Guard).

(v) Selective Service (in case of registrants only).

(vi) Federal or State hospitals or penal institutions when the veteran is a patient or inmate therein.

(vii) United States Public Health Service, or other governmental or contract agency in connection with research authorized by, or conducted for, the Department of Veterans Affairs.

(viii) Registered civilian physicians, on the request of the individual or his or her legal representative, when required in connection with the treatment of the veteran. (The transcript or resume should be accompanied by the statement ''it is expected that the information contained herein will be treated as confidential, as is customary in civilian professional medical practice.'')

(ix) The veteran on request, except information contained in the medical record which would prove injurious to his or her physical or mental health.

(x) The next of kin on request of the individual, or legal representative, when the information may not be disclosed to the veteran because it will prove injurious to his or her physical or mental health, and it will not be injurious to the physical or mental health of the next of kin or cause repugnance or resentment toward the veteran; and directly to the next of kin, or legal representative, when the veteran has been declared to be insane or is dead.

(xi) Health and social agencies, on the authority of the veteran or his or her duly authorized representative.

(2) In addition to the authorizations in paragraph (b)(1) of this section, the Department of Justice, the Department of the Treasury, and the U.S. Postal Service may, on request, be given pertinent information from medical records for use in connection with investigations conducted by these departments. Each such request shall be considered on its merits, and the information released should be the minimum necessary in connection with the investigation conducted by these departments.

(3) Compliance with court orders calling for the production of medical records in connection with litigation or criminal prosecutions will be effected in accordance with § 1.511.

[13 FR 7001, Nov. 27, 1948, as amended at 32 FR 10849, July 25, 1967; 60 FR 63938, Dec. 13, 1995]

§ 1.514 Disclosure to private physicians and hospitals other than Department of Veterans Affairs.

(a) When a beneficiary elects to obtain medical attention as a private patient from a private practitioner or in a medical center other than a Department of Veterans Affairs hospital, there may be disclosed to such private practitioner or head of such medical center (Federal, State, municipal, or private), such information as to the medical history, diagnosis, findings, or treatment as is requested, including the loan of original X-ray films, whether Department of Veterans Affairs clinical X-rays or service department entrance and separation X-rays, provided there is also submitted a written authorization from the beneficiary or his or her duly authorized representative. The information will be supplied without charge directly to the private physician or medical center head and not

through the beneficiary or representative. In forwarding this information, it will be accompanied by the stipulations that it is released with consent of or on behalf of the patient and that the information will be treated as confidential, as is customary in civilian professional medical practice.

(b) Such information may be released without charge and without consent of the patient or his or her duly authorized representative when a request for such information is received from:

(1) The superintendent of a State hospital for psychotic patients, a commissioner or head of a State department of mental hygiene, or head of a State, county, or city health department; or

(2) Any fee basis physician or institution in connection with authorized treatment of the veteran as a Department of Veterans Affairs beneficiary; or

(3) Any physician or medical installation treating the veteran under emergency conditions.

[34 FR 13368, Aug. 19, 1969, as amended at 54 FR 34980, Aug. 23, 1989]

§ 1.514a Disclosure to private psychologists.

When a beneficiary elects to obtain therapy or analysis as a private patient from a private psychologist, such information in the medical record as may be pertinent may be released. Generally, only information developed and documented by Department of Veterans Affairs psychologists will be considered pertinent, although other information from the medical record may be released if it is determined to be pertinent and will serve a useful purpose to the private psychologist in rendering his or her services. Information will be released under this section upon receipt of the written authorization of the beneficiary or his or her duly authorized representative. Information will be forwarded to private psychologists directly, not through the beneficiary or representative, without charge and with the stipulation that it is released with consent of or on behalf of the patient and must be treated as confidential as is customary in regular professional practice.

[34 FR 13368, Aug. 19, 1969]

§ 1.514b Disclosures to procurement organizations.

A VHA health care facility may disclose the name and home address of an ''individual'' as defined in § 1.460 to an authorized representative of a ''procurement organization'' as also defined in § 1.460 for the purpose of facilitating a determination by the procurement organization of whether the individual is a suitable potential organ, eye, or tissue donor if:

(a) The individual is currently an inpatient in a VHA health care facility;

(b) The individual is, in the clinical judgment of the individual's primary health care provider, near death or is deceased as defined in § 1.460;

(c) The VHA health care facility has a signed agreement with the procurement organization in accordance with the applicable requirements of the United States Department of Health and Human Services (HHS); and

(d) The VHA health care facility has confirmed with HHS that it has certified or recertified the organ procurement organization as provided in the applicable HHS regulations. VA medical centers must verify annually in January of each calendar year with FDA that an eye bank or tissue bank has complied with the FDA registration requirements of 21 CFR part 1271 and that the registration status is active before permitting an eye bank or tissue bank to receive protected health information.

(Authority: 38 U.S.C. 5701(k), 7332(b)(2)(E))

[72 FR 48242, Aug. 23, 2007, as amended at 73 FR 65260, Nov. 3, 2008]

§ 1.515 Disclosure of information to participate in state prescription drug monitoring programs.

(a) *General.* Information covered by §§ 1.500 through 1.527 of this part may be disclosed to State Prescription Drug Monitoring Programs pursuant to the limitations set forth in paragraph (c) of this section.

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

Controlled substance means any substance identified in 21 CFR part 1308 as a schedule II, III, IV, or V controlled substance.

State Prescription Drug Monitoring Program (PDMP) means a State controlled substance monitoring program, including a program approved by the Secretary of Health and Human Services under section 399O of the Public Health Service Act (42 U.S.C. 280g–3).

(c) *Participation in PDMPs.* VA may disclose to PDMPs any of the following information concerning the prescription of controlled substances:

(1) Demographic information of veterans and dependents of veterans who are prescribed a controlled substance. Examples include name, address, and telephone number.

(2) Information about the prescribed controlled substances. Examples include the identification of the substance by a national drug code number, quantity dispensed, number of refills ordered, whether the substances were dispensed as a refill of a prescription or as a first-time request, and date of origin of the prescription.

(3) Prescriber information. Examples include the prescriber's United States Drug Enforcement Administration-issued identification number authorizing the individual to prescribe controlled substances and United States Department of Health and Human Services-issued National Provider Identifier number.

(Authority: 5 U.S.C. 552a; 38 U.S.C. 5701, 7332; 45 CFR 164.512(b))

[78 FR 9593, Feb. 11, 2013]

§ 1.516 Disclosure of information to undertaker concerning burial of a deceased veteran.

When an undertaker requests information believed to be necessary in connection with the burial of a deceased veteran, such as the name and address of the beneficiary of the veteran's Government insurance policy, name and address of the next of kin, rank or grade of veteran and organization in which he or she served, character of the veteran's discharge, or date and place of birth of the veteran, and it appears that the undertaker is holding the body awaiting receipt of the information requested, the undertaker, in such instances, may be considered the duly authorized representative of the deceased veteran for the purpose of obtaining said information. In ordinary cases, however, the undertaker will be advised that information concerning the beneficiary of a Government insurance policy is confidential and cannot be disclosed; the beneficiary will be advised immediately of the inquiry, and the furnishing of the desired information will be discretionary with the beneficiary. In no case will the undertaker be informed of the net amount due under the policy or furnished information not specifically mentioned in this paragraph.

[46 FR 62059, Dec. 22, 1981]

§ 1.517 Disclosure of vocational rehabilitation and education information to educational institutions cooperating with the Department of Veterans Affairs.

Requests from educational institutions and agencies cooperating with the Department of Veterans Affairs in the vocational rehabilitation and education of veterans for the use of vocational rehabilitation and education records for research studies will be forwarded to central office with the facility head's recommendation for review by the Under Secretary for Benefits. Where the request to conduct a research study is approved by the Under Secretary for Benefits, the facility head is authorized by this section to release information for such studies from vocational rehabilitation and education records as required: *Provided, however,* That any data or information obtained shall not be published without prior approval of the Under Secretary for Benefits and that data contained in published material shall not identify any individual veteran.

[30 FR 6435, May 8, 1965]

§ 1.518 Addresses of claimants.

(a) It is the general policy of the Department of Veterans Affairs to refuse to furnish addresses from its records to persons who desire such information for debt collection, canvassing, harassing or for propaganda purposes.

(b) The address of a Department of Veterans Affairs claimant as shown by Department of Veterans Affairs files may be furnished to:

(1) Duly constituted police or court officials upon official request and the submission of a certified copy either of

the indictment returned against the claimant or of the warrant issued for his or her arrest.

(2) Police, other law enforcement agencies, or Federal, State, county, or city welfare agencies upon official written request showing that the purpose of the request is to locate a parent who has deserted his or her child or children and that other reasonable efforts to obtain an address have failed. The address will not be released when such disclosure would be prejudicial to the mental or physical health of the claimant. When an address is furnished it will be accompanied by the stipulation that it is furnished on a confidential basis and may not be disclosed to any other individual or agency.

(c) When an address is requested that may not be furnished under §§ 1.500 through 1.526, the person making the request will be informed that a letter, or in those cases involving judicial actions, the process or notice in judicial proceedings, enclosed in an unsealed envelope showing no return address, with the name of the addressee thereon, and bearing sufficient postage to cover mailing costs will be forwarded by the Department of Veterans Affairs. If a request indicates that judicial action is involved in which a process or notice in judicial proceedings is required to be forwarded, the Department of Veterans Affairs will inform the person who requests the forwarding of such a document that the envelope must bear sufficient postage to cover costs of mailing and certified or registered mailing fees, including cost of obtaining receipt for the certified or registered mail when transmission by this type special mail is desired. At the time the letter, process, or notice in judicial proceedings is forwarded, the facility's return address will be placed on the envelope. When the receipt for certified or registered mail or the undelivered envelope is returned to the Department of Veterans Affairs, the original sender will be notified thereof: However, the receipt or the envelope will be retained by the Department of Veterans Affairs. This provision will be applicable only when it does not interfere unduly with the functions of the Service or division concerned. In no event will letters be forwarded to aid in the collection of debts or for the purpose of canvassing, harassing, or propaganda. Neither will a letter be forwarded if the contents could be harmful to the physical or mental health of the recipient.

(d) Subject to the conditions set forth in § 1.922, the Department of Veterans Affairs may disclose to consumer reporting agencies information contained in a debtor's claims folder. Such information may include the debtor's name and/or address, Department of Veterans Affairs file number, Social Security number, and date of birth.

(Authority: 38 U.S.C. 5701(g))

[33 FR 10516, July 24, 1968 and 35 FR 5176, Mar. 27, 1970, as amended at 46 FR 62059, Dec. 22, 1981]

§ 1.519 Lists of names and addresses.

(a) Any organization wanting a list of names and addresses of present or former personnel of the armed services and their dependents from the Department of Veterans Affairs must make written application to the Department of Veterans Affairs Controller, except lists of educationally disadvantaged veterans should be requested from the Director of the nearest regional office. The application must:

(1) Clearly identify the type or category of names and addresses sought;

(2) Furnish proof satisfactory to the Department of Veterans Affairs that the organization seeking the list is a ''nonprofit organization.'' Normally, evidence establishing that the organization is exempt from taxation in accordance with the provisions of 26 U.S.C. 501 or is a governmental body or institution will be accepted as satisfying this criteria;

(3) Contain a statement clearly setting forth the purpose for which the list is sought, the programs and the resources the organization proposes to devote to this purpose, and establish how such purpose is ''directly connected with the conduct of programs and the utilization of benefits'' under title 38, U.S.C.; and

(4) Contain a certification that the organization, and all members thereof who will have access to the list, are aware of the penalty provisions of 38 U.S.C. 5701(f) and will not use the list

for any purpose other than that stated in the application.

(b) If the Director of the regional office concerned finds that the organization requesting the list of names and addresses of educationally disadvantaged veterans is a nonprofit organization and operates an approved program of special secondary, remedial, preparatory or other educational or supplementary assistance to veterans as provided under subchapter V, title 38 U.S.C., then he or she may authorize the release of such names and addresses to the organization requesting them.

(c) The Associate Deputy Assistant Secretary for Information Resources Management is authorized to release lists of names and addresses to organizations which have applied for such lists in accordance with paragraph (a) of this section, if he or she finds that the purpose for which the organization desires the names and addresses is directly connected with conduct of programs and the utilization of benefits under title 38 U.S.C. Lists of names and addresses authorized to be released pursuant to this paragraph shall not duplicate lists released to other elements, segments, or chapters of the same organization.

(d) If the list requested is one that the Department of Veterans Affairs has previously compiled or created, in the same format, to carry out one or more of its basic program responsibilities and it is determined that it can be released, the list may be furnished without charge. For other types of lists, a charge will be made in accordance with the provisions of § 1.526.

(e) Upon denial of a request, the Department of Veterans Affairs Controller or Regional Office Director will inform the requester in writing of the denial and the reasons therefor and advise the organization that it may appeal the denial to the General Counsel. In each instance of a denial of a request, the denial and the reasons therefor will be made a matter of record.

(f) Section 5701(f), title 38 U.S.C., provides that any organization, or member thereof, which uses the names and addresses furnished it for any purpose other than one directly connected with the conduct of programs and the utilization of benefits under title 38 U.S.C., shall be fined not more than $500 in the case of the first offense and not more than $5,000 in the case of the subsequent offenses. Any instance in which there is evidence of a violation of these penal provisions will be reported in accordance with § 14.560.

(Approved by the Office of Management and Budget under control number 2900–0438)

[38 FR 15601, June 14, 1973, as amended at 46 FR 62059, Dec. 22, 1981; 49 FR 32848, Aug. 17, 1984; 56 FR 59218, Nov. 25, 1991; 84 FR 12125, Apr. 1, 2019]

§ 1.520 Confidentiality of social data.

Persons having access to social data will be conscious of the fact that the family, acquaintances, and even the veteran have been willing to reveal these data only on the promise that they will be held in complete confidence. There will be avoided direct, ill-considered references which may jeopardize the personal safety of these individuals and the relationship existing among them, the patient, and the social worker, or may destroy their mutual confidence and influence, rendering it impossible to secure further cooperation from these individuals and agencies. Physicians in talking with beneficiaries will not quote these data directly but will regard them as indicating possible directions toward which they may wish to guide the patient's self-revelations without reproaching the patient for his or her behavior or arousing natural curiosity or suspicion regarding any informant's statement. The representatives of service organizations and duly authorized representatives of veterans will be especially cautioned as to their grave responsibility in this connection.

[46 FR 62059, Dec. 22, 1981]

§ 1.521 Special restrictions concerning social security records.

Information received from the Social Security Administration may be filed in the veteran's claims folder without special provisions. Such information will be deemed privileged and may not be released by the Department of Veterans Affairs except that information concerning the amount of social security benefits paid to a claimant or the

amount of social security tax contributions made by the claimant may be disclosed to the claimant or his or her duly authorized representative. Any request from outside the Department of Veterans Affairs for other social security information will be referred to the Social Security Administration for such action as they deem proper.

[27 FR 9599, Sept. 28, 1962]

§ 1.522 Determination of the question as to whether disclosure will be prejudicial to the mental or physical health of claimant.

Determination of the question when disclosure of information from the files, records, and reports will be prejudicial to the mental or physical health of the claimant, beneficiary, or other person in whose behalf information is sought, will be made by the Chief Medical Director; Chief of Staff of a hospital; or the Director of an outpatient clinic.

[33 FR 19009, Dec. 20, 1968]

§ 1.523 To commanding officers of State soldiers' homes.

When a request is received in a Department of Veterans Affairs regional office, center, or medical center from the commanding officer of a State soldiers' home for information other than information relative to the character of the discharge from a Department of Veterans Affairs center or medical center concerning a veteran formerly domiciled or hospitalized therein, the provisions of § 1.500 are applicable, and no disclosure will be made unless the request is accompanied by the authorization outlined in § 1.503. However, station heads, upon receipt of a request from the commanding officer of a State soldiers' home for the character of the discharge of a veteran from a period of hospital treatment or domiciliary care as a beneficiary of the Department of Veterans Affairs, will comply with the request, restricting the information disclosed solely to the character of the veteran's discharge from such treatment or care. Such information will be disclosed only upon receipt of a specific request therefor from the commanding officer of a State soldiers' home.

[30 FR 6435, May 8, 1965. Redesignated at 78 FR 9593, Feb. 11, 2013]

§ 1.524 Persons authorized to represent claimants.

A duly authorized representative will be:

(a) Any person authorized in writing by the claimant to act for him or her,

(b) An attorney who has filed the declaration required by § 14.629(b)(1) of this chapter, or

(c) His or her legally constituted fiduciary, if the claimant is incompetent. Where for proper reasons no legally constituted fiduciary has been or will be appointed, his or her spouse, his or her children, or, if the claimant is unmarried, either of his or her parents shall be recognized as the fiduciary of the claimant.

[33 FR 6536, Apr. 30, 1968]

§ 1.525 Inspection of records by or disclosure of information to recognized representatives of organizations and recognized attorneys.

(a)(1) The accredited representatives of recognized organizations (§ 14.627 of this chapter) holding appropriate power of attorney and recognized attorneys (§ 14.629(b) of this chapter) with the written authorization of the claimant may, subject to the restrictions imposed by paragraph (a)(2) of this section, inspect the claims, insurance and allied folders of any claimant upon the condition that only such information contained therein as may be properly disclosed under §§ 1.500 through 1.526 will be disclosed by him or her to the claimant or, if the claimant is incompetent, to his or her legally constituted fiduciary. Under the same restrictions, it is permissible to release information from and permit inspection of loan guaranty folders in which a request for a waiver of the debt of a veteran or his or her spouse has been received, or where there has been a denial of basic eligibility for loan guaranty benefits. All other information in the files shall be treated as confidential and will be used only in determining the status of the cases inspected or in connection with the presentation to officials of the Department of Veterans Affairs of the

claim of the claimant. The heads of field facilities and the directors of the services concerned in Central Office will each designate a responsible officer to whom requests for all files must be made, except that managers of centers with insurance activities will designate two responsible officials, recommended by the division chiefs concerned, one responsible for claims and allied folders and the other for insurance files. The term *claimant* as used in this paragraph includes insureds.

(2) In the case of a living veteran a representative acting under a power of attorney from any person not acting on behalf of the veteran will not be permitted to review the records of the veteran or be furnished any information therefrom to which the person is not entitled, *i.e.*, information not relating to such person alone. Powers of attorney submitted by the other person will be considered ''Limited'' and will be so noted when associated with the veteran's records. The provisions of this subparagraph are also applicable to recognized attorneys and the requisite declarations filed by them.

(3) When power of attorney does not obtain, the accredited representative will explain to the designated officer of the Department of Veterans Affairs the reason for requesting information from the file, and the information will be made available only when in the opinion of the designated officer it is justified; in no circumstances will such representatives be allowed to inspect the file; in such cases a contact report will be made out and attached to the case, outlining the reasons which justify the verbal or written release of the information to the accredited representative.

(4) In any case where there is an unrevoked power of attorney or declaration of representation, no persons or organizations other than the one named in such document shall be afforded information from the file except under the conditions set forth in § 14.629(b)(2) of this chapter. When any claimant has filed notice with the Department of Veterans Affairs that he or she does not want his or her file inspected, such file will not be made available for inspection.

(b)(1) Inspection of folders by accredited representatives or recognized attorneys holding a written authorization where such cases are being processed shall be in space assigned for such inspection. Otherwise station heads may permit inspection of folders at the desks of the accredited representatives, in the office(s) which they regularly occupy.

(2) An insured or after maturity of the insurance by death of the insured, the beneficiary, may authorize the release to a third person of such insurance information as the insured or the beneficiary would be entitled to receive, provided there is submitted to the Department of Veterans Affairs, a specific authorization in writing for this purpose.

(3) Unless otherwise authorized by the insured or the beneficiary, as the case may be, such authorized representative, recognized attorney or accredited representative shall not release information as to the designated beneficiary to anyone other than the insured or to the beneficiary after death of the insured. Otherwise, information in the insurance file shall be subject to the provisions of §§ 1.500 through 1.526.

(4) Clinical records and medical files, including files for outpatient treatment, may be inspected by accredited representatives or recognized attorneys holding a written authorization only to the extent such records or parts thereof are incorporated in the claims folder, or are made available to Department of Veterans Affairs personnel in the adjudication of the claim. Records or data in clinical or medical files which are not incorporated in the claims folder or which are not made available to Department of Veterans Affairs personnel for adjudication purposes will not be inspected by anyone other than those employees of the Department of Veterans Affairs whose duties require same for the purpose of clinical diagnosis or medical treatment.

(5) Under no circumstances shall any paper be removed from a file, except by

a Department of Veterans Affairs employee, for purpose of having an authorized copy made. Copying of material in a file shall not be permitted except in connection with the performance of authorized functions under the power of attorney or requisite declaration of a recognized attorney.

(6) In any case involving litigation against the Government, whether contemplated or initiated, inspection, subject to the foregoing, shall be within the discretion of the General Counsel or Regional Counsel, except that in insurance suits under 38 U.S.C. 1975, 1984, inspection shall be within the discretion of the official having jurisdiction of the claim. Files in such cases may be released to the Department of Justice, but close liaison will be maintained to insure their return intact upon termination of the litigation.

(c) Facility heads and the directors of the services concerned in central office will be responsible for the administrative compliance with and accomplishment of the foregoing within their jurisdiction, and any violations of the prescribed conditions for inspection of files or release of information therefrom will be brought to the immediate attention of the Secretary.

(d) Any person holding power of attorney, a recognized attorney who has filed the requisite declaration, or the accredited representative of a recognized organization holding power of attorney shall be supplied with a copy of each notice to the claimant respecting the adjudication of the claim. If a claimant dies before action on the claim is completed, the person or organization holding power of attorney or the attorney who has filed the requisite declaration may continue to act until the action is completed except where the power of attorney or requisite declaration was filed on behalf of a dependent.

(e) When in developing a claim the accredited representative of a recognized organization finds it necessary to call upon a local representative to assemble information or evidence, he or she may make such disclosures to the local representative as the circumstances of the case may warrant, provided the power of attorney to the recognized organization contains an authorization permitting such disclosure.

[13 FR 7002, Nov. 27, 1948, as amended at 31 FR 3459, Mar. 5, 1966; 32 FR 10849, July 25, 1967; 33 FR 6536, Apr. 30, 1968]

§ 1.526 Copies of records and papers.

(a) Any person desiring a copy of any record or document in the custody of the Department of Veterans Affairs, which is subject to be furnished under §§ 1.501 through 1.526, must make written application for such copy to the Department of Veterans Affairs installation having custody of the subject matter desired, stating specifically: (1) The particular record or document the copy of which is desired and whether certified and validated, or uncertified, (2) the purpose for which such copy is desired to be used.

(b) The types of services provided by the Department of Veterans Affairs for which fees will be charged are identified in paragraph (i) of this section.

(c) This section applies to the services furnished in paragraph (b) of this section when rendered to members of the public by the Department of Veterans Affairs. It does not apply to such services when rendered to or for other agencies or branches of the Federal Government, or State and local governments when furnishing the service will help to accomplish an objective of the Department of Veterans Affairs, or when performed in connection with a special research study or compilation when the party requesting such services is charged an amount for the whole job.

(d) When copies of a record or document are furnished under §§ 1.506, 1.507, 1.510, and 1.514, such copies shall be supplied without charge. Moreover, free service may be provided, to the extent of one copy, to persons who have been required to furnish original documents for retention by the Department of Veterans Affairs.

(e) The following are circumstances under which services may be provided free at the discretion of facility heads or responsible Central Office officials:

(1) When requested by a court, when the copy will serve as a substitute for personal court appearance of a Government witness.

(2) When furnishing the service free saves costs or yields income equal to the direct costs of the agency providing the service. This includes cases where the fee for the service would be included in a billing against the Government (for example, in cost-type contracts, or in the case of private physicians who are treating Government beneficiaries at Government expense).

(3) When a service is occasional and incidental, not of a type that is requested often, and if it is administratively determined that a fee would be inappropriate in such an occasional case.

(f) When information, statistics, or reports are released or furnished under § 1.501 or § 1.519, the fee charge, if any, will be determined upon the merits of each individual application.

(g) In those cases where it is determined that a fee shall be charged, the applicant will be advised to deposit the amount of the lawful charge for the copy desired. The amount of such charge will be determined in accordance with the schedule of fees prescribed in paragraph (i) of this section. The desired copy will not be delivered, except under court subpoena, until the full amount of the lawful charge is deposited. Any excess deposit of $1 or more over the lawful charge will be returned to the applicant. Excess deposits of less than $1 will be returned upon request. When a deposit is received with an application, such a deposit will be returned to the applicant should the application be denied.

(h) Copies of reports or records received from other Government departments or agencies will not be furnished except as provided in § 1.513.

(i) *Fees to be charged*—(1) *Schedule of fees:*

Activity	Fees
(i) Duplication of document by any type of reproduction process to produce plain one-sided paper copies of a standard size (8½″ × 11″; 8½″ × 14″; 11″ × 14″).	$0.15 per page after first 100 one-sided pages.
(ii) Duplication of non-paper records, such as microforms, audiovisual materials (motion pictures, slides, laser optical disks, video tapes, audiotapes, etc.) computer tapes and disks, diskettes for personal computers, and any other automated media output.	Actual direct cost to the Agency as defined in § 1.555(a)(2) of this part to the extent that it pertains to the cost of duplication.
(iii) Duplication of documents by any type of reproduction process not covered by paragraphs (i)(1) (i) and (ii) of this section to produce a copy in a form reasonably usable by a requester.	Actual direct cost to the Agency as defined in § 1.555(a)(2) of this part to the extent that it pertains to the cost of duplication.
(iv) Providing special information, statistics, reports, drawings, specifications, lists of names and addresses (either in paper or machine readable form), computer or other machine readable output.	Actual cost to the Agency including computer and manual search costs, copying costs, labor, and material and overhead expenses.
(v) Attestation under the seal of the Agency	$3.00 per document so certified.
(vi) Providing abstracts or copies of medical and dental records to insurance companies for other than litigation purposes.	$10.00 per request.
(vii) Providing files under court subpoena	Actual direct cost to the Agency.

(NOTE. If VA regularly contracts for duplicating services related to providing the requested records, such as the duplication of microfilm or architect's plans and drawings, the contractor fees may be included in the actual direct cost to the Agency)

(2) *Benefit records.* When VA benefit records are requested by a VA beneficiary or applicant for VA benefits, the duplication fee for one complete set of such records will be waived.

(Authority: 38 U.S.C. 5702(b))

(j) If the copy is to be transmitted by certified or registered mail, airmail, or special delivery mail, the postal fees therefor shall be added to the other fees provided in paragraph (i) of this section (or the order must include postage stamps or stamped return envelopes for the purpose).

(k) Those Department of Veterans Affairs installations not having copying equipment are authorized to arrange with the nearest Department of Veterans Affairs installation having such equipment to make the necessary authorized copies of records or documents.

(l) Administration, staff office, and field facility heads are authorized to designate employees to certify copies

of records and papers furnished under the provisions of paragraph (a) of this section.

[19 FR 3224, June 2, 1954, as amended at 32 FR 10850, July 25, 1967; 33 FR 9342, June 26, 1968; 35 FR 20001, Dec. 31, 1970; 37 FR 2676, Feb. 4, 1972; 39 FR 3938, Jan. 31, 1974; 53 FR 10376, Mar. 31, 1988; 54 FR 34980, Aug. 23, 1989]

§ 1.527 Administrative review.

(a) Any person may, in the event of a denial of his or her request to inspect or obtain information from or copies of records within the purview of §§ 1.501 through 1.526, appeal such denial. Such appeal, stating the circumstances of the denial, should be addressed, as appropriate, to the field facility, administration, or staff office head.

(b) A denial action not reversed by a field facility, administration, or staff office head on appeal, will be referred through normal channels to the General Counsel.

(c) The final agency decision in such appeals will be made by the General Counsel or the Deputy General Counsel.

[32 FR 10850, July 25, 1967, as amended at 55 FR 21546, May 25, 1990]

PROCEDURES FOR DISCLOSURE OF RECORDS UNDER THE FREEDOM OF INFORMATION ACT

§ 1.550 Purpose.

(a) Sections 1.550 through 1.562 contain the rules followed by VA in processing requests for records under the Freedom of Information Act (FOIA), 5 U.S.C. 552, as amended. These regulations should be read together with the FOIA, which provides the underlying legal basis for the regulations and other information regarding requests for records in the custody of a Federal agency. The regulations also should be read together with VA's FOIA Reference Guide, available on VA's FOIA home page (see § 1.552(a) for the pertinent Internet address) and FOIA fee guidance provided by the Office of Management and Budget (OMB), Uniform Freedom of Information Act Fee Schedule and Guidelines, available at *http://www.whitehouse.gov/sites/default/files/omb/assets/omb/inforeg/foia__fee__schedule__1987.pdf*.

(b) Requests for records about an individual, protected under the Privacy Act, 5 U.S.C. 552a, including one's own records and records that pertain to an individual and that may be sensitive, will be processed under the FOIA and the Privacy Act. The FOIA applies to third-party requests for documents concerning the general activities of the Government and of VA in particular. When a U.S. citizen or an individual lawfully admitted for permanent residence requests access to his or her own records, it is considered a Privacy Act request. Such records are maintained by VA under the individual's name or personal identifier. Although requests are considered either FOIA requests or Privacy Act requests, agencies process requests in accordance with both laws, which provides the greatest degree of lawful access while safeguarding an individual's personal privacy. In addition to the following FOIA regulations, see 1.575 through 1.584 for regulations applicable of Privacy Act records.

(c) Requests for records relating to a claim administered by VA pursuant to 38 U.S.C. 5701 will be processed under the FOIA and 38 U.S.C. 5701. In addition to the following FOIA regulations, see §§ 1.500 through 1.527 for regulations implementing 38 U.S.C. 5701.

(d) Requests for records relating to healthcare quality assurance reviews pursuant to 38 U.S.C. 5705 will be processed under the FOIA and 38 U.S.C. 5705. In addition to the following FOIA regulations, *see* 38 CFR 17.500 through 17.511 for regulations implementing 38 U.S.C. 5705.

(e) Requests for records relating to treatment for the conditions specified in 38 U.S.C. 7332, such as drug abuse, alcoholism or alcohol abuse, infection with the Human Immunodeficiency Virus (HIV), or sickle cell anemia, will be processed under the FOIA and 38 U.S.C. 7332. In addition to the following FOIA regulations, *see* §§ 1.460 through 1.499 of this part for regulations implementing 38 U.S.C. 7332.

(Authority: Sections 1.550 to 1.562 issued under 72 Stat. 1114; 38 U.S.C. 501, 552, 552a, 5701, 5705, 7332.)G1986

[76 FR 51892, Aug. 19, 2011, as amended at 84 FR 12125, Apr. 1, 2019]

§ 1.551 Definitions.

As used in §§ 1.550 through 1.562, the following definitions apply:

Agency means any executive department, military department, government corporation, government controlled corporation, or other establishment in the executive branch of the Federal government, or independent regulatory entity.

Appeal means a requester's written disagreement with an adverse determination under the FOIA.

Beneficiary means a veteran or other individual who has received benefits (including medical benefits) or has applied for benefits pursuant to title 38, United States Code.

Benefits records means an individual's records, which pertain to programs under any of the benefits laws administered by the Secretary of Veterans Affairs.

Business day means the time during which typical Federal government offices are open for normal business. It does not include Saturdays, Sundays, or Federal legal public holidays. The term ''day'' means business day unless otherwise specified.

Business information means confidential or privileged commercial or financial information obtained by VA from a submitter that may be protected from disclosure under Exemption 4 of the FOIA, 5 U.S.C. 552(b)(4).

Component means each distinct VA entity, including Administrations, staff offices, services, or facilities.

Expedited processing means giving a FOIA request priority for processing ahead of other pending requests because VA has determined that the requester has shown an exceptional need or urgency for the records as provided in these regulations.

Fees. For fees and fee-related definitions, see § 1.561.

FOIA Officer means the individual within a VA component whose responsibilities include addressing and granting or denying requests for records under the FOIA.

FOIA Public Liaison means a supervisory agency FOIA official who assists in the resolution of any disputes between the requester and the agency.

Perfected request means a written FOIA request that meets the requirements set forth in § 1.554 of this part and for which there are no remaining issues about the payment of applicable fees or any other matter that requires resolution prior to processing.

Reading room means space made available, as needed, in VA components where records are available for review pursuant to 5 U.S.C. 552(a)(2). Ordinarily, the VA component providing a public reading room space will be the component that maintains the record.

Record means a document, a portion of a document, and information contained within a document, and can include information derived from a document or a database. Such documents may be maintained in paper, electronic, and other forms, but do not include objects, such as tissue slides, blood samples, or computer hardware.

Request means a written demand for records under the FOIA as described § 1.554(a). The term request includes any action emanating from the initial demand for records, including any subsequent action related to the request.

Requester means, generally, any individual, partnership, corporation, association, or foreign or state or local government, which has made a demand to access an agency record.

Submitter means any person or entity (including corporations, state, local and tribal governments and foreign governments) from whom VA obtains trade secrets or confidential commercial or financial information either directly or indirectly.

VA means the Department of Veterans Affairs.

VA Central Office (VACO) means the headquarters of the Department of Veterans Affairs. The mailing address is 810 Vermont Avenue, NW., Washington, DC 20420.

Written or in writing means communications such as letters, photocopies of letters, electronic mail, and facsimiles (faxes), and does not include any form of oral communication.

[76 FR 51892, Aug. 19, 2011, as amended at 84 FR 12125, Apr. 1, 2019]

§ 1.552 General provisions.

(a) *Additional information*. Information regarding VA's FOIA and Privacy Act process generally, including how to file FOIA requests, and information

made available by VA under the FOIA, is available at the following internet address: *http://www.oprm.va.gov/foia/*.

(b) *Public Liaisons*. VA has made available FOIA Public Liaisons to assist in the resolution of disputes between the agency and the requester. Contact information for VA's FOIA Public Liaisons can be found on VA's FOIA home page. See §1.552(a) for the pertinent Internet address.

(c) *FOIA Annual Report*. Under 5 U.S.C. 552(e), VA is required to prepare an annual report regarding its FOIA activities. The report includes information about FOIA requests and appeals. Copies of VA's annual FOIA report may be obtained from VA's Chief FOIA Officer or by visiting VA's FOIA Web site. See §1.552(a) for the pertinent Internet address.

[76 FR 51893, Aug. 19, 2011, as amended at 84 FR 12125, Apr. 1, 2019]

§1.553 Public reading rooms and discretionary disclosures.

(a) VA maintains a public reading room electronically at its FOIA home page on the Internet, which contains the records that the FOIA requires to be regularly made available for public inspection and copying. See §1.552(a) for the pertinent Internet address. Information routinely provided to the public (press releases, for example) may be provided without following these sections. In addition, as a matter of policy, VA may make discretionary releases of records or information exempt from disclosure under the FOIA when permitted to do so in accordance with current law and governmental policy. Each VA component is responsible for determining which of its records are required to be made available and for making its records available electronically.

(b) VA may process, in accordance with the FOIA, records that it makes publicly available. Information in a public reading room record will be redacted, for example, if its release would be a clearly unwarranted invasion of an individual's personal privacy.

(c) Some VA components may also maintain physical public reading rooms. Information regarding these components and their contact information is available on VA's FOIA home page on the Internet. See §1.552(a) for the pertinent Internet address. If the requester does not have access to the Internet and wishes to obtain information regarding publicly available information or components that have a physical reading room, he or she may write VA's Chief FOIA Officer at the following address: Department of Veterans Affairs, FOIA Service (005R1C), 810 Vermont Avenue, NW., Washington, DC 20420.

[76 FR 51893, Aug. 19, 2011]

§1.554 Requirements for making requests.

(a) *Requests by letter and facsimile (fax)*. The FOIA request must be in writing and may be by letter or fax. To assist in processing, the request letter, envelope, or fax cover sheet of any FOIA request should be marked ''Freedom of Information Act Request.'' Information helpful for filing a request, such as a list of VA FOIA contacts, VA's FOIA Reference Guide, and the text of the FOIA, are available on VA's FOIA homepage on the internet. See §1.552(a) for the pertinent internet address. VA has a decentralized FOIA system, meaning that each VA component, *i.e.*, administrations and staff offices, the Veterans Health Administration (VHA) medical centers, Veterans Benefits Administration (VBA) regional offices, or offices located within the VA Central Office in Washington, DC (*e.g.*, the Office of the Secretary), maintain their own FOIA processes and respond to FOIA requests directly. Accordingly, requesters must write directly to the FOIA Officer for the VA component that maintains the records. If requesting records from a particular medical facility, regional office, or Central Office component, the request should be sent to the FOIA Office at the address listed for that component. A legible return address must be included with the FOIA request; the requester may wish to include other contact information as well, such as a telephone number and email address. If the requester is not sure where to send the request, he or she should seek assistance from the FOIA Contact for the office believed to manage the programs whose records are being requested or, if

these efforts fail, he or she should send the request to the Director, FOIA Service (005R1C), 810 Vermont Avenue NW, Washington, DC 20420, who will refer it for action to the FOIA contact at the appropriate component.

(b) *Requests by email.* VA accepts email FOIA requests. To assure prompt processing, email FOIA requests must be sent to official VA FOIA mailboxes established for the purpose of receiving FOIA requests. An email FOIA request that is sent to an individual VA employee's mailbox, or to any other entity, will not be considered a perfected FOIA request. Mailbox addresses designated to receive email FOIA requests are available on VA's FOIA homepage. See §1.552(a) for the pertinent internet address.

(c) *The content of a request.* Whether submitting the request by letter, fax, or email, the following applies: If the requester is seeking records about himself or herself or to which a confidentiality statute applies (38 U.S.C. 5701, *e.g.*), the requester must comply with the verification of identity requirements set forth in §1.577 of this part, which applies to requests for records maintained under the Privacy Act. If the requester is seeking records not covered by the Privacy Act, but which the requester believes may pertain to him or her, the requester may obtain greater access to the records by complying with the verification of identity requirements set forth in §1.577 of this part, by providing the image of the requester's signature (such as an attachment that shows the requester's handwritten signature), or by submitting a notarized, signed statement affirming his or her identity or a declaration made in compliance with 28 U.S.C. 1746. The suggested language for a statement under 28 U.S.C. 1746 is included on VA's FOIA homepage; see §1.552(a) for the pertinent internet address. If the requester is seeking records pertaining to another individual under the FOIA, whether by letter, fax, or email, the requester may obtain greater access to the records if he or she provides satisfactory authorization to act on behalf of the record subject to receive the records or by submitting proof that the record subject is deceased (*e.g.*, a copy of a death certificate or an obituary). Each component has discretion to require that a requester supply additional information to verify that a record subject has consented to disclosure.

(d) *Description of records sought.* (1) The requester must describe the records sought in enough detail to allow VA personnel to locate them with a reasonable amount of effort. To the extent possible, the requester should include specific information about each record sought, such as the date, title or name, author, recipient, and subject matter of the document. Generally, the more information the requester provides about the record sought, the more likely VA personnel will be able to locate any responsive records. Wide-ranging requests that lack specificity, or contain descriptions of very general subject matters, with no description of specific records, may be considered ''not reasonably described'' and thus not subject to further processing.

(2) Requests for voluminous amounts of records may be placed in a complex track of a multitrack processing system pursuant to §1.556(b); such requests also may meet the criteria for ''unusual circumstances,'' which are processed in accordance with §1.556(c) and may require more than 20 business days to process despite the agency's exercise of due diligence.

(3) If the FOIA Officer determines that the request does not reasonably describe the records sought, the FOIA Officer will tell the requester why the request is insufficient. The FOIA Officer will also provide an opportunity to discuss the request by documented telephonic communication or written correspondence in order to modify it to meet the requirements of this section.

(4) The time limit for VA to process the FOIA request will not start until the FOIA Officer determines that the requester has reasonably described the records sought in the FOIA request. If the FOIA Officer seeks additional clarification regarding the request and does not receive the requester's written response within 30 calendar days of the date of its communication with the requester, he or she will conclude that the requester is no longer interested in

pursuing the request and will close VA's files on the request.

(e) *Agreement to pay fees.* The time limit for processing a FOIA request will be tolled while any fee issue is unresolved. Depending on the circumstances, the FOIA Officer will notify the requester of the following: That the FOIA Officer anticipates that the fees for processing the request will exceed the amount that the requester has stated a willingness to pay or will amount to more than $25.00 or the amount set by Office of Management and Budget fee guidelines, whichever is higher; whether the FOIA Officer is requiring the requester to agree in writing to pay the estimated fee; or whether advance payment of the fee is required prior to processing the request (*i.e.*, if the estimated fee amount exceeds $250 or the requester previously has failed to pay a FOIA fee in a timely manner). If the FOIA Officer does not receive the requester's written response to the notice regarding any of these items within 10 business days of the date of the FOIA Officer's written communication with the requester, the FOIA Officer will close the request. If requesting a fee waiver under § 1.561, the requester nonetheless may state his or her willingness to pay a fee up to an identified amount in the event that the fee waiver is denied; this will allow the component to process the FOIA request while considering the fee waiver request. If the requester pays a fee in advance, and VA later determines that the requester overpaid or is entitled to a full or partial fee waiver, a refund will be made. (For more information on the collection of fees under the FOIA, see § 1.561.)

(f) The requester must meet all of the requirements of this section in order for the request to be perfected.

[76 FR 51893, Aug. 19, 2011, as amended at 84 FR 12125, Apr. 1, 2019]

§ 1.555 Responsibility for responding to requests.

(a) *General.* Except as stated in paragraphs (c) and (d) of this section, the FOIA Officer of the component that first receives a request for records is responsible for either processing the request or referring it to the designated FOIA Officer for the appropriate component. Offices that are within the component responsible for processing the FOIA request shall provide the component FOIA Officer all documents responsive to the request that are in their possession as of the date the search for responsive records begins.

(b) *Authority to grant or deny requests.* Each component shall designate a FOIA Officer who is responsible for making determinations pursuant to the FOIA.

(c) *Consultations and referrals.* When a component FOIA Officer determines that the component maintains responsive records that either originated with another component or agency, or which contain information provided by, or of substantial interest to, another component or agency, then the FOIA Officer shall either:

(1) Respond to the request, after consulting with the component or the agency that originated or has a substantial interest in the records involved; or

(2) Refer the responsibility for responding to the request or portion of the request to the component best able to determine whether to disclose the relevant records, or to the agency that created or initially acquired the record as long as that agency is subject to the FOIA. Ordinarily, the component or agency that created or initially acquired the record will be presumed to be best able to make the disclosure assessment. The referring component shall document the referral and maintain a copy of the records that it refers.

(d) *Classified information.* The FOIA Officer will refer requests for records containing classified information to the component or agency that classified the information for processing.

(e) *Notice of referral.* Whenever a FOIA Officer refers all or part of a request and responsibility for processing the request to another component or agency, the FOIA Officer will notify the requester in writing of the referral and provide the requester the name and contact information of the entity to which the request has been referred, after consulting with the entity to which the request is to be referred to ensure that the request is being referred to the correct entity. If only

part of the request was referred, the FOIA Officer will inform the requester and identify the referred part at the time of the referral or in the final response.

[76 FR 51894, Aug. 19, 2011]

§ 1.556 Timing of responses to requests.

(a) *General.* Components ordinarily shall respond to requests according to their order of receipt and within the time frames established under the FOIA. If a request for expedited processing is granted in accordance with paragraph (d) of this section, such request will be processed prior to requests in either of the tracks described in paragraph (b) of this section.

(b) *Multitrack processing.* (1) VA will use two processing tracks in addressing a request for records: Simple and complex, based upon the amount of work and/or time needed to process the request, including consideration of the number of pages involved.

(2) The FOIA Officer shall advise the requester of the track into which the request has been placed and of the criteria of the faster track. The FOIA Officer will provide requesters in the slower track the opportunity to limit the scope of their requests in order to qualify for processing in the faster track. The FOIA Officer may contact the requester either by telephone or in writing, whichever the FOIA Officer determines is most efficient and expeditious; telephonic communication will be documented.

(c) *Unusual circumstances.* (1) FOIA Officers may encounter ''unusual circumstances,'' where it is not possible to meet the statutory time limits for processing the request. In such cases, the FOIA Officer will extend the 20-business day time limit for 10 more business days and notify the requester in writing of the unusual circumstances and the date by which it expects to complete processing of the request. Where the extension exceeds 10 working days, the agency must, as described by the FOIA, provide the requester with an opportunity to modify the request or arrange an alternative time period for processing the original or modified request; notice of the availability of the VA FOIA Public Liaison, and the right to seek dispute resolution services from the Office of Government Information Services. Unusual circumstances consist of the following:

(i) The need to search for and collect the requested records from field facilities or components other than the office processing the request;

(ii) The need to search for, collect and examine a voluminous amount of separate and distinct records that are the subject of a single request; or

(iii) The need for consultation with another agency or among two or more VA components or another agency having a substantial interest in the subject matter of a request.

(2) Where the FOIA Officer reasonably believes that certain requests from the same requester, or a group of requesters acting in concert, actually constitute the same request that would otherwise satisfy the unusual circumstances specified in this paragraph, and the requests involve clearly related matters, the FOIA Officer may aggregate those requests. Multiple requests involving unrelated matters will not be aggregated.

(d) *Expedited processing.* (1) Requests will be processed out of the order in which they were received by the component responsible for processing the FOIA request and given expedited treatment when VA determines that:

(i) The failure to obtain the requested records on an expedited basis could reasonably be expected to pose an imminent threat to the life or physical safety of an individual;

(ii) There is an urgency to inform the public concerning actual or alleged Federal government activity, if the request is made by a person primarily engaged in disseminating information;

(iii) In the discretion of the FOIA Officer, the request warrants such treatment; or

(iv) There is widespread and exceptional interest in which possible questions exist about the government's integrity which affect public confidence.

(2) A requester who is seeking expedited processing must submit a statement, certified to be true to the best of the requester's knowledge and belief, providing a detailed basis for how there is a compelling need. VA may waive

the requirement for certification of the statement of compelling need as a matter of administrative discretion.

(3) Within 10 calendar days of its receipt of a request for expedited processing, the FOIA Officer shall determine whether to grant the request and will provide the requester written notice of the decision. If the FOIA Officer grants a request for expedited processing, the FOIA Officer shall give the request priority and process it as soon as practicable. If the FOIA Officer denies the request for expedited processing, the requester may appeal the denial, which appeal shall be addressed expeditiously.

[76 FR 51894, Aug. 19, 2011, as amended at 84 FR 12126, Apr. 1, 2019]

§ 1.557 Responses to requests.

(a) *Acknowledgement of requests.* When a request for records is received by a component designated to receive requests, the component's FOIA Officer will assign a FOIA request number; the FOIA Officer will send the requester written acknowledgement of receipt of the request and will advise the requester of the assigned FOIA request number and how the requester may obtain the status of his or her request.

(b) *Processing of requests.* Upon receipt of a perfected request by the appropriate component, the FOIA Officer will make a reasonable effort to search for records responsive to the request. The FOIA Officer ordinarily will include as responsive those records in its possession and control as of the date the search for responsive records began. This includes searching for records in electronic form or format, unless to do so would interfere significantly with the agency's automated information systems. If fees for processing the request are due under § 1.561, the FOIA Officer shall inform the requester of the amount of the fee as provided in § 1.554(e) and § 1.561. When a request is granted in part, the FOIA Officer shall mark, redact, or annotate the records to be released to show the amount of information deleted and, where technically feasible, indicate the exemption at the place of redaction unless doing so would harm an interest protected by an applicable exemption. The FOIA Officer will provide the records in the form or format sought by the requester, if readily reproducible in that form or format.

(c) *Time limits for processing requests.* A component must advise the requester within 20 business days from the date of VA's receipt of the request whether the request is granted in its entirety, granted in part, or denied in its entirety and provide the reasons therefor. If the request must be referred to another component, the response time will begin on the date that the request was received by the appropriate component, but in any event not later than 10 business days after the referring office receives the FOIA request; the referring component has an affirmative duty to refer the FOIA request within 10 business days.

(d) *Grants of requests in full.* When a component makes a determination to grant a request in full, it shall notify the requester in writing. The component also shall inform the requester of any fees charged under § 1.561. The component also must inform the requester of his or her right to appeal and to seek mediation or the assistance of the appropriate VA FOIA Public Liaison and provide the contact information for the Liaison.

(e) *Adverse determinations of requests.* When a component makes an adverse determination denying the request in any respect, the component FOIA Officer shall promptly notify the requester of the adverse determination in writing. Adverse determinations include decisions that a requested record is exempt from release in whole or in part, does not exist or cannot be located, is not readily reproducible in the form or format sought by the requester, or is not a record subject to the FOIA; adverse determinations also include denials regarding requests for expedited processing and requests involving fees, such as requests for fee waivers. The adverse determination notice must be signed by the component head or the component's FOIA Officer, and shall include the following:

(1) The name and title or position of the person responsible for the adverse determination;

(2) A brief statement of the reason(s) for the denial, including any FOIA exemptions applied by the FOIA Officer in denying the request;

(3) The amount of information withheld in number of pages or other reasonable form of estimation; an estimate is not necessary if the volume is indicated on redacted pages disclosed in part or if providing an estimate would harm an interest provided by an applicable exemption;

(4) Notice that the requester may appeal the adverse determination and a description of the requirements for an appeal under § 1.559 of this part; and

(5) Notice that the requester may seek assistance or dispute resolution services from the VA FOIA Public Liaison or dispute resolution services from the Office of Government Information Services.

[76 FR 51894, Aug. 19, 2011, as amended at 84 FR 12127, Apr. 1, 2019]

§ 1.558 Business information.

(a) *General.* Business information received by VA from a submitter will be considered under the FOIA pursuant to this section and in accordance with the requirements set forth in § 1.557 of this part.

(b) *Designation of business information.* The submitter of business information may designate that specific records or portions of records submitted are business information, at the time of submission or within a reasonable time thereafter. The submitter must use good faith efforts in designating records that the submitter claims could be expected to cause substantial competitive harm and thus warrant protection under Exemption 4 of the FOIA, 5 U.S.C. 552(b)(4). The submitter may mark the record submission as confidential or use the words ''business information'' or describe the specific records that contain business information. Such designation will be considered, but will not control, the FOIA Officer's decision on disclosing the material. A designation will remain in effect for a period of not more than 10 years after receipt by VA, unless the submitter provides acceptable justification for a longer period. The submitter may designate a shorter period by including an expiration date.

(c) *Notices to submitters.* (1) The FOIA Officer shall promptly notify the submitter in writing of a FOIA request seeking the submitter's business information whenever the FOIA Officer has reason to believe that the information may be protected under FOIA Exemption 4, 5 U.S.C. 552(b)(4), regarding business information. The written notice will provide the submitter an opportunity to object to disclosure of any specified portion of the records within the reasonable time period specified in the notice. The notice will either describe in detail the business information requested (e.g., an entire contract identified by a unique number) or shall provide copies of the requested record(s) or record portions containing the business information. When notification of a voluminous number of submitters is required, the FOIA Officer may notify the submitters by posting or publishing the notice in a place reasonably likely to accomplish notification.

(2) If the FOIA Officer determines to release business information over the objection(s) of the submitter, the FOIA Officer will notify the submitter pursuant to paragraph (e) of this section.

(3) Whenever the FOIA Officer notifies the submitter of VA's intent to disclose over the submitter's objections, the FOIA Officer will also notify the requester by separate correspondence.

(4) Exceptions to this notice provision are contained in paragraph (f) of this section.

(d) *Opportunity to object to disclosure.* When notification to a submitter is made pursuant to paragraph (c)(1) of this section, the submitter may object to the disclosure of any specified portion(s) of the record(s). The submitter's objection(s) must be in writing, addressed to the FOIA Officer, and must be received by the reasonable date specified in the FOIA Officer's notice in order for VA to consider such objections. If the submitter has any objection to disclosure of the record(s) requested, or any specified portion(s) thereof, the submitter must identify the specific record(s) or portion(s) of records for which objection(s) are made. The objection will specify in detail all grounds for withholding any record(s) or portion(s) of the record(s)

upon which disclosure is opposed under any exemption of the FOIA. In particular, if the submitter is asserting that the record is protected under Exemption 4, 5 U.S.C. 552(b)(4), it must show why the information is a trade secret or commercial or financial information that is privileged or confidential. The submitter must explain in detail how and why disclosure of the specified records would likely cause substantial competitive harm in the case of a required submission or state whether the records would customarily be disclosed by the submitter upon a request from the public in the case of a voluntary submission. The submitter's objections must be contained within a single written response; oral responses or subsequent, multiple responses generally will not be considered. If the submitter does not respond to the notice described in paragraph (c)(1) of this section within the specified time limit, the submitter will be considered to have no objection to disclosure of the information.

(e) *Consideration of objection(s) and notice of intent to disclose.* The FOIA Officer will consider all pertinent factors, including but not limited to, the submitter's timely objection(s) to disclosure and the specific grounds provided by the submitter for non-disclosure in deciding whether to disclose business information. Information provided by the submitter after the specified time limit and after the component has made its disclosure decision generally will not be considered. In addition to meeting the requirements of §1.557, when a FOIA Officer decides to disclose business information over the objection of a submitter, the FOIA Officer will provide the submitter with written notice, which includes:

(1) A statement of the reason(s) why each of the submitter's disclosure objections were not sustained;

(2) A description of the business information to be disclosed; and

(3) A specified disclosure date of not less than 10 days from the date of the notice (to allow the submitter time to take necessary legal action).

(f) *Exceptions to notice requirements.* The notice requirements set forth in paragraphs (c) and (g) of this section will not apply if:

(1) The FOIA Officer determines that the information should not be disclosed;

(2) The information lawfully has been published or has been officially made available to the public; or

(3) Disclosure of the information is required by statute, other than the FOIA, or by a regulation issued in accordance with the requirements of Executive Order 12600 or any other Executive Order.

(g) *Notice to requesters.* When VA receives a request for records that may contain confidential commercial information protected by FOIA Exemption 4, 5 U.S.C. 552(b)(4), regarding business information, the requester will be notified that the request is being processed under the provisions of this regulation and, as a consequence, there may be a delay in receiving a response. The notice to the requester will not include any of the specific information contained in the records being requested.

[76 FR 51895, Aug. 19, 2011, as amended at 84 FR 12127, Apr. 1, 2019]

§1.559 Appeals.

(a) *Informal resolution prior to appeal.* Before filing an appeal, the requester may wish to communicate with the contact person listed in the FOIA response or the component's FOIA Officer to see if the issue can be resolved informally. Informal resolution of the requester's concerns may be appropriate, for example, where additional details may be required for a search for responsive records. Communication with VA at this level does not toll the time limit for filing an administrative appeal.

(b) *How to file and address a written appeal.* The requester may appeal an adverse determination denying the request, in any respect, except for those concerning Office of Inspector General records, to the VA Office of the General Counsel (024), 810 Vermont Avenue NW, Washington, DC 20420. Any appeals concerning Office of Inspector General records must be sent to the VA Office of Inspector General, Office of Counselor (50), 810 Vermont Avenue NW, Washington, DC 20420. The FOIA appeal must be in writing and may be by letter or facsimile (fax); whichever method is used, the appeal must comply

with all requirements of this paragraph and paragraph (d). Information regarding where to fax the FOIA appeal is available on VA's FOIA homepage on the internet. See §1.552(a) of this part for the pertinent internet address.

(c) *How to file an email appeal.* VA accepts email appeals; the appeal must comply with all requirements of this paragraph and paragraph (d) of this section. In order to assure initial processing of an appeal filed by email, the email must be sent to one of the official VA FOIA mailboxes established for the purpose of receiving FOIA appeals; an email FOIA appeal that is sent to an individual VA employee's mailbox, or to any other entity, will not be considered a perfected FOIA appeal. Mailbox addresses designated to receive email FOIA appeals are available on VA's FOIA homepage. See §1.552(a) of this part for the pertinent internet address.

(d) *Time limits and content of appeal.* The appeal to the VA OGC (024) or VA Office of Inspector General (50) must be received or postmarked no later than 90 calendar days after the date of the adverse determination and must contain the following: A legible return address; clear identification of the determination being appealed, including any assigned request number (if no request number was assigned, other information must be provided such as the name of the FOIA officer, the address of the component, the date of the component's determination, if any, and the precise subject matter of the appeal); and identification of the part of the determination that is being appealed (if appealing only a portion of the determination). If the appeal involves records about the requester himself or herself or records to which a confidentiality statute applies, the requester must comply with the verification of identity requirements set forth in §1.577 of this part, which applies to requests for records maintained under the Privacy Act. If the appeal involves records not covered by the Privacy Act, but which the requester believes may pertain to him or her, the requester may obtain greater access to the records by complying with the verification of identity requirements set forth in §1.577 of this part, providing the image of the requester's signature (such as an attachment that shows the requester's handwritten signature), or submitting a notarized, signed statement affirming his or her identity or a declaration made in compliance with 28 U.S.C. 1746. The suggested language for a statement under 28 U.S.C. 1746 is included on VA's FOIA homepage. See §1.552(a) of this part for the pertinent internet address. If the appeal involves records pertaining to another individual (*i.e.*, the requester is not the record subject), the requester may obtain greater access to the records if he or she provides satisfactory authorization to act on behalf of the record subject to receive the records or by submitting proof that the record subject is deceased (*e.g.*, a copy of a death certificate or an obituary). Each component has discretion to require that a requester supply additional information to verify that a record subject has consented to disclosure. Appeals should be marked ''Freedom of Information Act Appeal.'' The requester may include other information as well, such as a telephone number and email address and a copy of the initial agency determination. An appeal is not perfected until VA either receives the required information identified above or the appeal is otherwise easily and sufficiently defined. The designated official within the Office of the General Counsel (024) will act on behalf of the Secretary on all appeals under this section, except those pertaining to the Office of Inspector General. The designated official in the Office of Inspector General will act on all appeals pertaining to Office of Inspector General records. A determination by the Office of General Counsel, or designated official within the Office of Inspector General, will be the final VA action.

(e) *Responses to appeals.* The Office of the General Counsel or the Office of Inspector General, as applicable, will provide the requester a decision on the appeal in writing. The decision will include a brief statement of the reasons for the decision, including, if applicable, any FOIA exemptions applied and notice of the right to judicial review of the decision.

(f) *Court review.* Unless the requester has been deemed to have exhausted all

administrative remedies, he or she must first appeal the adverse determination in accordance with this section before seeking review by a court.

[76 FR 51895, Aug. 19, 2011, as amended at 84 FR 12127, Apr. 1, 2019]

§ 1.560 Maintenance and preservation of records.

(a) Each component will preserve all correspondence pertaining to FOIA requests as well as copies of pertinent records, until disposition is authorized under title 44, U.S.C., or the National Archives and Records Administration's General Records Schedule 14.

(b) The FOIA Officer must maintain copies of records that are the subject of a pending request, appeal, or lawsuit under the FOIA. A copy of all records shall be provided promptly to the Office of the General Counsel upon request.

[76 FR 51895, Aug. 19, 2011]

§ 1.561 Fees.

(a) *General*. VA will charge for processing requests under the FOIA, as amended, and in accordance with this section. Requesters must pay fees by check or money order made payable to the Treasury of the United States. Payment by credit card also may be acceptable; the requester should contact the FOIA Officer for instructions on credit card payments. Note that fees associated with requests from VA beneficiaries, applicants for VA benefits, or other individuals, for records retrievable by their names or individual identifiers processed under 38 U.S.C. 5701 (records associated with claims for benefits) and 5 U.S.C. 552a (the Privacy Act), will be assessed fees in accordance with the applicable regulatory fee provisions relating to VA benefits and VA Privacy Act records.

(b) *Definitions*. For purposes of assessing or determining fees, the following definitions apply:

(1) *All other requests* means a request that does not fit into any of the categories in this section.

(2) *Commercial use request* means a request from or on behalf of one who seeks information for a use or purpose that furthers his or her commercial, trade, or profit interests, to include furthering those interests through litigation. To the extent possible, the FOIA Officer shall determine the use to which the requester will put the requested records. When the intended use of the records is unclear from the request or when there is reasonable cause to doubt the use to which the requester will put the records sought, the FOIA Officer will provide the requester a reasonable opportunity to submit further clarification.

(3) *Direct costs* mean expenses that VA incurs in responding to a FOIA request; direct costs include searching for and duplicating (and in the case of commercial use requesters, reviewing) records to respond to a FOIA request, the hourly wage of the employee performing the work plus 16 percent of the hourly wage, and the cost of operating duplication machinery. Direct costs do not include overhead expenses, such as the costs of space or heating and lighting of the facility where the records are kept.

(4) *Duplication* means making a copy of a record necessary to respond to a FOIA request; copies may take the form of paper, microform, audiovisual materials or machine readable-documentation (e.g., magnetic tape or disk), among others. The copy provided must be in a form that is reasonably usable by requesters.

(5) *Educational institution* means a pre-school, a public or private elementary or secondary school, an institution of undergraduate or graduate higher education, an institution of professional education, or an institution of vocational education, which operates a program or programs of scholarly research. To be in this category, the FOIA Officer must make a determination that the request is authorized by and made under the auspices of a qualifying institution and that the records are sought to further a scholarly research goal of the institution and not the individual goal of the requester or a commercial goal of the institution.

(6) *Non-commercial scientific institution* means an institution that is not operated on a ''commercial'' basis (as that term is defined in paragraph (b)(2) of

this section) and that is operated solely for the purpose of conducting scientific research, the results of which are not intended to promote any particular product or industry. To be in this category, the requester must show that the request is authorized by and is made under the auspices of a qualifying institution and that the records are sought to further scientific research and are not sought for a commercial use.

(7) *Representative of the news media* means any person or entity that gathers information of potential interest to a segment of the public, uses its editorial skills to turn the raw materials into a distinct work, and distributes that work to an audience. The term *news* means information that is about current events or that would be of current interest to the public. Examples of news media entities include television or radio stations broadcasting to the public at large and publishers of periodicals (but only if such entities qualify as disseminators of ''news'') who make their products available for purchase or subscription or free distribution to the general public. These examples are not all-inclusive. As methods of news delivery evolve (for example, the adoption of the electronic dissemination of newspapers through telecommunications services), such alternative media that otherwise meet the criteria for news media shall be considered to be news-media entities. Freelance journalists may be regarded as working for a news-media entity if they can demonstrate a solid basis for expecting publication through that entity, even though not actually employed by it. A publication contract would be the clearest proof, but the requester's publication history may also be considered. To be in this category, the requester must not be seeking the requested records for a commercial use; a records request supporting the requester's news-dissemination function shall not be considered to be for a commercial use.

(8) *Review* means examining a record including audiovisual, electronic mail, data bases, documents and the like in response to a commercial use request to determine whether any portion of it is exempt from disclosure. Review includes the deletion of exempt material or other processing necessary to prepare the record(s) for disclosure. Review time includes time spent contacting any submitter and considering or responding to any objections to disclosure made by a submitter under §1.558(d) but does not include time spent resolving general legal or policy issues regarding the application of exemptions. Review costs are recoverable even if, after review, a record is not disclosed.

(9) *Search* means the process of looking for and retrieving records that are responsive to a request, including line-by-line or page-by-page identification of responsive information within records. *Search* also includes reasonable efforts to locate and retrieve information from records maintained in electronic form or format. The component will conduct searches in the most efficient and least expensive manner reasonably possible. The FOIA Officer may charge for time spent searching even if he or she does not locate any responsive record(s) or if any record(s) located is withheld as entirely exempt from disclosure.

(10) *Fee waiver* means waiving or reducing processing fees if a requester can demonstrate that certain statutory standards are satisfied, including that the information is in the public interest and is not requested for commercial interest.

(c) *Categories of requesters and fees to be charged each category*. There are four categories of FOIA requesters: Commercial use requesters, educational and non-commercial scientific institutional requesters, representatives of the news media, and all other requesters. Unless a waiver or reduction of fees is granted under paragraph (n) of this section or is limited in accordance with paragraph (e) of this section, specific levels of fees will be charged for each category as follows:

(1) *Commercial use requesters*. Subject to the limitations in paragraph (e) of this section, commercial use requesters will be charged the full direct costs of the search, review, and duplication of records sought. Commercial use requesters are not entitled to 2 hours of free search time or the first 100 pages

of reproduced documents free of charge.

(2) *Duplication*. When the agency provides duplicated records in response to a request, no more than one copy will be provided.

(3) *Representative of the news media*. Subject to the limitations in paragraph (e) of this section, representatives of the news media will be charged for the cost of reproduction only, excluding charges for the first 100 pages.

(4) *All other requesters*. Subject to the limitations in paragraph (e) of this section, a requester who does not fit into any of the categories in this section will be charged fees to recover the full, reasonable direct cost of searching for and reproducing records responsive to a request, except that the first 2 hours of search time and the first 100 pages of reproduction will be furnished without cost.

(d) *Fees to be charge.d* The following fees will be used when calculating the fee owed pursuant to a request or appeal. The fees also apply to making documents available for public inspection and copying under §1.553 of this part.

(1) *Search*—(i) *Search fees*. When a FOIA Officer determines that a search fee applies, the fee will be based on the hourly salary of VA personnel performing the search, plus 16 percent of the salary. The type and number of personnel involved in addressing the request or appeal depends on the nature and complexity of the request and responsive records. Fees are charged in quarter hour increments.

(ii) *Computer search*. In cases where a computer search is required, the requester will be charged the direct costs of conducting the search, although certain requesters (as provided in paragraph (e)(1) of this section) will be charged no search fee and certain other requesters (as provided in paragraph (e)(4) of this section) will be entitled to the cost of 2 hours of employee search time without charge. When a computer search is required, VA will combine the hourly cost of operating the computer with the employee's salary, plus 16 percent of the salary. When the cost of the search (including the employee time, to include the cost of developing a search methodology, and the cost of the computer to process a request) equals the dollar amount of 2 hours of the salary of the employee performing the search, VA will begin to assess charges for a computer search.

(2) *Duplication*. When a duplication fee applies, the FOIA Officer will charge a fee of 15 cents per one-sided page for a paper photocopy of a record; no more than one copy will be provided. For other forms of duplication, including electronic copies, the FOIA Officer will charge the direct costs of that duplication.

(3) *Review*. When review fees apply, review fees will be charged at the initial level of review only, when the component responsible for processing the request determines whether an exemption applies to a record or portion of a record. For review at the appeal level, no fee will be charged for an exemption that has already been applied and is determined to still apply. However, record or record portions withheld under an exemption that is subsequently determined not to apply may be reviewed again to determine whether any other exemption not previously considered applies; the costs of that review are chargeable. Review fees will be charged at the same rates as those charged for search under paragraph (d)(1) of this section.

(e) *Limitations on charging fees*. (1) When VA determines that a requester is an educational institution, a noncommercial scientific institution, or a representative of the news media, VA will not charge search fees.

(2) VA charges fees in quarter hour increments; no search or review fee will be charged for a quarter hour period unless more than half of that period is required for search or review.

(3) VA may provide free copies of records or free services in response to an official request from another government agency or a congressional office and when a component head or designee determines that doing so will assist in providing medical care to a VA patient or will otherwise assist in the performance of VA's mission.

(4)(i) If VA fails to comply with the time limit to respond to a request, it may not charge search fees, or, in cases of requests from requesters described in paragraph (e)(1) of this section, may

not charge duplication fees, except as described in paragraph (e)(4)(ii) through (iv) of this section.

(ii) If VA has determined that unusual circumstances as defined by the FOIA apply and has provided timely written notice to the requester in accordance with the FOIA, a failure to comply with the time limit shall be excused for an additional 10 days.

(iii) If VA has determined that unusual circumstances as defined by the FOIA apply and more than 5,000 pages are necessary to respond to the request, VA may charge search fees, or in the case of requesters described in paragraph (e)(1) of this section, may charge duplication fees, if the following steps are taken: VA must provide timely written notice of unusual circumstances to the requester in accordance with the FOIA and must discuss with the requester via written mail, email or telephone (and later confirmed in writing) (or have made not less than three good-faith attempts to do so) how the requester could effectively limit the scope of the request in accordance with 5 U.S.C. 552(a)(6)(B)(ii). If this exception is satisfied, the component may charge all applicable fees incurred in the processing of the request.

(iv) if a court has determined that exceptional circumstances exist, as defined by the FOIA, a failure to comply with the time limits shall be excused for the length of time provided by the court order.

(f) The following table summarizes the chargeable fees for each category of requester.

Category	Search fees	Review fees	Duplication fees
(1) Commercial Use	Yes	Yes	Yes.
(2) Educational Institution and Non-Commercial Scientific Institution.	No	No	Yes (100 pages or 1 disc free).
(3) News Media	No	No	Yes (100 pages or 1 disc free).
(4) All other	Yes (2 hours free)	No	Yes (100 pages or 1 disc free).

(g) *Fee schedule.* If it is determined that a fee will be charged for processing the FOIA request, VA will charge the direct cost to the agency and in accordance with the requester's fee category (see § 1.561(c)); to the extent possible, direct costs are itemized in paragraph 1 of this section. Duplication fees also are applicable to records provided in response to requests made under the Privacy Act (see § 1.577(e),(f)).

(1) Schedule of fees:

Activity	Fees
(i) Duplication of standard size (8½″ x 11″; 8½″ x 14″) paper records or records on electronic media.	Paper records: $0.15 per page. Electronic media: $3.00 per each compact disc (CD) or digital versatile disc (DVD).
(ii) Duplication of non-paper items (*e.g.,* x-rays), paper records which are not of a standard size (*e.g.,* architectural drawings/construction plans or EKG tracings).	Direct cost to VA.
(iii) Record search by manual (non-automated) methods	Hourly wage of the employee(s), plus 16 percent.
(iv) Record search using automated methods, such as by computer.	Direct cost to VA.
(v) Record review (for Commercial Use Requesters only)	Hourly rate of employees performing review to determine whether to release records and to prepare them for release, plus 16 percent.
(vi) Other activities, such as: Attesting under seal or certifying that records are true copies; sending records by special methods; forwarding mail; compiling and providing special reports, drawings, specifications, statistics, lists, abstracts or other extracted information; generating computer output; providing files under court process where the Federal Government is not a party to, and does not have an interest in, the litigation.	Direct cost to VA.

NOTE TO PARAGRAPH (g)(1): VA will charge fees consistent with the salary scale published by the Office of Personnel Management (OPM).

(2) [Reserved]

(h) *Notification of fee estimate or other fee issues.* (1) VA will not charge the requester if the fee is $25.00 or less.

(2) When a FOIA Officer determines or estimates that the fees to be charged under this section will amount to more than $25.00 or the amount set by OMB fee guidelines, whichever is higher, the FOIA Officer will notify the requester in writing of the actual or estimated amount of fees and ask the requester to provide written assurance of the payment of all fees or fees up to a designated amount, unless he or she has indicated a willingness to pay fees as high as those anticipated. Any such agreement to pay the fees shall be memorialized in writing. When the requester does not provide sufficient information upon which VA can identify a fee category (see paragraphs (c)(1) through (c)(4) of this section), or a clarification is otherwise required regarding a fee, the FOIA Officer may notify the requester and seek clarification; the notification to the requester will state that if a written response is not received within 10 days, the request will be closed. The timeline for responding to the request will be tolled and no further work will be done on the request until the fee issue has been resolved.

(i) *Charges for other services.* Apart from the other provisions of this section, VA will charge the requester the direct costs of providing any special handling or services requested, such as certifying that records are true copies or sending them by other than ordinary mail. The FOIA Officer may choose to provide such a service as a matter of administrative discretion.

(j) *Charging interest.* The FOIA Officer may charge interest on any unpaid bill starting on the 31st day following the date of billing the requester. Interest charges will be assessed at the rate provided in 31 U.S.C. 3717 and will accrue until payment is received by the component. Components will follow the provisions of the Debt Collection Act of 1982 (Pub. L. 97–365, 96 Stat. 1749), as amended, and its administrative procedures, including the use of consumer reporting agencies, collection agencies, and offset.

(k) *Aggregating requests.* Whenever a FOIA Officer reasonably believes that a requester or group of requesters acting together is attempting to divide a request into a series of requests for the purpose of avoiding fees, the FOIA Officer may aggregate those requests and charge accordingly. FOIA Officers may presume that multiple requests of this type made within a 30-day period have been made in order to avoid fees. Where requests are separated by a longer period, the FOIA Officer will aggregate them only where there exists a solid basis for determining that aggregation is warranted under all the circumstances involved. Multiple requests involving unrelated matters will not be aggregated.

(l) *Advance payments.* (1) For requests other than those described in paragraphs (l)(2) and (l)(3) of this section, a FOIA Officer shall not require the requester to make an advance payment—in other words, a payment made before work is begun or continued on a request. Payment owed for work already completed (*i.e.*, a prepayment before copies are sent to the requester) is not an advance payment.

(2) Where a FOIA Officer determines or estimates that a total fee to be charged under this section will be more than $250.00, the FOIA Officer may require the requester to make an advance payment of an amount up to the amount of the entire anticipated fee before beginning to process the request.

(3) Where the requester previously has failed to pay a properly charged FOIA fee to VA within 30 days of the date of billing, a FOIA Officer may require the requester to pay the full amount due, plus any applicable interest as specified in this section, and to make an advance payment of the full amount of any anticipated fee, before the FOIA Officer begins to process a new request or continues to process a pending request from that requester.

(4) When the requester has a history of prompt payment, the FOIA Officer may accept a satisfactory assurance of full payment from the requester rather than an advance payment.

(5) In cases in which a FOIA Officer requires advance payment or payment is due under this section, the time for responding to the request will be tolled and further work will not be done on the request until the required payment is received.

(m) *Other statutes specifically providing for fees.* The fee schedule of this section does not apply to fees charged under any statute that specifically requires an agency to set and collect fees for particular types of records. Where records responsive to requests are maintained for distribution by agencies operating such statutorily-based fee schedule programs, the FOIA Officer will inform requesters of the steps for obtaining records from those sources so that they may do so most economically.

(n) *Requirements for waiver or reduction of fees.* (1) *Waiving or reducing fees.* Fees for processing the request may be waived if the requester meets the criteria listed in this section. The requester must submit adequate justification for a fee waiver; without adequate justification, the request will be denied. The FOIA Officer may, at his or her discretion, communicate with the requester to seek additional information, if necessary, regarding the fee waiver request. If the additional information is not received from the requester within 10 days of the FOIA Officer's communication with the requester, VA will assume that the requester does not wish to pursue the fee waiver request and the fee waiver request will be closed. If the request for waiver or reduction is denied or closed, the underlying FOIA request will continue to be processed in accordance with the applicable provisions of this Part. Requests for fee waivers are decided on a case-by-case basis; receipt of a fee waiver in the past does not establish entitlement to a fee waiver each time a request is submitted.

(2) Records responsive to a request will be furnished without charge or at a charge reduced below that established under paragraph (d) of this section where a FOIA Officer determines, based on all available evidence, that the requester has demonstrated that:

(i) Disclosure of the requested information is in the public interest because it is likely to contribute significantly to public understanding of the operations or activities of the government, and

(ii) Disclosure of the information is not primarily in the commercial interest of the requester.

(3) To determine whether the fee waiver requirement under paragraph (n)(2)(i) of this section is met, the FOIA Officer will consider the following factors:

(i) *The subject of the request: Whether the subject of the requested records concerns ''the operations or activities of the government.''* The subject of the requested records must concern identifiable operations or activities of the federal government, with a connection that is direct and clear, not remote or attenuated.

(ii) *The informative value of the information to be disclosed: Whether the disclosure is ''likely to contribute'' to an understanding of government operations or activities.* The disclosable portions of the requested records must be meaningfully informative about government operations or activities in order to be ''likely to contribute'' to an increased public understanding of those operations or activities. The disclosure of information that already is in the public domain, in either a duplicative or a substantially identical form, would not be as likely to contribute to such understanding where nothing new would be added to the public's understanding.

(iii) *The contribution to an understanding of the subject by the public likely to result from disclosure: Whether disclosure of the requested information will contribute to ''public understanding.''* The disclosure must contribute to the understanding of a reasonably broad audience of persons interested in the subject, as opposed to the individual understanding of the requester. The requester's expertise in the subject area and ability and intention to effectively convey information to the public shall be considered. It shall be presumed that a representative of the news media will satisfy this consideration.

(iv) *The significance of the contribution to public understanding: Whether the disclosure is likely to contribute ''significantly'' to public understanding of government operations or activities.* The

public's understanding of the subject in question, as compared to the level of public understanding existing prior to the disclosure, must be enhanced by the disclosure to a significant extent. The FOIA Officer will not make value judgments about whether information that would contribute significantly to public understanding of the operations or activities of the government is important enough to be made public.

(4) To determine whether the fee waiver requirement under paragraph (n)(2)(ii) of this section is met, the FOIA Officer will consider the following factors:

(i) *The existence and magnitude of a commercial interest: Whether the requester has a commercial interest that would be furthered by the requested disclosure.* The FOIA Officer shall consider any commercial interest of the requester (with reference to the definition of ''commercial use'' in paragraph (b)(2) of this section), or of any person on whose behalf the requester may be acting, that would be furthered by the requested disclosure. Requesters shall be given an opportunity in the administrative process to provide explanatory information regarding this consideration.

(ii) *The primary interest in disclosure: Whether any identified commercial interest of the requester is sufficiently large, in comparison with the public interest in disclosure, that disclosure is ''primarily in the commercial interest of the requester.''* A fee waiver or reduction is justified where the public interest standard is satisfied and that public interest is greater in magnitude than that of any identified commercial interest in disclosure. The FOIA Officer ordinarily shall presume that where a news media requester has satisfied the public interest standard, the public interest will be the interest primarily served by disclosure to that requester. Disclosure to data brokers or others who merely compile and market government information for direct economic return will not be presumed to primarily serve the public interest.

(5) Where only some of the records to be released satisfy the requirements for a waiver of fees, a fee waiver will be granted only for those records which so qualify.

(6) Requests for the waiver or reduction of fees should address the factors listed in paragraph (n)(3) and (4) of this section, insofar as they apply to each request. FOIA Officers will exercise their discretion to consider the cost-effectiveness of their investment of administrative resources in this decision-making process, however, in deciding to grant waivers or reductions of fees.

(7) An appeal from an adverse fee determination will be processed in accordance with § 1.559.

(8) When considering a request for fee waiver, VA may require proof of identity.

[76 FR 51895, Aug. 19, 2011, as amended at 84 FR 12128, Apr. 1, 2019; 84 FR 14874, Apr. 12, 2019]

§ 1.562 Other rights and services.

Nothing in this part shall be construed to entitle any person, as of right, to any service or to the disclosure of any record to which such person is not entitled under the FOIA.

(Authority:Sections 1.550 to 1.562 issued under 72 Stat. 1114; 38 U.S.C. 501)

[76 FR 51895, Aug. 19, 2011]

SAFEGUARDING PERSONAL INFORMATION IN DEPARTMENT OF VETERANS AFFAIRS RECORDS

NOTE: Sections 1.575 through 1.584 concern the safeguarding of individual privacy from the misuse of information from files, records, reports, and other papers and documents in Department of Veterans Affairs custody. As to the release of information from Department of Veterans Affairs claimant records see § 1.500 series. As to the release of information from Department of Veterans Affairs records other than claimant records see § 1.550 series. Section 1.575 series implement the provisions of Pub. L. 93–579, December 31, 1974, adding a section 552a to title 5 U.S.C. providing that individuals be granted access to records concerning them which are maintained by Federal agencies, and for other purposes.

SOURCE: 40 FR 33944, Aug. 12, 1975, unless otherwise noted.

§ 1.575 Social security numbers in veterans' benefits matters.

(a) Except as provided in paragraph (b) of this section, no one will be denied any right, benefit, or privilege provided by law because of refusal to disclose to

the Department of Veterans Affairs a social security number.

(b) VA shall require mandatory disclosure of a claimant's or beneficiary's social security number (including the social security number of a dependent of a claimant or beneficiary) on necessary forms as prescribed by the Secretary as a condition precedent to receipt or continuation of receipt of compensation or pension payable under the provisions of chapters 11, 13 and 15 of title 38, United States Code, provided, however, that a claimant shall not be required to furnish VA with a social security number for any person to whom a social security number has not been assigned. VA may also require mandatory disclosure of an applicant's social security number as a condition for receiving loan guaranty benefits and a social security number or other taxpayer identification number from existing direct and vendee loan borrowers and as a condition precedent to receipt of a VA-guaranteed loan, direct loan or vendee loan, under chapter 37 of title 38, United States Code. (Pub. L. 97–365, sec. 4)

(c) A person requested by VA to disclose a social security number shall be told, as prescribed by § 1.578(c), whether disclosure is voluntary or mandatory. The person shall also be told that VA is requesting the social security number under the authority of title 38 U.S.C., or in the case of existing direct or vendee loan borrowers, under the authority of 26 U.S.C. 6109(a) in conjunction with sections 145 and 148 of Pub. L. 98–369, or in the case of loan applicants, under the authority of section 4 of Pub. L. 97–365. The person shall also be told that it will be used in the administration of veterans' benefits in the identification of veterans or persons claiming or receiving VA benefits and their records, that it may be used in making reports to the Internal Revenue Service where required by law, and to determine whether a loan guaranty applicant has been identified as a delinquent taxpayer by the Internal Revenue Service, and that such taxpayers may have their loan applications rejected, and that it may be used to verify social security benefit entitlement (including amounts payable) with the Social Security Administration and, for other purposes where authorized by both title 38 U.S.C., and the Privacy Act of 1974, (Pub. L. 93–579), or, where required by another statute. (Pub. L. 97–365, sec. 4)

(Authority: 38 U.S.C. 5101)

[44 FR 22068, Apr. 13, 1979, as amended at 51 FR 21750, June 16, 1986; 56 FR 25044, June 3, 1991]

§ 1.576 General policies, conditions of disclosure, accounting of certain disclosures, and definitions.

(a) The Department of Veterans Affairs will safeguard an individual against an invasion of personal privacy. Except as otherwise provided by law or regulation its officials and employees will:

(1) Permit an individual to determine what records pertaining to him or her will be collected, maintained, used, or disseminated by the Department of Veterans Affairs.

(2) Permit an individual to prevent records pertaining to him or her, obtained by the Department of Veterans Affairs for a particular purpose, from being used or made available for another purpose without his or her consent.

(3) Permit an individual to gain access to information pertaining to him or her in Department of Veterans Affairs records, to have a copy made of all or any portion thereof, and to correct or amend such records.

(4) Collect, maintain, use, or disseminate any record of identifiable personal information in a manner that assures that such action is for a necessary and lawful purpose, that the information is correct and accurate for its intended use, and that adequate safeguards are provided to prevent misuse of such information.

(5) Permit exemptions from records requirements provided in 5 U.S.C. 552a only where an important public policy need for such exemption has been determined pursuant to specific statutory authority.

(b) The Department of Veterans Affairs will not disclose any record contained in a system of records by any means of communication to any person or any other agency except by written request of or prior written consent of

the individual to whom the record pertains unless such disclosure is:

(1) To those officers and employees of the agency which maintains the record and who have a need for the record in the performance of their duties;

(2) Required under 5 U.S.C. 552;

(3) For a routine use of the record compatible with the purpose for which it was collected;

(4) To the Bureau of the Census for purposes of planning or carrying out a census or survey or related activity pursuant to title 13 U.S.C.;

(5) To a recipient who has provided the Department of Veterans Affairs with advance adequate written assurance that the record will be used solely as a statistical research or reporting record, and the record is to be transferred in a form that is not individually identifiable;

(6) To the National Archives of the United States as a record which has sufficient historical or other value to warrant its continued preservation by the U.S. Government, or for evaluation by the Administrator of General Services or designee to determine whether the record has such value;

(7) To another agency or to an instrumentality of any governmental jurisdiction within or under the control of the United States for a civil or criminal law enforcement activity if the activity is authorized by law, and if the head of the agency or instrumentality has made a written request to the Department of Veterans Affairs specifying the particular portion desired and the law enforcement activity for which the record is sought;

(8) To a person pursuant to a showing of compelling circumstances affecting the health or safety of an individual if upon such disclosure notification is transmitted to the last known address of such individual;

(9) To either House of Congress, or, to the extent of matter within its jurisdiction, any committee or subcommittee thereof, any joint committee of Congress or subcommittee of any such joint committee;

(10) To the Comptroller General, or any authorized representatives, in the course of the performance of the duties of the General Accounting Office; or

(11) Pursuant to the order of a court of competent jurisdiction.

(c) With respect to each system of records (*i.e.*, a group of records from which information is retrieved by the name of the individual or by some identifying number, symbol, or other identifying particular assigned to the individual) under Department of Veterans Affairs control, the Department of Veterans Affairs will (except for disclosures made under paragraph (b)(1) or (2) of this section) keep an accurate accounting as follows:

(1) For each disclosure of a record to any person or to another agency made under paragraph (b) of this section, maintain information consisting of the date, nature, and purpose of each disclosure, and the name and address of the person or agency to whom the disclosure is made;

(2) Retain the accounting made under paragraph (c)(1) of this section for at least 5 years or the life of the record, whichever is longer, after the disclosure for which the accounting is made;

(3) Except for disclosures made under paragraph (b)(7) of this section, make the accounting under paragraph (c)(1) of this section available to the individual named in the record at his or her request; and

(4) Inform any person or other agency about any correction or notation of dispute made by the agency in accordance with § 1.579 of any record that has been disclosed to the person or agency if an accounting of the disclosure was made.

(d) For the purposes of §§ 1.575 through 1.584, the parent of any minor, or the legal guardian of any individual who has been declared incompetent due to physical or mental incapacity or age by a court of competent jurisdiction, may act on behalf of the individual.

(e) Section 552a(i), title 5 U.S.C., provides that:

(1) Any officer or employee of the Department of Veterans Affairs, who by virtue of his or her employment or official position, has possession of, or access to, Department of Veterans Affairs records which contain individually identifiable information the disclosure of which is prohibited by 5 U.S.C. 552a

or by §1.575 series established thereunder, and who knowing that disclosure of the specific material is so prohibited, willfully discloses the material in any manner to any person or agency not entitled to receive it, shall be guilty of a misdemeanor and fined not more than $5,000.

(2) Any officer or employee of the Department of Veterans Affairs who willfully maintains a system of records without meeting the notice requirements of 5 U.S.C. 552a(e)(4) (see §1.578(d)) shall be guilty of a misdemeanor and fined not more than $5,000.

(3) Any person who knowingly and willfully requests or obtains any record concerning an individual from the Department of Veterans Affairs under false pretenses shall be guilty of a misdemeanor and fined not more than $5,000.

(f) For purposes of §1.575 series the following definitions apply:

(1) The term *agency* includes any executive department, military department, Government corporation, Government controlled corporation, or other establishment in the executive branch of the government (including the Executive Office of the President), or any independent regulatory agency.

(2) The term *individual* means a citizen of the United States or an alien lawfully admitted for permanent residence.

(3) The term *maintain* includes maintain, collect, use, or disseminate.

(4) The term *record* means any item, collection, or grouping of information about an individual that is maintained by an agency, including, but not limited to, his or her education, financial transactions, medical history, and criminal or employment history and that contains his or her name, or the identifying number, symbol, or other identifying particular assigned to the individual, such as a finger or voice print or a photograph.

(5) The term *system of records* means a group of any records under the control of any agency from which information is retrieved by the name of the individual or by some identifying number, symbol, or other identifying particular assigned to the individual.

(6) The term *statistical record* means a record in a system of records maintained for statistical research or reporting purposes only and not used in whole or in part in making any determination about an identifiable individual except as provided by section 8 of title 13 U.S.C.

(7) The term *routine use* means, with respect to the disclosure of a record, the use of such record for a purpose which is compatible with the purpose for which it was collected.

(g) When the Department of Veterans Affairs provides by a contract for the operation by or on behalf of the Department of Veterans Affairs of a system of records to accomplish a Department of Veterans Affairs function, the Department of Veterans Affairs will, consistent with its authority, cause the requirements of 5 U.S.C. 552a (as required by subsection (m)) and those of the §1.575 series to be applied to such system. For the purposes of 5 U.S.C. 552a(i) and §1.576(e) any such contractor and any employee of such contractor, if such contract is agreed to on or after September 27, 1975, will be considered to be an employee of the Department of Veterans Affairs.

(h) The Department of Veterans Affairs will, for the purposes of 5 U.S.C. 552a, consider that it maintains any agency record which it deposits with the Administrator of General Services for storage, processing, and servicing in accordance with section 3103 of title 44 U.S.C. Any such record will be considered subject to the provisions of §1.575 series implementing 5 U.S.C. 552a and any other applicable Department of Veterans Affairs regulations. The Administrator of General Services is not authorized to disclose such a record except to the Department of Veterans Affairs, or under regulations established by the Department of Veterans Affairs which are not inconsistent with 5 U.S.C. 552a.

(i) The Department of Veterans Affairs will, for the purposes of 5 U.S.C. 552a, consider that a record is maintained by the National Archives of the United States if it pertains to an identifiable individual and was transferred to the National Archives prior to September 27, 1975, as a record which has sufficient historical or other value to

warrant its continued preservation by the United States Government. Such records are not subject to the provisions of 5 U.S.C. 552a except that a statement generally describing such records (modeled after the requirements relating to records subject to subsections (e)(4)(A) through (G) of 5 U.S.C. 552a) will be published in the FEDERAL REGISTER.

(j) The Department of Veterans Affairs will also, for the purposes of 5 U.S.C. 552a, consider that a record is maintained by the National Archives of the United States if it pertains to an identifiable individual and is transferred to the National Archives on or after September 27, 1975, as a record which has sufficient historical or other value to warrant its continued preservation by the United States Government. Such records are exempt from the requirements of 5 U.S.C. 552a except subsections (e)(4) (A) through (G) and (e)(9) thereof.

(Authority: 38 U.S.C. 501)

[40 FR 33944, Aug. 12, 1975, as amended at 40 FR 58644, Dec. 18, 1975; 47 FR 16323, Apr. 16, 1982]

§ 1.577 Access to records.

(a) Except as otherwise provided by law or regulation any individual upon request may gain access to his or her record or to any information pertaining to him or her which is contained in any system of records maintained by the Department of Veterans Affairs. The individual will be permitted, and upon his or her request, a person of his or her own choosing permitted to accompany him or her, to review the record and have a copy made of all or any portion thereof in a form comprehensible to him or her. The Department of Veterans Affairs will require, however, a written statement from the individual authorizing discussion of that individual's record in the accompanying person's presence.

(b) Any individual will be notified, upon request, if any Department of Veterans Affairs system of records named contains a record pertaining to him or her. Such request must be in writing, over the signature of the requester. The request must contain a reasonable description of the Department of Veterans Affairs system or systems of records involved, as described at least annually by notice published in the FEDERAL REGISTER describing the existence and character of the Department of Veterans Affairs system or systems of records pursuant to §1.578(d). The request should be made to the office concerned (having jurisdiction over the system or systems of records involved) or, if not known, to the Director or Department of Veterans Affairs Officer in the nearest Department of Veterans Affairs regional office, or to the Department of Veterans Affairs Central Office, 810 Vermont Avenue, NW., Washington, DC 20420. Personal contact should normally be made during the regular duty hours of the office concerned, which are 8:00 a.m. to 4:30 p.m., Monday through Friday for Department of Veterans Affairs Central Office and most field facilities. Identification of the individual requesting the information will be required and will consist of the requester's name, signature, address, and claim, insurance or other identifying file number, if any, as a minimum. Additional identifying data or documents may be required in specified categories as determined by operating requirements and established and publicized by the promulgation of Department of Veterans Affairs regulations. (5 U.S.C. 552a(f)(1))

(c) The VA component or staff office having jurisdiction over the records subject to the Privacy Act request will establish appropriate disclosure procedures, including notifying the individual who filed the Privacy Act request of the time, place, and conditions under which the VA will comply with the request, in accordance with applicable laws and regulations. Access requests for Privacy Act records or information must be sent to the staff office that maintains the records; the individual seeking access may consult the system of record notice (*https://www.oprm.va.gov/privacy/systems_of_records.aspx*) in order to identify the office to which the request should be sent. Each component has discretion to require that a requester supply additional information to verify his or her identity. If the Privacy Officer determines that the request does not reasonably describe the records

being sought, the Privacy Officer will advise the requester how the request is insufficient; the Privacy Officer will provide an opportunity to discuss the request by documented telephonic communication or written correspondence in order to modify it to clearly identify the records being sought.

(d) Nothing in 5 U.S.C. 552a, however, allows an individual access to any information compiled in reasonable anticipation of civil action or proceeding. (5 U.S.C. 552a(d)(5))

(e) Fees to be charged, if any, to any individual for making copies of his or her record shall not include the cost of and search for and review of the record. Fees under $25.00 shall be waived. Fees to be charged are as follows:

Activity	Fees
(1) Duplication of documents by any type of reproduction process to produce plain one-sided paper copies of a standard size (8½″ x 11″; 8½″ x 14″; 11″ x 14″).	$0.15 per page after first 100 one-sided pages or electronic equivalent.
(2) Duplication of non-paper records, such as microforms, audiovisual materials (motion pictures, slides, laser optical disks, video tapes, audio tapes, etc.), computer tapes and disks, diskettes for personal computers, and any other automated media output.	Direct cost to the Agency as defined in § 1.561(b)(3) of this part to the extent that it pertains to the cost of duplication.
(3) Duplication of document by any type of reproduction process not covered by paragraphs (e)(1) or (2) of this section to produce a copy in a form reasonably usable by the requester.	Direct cost to the Agency as defined in § 1.561(b)(3) of this part to the extent that it pertains to the cost of duplication.

(f) When VA benefit records, which are retrievable by name or individual identifier of a VA beneficiary or applicant for VA benefits, are requested by the individual to whom the record pertains, the duplication fee for one complete set of such records will be waived.

(Authority: 5 U.S.C. 552a(f)(5)) (38 U.S.C. 501)

[40 FR 33944, Aug. 12, 1975, as amended at 47 FR 16323, Apr. 16, 1982; 53 FR 10380, Mar. 31, 1988; 55 FR 21546, May 25, 1990; 78 FR 45457, July 29, 2013; 84 FR 12130, Apr. 1, 2019]

§ 1.578 [Reserved]

§ 1.579 Amendment of records.

(a) Any individual may request amendment of any Department of Veterans Affairs record pertaining to him or her. Not later than 10 days (excluding Saturdays, Sundays, and legal public holidays) after the date or receipt of such request, the Department of Veterans Affairs will acknowledge in writing such receipt. The Department of Veterans Affairs will complete the review to amend or correct a record as soon as reasonably possible, normally within 30 days from the receipt of the request (excluding Saturdays, Sundays, and legal public holidays) unless unusual circumstances preclude completing action within that time. The Department of Veterans Affairs will promptly either:

(1) Correct any part thereof which the individual believes is not accurate, relevant, timely or complete; or

(2) Inform the individual of the Department of Veterans Affairs refusal to amend the record in accordance with his or her request, the reason for the refusal, the procedures by which the individual may request a review of that refusal by the Secretary or designee, and the name and address of such official.

(Authority: 5 U.S.C. 552a(d)(2))

(b) The administration or staff office having jurisdiction over the records involved will establish procedures for reviewing a request from an individual concerning the amendment of any record or information pertaining to the individual, for making a determination on the request, for an appeal within the Department of Veterans Affairs of an initial adverse Department of Veterans Affairs determination, and for whatever additional means may be necessary for each individual to be able to exercise fully, his or her right under 5 U.S.C. 552a.

(1) Headquarters officials designated as responsible for the amendment of records or information located in Central Office and under their jurisdiction include, but are not limited to: Secretary; Deputy Secretary, as well as

other appropriate individuals responsible for the conduct of business within the various Department of Veterans Affairs administrations and staff offices. These officials will determine and advise the requester of the identifying information required to relate the request to the appropriate record, evaluate and grant or deny requests to amend, review initial adverse determinations upon request, and assist requesters desiring to amend or appeal initial adverse determinations or learn further of the provisions for judicial review.

(2) The following field officials are designated as responsible for the amendment of records or information located in facilities under their jurisdiction, as appropriate: The Director of each Center, Domiciliary, Medical Center, Outpatient Clinic, Regional Office, Supply Depot, and Regional Counsels. These officials will function in the same manner at field facilities as that specified in the preceding subparagraph for headquarters officials in Central Office.

(Authority: 5 U.S.C. 552a(f)(4))

(c) Any individual who disagrees with the Department of Veterans Affairs refusal to amend his or her record may request a review of such refusal. The Department of Veterans Affairs will complete such review not later than 30 days (excluding Saturdays, Sundays, and legal public holidays) from the date on which the individual request such review and make a final determination unless, for good cause shown, the Secretary extends such 30-day period. If, after review, the Secretary or designee also refuses to amend the record in accordance with the request the individual will be advised of the right to file with the Department of Veterans Affairs a concise statement setting forth the reasons for his or her disagreement with the Department of Veterans Affairs refusal and also advise of the provisions for judicial review of the reviewing official's determination. (5 U.S.C. 552a(g)(1)(A))

(d) In any disclosure, containing information about which the individual has filed a statement of disagreement, occurring after the filing of the statement under paragraph (c) of this section, the Department of Veterans Affairs will clearly note any part of the record which is disputed and provide copies of the statement (and, if the Department of Veterans Affairs deems it appropriate, copies of a concise statement of the Department of Veterans Affairs reasons for not making the amendments requested) to persons or other agencies to whom the disputed record has been disclosed. (5 U.S.C. 552a(d)(4)) (38 U.S.C. 501)

[47 FR 16324, Apr. 16, 1982]

§ 1.580 Administrative review.

(a) Upon consideration and denial of a request under § 1.577 or § 1.579 of this part, the responsible VA official or designated employee will inform the requester *in writing* of the denial. The adverse determination notice must be signed by the component head or the component's Privacy Officer, and shall include the following:

(1) The name and title or position of the person responsible for the adverse determination;

(2) A brief statement of the reason(s) for the denial and the policy upon which the denial is based; and

(3) Notice that the requester may appeal the adverse determination under paragraph (b) of this section to the Office of General Counsel (providing the address as follows: Office of General Counsel (024), 810 Vermont Avenue NW, Washington, DC 20420), and instructions on what information is required for an appeal, which includes why the individual disagrees with the initial denial with specific attention to one or more of the four standards (*e.g.*, accuracy, relevance, timeliness, and completeness), and a copy of the denial letter and any supporting documentation that demonstrates why the individual believes the information does not meet these requirements.

(b) The final agency decision in appeals of adverse determinations described in paragraph (a) of this section will be made by the designated official within the Office of General Counsel (024).

(c) A written denial must have occurred to appeal to OGC. The absence of a response to an access *or* amendment request filed with a VA component is *not* a denial. If an individual

has not received a response to a request for access to or amendment of records, the individual must pursue the request with the Privacy Officer of the administration office (*e.g.*, the VHA, VBA, or National Cemetery Administration Privacy Officer) or staff office (*e.g.*, the Office of Information Technology or Office of Inspector General Privacy Staff Officer) that has custody over the records.

[84 FR 12130, Apr. 1, 2019]

§ 1.581 [Reserved]

§ 1.582 Exemptions.

(a) Certain systems of records maintained by the Department of Veterans Affairs are exempted from provisions of the Privacy Act in accordance with exemptions (j) and (k) of 5 U.S.C. 552a.

(b) *Exemption of Inspector General Systems of Records*. The Department of Veterans Affairs provides limited access to Inspector General Systems of Records as indicated.

(1) The following systems of records are exempted pursuant to the provisions of 5 U.S.C. 552a(j)(2) from subsections (c)(3) and (4), (d), (e)(1), (2) and (3), (e)(4) (G), (H) and (I), (e)(5) and (8), (f) and (g) of 5 U.S.C. 552a; in addition, the following systems of records are exempted pursuant to the provisions of 5 U.S.C. 552a(k)(2) from subsections (c)(3), (d), (e)(1), (e)(4) (G), (H), and (I), and (f) of 5 U.S.C. 552a:

(i) Investigation Reports of Persons Allegedly Involved in Irregularities Concerning VA and Federal Laws, Regulations, Programs, etc.—VA (11 VA51); and

(ii) Inspector General Complaint Center Records—VA (66VA53).

(2) These exemptions apply to the extent that information in those systems is subject to exemptions pursuant to 5 U.S.C. 552a (j)(2) and (k)(2).

(3) For the reasons set forth, the systems of records listed under paragraph (b)(1) of this section are exempted under sections 552a (j)(2) and (k)(2) from the following provisions of 5 U.S.C. 552a:

(i) 5 U.S.C. 552a(c)(3) requires that upon request, an agency must give an individual named in a record an accounting which reflects the disclosure of the record to other persons or agencies. This accounting must state the date, nature and purpose of each disclosure of the record and the name and address of the recipient. The application of this provision would alert subjects to the existence of the investigation and identify that such persons are subject of that investigation. Since release of such information to subjects would provide them with significant information concerning the nature of the investigation, it could result in the altering or destruction of derivative evidence which is obtained from third parties, improper influencing of witnesses, and other activities that could impede or compromise the investigation.

(ii) 5 U.S.C. 552a(c)(4), (d), (e)(4) (G) and (H), (f) and (g) relate to an individual's right to be notified of the existence of records pertaining to such individual; requirements for identifying an individual who requests access to records; the agency procedures relating to access to records and the amendment of information contained in such records; and the civil remedies available to the individual in the event of adverse determinations by an agency concerning access to or amendment of information contained in record systems. This system is exempt from the foregoing provisions for the following reasons: To notify an individual at the individual's request of the existence of records in an investigative file pertaining to such individual or to grant access to an investigative file could interfere with investigative and enforcement proceedings, threaten the safety of individuals who have cooperated with authorities, constitute an unwarranted invasion of personal privacy of others, disclose the identity of confidential sources, reveal confidential information supplied by these sources, and disclose investigative techniques and procedures.

(iii) 5 U.S.C. 552a(e)(4)(I) requires the publication of the categories of sources of records in each system of records. The application of this provision could disclose investigative techniques and procedures and cause sources to refrain from giving such information because of fear of reprisal, or fear of breach of promises of anonymity and confidentiality. This could compromise the ability to conduct investigations and

to identify, detect and apprehend violators. Even though the agency has claimed an exemption from this particular requirement, it still plans to generally identify the categories of records and the sources for these records in this system. However, for the reasons stated in paragraph (b)(3)(ii) of this section, this exemption is still being cited in the event an individual wants to know a specific source of information.

(iv) 5 U.S.C. 552a(e)(1) requires each agency to maintain in its records only such information about an individual that is relevant and necessary to accomplish a purpose of the agency required by statute or Executive order. These systems of records are exempt from the foregoing provisions because:

(A) It is not possible to detect the relevance or necessity of specific information in the early stages of a criminal or other investigation.

(B) Relevance and necessity are questions of judgment and timing. What appears relevant and necessary may ultimately be determined to be unnecessary. It is only after the information is evaluated that the relevance and necessity of such information can be established.

(C) In any investigation the Inspector General may obtain information concerning the violations of laws other than those within the scope of his/her jurisdiction. In the interest of effective law enforcement, the Inspector General should retain this information as it may aid in establishing patterns of criminal activity and provide leads for those law enforcement agencies charged with enforcing other segments of civil or criminal law.

(v) 5 U.S.C. 552a(e)(2) requires an agency to collect information to the greatest extent practicable directly from the subject individual when the information may result in adverse determinations about an individual's rights, benefits, and privileges under Federal programs. The application of this provision would impair investigations of illegal acts, violations of the rules of conduct, merit system and any other misconduct for the following reasons:

(A) In order to successfully verify a complaint, most information about a complainant or an individual under investigation must be obtained from third parties such as witnesses and informers. It is not feasible to rely upon the subject of the investigation as a source for information regarding his/her activities because of the subject's rights against self-incrimination and because of the inherent unreliability of the suspect's statements. Similarly, it is not always feasible to rely upon the complainant as a source of information regarding his/her involvement in an investigation.

(B) The subject of an investigation will be alerted to the existence of an investigation if an attempt is made to obtain information from the subject. This would afford the individual the opportunity to conceal any criminal activities to avoid apprehension.

(vi) 5 U.S.C. 552a(e)(3) requires that an agency must inform the subject of an investigation who is asked to supply information of:

(A) The authority under which the information is sought and whether disclosure of the information is mandatory or voluntary;

(B) The purposes for which the information is intended to be used;

(C) The routine uses which may be made of the information; and

(D) The effects on the subject, if any, of not providing the requested information. The reasons for exempting this system of records from the foregoing provision are as follows:

(*1*) The disclosure to the subject of the purposes of the investigation as stated in paragraph (b)(3)(vi)(B) of this paragraph would provide the subject with substantial information relating to the nature of the investigation and could impede or compromise the investigation.

(*2*) If the complainant or the subject were informed of the information required by this provision, it could seriously interfere with undercover activities requiring disclosure of the authority under which the information is being requested. This could conceivably jeopardize undercover agents' identities and impair their safety, as well as impair the successful conclusion of the investigation.

(*3*) Individuals may be contacted during preliminary information gathering

in investigations before any individual is identified as the subject of an investigation. Informing the individual of the matters required by this provision would hinder or adversely affect any present or subsequent investigations.

(vii) 5 U.S.C. 552a(e)(5) requires that records be maintained with such accuracy, relevance, timeliness, and completeness as is reasonably necessary to assure fairness to the individual in making any determination about an individual. Since the law defines *maintain* to include the collection of information, complying with this provision would prevent the collection of any data not shown to be accurate, relevant, timely, and complete at the moment of its collection. In gathering information during the course of an investigation it is not always possible to determine this prior to collection of the information. Facts are first gathered and then placed into a logical order which objectively proves or disproves criminal behavior on the part of the suspect. Material which may seem unrelated, irrelevant, incomplete, untimely, etc., may take on added meaning as an investigation progresses. The restrictions in this provision could interfere with the preparation of a complete investigative report.

(viii) 5 U.S.C. 552a(e)(8) requires an agency to make reasonable efforts to serve notice on an individual when any record on such individual is made available to any person under compulsory legal process when such process becomes a matter of public record. The notice requirement of this provision could prematurely reveal an ongoing criminal investigation to the subject of the investigation.

(c) *Exemption of Loan Guaranty Service, Veterans Benefits Administration, Systems of Records.* The Department of Veterans Affairs provides limited access to Loan Guaranty Service, Veterans Benefits Administration, systems of records as indicated:

(1) The following systems of records are exempted pursuant to the provisions of 5 U.S.C. 552a(k)(2) from subsections (c)(3), (d), (e)(1) and (e)(4) (G), (H) and (I) and (f):

(i) Loan Guaranty Fee Personnel and Program Participant Records—VA (17VA26); and

(ii) Loan Guaranty Home Condominium and Mobile Home Loan Applicant Records and Paraplegic Grant Application Records—VA (55VA26).

(2) These exemptions apply to the extent that information in these systems is subject to exemption pursuant to 5 U.S.C. 552a(k)(2).

(3) For the reasons set forth, the systems of records listed under paragraph (c)(1) of this section are exempted under 5 U.S.C. 552a(k)(2) from the following provisions of 5 U.S.C. 552a:

(i) 5 U.S.C. 552a(c)(3) requires that an agency make accountings of disclosures of records available to individuals named in the records at their request. These accountings must state the date, nature and purpose of each disclosure of the record and the name and address of the recipient. The application of this provision would alert subjects of an investigation to the existence of the investigation and that such persons are subjects of that investigation. Since release of such information to subjects of an investigation would provide the subjects with significant information concerning the nature of the investigation, it could result in the altering or destruction of documentary evidence, improper influencing of witnesses and other activities that could impede or compromise the investigation.

(ii) 5 U.S.C. 552a(d), (e)(4) (G) and (H) and (f) relate to an individual's right to be notified of the existence of records pertaining to such individual; requirements for identifying an individual who requests access to records; and the agency procedures relating to access to records and the contest of information contained in such records. This system is exempt from the foregoing provisions for the following reasons: To notify an individual at the individual's request of the existence of records in an investigative file pertaining to such individual or to grant access to an investigative file could interfere with investigative and enforcement proceedings; constitute an unwarranted invasion of the personal privacy of others; disclose the identity of confidential sources and reveal confidential information supplied by these sources and disclose investigative techniques and procedures.

(iii) 5 U.S.C. 552a(e)(4)(I) requires the publication of the categories of sources of records in each system of records. The application of this provision could disclose investigative techniques and procedures and cause sources to refrain from giving such information because of fear of reprisal, or fear of breach of promises of anonymity and confidentiality. This would compromise the ability to conduct investigations. Even though the agency has claimed an exemption from this particular requirement, it still plans to generally identify the categories of records and the sources for these records in this system. However, for the reasons stated above, this exemption is still being cited in the event an individual wanted to know a specific source of information.

(iv) 5 U.S.C. 552a(e)(1) requires each agency to maintain in its records only such information about an individual that is relevant and necessary to accomplish a purpose of the agency required by statute or Executive order. This system of records is exempt from the foregoing provision because:

(A) It is not possible to detect relevance or necessity of specific information in the early stages of an investigation.

(B) Relevance and necessity are questions of judgment and timing. What appears relevant and necessary when collected may ultimately be determined to be unnecessary. It is only after the information is evaluated that the relevance and necessity of such information can be established.

(C) In interviewing persons or obtaining other forms of evidence during an investigation, information may be supplied to the investigator which relates to matters incidental to the main purpose of the investigation but which is appropriate in a thorough investigation. Oftentimes, such information cannot readily be segregated.

(4) The following system of records is exempt pursuant to the provisions of 5 U.S.C. 552a(k)(5) from subsections (c)(3), (d), (e)(1), (e)(4) (G), (H) and (I) and (f): Loan Guaranty Fee Personnel and Program Participant Records—VA (17 VA 26).

(5) This exemption applies to the extent that information in this system is subject to exemption pursuant to 5 U.S.C. 552a(k)(5).

(6) For the reasons set forth, the system of records listed in paragraph (c)(4) of this section is exempt under 5 U.S.C. 552a(k)(5) from the following provisions of 5 U.S.C. 552a:

(i) 5 U.S.C. 552a(c)(3) requires that an agency make accountings of disclosures of records available to individuals named in the records at their request. These accountings must state the date, nature and purpose of each disclosure of the record and the name and address of the recipient. The application of this provision would alert subjects of background suitability investigations to the existence of the investigation and reveal that such persons are subjects of that investigation. Since release of such information to subjects of an investigation would provide the subjects with significant information concerning the nature of the investigation, it could result in revealing the identity of a confidential source.

(ii) 5 U.S.C. 552a(d), (e)(4) (G) and (H) and (f) relate to an individual's right to be notified of the existence of records pertaining to such individual; requirements for identifying an individual who requests access to records; and the agency procedures relating to access to records and the contest of information contained in such records. This system is exempt from the foregoing provisions for the following reasons: To notify an individual at the individual's request of the existence of records in an investigative file pertaining to such an individual or to grant access to an investigative file would disclose the identity of confidential sources and reveal confidential information supplied by these sources.

(iii) 5 U.S.C. 552a(e)(4)(I) requires the publication of the categories of sources of records in each system of records. The application of this provision could disclose sufficient information to disclose the identity of a confidential source and cause sources to refrain from giving such information because of fear of reprisal, or fear of breach of promises of anonymity and confidentiality. This would compromise the ability to conduct background suitability investigations.

(iv) 5 U.S.C. 552a(e)(1) requires each agency to maintain in its records only such information about an individual that is relevant and necessary to accomplish a purpose of the agency required by statute or Executive order. This system of records is exempt from the foregoing provision because:

(A) It is not possible to detect relevance and necessity of specific information from a confidential source in the early stages of an investigation.

(B) Relevance and necessity are questions of judgment and timing. What appears relevant and necessary when collected may ultimately be determined to be unnecessary. It is only after the information is evaluated that the relevance and necessity of such information can be established regarding suitability for VA approval as a fee appraiser or compliance inspector.

(C) In interviewing persons or obtaining other forms of evidence during an investigation for suitability for VA approval, information may be supplied to the investigator which relates to matters incidental to the main purpose of the investigation but which is appropriate in a thorough investigation. Oftentimes, such information cannot readily be segregated and disclosure might jeopardize the identity of a confidential source.

(d) *Exemption of Police and Security Records.* VA provides limited access to one Security and Law Enforcement System of Records, Police and Security Records—VA (103VA07B).

(1) The investigations records and reports contained in this System of Records are exempted [pursuant to 5 U.S.C. 552a(j)(2) of the Privacy Act of 1974] from Privacy Act subsections (c)(3) and (c)(4); (d); (e)(1) through (e)(3), (e)(4)(G) through (e)(4)(I), (e)(5), and (e)(8); (f); and (g); in addition, they are exempted [pursuant to 5 U.S.C. 552a(k)(2) of the Privacy Act of 1974] from Privacy Act subsections (c)(3); (d); (e)(1), (e)(4)(G) through (e)(4)(I); and (f).

(2) These records contained in the Police and Security Records—VA (103VA076B) are exempted for the following reasons:

(i) The application of Privacy Act subsection (c)(3) would alert subjects to the existence of the investigation and reveal that they are subjects of that investigation. Providing subjects with information concerning the nature of the investigation could result in alteration or destruction of evidence which is obtained from third parties, improper influencing of witnesses, and other activities that could impede or compromise the investigation.

(ii) The application of Privacy Act subsections (c)(4); (d); (e)(4)(G) and (e)(4)(H); (f); and (g) could interfere with investigative and enforcement proceedings, threaten the safety of individuals who have cooperated with authorities, constitute an unwarranted invasion of personal privacy of others, disclose the identity of confidential sources, reveal confidential information supplied by these sources, and disclose investigative techniques and procedures.

(iii) The application of Privacy Act subsection (e)(4)(I) could disclose investigative techniques and procedures and cause sources to refrain from giving such information because of fear of reprisal, or fear of breach of promises of anonymity and confidentiality. This could compromise the ability to conduct investigations and to identify, detect and apprehend violators. Even though the agency has claimed an exemption from this particular requirement, it still plans to generally identify the categories of records and the sources of these records in this system. However, for the reason stated in paragraph (d)(2)(ii) of this section, this exemption is still being cited in the event an individual wants to know a specific source of information.

(iv) These records contained in the Police and Security Records—VA (103VA076B) are exempt from Privacy Act subsection (e)(1) because it is not possible to detect the relevance or necessity of specific information in the early stages of a criminal or other investigation. Relevance and necessity are questions of judgment and timing. What appears relevant and necessary may ultimately be determined to be unnecessary. It is only after the information is evaluated that the relevance and necessity of such information can be established. In any investigation, the Office of Security and Law Enforcement may obtain information

concerning violations of laws other than those within the scope of its jurisdiction. In the interest of effective law enforcement, the Office of Security and Law Enforcement should retain this information as it may aid in establishing patterns of criminal activity and provide leads for those law enforcement agencies charged with enforcing other segments of civil or criminal law.

(v) The application of Privacy Act subsection (e)(2) would impair investigations of illegal acts, violations of the rules of conduct, merit system and any other misconduct for the following reasons:

(A) In order to successfully verify a complaint, most information about a complainant or an individual under investigation must be obtained from third parties such as witnesses and informers. It is not feasible to rely upon the subject of the investigation as a source for information regarding his/her activities because of the subject's rights against self-incrimination and because of the inherent unreliability of the suspect's statements. Similarly, it is not always feasible to rely upon the complainant as a source of information regarding his/her involvement in an investigation.

(B) The subject of an investigation will be alerted to the existence of an investigation if an attempt is made to obtain information from the subject. This would afford the individual the opportunity to conceal any criminal activities to avoid apprehension.

(vi) The reasons for exempting these records in the Police and Security Records—VA (103VA07B) from Privacy Act subsection (e)(3) are as follows:

(A) The disclosure to the subject of the purposes of the investigation would provide the subject with substantial information relating to the nature of the investigation and could impede or compromise the investigation.

(B) Informing the complainant or the subject of the information required by this provision could seriously interfere with undercover activities, jeopardize the identities of undercover agents and impair their safety, and impair the successful conclusion of the investigation.

(C) Individuals may be contacted during preliminary information gathering in investigations before any individual is identified as the subject of an investigation. Informing the individual of the matters required by this provision would hinder or adversely affect any present or subsequent investigations.

(vii) Since the Privacy Act defines ''maintain'' to include the collection of information, complying with subsection (e)(5) would prevent the collection of any data not shown to be accurate, relevant, timely, and complete at the moment of its collection. In gathering information during the course of an investigation, it is not always possible to make this determination prior to collecting the information. Facts are first gathered and then placed into a logical order which objectively proves or disproves criminal behavior on the part of the suspect. Material that may seem unrelated, irrelevant, incomplete, untimely, etc., may take on added meaning as an investigation progresses. The restrictions in this provision could interfere with the preparation of a complete investigative report.

(viii) The notice requirement of Privacy Act subsection (e)(8) could prematurely reveal an ongoing criminal investigation to the subject of the investigation.

(Authority: 5 U.S.C. 552a (j) and (k); 38 U.S.C. 501)

[48 FR 29847, June 29, 1983, as amended at 68 FR 35298, June 13, 2003]

§§ 1.583–1.584 [Reserved]

INVENTIONS BY EMPLOYEES OF DEPARTMENT OF VETERANS AFFAIRS

AUTHORITY: Sections 1.650 to 1.666 issued under sect. 1, 66 Stat. 811, 72 Stat. 1114; 35 U.S.C. 266; 15 U.S.C. 3710a; 38 U.S.C. 501; E.O. 10096, E.O. 10930, 15 FR 389; 3 CFR 1949–1953 Comp.

EXPANDED REMOTE ACCESS TO COMPUTERIZED VETERANS CLAIMS RECORDS BY ACCREDITED REPRESENTATIVES

§ 1.600 Purpose.

(a) Sections 1.600 through 1.603 establish policy, assign responsibilities and prescribe procedures with respect to:

(1) When, and under what circumstances, VA will grant authorized claimants' representatives read-only access to the automated Veterans Benefits Administration (VBA) claims

records of those claimants whom they represent;

(2) The exercise of authorized access by claimants' representatives; and

(3) The bases and procedures for disqualification of a representative for violating any of the requirements for access.

(b) VBA will grant access to its automated claimants' claims records from locations outside Regional Offices under the following conditions. Access will be provided:

(1) Only to individuals and organizations granted access to automated claimants' records under §§1.600 through 1.603;

(2) Only to the claims records of VA claimants whom the organization or individual represents as reflected in the claims file;

(3) Solely for the purpose of the representative assisting the individual claimant whose records are accessed in a claim for benefits administered by VA; and

(4) On a read-only basis. Individuals authorized access to VBA automated claims records under §§1.600 through 1.603 will not be permitted to modify the data.

(c)(1) Access will be authorized only to the inquiry commands of the Benefits Delivery Network which provide access to the following categories of data:

(i) Beneficiary identification data such as name, social security number, sex, date of birth, service number and related service data; and

(ii) Claims history and processing data such as folder location, claim status, claim establishment date, claim processing history, award data, rating data, including service-connected medical conditions, income data, dependency data, deduction data, payment data, educational facility and program data (except chapter 32 benefits), and education program contribution and delimiting data (except chapter 32 benefits).

(2) Access to this information will currently be through the inquiry commands of BINQ (BIRLS (Beneficiaries Identification and Records Location Subsystem) Inquiry), SINQ (Status Inquiry), MINQ (Master Record Inquiry), PINQ (Pending Issue Inquiry) and TINQ (Payment History Inquiry). The identifying information received from BIRLS to representative inquiries will be limited to file number, veteran's name, date of death, folder location and transfer date of folder, insurance number, insurance type, insurance lapse date and insurance folder jurisdiction.

(d) Sections 1.600 through 14.603 are not intended to, and do not:

(1) Waive the sovereign immunity of the United States; or

(2) Create, and may not be relied upon to create, any right or benefit, substantive or procedural, enforceable at law against the United States or the Department of Veterans Affairs.

[59 FR 47084, Sept. 14, 1994. Redesignated and amended at 73 FR 29870, 29879, May 22, 2008]

§ 1.601 Qualifications for access.

(a) An applicant for read-only access to VBA automated claims records from a location other than a VA Regional Office must be:

(1) An organization, representative, attorney or agent approved or accredited by VA under §§14.626 through 14.635; or

(2) An attorney of record for a claimant in proceedings before the Court of Veterans Appeals or subsequent proceedings who requests access to the claimant's automated claims records as part of the representation of the claimant.

(b) The hardware, modem and software utilized to obtain access, as well as their location, must be approved in advance by VBA.

(c) Each individual and organization approved for access must sign and return a notice provided by the Regional Office Director (or the Regional Office Director's designee) of the Regional Office of jurisdiction for the claim. The notice will specify the applicable operational and security requirements for access and an acknowledgment that the breach of any of these requirements is grounds for disqualification from access.

[59 FR 47084, Sept. 14, 1994. Redesignated at 73 FR 29870, May 22, 2008]

§ 1.602 Utilization of access.

(a) Once an individual or organization has been issued the necessary

passwords to obtain read-only access to the automated claims records of individuals represented, access will be exercised in accordance with the following requirements:

(1) The individual or organization will obtain access only from equipment and software approved in advance by the Regional Office from the location where the individual or organization primarily conducts its representation activities which also has been approved in advance;

(2) The individual will use only his or her assigned password to obtain access;

(3) The individual will not reveal his or her password to anyone else, or allow anyone else to use his or her password;

(4) The individual will access only the VBA automated claims records of VA claimants who are represented by the person obtaining access or by the organization employing the person obtaining access;

(5) The individual will access a claimant's automated claims record solely for the purpose of representing that claimant in a claim for benefits administered by VA;

(6) Upon receipt of the password, the individual will destroy the hard copy; no written or printed record containing the password will be retained; and

(7) The individual and organization will comply with all security requirements VBA deems necessary to ensure the integrity and confidentiality of the data and VBA's automated computer systems.

(b) An organization granted access shall ensure that all employees provided access in accordance with these regulations will receive regular, adequate training on proper security, including the items listed in §1.603(a). Where an individual such as an attorney or registered agent is granted access, he or she will regularly review the security requirements for the system as set forth in these regulations and in any additional materials provided by VBA.

(c) VBA may, at any time without notice:

(1) Inspect the computer hardware and software utilized to obtain access and their location;

(2) Review the security practices and training of any individual or organization granted access under these regulations; and

(3) Monitor an individual's or organization's access activities. By applying for, and exercising, the access privileges under §§1.600 through 1.603, the applicant expressly consents to VBA monitoring the access activities of the applicant at any time.

[59 FR 47084, Sept. 14, 1994. Redesignated and amended at 73 FR 29870, 29879, May 22, 2008]

§1.603 Disqualification.

(a) The Regional Office Director or the Regional Office Director's designee may revoke an individual's or an organization's access privileges to a particular claimant's records because the individual or organization no longer represents the claimant, and, therefore, the beneficiary's consent is no longer in effect. The individual or organization is no longer entitled to access as a matter of law under the Privacy Act, 5 U.S.C. 552a, and 38 U.S.C. 5701 and 7332. Under these circumstances, the individual or organization is not entitled to any hearing or to present any evidence in opposition to the revocation.

(b) The Regional Office Director or the Regional Office Director's designee may revoke an individual's or an organization's access privileges either to an individual claimant's records or to all claimants' records in the VBA automated claims benefits systems if the individual or organization:

(1) Violates any of the provisions of §§1.600 through 1.603;

(2) Accesses or attempts to access data for a purpose other than representation of an individual veteran;

(3) Accesses or attempts to access data other than the data specified in these regulations;

(4) Accesses or attempts to access data on a VA beneficiary who is not represented either by the individual who obtains access or by the organization employing the individual who obtains access;

(5) Utilizes unapproved computer hardware or software to obtain or attempt to obtain access to VBA computer systems;

(6) Modifies or attempts to modify data in the VBA computer systems.

(c) If VBA is considering revoking an individual's access under §1.603(b), and that individual works for an organization, the Regional Office of jurisdiction will notify the organization of the pendency of the action.

(d) After an individual's access privileges are revoked, if the conduct which resulted in revocation was such that it merits reporting to an appropriate governmental licensing organization such as a State bar, the VBA Regional Office of jurisdiction will immediately inform the licensing organization in writing of the fact that the individual's access privileges were revoked and the reasons why.

(e) The VBA Regional Office of jurisdiction may temporarily suspend access privileges prior to any determination on the merits of the proposed revocation where the Regional Office Director or the Director's designee determines that such immediate suspension is necessary in order to protect the integrity of the system or confidentiality of the data in the system from a reasonably foreseeable compromise. However, in such case, the Regional Office shall offer the individual or organization an opportunity to respond to the charges immediately after the temporary suspension.

[59 FR 47084, Sept. 14, 1994. Redesignated and amended at 73 FR 29870, 29879, May 22, 2008]

INVENTIONS BY EMPLOYEES OF DEPARTMENT OF VETERANS AFFAIRS

AUTHORITY: Sections 1.650 to 1.666 issued under sect. 1, 66 Stat. 811, 72 Stat. 1114; 35 U.S.C. 266; 15 U.S.C. 3710a; 38 U.S.C. 501; E.O. 10096, E.O. 10930, 15 FR 389; 3 CFR 1949–1953 Comp.

§ 1.650 Purpose.

The purpose of these regulations is to prescribe the procedure to be followed in determining and protecting the respective rights of the United States Government and of Department of Veterans Affairs employees who make inventions.

[21 FR 10377, Dec. 28, 1956, as amended at 61 FR 29658, June 12, 1996]

§ 1.651 Definitions.

The terms as used in the regulations concerning inventions by employees of the Department of Veterans Affairs are defined as follows:

(a) The term *invention* includes any art, machine, manufacture, design, or composition of matter, or any new and useful improvement thereof, or any variety of plant, which is or may be patentable under the patent laws of the United States.

(b) The term *employee* or *Government employee* means any officer or employee, civilian or military, of the Department of Veterans Affairs. Part-time, without compensation (WOC) employees and part-time consultants are included.

(c) The term *Secretary of Commerce* means the Under Secretary of Commerce for Technology.

[21 FR 10377, Dec. 28, 1956, as amended at 31 FR 5291, Apr. 2, 1966; 61 FR 29658, June 12, 1996]

§ 1.652 Criteria for determining rights to employee inventions.

(a) The criteria to be applied in determining the respective rights of the Government and of the employee-inventor in and to any invention subject to these provisions shall be in accordance with the Uniform Patent Policy regulations found at 37 CFR 501.6 and 501.7.

(b) Ownership in and to inventions arising under Cooperative Research and Development Agreements (CRADAs) pursuant to 15 USC 3710a shall be governed by the provisions of the pertinent CRADA, as authorized by the Federal Technology Transfer Act.

(Authority: 15 U.S.C. 3710a; 37 CFR part 501)

[61 FR 29658, June 12, 1996]

§ 1.653 Delegation of authority.

The General Counsel, Deputy General Counsel or Assistant General Counsel for Professional Staff Group IV is authorized to act for the Secretary of Veterans Affairs in matters concerning patents and inventions, unless otherwise required by law. The determination of rights to an invention as between the Government and the employee where there is no cooperative research and development agreement

shall be made by the General Counsel, Deputy General Counsel or the Assistant General Counsel for Professional Staff Group IV, in accordance with 37 CFR part 500.

[62 FR 14822, Mar. 28, 1997]

§ 1.654 Patenting of inventions.

Any invention owned by the Government under the criteria as set forth in 37 CFR 501.6 should be protected by an application for a domestic patent and other necessary documents executed by the employee inventor prepared by or through the General Counsel, Deputy General Counsel or Assistant General Counsel for Professional Staff Group IV, unless some other agency has primary interest or it is decided to dedicate the invention to the public. Such dedication requires approval of the Secretary of Commerce. Applications on behalf of the Government for foreign patents may be made if determined to be in the public interest. The payment of necessary expenses in connection with any application filed or patent obtained under this section by the Department of Veterans Affairs is authorized.

[31 FR 5291, Apr. 2, 1966, as amended at 54 FR 26027, June 21, 1989; 61 FR 29658, June 12, 1996; 62 FR 14822, Mar. 28, 1997]

§ 1.655 Government license in invention of employee.

If an invention is made by an employee and it is determined that the employee inventor is entitled to full ownership under 37 CFR 501.6, subject to a nonexclusive, irrevocable, royalty-free license in the Government with power to grant sublicenses for all Governmental purposes, it shall be the duty of the employee inventor to notify the Office of General Counsel of the status of the patent application, including the patent application number, so that the Department may protect the interests reserved to the Government under 37 CFR 501.6.

[61 FR 29658, June 12, 1996]

§ 1.656 Information to be submitted by inventor.

(a) In the case of an invention or believed invention, the inventor will prepare a statement for submission to his or her immediate superior. It will be submitted regardless of where the ownership is believed to exist. The statement will consist of two parts:

(1) One part of the statement will be a disclosure of the invention sufficient to permit the preparation of a patent applicant. It shall consist of a description, including where applicable, of the parts or components of the invention as shown on the drawings or blueprints, accompanied further by a description of the construction and operation of the invention. Photographs of the invention may be included. The inventor should state pertinent prior art known to him or her, and set forth in detail as clearly as possible the respects which his or her invention differs.

(2) The other part of the statement will set forth the circumstances attending the making of the invention. It will include the full name and address of the inventor; the grade and title of his or her position; whether full time or part time; his or her duties at the time the invention was made; the facts pertinent to a determination whether the invention bore a direct relation to or was made in consequence of such official duties; whether there was, and if so, the terms of any special agreement or understanding with respect to use or manufacture of his or her invention; date of the invention; when and where it was conceived, constructed and tested; whether it was made entirely during working hours; whether, and to what extent there was a contribution by the Government of any of the following: Facilities; equipment; materials or supplies; funds; information; time or services of other Government employees on duty. When the invention is disclosed through publication, or in consultation with a manufacturer or attorney, simultaneous notification of the publication shall be given to the Office of General Counsel. A copy of the article will accompany the notification.

(b) The inventor's immediate superior shall promptly review the statement of the employee inventor for completeness and accuracy, and shall certify that the employee's statement of circumstances attending the invention is or is not correct, giving reasons if pertinent. The file should then be

submitted through the facility head (or administration heads or top staff officials in the case of Central Office employees) to the General Counsel together with any comments or recommendations.

[61 FR 29658, June 12, 1996]

§ 1.657 Determination of rights.

The General Counsel, Deputy General Counsel or Assistant General Counsel for Professional Staff Group IV will make a determination of rights subject to review where required by the Secretary of Commerce. The determination will be in accordance with 37 CFR 501.7.

[61 FR 29658, June 12, 1996, as amended at 62 FR 14822, Mar. 28, 1997]

§ 1.658 Right of appeal.

In accordance with 37 CFR 501.8, the employee has a right of appeal to the Secretary of Commerce within 30 days of receipt of the Department's determination of ownership rights. The decision reached by the Secretary of Commerce will be communicated to the employee.

[61 FR 29658, June 12, 1996]

§ 1.659 Relationship to incentive awards program.

Procedures set out in the regulations concerning inventions by employees of the Department of Veterans Affairs are not affected by the submission or proposed submission of an employee suggestion or idea on an item which may be patentable. Consideration of an item for a determination of ownership rights and also for an incentive award will proceed simultaneously, usually on separate correspondence. An employee suggestion or copies and extracts of the file may be forwarded to the General Counsel by the reviewing or awarding authority, or by the facility head, for an ownership determination where the employee idea or suggestion involves an invention. The employee shall be directed to submit a disclosure of invention in accordance with these regulations if such has not been previously submitted.

[31 FR 5291, Apr. 2, 1966, as amended at 61 FR 29659, June 12, 1996]

§ 1.660 Expeditious handling.

No patent may be granted where the invention has been in public use or publicly disclosed for more than one year before filing of a patent application. Hence, submissions involving inventions should be made as promptly as possible in order to avoid delay which might jeopardize title to the invention or impair the rights of the inventor or the Government.

[61 FR 29659, June 12, 1996]

§ 1.661 Information to be kept confidential.

All information pertaining to inventions and pending patent applications is confidential, and employees having access to such information are forbidden to disclose or reveal the same except as required in the performance of their official duties.

[21 FR 10378, Dec. 28, 1956. Redesignated at 61 FR 29659, June 12, 1996]

§ 1.662 Provisions of regulations made a condition of employment.

The provisions of the regulations concerning inventions by employees of the Department of Veterans Affairs shall be a condition of employment of all employees.

[21 FR 10378, Dec. 28, 1956. Redesignated at 61 FR 29659, June 12, 1996]

§ 1.663 Licensing of Government-owned inventions.

(a) The licensing of Government-owned inventions under VA control and custody will be conducted pursuant to the regulations on the licensing of Government-owned inventions contained in 37 CFR part 404, and 15 U.S.C. 3710a, as appropriate.

(b) Any person whose application for a license in an invention under VA control and custody has been denied; whose license in such an invention has been modified or terminated, in whole or in part; or who timely filed a written objection in response to a proposal to grant an exclusive or partially exclusive license in an invention under VA control or custody, may, if damaged, appeal any decision or determination concerning the grant, denial, interpretation, modification, or termination of a license to the Secretary of

Veterans Affairs. Such appeal shall be in writing; shall set forth with specificity the basis of the appeal; and shall be postmarked not later than 60 days after the action being appealed. Upon request of the appellant, such appeal may be considered by one to three persons appointed on a case-by-case basis by the Secretary of Veterans Affairs. Such a request will be granted only if it accompanies the written appeal. Appellant may appear and be represented by counsel before such a panel, which will sit in Washington, DC. If the appeal challenges a decision to grant an exclusive or partially exclusive license in an invention under VA control or custody, the licensee shall be furnished a copy of the appeal, shall be given the opportunity to respond in writing, may appear and be represented by counsel at any hearing requested by appellant, and may request a hearing if appellant has not, under the same terms and conditions, at which the appellant may also appear and be represented by counsel.

[61 FR 29659, June 12, 1996]

§§ 1.664–1.666 [Reserved]

ADMINISTRATIVE CONTROL OF FUNDS

SOURCE: 48 FR 30622, July 5, 1983, unless otherwise noted.

§ 1.670 Purpose.

The following regulations establish a system of administrative controls for all appropriations and funds available to the Department of Veterans Affairs to accomplish the following purposes:

(a) Establish an administrative subdivision of controls to restrict obligations and expenditures against each appropriation or fund to the amount of the apportionment or the reapportionment; and

(b) Fix responsibility for the control of appropriations or funds to high level officials who bear the responsibility for apportionment or reapportionment control.

(Authority: 31 U.S.C. 1514)

§ 1.671 Definitions.

For the purpose of §§ 1.670 through 1.673, the following definitions apply:

(a) *Administrative subdivision of funds.* An administrative subdivision of funds is any administrative subdivision of an appropriation or fund which makes funds available in a specified amount for the purpose of controlling apportionments or reapportionments.

(b) *Allotment.* An allotment is an authorization by the Director, Office of Budget and Finance, to department and staff office heads (allottees) to incur obligations within specified amounts, during a specified period, pursuant to an Office of Management and Budget apportionment or reapportionment action. The creation of an obligation in excess of an allotment is a violation of the administrative subdivision of funds.

(c) *Allowance.* An allowance is a subdivision below the allotment level, and is a guideline which may be issued by department or staff office heads (allottees) to facility directors and other officials, showing the expenditure pattern or operating budget they will be expected to follow in light of the program activities contemplated by the overall VA budget or plan of expenditure. The creation of an obligation in excess of an allowance is not a violation of the administrative subdivision of funds.

(Authority: 31 U.S.C. 1514)

§ 1.672 Responsibilities.

(a) The issuance of an allotment to the administration and staff office heads (allottees) is required and is the responsibility of the Director, Office of Budget and Finance. The sum of such allotments shall not be in excess of the amount indicated in the apportionment or reapportionment document.

(b) The issuance of an allowance is discretionary with department or staff office heads (allottees), as an allowance is merely a management device which allottees may utilize in carrying out their responsibilities. Allottees are responsible for keeping obligations within the amounts of their allotments, whether allowances are issued or not.

(c) The Director, Office of Budget and Finance, is responsible for requesting apportionments and reapportionments from the Office of Management and Budget. Administration and staff heads

shall promptly request that an appropriation or fund be reapportioned if feasible whenever it appears that obligations may exceed the level of the apportionment.

(Authority: 31 U.S.C. 1514)

§ 1.673 Responsibility for violations of the administrative subdivision of funds.

(a) In the event an allotment or an apportionment is exceeded except in the circumstances described in paragraph (b) of this section, the following factors will be considered in determining which official, or officials, are responsible for the violation.

(1) Knowledge of circumstances which could lead to an allotment or apportionment being exceeded;

(2) Whether the official had received explicit instructions to continue or cease incurring obligations;

(3) Whether any action was taken in contravention of or with disregard for, instructions to monitor obligations incurred;

(4) Whether the official had the authority to curtail obligations by directing a change in the manner of operations of the department or staff office; or

(5) Any other facts which tend to fix the responsibility for the obligations which resulted in the allotment or apportionment being exceeded.

(b) In the event that the sum of the allotments made in a particular fiscal year exceeds the amount apportioned by the Office of Management and Budget, and the apportionment is subsequently exceeded because of this action, the official who made the excess allotments will be the official responsible for the violation.

(Authority: 31 U.S.C. 1514)

USE OF OFFICIAL MAIL IN THE LOCATION AND RECOVERY OF MISSING CHILDREN

SOURCE: 52 FR 10889, Apr. 6, 1987, unless otherwise noted.

§ 1.700 Purpose.

Sections 1.700 through 1.705 of this title provide a Missing Children Official Mail Program in the Department of Veterans Affairs.

(Authority: 39 U.S.C. 3220(a)(2), 5 U.S.C. 301)

[60 FR 48387, Sept. 19, 1995]

§ 1.701 Contact person for missing children official mail program.

The Department of Veterans Affairs contact person for the Missing Children Official Mail Program is: Mrs. Roslynd R. Stewart, Information Management Service (045A4), Office of Policy and Program Assistance, Office of Information Resources Management, Office of Management, Department of Veterans Affairs, 810 Vermont Avenue, NW., Washington, DC 20420–0001. Telephone: (202) 565–8949.

(Authority: 39 U.S.C. 3220(a)(2), 5 U.S.C. 301)

[60 FR 48388, Sept. 19, 1995]

§ 1.702 Policy.

(a) The Department of Veterans Affairs will supplement and expand the national effort to assist in the location and recovery of missing children by maximizing the economical use of missing children information in domestic official mail and publications directed to members of the public and Department of Veterans Affairs employees.

(b) The Department of Veterans Affairs will insert pictures and biographical information related to missing children in a variety of official mail originating at the Department of Veterans Affairs automation centers. In addition, pictures and biographical information are printed in self-mailers and other Department of Veterans Affairs publications (newsletters, bulletins, etc.).

(c) The National Center for Missing and Exploited Children (National Center) is the sole source from which the Department of Veterans Affairs will acquire the camera-ready and other photographic and biographical materials to be disseminated for use by Department of Veterans Affairs organizational units. The information is ordered and disseminated by Information Management Service.

(d) The Department of Veterans Affairs will remove all printed inserts and other materials from circulation or other use within a three-month period

from the date the National Center notifies the Department of Veterans Affairs that a child whose picture and biographical information have been made available to the Department of Veterans Affairs has been recovered or that permission of the parent(s) or guardian to use the child's photograph and biographical information has been withdrawn. The National Center is responsible for immediately notifying the Department of Veterans Affairs contact person, in writing, of the need to withdraw from circulation official mail and other materials related to a particular child. Photographs which were reasonably current as of the time of the child's disappearence shall be the only acceptable form of visual medium or pictorial likeness used in official mail.

(e) The Department of Veterans Affairs will give priority to official mail that is addressed to:

(1) Members of the public that will be received in the United States, its territories and possessions; and

(2) Inter- and intra-agency publications and other media that will also be widely disseminated to Department of Veterans Affairs employees.

(f) The Department of Veterans Affairs will avoid repetitive mailings of material to the same individuals.

(g) All Department of Veterans Affairs employee suggestions and/or recommendations for additional cost-effective opportunities to use photographs and biographical data on missing children will be provided to the Department of Veterans Affairs contact person.

(h) These shall be the sole regulations for the Department of Veterans Affairs and its component organizational units.

(Authority: 39 U.S.C. 3220(a)(2), 5 U.S.C. 301).

[52 FR 10889, Apr. 6, 1987, as amended at 60 FR 48388, Sept. 19, 1995]

§ 1.703 Percentage estimate.

It is the Department of Veterans Affairs objective that 20 percent of its first class official mail addressed to the public contain missing children photographs and information.

(Authority: 39 U.S.C. 3220(a)(2), 5 U.S.C. 301)

[60 FR 48388, Sept. 19, 1995]

§ 1.704 [Reserved]

§ 1.705 Restrictions on use of missing children information.

Missing children pictures and biographical data shall not be:

(a) Printed on official envelopes and other materials ordered and stocked in quantities that represent more than a 90-day supply.

(b) Printed on blank pages or covers of publications that may be included in the Superintendent of Documents Sales Program or be distributed to depository libraries.

(c) Inserted in any envelope or publication the contents of which may be construed to be inappropriate for association with the missing children program.

(d) Inserted in any envelope where the insertion would increase the postage cost for the item being mailed.

(e) Placed on letter-size envelopes on the official indicia, the area designated for optical character readers (OCRs), bar code read area, and return address area in accordance with the Office of Juvenile Justice and Delinquency Prevention guidelines and U.S. Postal Service standards.

(Authority: 39 U.S.C. 3220(a)(2), 5 U.S.C. 301)

[52 FR 10889, Apr. 6, 1987, as amended at 60 FR 48388, Sept. 19, 1995]

HOMELESS CLAIMANTS

§ 1.710 Homeless claimants: Delivery of benefit payments and correspondence.

(a) All correspondence and all checks for benefits payable to claimants under laws administered by the Department of Veterans Affairs shall be directed to the address specified by the claimant. The Department of Veterans Affairs will honor for this purpose any address of the claimant in care of another person or organization or in care of general delivery at a United States post office. In no event will a claim or payment of benefits be denied because the claimant provides no mailing address.

(Authority: 38 U.S.C. 5103; 5120)

(b) To ensure prompt delivery of benefit payments and correspondence, claimants who seek personal assistance

from Veterans Benefits Counselors when filing their claims shall be counseled as to the importance of providing his or her current mailing address and, if no address is provided, the procedures for delivery described in paragraph (d) of this section.

(Authority: 38 U.S.C. 5103; 5120)

(c) The Department of Veterans Affairs shall prepare and distribute to organizations specially serving the needs of veterans and the homeless, including but not limited to shelters, kitchens and private outreach facilities, information encouraging such organizations to counsel individuals on the importance of providing mailing addresses to the Department of Veterans Affairs and advising them of this regulation.

(Authority: 38 U.S.C. 5103; 5120)

(d) If a claimant fails or refuses to provide a current mailing address to the Department of Veterans Affairs, all correspondence and any checks for benefits to which the claimant is entitled will be delivered to the Agent Cashier of the regional office which adjudicated or is adjudicating the claim in the case of compensation, pension or survivors' benefits, to the Agent Cashier of the Department of Veterans Affairs facility closest to the educational institution or training establishment attended by a claimant in the case of education benefits, or to the Agent Cashier of any other Department of Veterans Affairs facility deemed by the Agency to be appropriate under the circumstances of the particular case. The claimant, within 30 days after issuance, may obtain delivery of any check or correspondence held by an Agent Cashier upon presentation of proper identification. Checks unclaimed after 30 days will be returned to the Department of the Treasury and the correspondence to the regional office or facility of jurisdiction. Thereafter, the claimant must request the reissuance of any such check or item of correspondence by written notice to the Department of Veterans Affairs.

(Authority: 38 U.S.C. 5103; 5120)

[53 FR 22654, June 17, 1988]

§§ 1.780–1.783 [Reserved]

PART-TIME CAREER EMPLOYMENT PROGRAM

SOURCE: 44 FR 55172, Sept. 25, 1979, unless otherwise noted.

§ 1.891 Purpose of program.

Many individuals in society possess great productive potential which goes unrealized because they cannot meet the requirements of a standard workweek. Permanent part-time employment also provides benefits to other individuals in a variety of ways, such as providing older individuals with a gradual transition into retirement, providing employment opportunities to handicapped individuals or others who requires a reduced workweek, providing parents opportunities to balance family responsibilities with the need for additional income, and assisting students who must finance their own education or vocational training. In view of this, the Department of Veterans Affairs will operate a part-time career employment program, consistent with the needs of its beneficiaries and its responsibilities.

(Authority: 5 U.S.C. 3401 note)

§ 1.892 Review of positions.

Positions becoming vacant, unless excepted as provided by § 1.897, will be reviewed to determine the feasibility of converting them to part-time. Among the criteria which may be used when conducting this review are:

(a) Mission requirements.

(b) Workload.

(c) Employment ceilings and budgetary considerations.

(d) Availability of qualified applicants willing to work part time.

(e) Other criteria based on local needs and circumstances.

(Authority: 5 U.S.C. 3402)

§ 1.893 Establishing and converting part-time positions.

Position management and other internal reviews may indicate that positions may be either converted from full-time or initially established as part-time positions. Criteria listed in

§ 1.892 may be used during these reviews. If a decision is made to convert to or to establish a part-time position, regular position management and classification procedures will be followed.

(Authority: 5 U.S.C. 3402)

§ 1.894 Annual goals and timetables.

An departmentwide plan for promoting part-time employment opportunities will be developed annually. This plan will establish annual goals and set interim and final deadlines for achieving these goals. This plan will be applicable throughout the agency, but may be supplemented by field facilities.

(Authority: 5 U.S.C. 3402)

§ 1.895 Review and evaluation.

The part-time career employment program will be reviewed through regular employment reports to determine levels of part-time employment. This program will also be designated an item of special interest to be reviewed during personnel management reviews.

(Authority: 5 U.S.C. 3402)

[61 FR 38571, July 25, 1996]

§ 1.896 Publicizing vacancies.

When applicants from outside the Federal service are desired, part-time vacancies may be publicized through various recruiting means, such as:

(a) Federal Job Information Centers.
(b) State Employment offices.
(c) VA Recruiting Bulletins.

(Authority: 5 U.S.C. 3402)

§ 1.897 Exceptions.

The Secretary of Veterans Affairs, or designees, may except positions from inclusion in this program as necessary to carry out the mission of the Department.

(Authority: 5 U.S.C. 3402)

STANDARDS FOR COLLECTION, COMPROMISE, SUSPENSION OR TERMINATION OF COLLECTION EFFORT, AND REFERRAL OF CIVIL CLAIMS FOR MONEY OR PROPERTY

AUTHORITY: Sections 1.900 through 1.953 are issued under the authority of 31 U.S.C. 3711 through 3720E; 38 U.S.C. 501, 5302, 5302A, 5314, and as noted in specific sections.

SOURCE: 32 FR 2613, Feb. 8, 1967, unless otherwise noted.

§ 1.900 Prescription of standards.

(a) The standards contained in §§ 1.900 through 1.953 are issued pursuant to the Federal Claims Collection Standards, issued by the Department of the Treasury (Treasury) and the Department of Justice (DOJ) in parts 900 through 904 of 31 CFR, as well as other debt collection authority issued by Treasury in part 285 of 31 CFR, and apply to the collection, compromise, termination, and suspension of debts owed to VA, and the referral of such debts to Treasury (or other Federal agencies designated by Treasury) for offset and collection action and to DOJ for litigation, unless otherwise stated in this part or in other statutory or regulatory authority, or by contract.

(b) Standards and policies regarding the classification of debt for accounting purposes (for example, write-off of uncollectible debt) are contained in the Office of Management and Budget's Circular A–129 (Revised), ''Policies for Federal Credit Programs and Non-Tax Receivables.''

(Authority: 31 U.S.C. 3711; 38 U.S.C. 501)

[69 FR 62191, Oct. 25, 2004]

§ 1.901 No private rights created.

Sections 1.900 through 1.953 do not create any right or benefit, substantive or procedural, enforceable at law or in equity by a party against the United States, its agencies, its officers, or any other person, nor shall the failure of VA to comply with any of the provisions of §§ 1.900 through 1.953 be available to any debtor as a defense.

(Authority: 31 U.S.C. 3711; 38 U.S.C. 501)

[69 FR 62191, Oct. 25, 2004]

§ 1.902 Antitrust, fraud, and tax and interagency claims.

(a) The standards in §§ 1.900 through 1.953 relating to compromise, suspension, and termination of collection activity do not apply to any debt based in whole or in part on conduct in violation of the antitrust laws or to any debt involving fraud, the presentation

of a false claim, or misrepresentation on the part of the debtor or any party having an interest in the claim. Only the Department of Justice (DOJ) has the authority to compromise, suspend, or terminate collection activity on such claims. The standards in §§ 1.900 through 1.953 relating to the administrative collection of claims do apply, but only to the extent authorized by DOJ in a particular case. Upon identification of a claim based in whole or in part on conduct in violation of the antitrust laws or any claim involving fraud, the presentation of a false claim, or misrepresentation on the part of the debtor or any party having an interest in the claim, VA shall promptly refer the case to DOJ. At its discretion, DOJ may return the claim to VA for further handling in accordance with the standards in §§ 1.900 through 1.953.

(b) Sections 1.900 through 1.953 do not apply to tax debts.

(c) Sections 1.900 through 1.953 do not apply to claims between Federal agencies.

(d) Federal agencies should attempt to resolve interagency claims by negotiation in accordance with Executive Order 12146 (3 CFR, 1980 Comp., pp. 409–412).

(Authority: 31 U.S.C. 3711; 38 U.S.C. 501)

[69 FR 62192, Oct. 25, 2004]

§ 1.903 Settlement, waiver, or compromise under other statutory or regulatory authority.

Nothing in §§ 1.900 through 1.953 precludes VA settlement, waiver, compromise, or other disposition of any claim under statutes and implementing regulations other than subchapter II of chapter 37 of Title 31 of the United States Code (Claims of the United States Government) and the standards in Title 31 CFR parts 900 through 904. See, for example, the Federal Medical Care Recovery Act (42 U.S.C. 2651 *et seq.*) and applicable regulations, 28 CFR part 43. In such cases, the laws and regulations that are specifically applicable to claims collection activities of VA generally take precedence over 31 CFR parts 900 through 904.

(Authority: 31 U.S.C. 3711; 38 U.S.C. 501)

[69 FR 62192, Oct. 25, 2004]

§ 1.904 Form of payment.

Claims may be paid in the form of money or, when a contractual basis exists, VA may demand the return of specific property or the performance of specific services.

(Authority: 31 U.S.C. 3711; 38 U.S.C. 501)

[69 FR 62192, Oct. 25, 2004]

§ 1.905 Subdivision of claims not authorized.

Debts may not be subdivided to avoid the monetary ceiling established by 31 U.S.C. 3711(a)(2). A debtor's liability arising from a particular transaction or contract shall be considered as a single debt in determining whether the debt is one of less than $100,000 (excluding interest, penalties, and administrative costs) or such higher amount as the Attorney General shall from time to time prescribe for purposes of compromise, suspension, or termination of collection activity.

(Authority: 31 U.S.C. 3711; 38 U.S.C. 501)

[69 FR 62192, Oct. 25, 2004]

§ 1.906 Required administrative proceedings.

(a) In applying §§ 1.900 through 1.953, VA is not required to omit, foreclose, or duplicate administrative proceedings required by contract or other laws or regulations.

(b) Nothing contained in §§ 1.900 through 1.953 is intended to foreclose the right of any debtor to an administrative proceeding, including appeals, waivers, and hearings provided by statute, contract, or VA regulation (see 38 U.S.C. 3720(a)(4) and 5302 and 42 U.S.C. 2651–2653).

(Authority: 38 U.S.C. 501, 3720(a)(4), 5302; 42 U.S.C. 2651 through 2653)

[69 FR 62192, Oct. 25, 2004]

§ 1.907 Definitions.

(a) The definitions and construction found in the Federal Claims Collection Standards in 31 CFR 900.2(a) through (d), and the definitions in the provisions on administrative wage garnishment in 31 CFR 285.11(c) shall apply to §§ 1.900 through 1.953, except as otherwise stated.

(b) As used in §§ 1.900 through 1.953, *referral for litigation* means referral to the Department of Justice for appropriate legal actions, except in those specified instances where a case is referred to a VA Regional Counsel for legal action.

(c) As used in §§ 1.900 through 1.953, *VA benefit program* means medical care, home loan, and benefits payment programs administered by VA under Title 38 of the United States Code, except as otherwise stated.

(d) As used in §§ 1.900 through 1.953, *Treasury* means the United States Department of the Treasury.

(Authority: 31 U.S.C. 3701, 3711; 38 U.S.C. 501, 5316)

[69 FR 62192, Oct. 25, 2004]

STANDARDS FOR COLLECTION OF CLAIMS

AUTHORITY: Sections 1.900 through 1.953 are issued under the authority of 31 U.S.C. 3711 through 3720E; 38 U.S.C. 501, and as noted in specific sections.

SOURCE: 32 FR 2613, Feb. 8, 1967, unless otherwise noted.

§ 1.910 Aggressive collection action.

(a) VA will take aggressive collection action on a timely basis, with effective follow-up, to collect all claims for money or property arising from its activities.

(b) In accordance with 31 U.S.C. 3711(g) and the procedures set forth at 31 CFR 285.12, VA shall transfer to Treasury any non-tax debt or claim that has been delinquent for a period of 180 days or more so that Treasury may take appropriate action to collect the debt or terminate collection action. This requirement does not apply to any debt that:

(1) Is in litigation or foreclosure;

(2) Will be disposed of under an approved asset sale program;

(3) Has been referred to a private collection contractor for a period of time acceptable to the Secretary of the Treasury;

(4) Is at a debt collection center for a period of time acceptable to the Secretary of the Treasury;

(5) Will be collected under internal offset procedures within 3 years after the debt first became delinquent; or

(6) Is exempt from this requirement based on a determination by the Secretary of the Treasury that exemption for a certain class of debt is in the best interest of the United States. VA may request that the Secretary of the Treasury exempt specific classes of debts.

(c) In accordance with 31 U.S.C. 3716(c)(6) and the procedures set forth in 31 CFR part 285, VA shall notify Treasury of all past due, legally enforceable non-tax debt that is over 180 days delinquent for purposes of administrative offset, including tax refund offset and federal salary offset. (Procedures for referral to Treasury for tax refund offset are found at 31 CFR 285.2 and procedures for referral to Treasury for federal salary offset are found at 38 CFR 1.995 and 31 CFR 285.7.)

(Authority: 31 U.S.C. 1311, 1316; 38 U.S.C. 501, 5314; 31 CFR part 285)

[69 FR 62192, Oct. 25, 2004]

§ 1.911 Collection of debts owed by reason of participation in a benefits program.

(a) *Scope*. This section applies to the collection of debts resulting from an individual's participation in a VA benefit or home loan program. It does not apply to VA's other debt collection activities. Standards for the demand for payment of all other debts owed to VA are set forth in § 1.911a. School liability debts are governed by § 21.4009 of this title.

(b) *Written demands*. When VA has determined that a debt exists by reason of an administrative decision or by operation of law, VA shall promptly demand, in writing, payment of the debt. VA shall notify the debtor of his or her rights and remedies and the consequences of failure to cooperate with collection efforts. Generally, one demand letter is sufficient, but subsequent demand letters may be issued as needed.

(c) *Rights and remedies*. Subject to limitations referred to in this paragraph, the debtor has the right to informally dispute the existence or amount of the debt, to request waiver of collection of the debt, to a hearing on the waiver request, and to appeal the Department of Veterans Affairs decision underlying the debt. These

rights can be exercised separately or simultaneously. Except as provided in § 1.912a (collection by offset), the exercise of any of these rights will not stay any collection proceeding.

(1) *Informal dispute*. This means that the debtor writes to the Department of Veterans Affairs and questions whether he or she owes the debt or whether the amount is accurate. The Department of Veterans Affairs will, as expeditiously as possible, review the accuracy of the debt determination. If the resolution is adverse to the debtor, he or she may also request waiver of collection as indicated in paragraphs (c)(2) and (3) of this section.

(2) *Request for waiver; hearing on request*. The debtor has the right to request waiver of collection, in accordance with § 1.963 or § 1.964, and the right to a hearing on the request. Requests for waivers must be filed in writing. A waiver request must be filed within the time limit set forth in 38 U.S.C. 5302. If waiver is granted, in whole or in part, the debtor has a right to refund of amounts already collected up to the amount waived.

(3) *Appeal*. In accordance with parts 19 and 20 of this title, the debtor may appeal the decision underlying the debt.

(d) *Notification*. The Department of Veterans Affairs shall notify the debtor in writing of the following:

(1) The exact amount of the debt;

(2) The specific reasons for the debt, in simple and concise language;

(3) The rights and remedies described in paragraph (c) of this section, including a brief explanation of the concept of, and requirements for, waiver;

(4) That collection may be made by offset from current or future VA benefit payments (see § 1.912a). In addition, the debtor shall be advised of any policies with respect to the use of credit bureaus, debt collection centers, and collection agencies; any other remedies to enforce payment of the debt, including administrative wage garnishment, Federal salary offset, tax refund offset, and litigation; and the requirement that any debt delinquent for more than 180 days be transferred to Treasury for administrative offset or collection.

(5) That interest and administrative costs may be assessed in accordance with § 1.915, as appropriate;

(6) That the debtor shall have the opportunity to inspect and copy records; and

(7) That the debtor shall have the opportunity to enter into a repayment agreement.

(e) *Sufficiency of notification*. Notification is sufficient when sent by ordinary mail directed to the debtor's last known address and not returned as undeliverable by postal authorities.

(f) *Further explanation*. Further explanation may be found for—

(1) Appellate rights, in parts 19 and 20 of this title;

(2) Notification of any decision affecting the payment of benefits or granting relief, in § 3.103(e);

(3) Right to appeal a waiver decision, in § 1.958;

(4) Refund to a successful waiver applicant of money already collected, in § 1.967; and

(5) The assessment of interest and administrative costs, in § 1.915.

(Authority: 38 U.S.C. 501, 5302, 5314)

[48 FR 1055, Jan. 10, 1983; 48 FR 6336, Feb. 11, 1983. Redesignated and amended at 52 FR 42105, Nov. 3, 1987; 54 FR 34980, Aug. 23, 1989; 69 FR 62193, Oct. 25, 2004]

§ 1.911a Collection of non-benefit debts.

(a) This section is written in accordance with 31 CFR 901.2 and applies to the demand for payment of all debts, except those debts arising out of participation in a VA benefit or home loan program. Procedures for the demand for payment of VA benefit or home loan program debts are set forth in § 1.911.

(b) Written demand as described in paragraph (c) of this section shall be made promptly upon a debtor of VA in terms that inform the debtor of the consequences of failing to cooperate with VA to resolve the debt. Generally, one demand letter is sufficient, but subsequent letters may be issued. In determining the timing of the demand letter, VA should give due regard to the need to refer debts promptly to the Department of Justice for litigation, in accordance with §§ 1.950 through 1.953.

When necessary to protect VA's interest (for example, to prevent the running of a statute of limitations), written demand may be preceded by other appropriate actions under 38 CFR 1.900 through 1.953, including immediate referral for litigation.

(c) The written demand letter shall inform the debtor of:

(1) The basis for the indebtedness and any rights the debtor may have to seek review within VA, including the right to request waiver;

(2) The applicable standards for imposing any interest or other late payment charges;

(3) The date by which payment should be made to avoid interest and other late payment charges and enforced collection, which generally should not be more than 30 days from the date that the demand letter is mailed;

(4) The name, address, and phone number of a contact person or office within the agency;

(5) The opportunity to inspect and copy VA records related to the debt; and

(6) The opportunity to make a written agreement to repay the debt.

(d) In addition to the items listed in paragraph (c) of this section, VA should include in the demand letter VA's willingness to discuss alternative methods of payment and its policies with respect to the use of credit bureaus, debt collection centers, and collection agencies. The letter should also indicate the agency's remedies to enforce payment of the debt (including assessment of interest, administrative costs and penalties, administrative garnishment, Federal salary offset, tax refund offset, administrative offset, and litigation) and the requirement that any debt delinquent for more than 180 days be transferred to Treasury for collection.

(e) VA should respond promptly to communications from debtors and should advise debtors who dispute debts, or request waiver, to furnish available evidence to support their contentions.

(f) Prior to referring a debt for litigation, VA should advise each debtor determined to be liable for the debt that, unless the debt can be collected administratively, litigation may be initiated. This notification may be given as part of a demand letter under paragraph (c) of this section or in a separate letter.

(g) When VA learns that a bankruptcy petition has been filed with respect to a debtor, before proceeding with further collection action, VA should immediately seek legal advice from either VA's General Counsel or Regional Counsel concerning the impact of the Bankruptcy Code on any pending or contemplated collection activities. Unless VA determines that the automatic stay imposed at the time of filing pursuant to 11 U.S.C. 362 has been lifted or is no longer in effect, in most cases collection activity against the debtor should stop immediately.

(1) After VA seeks legal advice, a proof of claim should be filed in most cases with the bankruptcy court or the Trustee. VA should refer to the provisions of 11 U.S.C. 106 relating to the consequences on sovereign immunity of filing a proof of claim.

(2) If VA is a secured creditor, it may seek relief from the automatic stay regarding its security, subject to the provisions and requirements of 11 U.S.C. 362.

(3) Offset is prohibited in most cases by the automatic stay. However, VA should seek legal advice from VA's General Counsel or Regional Counsel to determine whether payments to the debtor and payments of other agencies available for offset may be frozen by VA until relief from the automatic stay can be obtained from the bankruptcy court. VA also should seek legal advice from VA's General Counsel or Regional Counsel to determine whether recoupment is available.

(Authority: 31 U.S.C. 3711; 38 U.S.C. 501)

[69 FR 62193, Oct. 25, 2004]

§ 1.912 Collection by offset.

(a) *Authority and scope.* In accordance with the procedures set forth in 31 CFR 901.3, as well as 31 CFR part 285, VA shall collect debts by administrative offset from payments made by VA to a debtor indebted to VA. Also in accordance with 31 CFR 901.3(b), as well as 31 CFR part 285, VA shall refer past due, legally enforceable non-tax debts which are over 180 days delinquent to

Treasury for collection by centralized administrative offset (further procedures are set forth in paragraph (g) of this section). This section does not pertain to offset from either VA benefit payments made under the authority of 38 U.S.C. 5314 or from current salary, but does apply to offset from all other VA payments, including an employee's final salary check and lump-sum leave payment. Procedures for offset from benefit payments are found in §1.912a. Procedures for offset from current Federal salary are found in §§1.980 through 1.995. NOTE: VA cannot offset, or refer for the purpose of offset, either under the authority of this section or under any other authority found in §§1.900 through 1.953 and §§1.980 through 1.995, any VA home loan program debt described in 38 U.S.C. 3726 unless the requirements set forth in that section have been met.

(b) *Notification.* Prior to initiation of administrative offset, if not provided in the initial notice of indebtedness, VA is required to provide the debtor with written notice of:

(1) The nature and amount of the debt;

(2) VA's intention to pursue collection by offset procedures from the specified VA payment, the date of commencement of offset, and the exact amount to be offset;

(3) The opportunity to inspect and copy VA records pertaining to the debt;

(4) The right to contest either the existence or amount of the debt or the proposed offset schedule, or if applicable, to request a waiver of collection of the debt, or to request a hearing on any of these matters;

(5) That commencement of offset will begin, unless the debtor makes a written request for the administrative relief discussed in paragraph (b)(4) of this section within 30 days of the date of this notice; and

(6) The opportunity to enter into a written agreement with VA to repay the debt in lieu of offset.

(c) *Deferral of offset.* (1) If the debtor, within 30 days of the date of the notification required by paragraph (b) of this section, disputes in writing the existence or amount of the debt or the amount of the scheduled offset, offset shall not commence until the dispute is reviewed and a decision is rendered by VA adverse to the debtor.

(2) If the debtor, within 30 days of the date of the required notification by VA, requests in writing the waiver of collection of the debt in accordance with §1.963, §1.963a, or §1.964, offset shall not commence until VA has made an initial decision to deny the waiver request.

(3) If the debtor, within 30 days of the required notification by VA, requests in writing a hearing on the issues found in paragraphs (c)(1) and (2) of this section, offset shall not commence until a decision is rendered by VA on the issue which is the basis of the hearing.

(d) *Exceptions.* (1) Offset may commence prior to either resolution of a dispute or decision on a waiver request as discussed in paragraph (c) of this section, if collection of the debt would be jeopardized by deferral of offset (for example, if VA first learns of the debt when there is insufficient time before a final payment would be made to the debtor to allow for prior notice and opportunity for review or waiver consideration). In such a case, notification pursuant to paragraph (b) of this section shall be made at the time offset begins or as soon thereafter as possible. VA shall promptly refund any money that has been collected that is ultimately found not to have been owed to the Government.

(2) If the United States has obtained a judgment against the debtor, offset may commence without the notification required by paragraph (b) of this section. However, a waiver request filed in accordance with the time limits and other requirements of §1.963, §1.963a, or §1.964 will be considered, even if filed after a judgment has been obtained against the debtor. If waiver is granted, in whole or in part, refund of amounts already collected will be made in accordance with §1.967.

(3) The procedures set forth in paragraph (b) of this section may be omitted when the debt arises under a contract that provides for notice and other procedural protections.

(4) Offset may commence without the notification required by paragraph (b) of this section when the offset is in the nature of a recoupment. As defined in

31 CFR 900.2(d), recoupment is a special method for adjusting debts arising under the same transaction or occurrence.

(e) *Hearing*. (1) After a debtor requests a hearing, VA shall notify the debtor of the form of the hearing to be provided; *i.e.*, whether the hearing will either be oral or paper. If an oral hearing is determined to be proper by the hearing official, the notice shall set forth the date, time, and location of the hearing. If the hearing is to be a paper review, the debtor shall be notified that he or she should submit his or her position and arguments in writing to the hearing official by a specified date, after which the record shall be closed. This date shall give the debtor reasonable time to submit this information.

(2) Unless otherwise required by law, an oral hearing under this paragraph is not required to be a formal evidentiary type of hearing.

(3) A debtor who requests a hearing shall be provided an oral hearing if VA determines that the matter cannot be resolved by review of documentary evidence. Whenever an issue of credibility or veracity is involved, an oral hearing will always be provided the debtor. For example, the credibility or veracity of a debtor is always an issue whenever the debtor requests a waiver of collection of the debt. Thus, a hearing held in conjunction with a waiver request will always be an oral hearing. If a determination is made to provide an oral hearing, the hearing official may offer the debtor the opportunity for a hearing by telephone conference call. If this offer is rejected or if the hearing official declines to offer a telephone conference call, the debtor shall be provided an oral hearing permitting the personal appearance of the debtor, his or her personal representative, and witnesses. Witnesses shall testify under oath or affirmation.

(4) In all other cases where a debtor requests a hearing, a paper hearing shall be provided. The debtor shall be provided an opportunity to submit material for the record. A paper hearing shall consist of a review of the written evidence of record by the designated hearing official.

(f) *Statutes of limitation; multiple debts*. When collecting multiple debts by administrative offset, VA shall apply the recovered amounts to those debts in accordance with the best interests of the United States, as determined by the facts and circumstances of the particular case, paying special attention to applicable statutes of limitation. In accordance with 31 CFR 901.3(a)(4), VA may not initiate offset to collect a debt more than 10 years after VA's right to collect the debt first accrued (with certain exceptions as specified in 31 CFR 901.3(a)(4)).

(g) *Centralized administrative offset*. (1) When VA refers delinquent debts to Treasury for centralized administrative offset in accordance with 31 CFR part 285, VA must certify that:

(i) The debts are past due and legally enforceable; and

(ii) VA has complied with all due process requirements under 31 U.S.C. 3716(a) and paragraphs (b) and (c) of this section.

(2) Payments that are prohibited by law from being offset are exempt from centralized administrative offset.

(h) *Computer Matching and Privacy Act waiver*. In accordance with 31 U.S.C. 3716(f), the Secretary of the Treasury may waive the provisions of the Computer Matching and Privacy Protection Act of 1988 concerning matching agreements and post-match notification and verification (5 U.S.C. 552a(o) and (p)) for centralized administrative offset upon receipt of a certification from a creditor agency that the due process requirements enumerated in 31 U.S.C. 3716(a) and paragraphs (b) and (c) of this section have been met. The certification of a debt in accordance with paragraph (g) of this section will satisfy this requirement. If such a waiver is granted, only the Data Integrity Board of the Department of the Treasury is required to oversee any matching activities, in accordance with 31 U.S.C. 3716(g).

(i) *Requests by creditor agencies for offset*. Unless the offset would not be in VA's best interest, or would otherwise be contrary to law, VA will comply with requests by creditor agencies to offset VA payments (except for current salary or benefit payments) made to a person indebted to the creditor agency.

However, before VA may initiate offset, the creditor agency must certify in writing to VA that the debtor has been provided:

(1) Written notice of the type and amount of the debt and the intent of the creditor agency to use administrative offset to collect the debt;

(2) The opportunity to inspect and copy agency records related to the debt;

(3) The opportunity for review within the agency of the determination of the indebtedness; and

(4) The opportunity to make a written agreement to repay the debt.

(Authority: 31 U.S.C. 3711; 38 U.S.C. 501)

[52 FR 42105, Nov. 3, 1987, as amended at 54 FR 34980, Aug. 23, 1989; 69 FR 62194, Oct. 25, 2004]

§ 1.912a Collection by offset—from VA benefit payments.

(a) *Authority and scope.* VA shall collect debts governed by §1.911 of this part by offset against any current or future VA benefit payments to the debtor. Unless paragraphs (c) or (d) of this section apply, offset shall commence promptly after notification to the debtor as provided in paragraph (b) of this section. Certain military service debts shall be collected by offset against current or future compensation or pension benefit payments to the debtor under authority of 38 U.S.C. 5301(c), as provided in paragraph (e) of this section.

(b) *Notification.* Unless paragraph (d) of this section applies, offset shall not commence until the debtor has been notified in writing of the matters described in §1.911(c) and (d) and paragraph (c) of this section.

(c) *Deferral of offset.* (1) If the debtor, within thirty days of the date of the notification required by paragraph (b) of this section, disputes, in writing, the existence or amount of the debt in accordance with §1.911(c)(1), offset shall not commence until the dispute is reviewed as provided in §1.911(c)(1) and unless the resolution is adverse to the debtor.

(2) If the debtor, within thirty days of the date of notification required by paragraph (b) of this section, requests, in writing, waiver of collection in accordance with §1.963 or §1.964, as applicable, offset shall not commence until the Department of Veterans Affairs has made an initial decision on waiver.

(3) If the debtor, within thirty days of the notification required by paragraph (b) of this section, requests, in writing, a hearing on the waiver request, no decision shall be made on the waiver request until after the hearing has been held.

(4) VA will pursue collection action once an adverse initial decision is reached on the debtor's request for waiver and/or the debtor's informal dispute (as described in §1.911(c)(1)) concerning the existence or amount of the debt, even if the debtor subsequently pursues appellate relief in accordance with parts 19 and 20 of this title.

(d) *Exceptions.* Offset may commence prior to the resolution of a dispute or a decision on a waiver request if collection of the debt would be jeopardized by deferral of offset. In such case, notification pursuant to §1.911(d) shall be made at the time offset begins or as soon thereafter as possible.

(Authority: 38 U.S.C. 5314, Ch. 37)

(e) *Offset of military service debts.* (1) In accordance with 38 U.S.C. 5301(c), VA shall collect by offset from any current or future compensation or pension benefits payable to a veteran under laws administered by VA, the uncollected portion of the amount of any indebtedness associated with the veteran's participation in a plan prescribed in subchapter I or II of 10 U.S.C. chapter 73.

(2) Offsets of a veteran's compensation or pension benefit payments to recoup indebtedness to the military services as described in paragraph (e)(1) of this section shall only be made by VA when the military service owed the debt has:

(i) Determined the amount of the indebtedness of the veteran;

(ii) Certified to VA that due process in accordance with the procedures prescribed in 31 U.S.C. 3716 have been provided to the veteran; and

(iii) Requested collection of the total debt amount due.

(3) Offset from any compensation or pension benefits under the authority of 38 U.S.C. 5301(c) shall not exceed 15% of

the net monthly compensation or pension benefit payment. The net monthly compensation or pension benefit payment is defined as the authorized monthly compensation or pension benefit payment less all current deductions.

(Authority: 38 U.S.C. 5301(c) and 5314)

[48 FR 1055, Jan. 10, 1983, as amended at 52 FR 42106, Nov. 3, 1987; 57 FR 47263, Oct. 15, 1992; 69 FR 62194, Oct. 25, 2004]

§ 1.913 Liquidation of collateral.

(a) VA should liquidate security or collateral through the exercise of a power of sale in the security instrument or a nonjudicial foreclosure, and apply the proceeds to the applicable debt, if the debtor fails to pay the debt within 180 days after demand and if such action is in the best interest of the United States. Collection from other sources, including liquidation of security or collateral, is not a prerequisite to requiring payment by a surety, insurer, or guarantor, unless such action is expressly required by statute or contract.

(b) When VA learns that a bankruptcy petition has been filed with respect to a debtor, VA should seek legal advice from VA's General Counsel or Regional Counsel concerning the impact of the Bankruptcy Code, including, but not limited to, 11 U.S.C. 362, to determine the applicability of the automatic stay and the procedures for obtaining relief from such stay prior to proceeding under paragraph (a) of this section.

(Authority: 31 U.S.C. 3711; 38 U.S.C. 501)

[69 FR 62195, Oct. 25, 2004]

§ 1.914 Collection in installments.

(a) Whenever feasible, VA shall collect the total amount of a debt in one lump sum. If a debtor is financially unable to pay a debt in one lump sum, VA may accept payment in regular installments. VA should obtain financial statements from debtors who represent that they are unable to pay in one lump sum and independently verify such representations whenever possible. If VA agrees to accept payments in regular installments, VA should obtain a legally enforceable written agreement from the debtor that specifies all of the terms of the arrangement and contains a provision accelerating the debt in the event of default.

(b) The size and frequency of installment payments should bear a reasonable relation to the size of the debt and the debtor's ability to pay. If possible, the installment payments should be sufficient in size and frequency to liquidate the debt in 3 years or less.

(c) Security for deferred payments should be obtained in appropriate cases. However, VA may accept installment payments if the debtor refuses to execute a written agreement or to give security.

(Authority: 31 U.S.C. 3711; 38 U.S.C. 501)

[69 FR 62195, Oct. 25, 2004]

§ 1.915 Interest, administrative costs, and penalties.

(a) Except as otherwise provided by statute, contract, or other regulation to the contrary, and subject to 38 U.S.C. 3485(e) and 5302, VA shall assess:

(1) Interest on all indebtedness to the United States arising out of participation in a VA benefit, medical care, or home loan program under authority of Title 38, U.S. Code.

(2) Interest and administrative costs of collection on such debts described in paragraph (a)(1) of this section where repayment has become delinquent (as defined in 31 CFR 900.2(b)), and

(3) Interest, administrative costs, and penalties in accordance with 31 CFR 901.9 on all debts other than those described in paragraph (a)(1) of this section.

(b) Every party entering into an agreement with the Department of Veterans Affairs for repayment of indebtedness in installments shall be advised of the interest charges to be added to the debt. All debtors being provided notice of indebtedness, including those entering into repayment agreements, shall be advised that upon the debt becoming delinquent, or in the case of repayment of already delinquent debts, interest and the administrative costs of collection will be added to the principal amount of the debt.

(c) The rate of interest charged by VA shall be based on the rate established annually by the Secretary of the Treasury in accordance with 31 U.S.C.

3717 and shall be adjusted annually by VA on the first day of the calendar year. Once the rate of interest has been determined for a particular debt, the rate shall remain in effect throughout the duration of repayment of that debt. When a debtor defaults on a repayment agreement and seeks to enter into a new agreement, VA may require payment of interest at a new rate that reflects the current value of funds to the Treasury at the time the new agreement is executed. Interest shall not be compounded, that is, interest shall not be charged on accrued interest and administrative costs required by this section. If, however, a debtor defaults on a previous repayment agreement, interest and administrative costs that accrued but were not collected under the defaulted agreement shall be added to the principal under the new agreement.

(d) Interest on amounts covered by this section shall accrue from the date the initial notice of the debt is mailed to the debtor. Notification shall be considered sufficient when effected by ordinary mail, addressed to the last known address, and such notice is not returned as undeliverable by postal authorities.

(e) Interest under this section shall not be charged if the debt is paid in full within 30 days of mailing of the initial notice described in paragraph (b) of this section. Once interest begins to accrue, and after expiration of the time period for payment of the debt in full to avoid assessment of interest and administrative costs, any amount received toward the payment of such debt shall be first applied to payment of outstanding administrative cost charges and then to accrued interest or costs, and then to principal, unless a different rule is prescribed by statute, contract, or other regulation.

(f) All or any part of the interest and administrative costs assessed under this section are subject to consideration for waiver under section 5302 of title 38 U.S.C., and appropriate administrative procedures.

(1) In general, interest and administrative costs may be waived only when the principal of the debt on which they are assessed is waived by a Committee on Waivers and Compromises. However, VA may forbear collection of interest and administrative costs, exclusive of collection of the principal of the debt on which they are assessed, as well as terminate further assessment of interest and administrative costs when the collection of such interest and costs are determined to be not in the government's best interest. Collection of interest and administrative costs shall not be considered to be in the best interest of the government when the amount of assessed interest and administrative cost is so large that there is a reasonable certainty that the original debt will never be repaid. The determination to forbear collection of interest and administrative cost, exclusive of collection of the principal of the debt, shall be made by the Chief of the Fiscal activity at the station responsible for the collection of the debt. Such a determination is not within the jurisdiction of a Committee on Waivers and Compromises.

(2) [Reserved]

(g) Administrative costs assessed under this section shall be the average costs of collection of similar debts, or actual collection costs as may be accurately determined in the particular case. No administrative costs of collection will be assessed under this section in any cases where the indebtedness is paid in full prior to the 30-day period specified in paragraph (e) of this section, or in any case where a repayment plan is proposed by the debtor and accepted by VA within that 30-day period, unless such repayment agreement becomes delinquent (as defined in 31 CFR 900.2(b)).

(Authority: 31 U.S.C. 3717; 38 U.S.C. 501, 5302, 5315)

[46 FR 62057, Dec. 22, 1981, as amended at 52 FR 42107, Nov. 3, 1987. Redesignated and amended at 69 FR 62195, Oct. 25, 2004]

§ 1.916 Disclosure of debt information to consumer reporting agencies (CRA).

(a) The Department of Veterans Affairs may disclose all information determined to be necessary, including the name, address, Department of Veterans Affairs file number, Social Security number, and date of birth, to consumer reporting agencies for the purpose of—

(1) Obtaining the location of an individual indebted to the United States as

a result of participation in any benefits program administered by VA or indebted in any other manner to VA;

(2) Obtaining a consumer report in order to assess an individuals ability to repay a debt when such individual has failed to respond to the Department's demand for repayment or when such individual has notified the Department that he/she will not repay the indebtedness; or

(3) Obtaining the location of an individual in order to conduct program evaluation studies as required by 38 U.S.C. 527 or any other law.

(b) Information disclosed by the Department of Veterans Affairs under paragraph (a) of this section to consumer reporting agencies shall neither expressly nor implicitly indicate that an individual is indebted to the United States nor shall such information be recorded by consumer reporting agencies in a manner that reflects adversely upon the individual. Prior to disclosing this information, the Department of Veterans Affairs shall ascertain that consumer reporting agencies with which it contracts are able to comply with this requirement. The Department of Veterans Affairs shall also make reasonable efforts to insure compliance by its contractor with this requirement.

(c) Subject to the conditions set forth in paragraph (d) of this section, information concerning individuals may be disclosed to consumer reporting agencies for inclusion in consumer reports pertaining to the individual, or for the purpose of locating the individual. Disclosure of the fact of indebtedness will be made if the individual fails to respond in accordance with written demands for repayment, or refuses to repay a debt to the United States. In making any disclosure under this section, VA will provide consumer reporting agencies with sufficient information to identify the individual, including the individual's name, address, if known, date of birth, VA file number, and Social Security number.

(d)(1) Prior to releasing information under paragraph (c) of this section, the Department of Veterans Affairs will send a notice to the individual. This notice will inform the individual that—

(i) The Department of Veterans Affairs has determined that he or she is indebted to the Department of Veterans Affairs;

(ii) The debt is presently delinquent; and

(iii) The fact of delinquency may be reported to consumer reporting agencies after 30 days have elapsed from the date of the notice.

(2)(i) In accordance with §1.911 and §1.911a, VA shall notify each individual of the right to dispute the existence and amount of the debt and to request a waiver of the debt, if applicable.

(ii) If the Department of Veterans Affairs has not previously notified the individual of the rights described in paragraph (d)(2)(i) of this section, the Department of Veterans Affairs will include this information in the notice described in paragraph (d)(1) of this section. The individual shall be afforded a minimum of 30 days from the date of the notice to respond to it before information is reported to consumer reporting agencies.

(3) The Department of Veterans Affairs will defer reporting information to a consumer reporting agency if the individual disputes the existence or amount of any debt or requests waiver of the debt within the time limits set forth in paragraph (d)(2)(ii) of this section. The Department of Veterans Affairs will review any dispute and notify the individual of its findings. If the original decision is determined to be correct, or if the individual's request for waiver is denied, the Department of Veterans Affairs may report the fact of delinquency to a consumer reporting agency. However, the individual shall be afforded 30 days from date of the notice of the agency's determination to repay the debt.

(4) Nothing in this section affects an individual's right to appeal an agency decision to the Board of Veterans Appeals. However, information concerning the debt may be disclosed while an appeal is pending before the Board of Veterans Appeals.

(5) Upon request, the Department of Veterans Affairs will notify an individual—

(i) Whether information concerning a debt has been reported to consumer reporting agencies;

(ii) Of the name and address of each consumer reporting agency to which information has been released; and

(iii) Of the specific information released.

A notice of the right to request this information will be sent with the notice described in paragraph (d)(1) of this section.

(e) Subsequent to disclosure of information to consumer reporting agencies as described in paragraph (c) of this section, the Department of Veterans Affairs shall:

(1) Notify on a monthly basis each consumer reporting agency concerned of any substantial change in the status or amount of indebtedness.

(2) Promptly verify any and all information disclosed if so requested by the consumer reporting agency concerned.

(f) In the absence of a different rule prescribed by statute, contract, or other regulation, an indebtedness is considered delinquent if not paid by the individual by the date due specified in the notice of indebtedness, unless satisfactory arrangements are made by such date.

(g) Notification shall be considered sufficient when effected by ordinary mail, addressed to the last known address, and such notice is not returned as undeliverable by postal authorities.

(h) The Privacy Act (5 U.S.C. 552a) does not apply to any contract between the Department of Veterans Affairs and a consumer reporting agency, nor does it apply to a consumer reporting agency and its employees. See 38 U.S.C. 5701(i). This paragraph does not relieve the Department of Veterans Affairs of its obligation to comply with the Privacy Act.

(i) The term ''consumer reporting agency'' means any person or agency which, for monetary fees, dues, or on a cooperative nonprofit basis, regularly engages in whole or in part in the practice of assembling or evaluating consumer credit information or other information on consumers for the purpose of furnishing consumer reports to third parties or to other consumer reporting agencies. The term ''consumer reporting agency'' shall also mean any person or agency which serves as a marketing agent under arrangements enabling third parties to obtain such information from consumer reporting agencies, or which obtain such information for the purpose of furnishing it to consumer reporting agencies.

(Authority: 31 U.S.C. 3711(e); 38 U.S.C. 501, 5701(g) and (i))

[46 FR 62058, Dec. 22, 1981, as amended at 52 FR 42107, Nov. 3, 1987. Redesignated and amended at 69 FR 62195, Oct. 25, 2004]

§ 1.917 Contracting for collection services.

(a) VA has authority to contract for collection services to recover delinquent debts, provided that:

(1) The authority to resolve disputes, compromise claims, suspend or terminate collection and refer the matter for litigation shall be retained by VA;

(2) The contractor shall be subject to 38 U.S.C. 5701, and to the Privacy Act of 1974, as amended, to the extent specified in 5 U.S.C. 552a(m), and to applicable Federal and State laws and regulations pertaining to debt collection practices, such as the Fair Debt Collection Practices Act, 15 U.S.C. 1692 *et seq.*

(3) The contractor shall be required to strictly account for all amounts collected;

(4) Upon returning an account to VA for subsequent referral to the Department of Justice for litigation, the contractor must agree to provide any data contained in its files relating to § 1.951.

(b) In accordance with 31 U.S.C. 3718(d), or as otherwise permitted by law, collection service contracts may be funded in the following manner:

(1) VA may fund a collection service contract on a fixed-fee basis (*i.e.*, payment of a fixed fee determined without regard to the amount actually collected under the contract). Payment of the fee under this type of contract must be charged to available appropriations;

(2) VA may also fund a collection service contract on a contingent-fee basis (*i.e.*, by including a provision in the contract permitting the contractor to deduct its fee from amounts collected under the contract). The fee should be based upon a percentage of the amount collected, consistent with prevailing commercial practice;

(3) VA may enter into a contract under paragraph (b)(1) of this section only if and to the extent that funding

for the contract is provided for in advance by an appropriation act or other legislation, except that this requirement does not apply to the use of a revolving fund authorized by statute;

(4) Except as authorized under paragraphs (b)(2) and (b)(5) of this section, or unless otherwise specifically provided by law, VA shall deposit all amounts recovered under collection service contracts for Loan Guaranty debts into the Loan Guaranty Revolving Fund, and for all other debts in the Treasury as miscellaneous receipts pursuant to 31 U.S.C. 3302.

(5) For benefit overpayments recovered under collection service contract, VA, pursuant to 31 U.S.C. 3302, shall deposit:

(i) Amounts equal to the original overpayments in the appropriations account from which the overpayments were made, and

(ii) Amount of interest or administrative costs in the Treasury as miscellaneous receipts.

(c) VA shall use government-wide debt collection contracts to obtain debt collection services provided by private collection contractors. However, VA may refer debts to private collection contractors pursuant to a contract between VA and a private collection contractor only if such debts are not subject to the requirement to transfer debts to Treasury for debt collection. See 31 U.S.C. 3711(g), 31 CFR 285.12(e), and 38 CFR 1.910.

(d) VA may enter into contracts for locating and recovering assets of the United States, such as unclaimed assets.

(e) VA may enter into contracts for debtor asset and income search reports. In accordance with 31 U.S.C. 3718(d), such contracts may provide that the fee a contractor charges the agency for such services may be payable from the amounts recovered, unless otherwise prohibited by statute.

(Authority: 31 U.S.C. 3718; 38 U.S.C. 501)

[52 FR 42107, Nov. 3, 1987. Redesignated and amended at 69 FR 62195, Oct. 25, 2004]

§ 1.918 Use and disclosure of mailing addresses.

(a) When attempting to locate a debtor in order to compromise or collect a debt in accordance with §§ 1.900 through 1.953, VA may send a request to the Secretary of the Treasury, or his/her designee, in order to obtain the debtor's most current mailing address from the records of the Internal Revenue Service.

(b) VA is authorized to use mailing addresses obtained under paragraph (a) of this section to enforce collection of a delinquent debt and may disclose such mailing addresses to other agencies and to collection agencies for collection purposes.

(Authority: 31 U.S.C. 3711; 38 U.S.C. 501)

[52 FR 42108, Nov. 3, 1987. Redesignated and amended at 69 FR 62196, Oct. 25, 2004]

§ 1.919 Administrative offset against amounts payable from Civil Service Retirement and Disability Fund, Federal Employees Retirement System (FERS), final salary check, and lump sum leave payments.

(a) Unless otherwise prohibited by law or regulation, and in accordance with 31 CFR 901.3(d), VA may request that money which is due and payable to a debtor from either the Civil Service Retirement and Disability Fund or FERS be administratively offset in reasonable amounts in order to collect, in one full payment or a minimal number of payments, debts that are owed to VA by the debtor. Such requests shall be made to the appropriate officials at the Office of Personnel Management (OPM) in accordance with such regulations prescribed by the Director of OPM. (See 5 CFR 831.1801 through 831.1808). In addition, VA may also offset against a Federal employee's final salary check and lump sum leave payment. See § 1.912 for procedures for offset against a final salary check and lump sum leave payment.

(b) When making a request to the Office of Personnel Management for administrative offset under paragraph (a) of this section, VA shall include a written certification that:

(1) The debtor owes VA a debt, including the amount of the debt;

(2) VA has complied with the applicable statutes, regulations, and procedures of the Office of Personnel Management; and

(3) VA has complied with §§ 1.911, 1.911a, 1.912, 1.912a, and 31 CFR 901.3, to

the extent applicable, including any required hearing or review.

(c) Once VA decides to request administrative offset from the Civil Service Retirement and Disability Fund or Federal Employees Retirement System (FERS) under paragraph (a) of this section, it shall make the request as soon as possible after completion of the applicable procedures in order that the Office of Personnel Management may identify the debtor's account in anticipation of the time when the debtor requests or becomes eligible to receive payments from the Fund or FERS. This will satisfy any requirement that offset be initiated prior to expiration of the applicable statutes of limitations. At such time as the debtor makes a claim for payments from the Fund or FERS, if at least a year has elapsed since the offset request was originally made, the debtor should be permitted to offer a satisfactory repayment plan in lieu of offset upon establishing that such offset will create financial hardship.

(d) If VA collects all or part of the debt by other means before deductions are made or completed in accordance with paragraph (a) of this section, VA shall promptly act to modify or terminate its request for offset under paragraph (a) of this section.

(e) The Office of Personnel Management is neither required nor authorized by this section to review the merits of VA's determination with respect to the amount and validity of the debt waiver under 5 U.S.C. 5584 or 38 U.S.C. 5302, or providing or not providing an oral hearing.

(Authority: 5 U.S.C. 8461; 31 U.S.C. 3711, 3716; 38 U.S.C. 501)

[52 FR 42108, Nov. 3, 1987. Redesignated and amended at 69 FR 62196, Oct. 25, 2004]

§ 1.920 Referral of VA debts.

(a) When authorized, VA may refer an uncollectible debt to another Federal or State agency for the purpose of collection action. Collection action may include the offsetting of the debt from any current or future payment, except salary (see paragraph (e) of this section), made by such Federal or State agency to the person indebted to VA.

(b) VA must certify in writing that the individual owes the debt, the amount and basis of the debt, the date on which payment became due, and the date VA's right to collect the debt first accrued.

(c) This certification will also state that VA provided the debtor with written notice of:

(1) The nature and amount of the debt;

(2) VA's intention to pursue collection by offset procedures;

(3) The opportunity to inspect and copy VA records pertaining to the debt;

(4) The right to contest both the existence and amount of the debt and to request a waiver of collection of the debt (if applicable), as well as the right to a hearing on both matters;

(5) The opportunity to enter into a written agreement with VA for the repayment of the debt; and

(6) Other applicable notices required by §§ 1.911, 1.911a, 1.912, and 1.912a.

(d) The written certification required by paragraphs (b) and (c) of this section will also contain (for all debts) a listing of all actions taken by both VA and the debtor subsequent to the notice, as well as the dates of such actions.

(e) The referral by VA of a VA debt to another agency for the purpose of salary offset shall be done in accordance with 38 CFR 1.980 through 1.995 and regulations prescribed by the Director of the Office of Personnel Management (OPM) in 5 CFR part 550, subpart K.

(Authority: 31 U.S.C. 3711; 38 U.S.C. 501)

[52 FR 42108, Nov. 3, 1987. Redesignated and amended at 69 FR 62196, Oct. 25, 2004]

§ 1.921 Analysis of costs.

VA collection procedures should provide for periodic comparison of costs incurred and amounts collected. Data on costs and corresponding recovery rates for debts of different types and in various dollar ranges should be used to compare the cost effectiveness of alternative collection techniques, establish guidelines with respect to points at which costs of further collection efforts are likely to exceed recoveries, assist in evaluating offers in compromise, and establish minimum debt amounts

below which collection efforts need not be taken.

(Authority: 31 U.S.C. 3711–3719; 38 U.S.C. 501)

[69 FR 62196, Oct. 25, 2004]

§ 1.922 Exemptions.

(a) Sections 1.900 through 1.953, to the extent they reflect remedies or procedures prescribed by the Debt Collection Act of 1982 and the Debt Collection Improvement Act of 1996, such as administrative offset, use of credit bureaus, contracting for collection agencies, and interest and related charges, do not apply to debts arising under, or payments made under, the Internal Revenue Code of 1986, as amended (26 U.S.C. 1 *et seq.*); the Social Security Act (42 U.S.C. 301 *et seq.*), except to the extent provided under 42 U.S.C. 404 and 31 U.S.C. 3716(c); or the tariff laws of the United States. These remedies and procedures, however, may be authorized with respect to debts that are exempt from the Debt Collection Act of 1982 and the DCIA of 1996, to the extent that they are authorized under some other statute or the common law.

(b) This section should not be construed as prohibiting the use of §§ 1.900 through 1.953 when collecting debts owed by persons employed by agencies administering the laws cited in paragraph (a) of this section unless the debt arose under those laws.

(Authority: 31 U.S.C. 3711; 38 U.S.C. 501)

[69 FR 62196, Oct. 25, 2004]

§ 1.923 Administrative wage garnishment.

(a) In accordance with the procedures set forth in 31 U.S.C. 3720D and 31 CFR 285.11, VA or Treasury may request that a non-Federal employer garnish the disposable pay of an individual to collect delinquent non-tax debt owed to VA. VA may pursue wage garnishment independently in accordance with this section or VA or Treasury may pursue garnishment after VA refers a debt to Treasury in accordance with § 1.910 of this part and 31 CFR 285.12. For the purposes of this section, any reference to Treasury also includes any private collection agency under contract to Treasury.

(b) At least 30 days prior to the initiation of garnishment proceedings, VA or Treasury shall send a written notice, as described in 31 CFR 285.11(e), by first class mail to the debtor's last known address. This notice shall inform the debtor of:

(1) The nature and amount of the debt;

(2) The intention of VA or Treasury to initiate proceedings to collect the debt through deductions from the debtor's pay until the debt and all accumulated interest, and other late payment charges, are paid in full, and;

(3) An explanation of the debtor's rights, including the opportunity:

(i) To inspect and copy VA records pertaining to the debt;

(ii) To enter into a written repayment agreement with VA or Treasury under terms agreeable to VA or Treasury, and;

(iii) To a hearing in accordance with 31 CFR 285.11(f) and paragraph (c) of this section concerning the existence or amount of the debt or the terms of the proposed repayment schedule under the garnishment order. However, the debtor is not entitled to a hearing concerning the terms of the proposed repayment schedule if these terms have been established by written agreement under paragraph (b)(3)(ii) of this section.

(c) Any hearing conducted as part of the administrative wage garnishment process shall be conducted by the designated hearing official in accordance with the procedures set forth in 31 CFR 285.11(f). This hearing official may be any VA hearing official. This hearing official may also conduct administrative wage garnishment hearings for other Federal agencies.

(1) The hearing may be oral or written as determined by the designated hearing official. The hearing official shall provide the debtor with a reasonable opportunity for an oral hearing when the hearing official determines that the issue in dispute cannot be resolved by review of documentary evidence, for example, when the validity of the claim turns on the issue of credibility or veracity. The hearing official shall establish the time and place of any oral hearing. At the debtor's option, an oral hearing may be conducted either in person or by telephone conference call. A hearing is not required

to be a formal, evidentiary-type hearing, but witnesses who testify in oral hearings must do so under oath or affirmation. While it is not necessary to produce a transcript of the hearing, the hearing official must maintain a summary record of the proceedings. All travel expenses incurred by the debtor in connection with an in-person hearing shall be borne by the debtor. VA or Treasury shall be responsible for all telephone expenses. In the absence of good cause shown, a debtor who fails to appear at a hearing will be deemed as not having timely filed a request for a hearing.

(2) If the hearing official determines that an oral hearing is not necessary, then he/she shall afford the debtor a ''paper hearing.'' In a ''paper hearing,'' the hearing official will decide the issues in dispute based upon a review of the written record.

(3) If the debtor's written request for a hearing is received by either VA or Treasury within 15 business days following the mailing of the notice described in paragraph (b) of this section, then VA or Treasury shall not issue a withholding order as described in paragraph (d) of this section until the debtor is afforded the requested hearing and a decision rendered. If the debtor's written request for a hearing is not received within 15 business days following the mailing of the notice described in paragraph (b) of this section, then the hearing official shall provide a hearing to the debtor, but will not delay issuance of a withholding order as described in paragraph (d) of this section, unless the hearing official determines that the delay in filing was caused by factors beyond the debtor's control.

(4) The hearing official shall notify the debtor of:

(i) The date and time of a telephone conference hearing;

(ii) The date, time, and location of an in-person oral hearing, or;

(iii) The deadline for the submission of evidence for a written hearing.

(5) Except as provided in paragraph (c)(6)of this section, VA or Treasury shall have the burden of going forward to prove the existence or amount of the debt, after which the debtor must show, by a preponderance of the evidence, that no debt exists or that the amount of the debt is incorrect. In general, this means that the debtor must show that it is more likely than not that a debt does not exist or that the amount of the debt is incorrect. The debtor may also present evidence that terms of the repayment agreement are unlawful, would cause a financial hardship, or that collection of the debt may not be pursued due to operation of law.

(6) If the debtor has previously contested the existence and/or amount of the debt in accordance with §1.911(c)(1) or §1.911a(c)(1) and VA subsequently rendered a decision upholding the existence or amount of the debt, then such decision shall be incorporated by reference and become the basis of the hearing official's decision on such matters.

(7) The hearing official shall issue a written decision as soon as practicable, but not later than 60 days after the date on which the request for such hearing was received by VA or Treasury. The decision will be the final action for the purposes of judicial review under the Administrative Procedure Act (5 U.S.C. 701 *et seq.*). The decision shall include:

(i) A summary of the facts presented;

(ii) The hearing official's findings, analysis, and conclusions, and;

(iii) The terms of the repayment schedule, if applicable.

(d) In accordance with 31 CFR 285.11(g) and (h), VA or Treasury shall send a Treasury-approved withholding order and certification form by first class mail to the debtor's employer within 30 days after the debtor fails to make a timely request for a hearing. If a timely request for a hearing has been filed by the debtor, then VA or Treasury shall send a withholding order and certification form by first class mail to the debtor's employer within 30 days after a final decision is made to proceed with the garnishment. The employer shall complete and return the certification form as described in 31 CFR 285.11(h).

(e) After receipt of the garnishment order, the employer shall withhold the amount of garnishment as described in 31 CFR 285.11(i) from all disposable pay payable to the applicable debtor during each pay period.

(f) A debtor whose wages are subject to a wage withholding order under 31 CFR 285.11 may request a review, under the procedures set forth in 31 CFR 285.11(k), of the amount garnished. A request for review shall only be considered after garnishment has been initiated. The request must be based on materially changed circumstances such as disability, divorce, or catastrophic illness which result in financial hardship that limit the debtor's ability to provide food, housing, clothing, transportation, and medical care for himself/herself and his/her dependents.

(Authority: 31 U.S.C. 3720D; 38 U.S.C. 501; 31 CFR 285.11)

[69 FR 62196, Oct. 25, 2004, as amended at 72 FR 65462, Nov. 21, 2007]

§ 1.924 Suspension or revocation of eligibility for federal loans, loan insurance, loan guarantees, licenses, permits, or privileges.

(a) In accordance with 31 U.S.C. 3720B and the procedures set forth in 31 CFR 285.13 and § 901.6, a person owing an outstanding non-tax debt that is in delinquent status shall not be eligible for Federal financial assistance unless exempted under paragraph (d) of this section or waived under paragraph (e) of this section.

(b) Federal financial assistance or financial assistance means any Federal loan (other than a disaster loan), loan insurance, or loan guarantee.

(c) For the purposes of this section only, a debt is in a delinquent status if the debt has not been paid within 90 days of the payment due date or by the end of any grace period provided by statute, regulation, contract, or agreement. The payment due date is the date specified in the initial written demand for payment. Further guidance concerning the delinquent status of a debt may be found at 31 CFR 285.13(d).

(d) Upon the written request and recommendation of the Secretary of Veterans Affairs, the Secretary of the Treasury may grant exemptions from the provisions of this section. The standards for exemptions granted for classes of debts are set forth in 31 CFR 285.13(f).

(e)(1) VA's Chief Financial Officer or Deputy Chief Financial Officer may waive the provisions of paragraph (a) of this section only on a person-by-person basis.

(2) The Chief Financial Officer or Deputy Chief Financial Officer should balance the following factors when deciding whether to grant a waiver:

(i) Whether the denial of the financial assistance to the person would tend to interfere substantially with or defeat the purposes of the financial assistance program or otherwise would not be in the best interests of the Federal government; and

(ii) Whether the granting of the financial assistance to the person is contrary to the government's goal of reducing losses by requiring proper screening of potential borrowers.

(3) When balancing the factors described in paragraph (e)(2)(i) and (e)(2)(ii) of this section, the Chief Financial Officer or Deputy Chief Financial Officer should consider:

(i) The age, amount, and cause(s) of the delinquency and the likelihood that the person will resolve the delinquent debt; and

(ii) The amount of the total debt, delinquent or otherwise, owed by the person and the person's credit history with respect to repayment of debt.

(4) A centralized record shall be retained of the number and type of waivers granted under this section.

(f) In non-bankruptcy cases, in seeking the collection of statutory penalties, forfeitures, or other similar types of claims, VA may suspend or revoke any license, permit, or other privilege granted a debtor when the debtor inexcusably or willfully fails to pay such a debt. The debtor should be advised in VA's written demand for payment of VA's ability to suspend or revoke licenses, permits, or privileges. VA may suspend or disqualify any lender, contractor, or broker who is engaged in making, guaranteeing, insuring, acquiring, or participating in loans from doing further business with VA or engaging in programs sponsored by VA if such lender, contractor, or broker fails to pay its debts to the Government within a reasonable time, or if such lender, contractor, or broker has been suspended, debarred, or disqualified from participation in a program or activity by another Federal agency. The failure of any surety to honor its

obligations in accordance with 31 U.S.C. 9305 should be reported to Treasury.

(g) In bankruptcy cases, before advising the debtor of the intention to suspend or revoke licenses, permits, or privileges, VA should seek legal advice from VA's General Counsel or Regional Counsel concerning the impact of the Bankruptcy Code, particularly 11 U.S.C. 362 and 525, which may restrict such action.

(Authority: 31 U.S.C. 3720B; 38 U.S.C. 501)

[69 FR 62197, Oct. 25, 2004]

§ 1.929 Reduction of debt through performance of work-study services.

(a) *Scope.* (1) Subject to the provisions of this section VA may allow an individual to reduce an indebtedness to the United States through offset of benefits to which the individual becomes entitled by performance of work-study services under 38 U.S.C. 3485 and 3537 when the debt arose by virtue of the individual's participation in a benefits program provided under any of the following:

(i) 38 U.S.C. chapter 30;

(ii) 38 U.S.C. chapter 31;

(iii) 38 U.S.C. chapter 32;

(iv) 38 U.S.C. chapter 34;

(v) 38 U.S.C. chapter 35;

(vi) 38 U.S.C. chapter 36 (other than an education loan provided under subpart F, part 21 of this title); or

(vii) 10 U.S.C. chapter 1606 (other than an indebtedness arising from a refund penalty imposed under 10 U.S.C. 16135).

(2) This section shall not apply in any case in which the individual has a pending request for waiver of the debt under §§ 1.950 through 1.970.

(Authority: 38 U.S.C. 3485(e)(1); Pub. L. 102–16)

(b) *Selection criteria.* (1) If there are more candidates for a work-study allowance than there are work-study positions available in the area in which the services are to be performed, VA will give priority to the candidates who are pursuing a program of education or rehabilitation.

(2) Only after all candidates in the area described in paragraph (b)(1) of this section either have been given work-study contracts or have withdrawn their request for contracts will VA offer contracts to those who are not pursuing a program of education or rehabilitation and who wish to reduce their indebtedness through performance of work-study services.

(3) VA shall not offer a contract to an individual who is receiving compensation from another source for the work-study services the individual wishes to perform.

(4) VA shall not offer a contract to an individual if VA determines that the debt can be collected through other means such as collection in a lump sum, collection in installments as provided in § 1.917 or compromise as provided in § 1.918.

(Authority: 38 U.S.C. 3485(e); Pub. L. 102–16)

(c) *Utilization.* The work-study services to be performed under a debt-liquidation contract will be limited as follows:

(1) If the individual is concurrently receiving educational assistance in a program administered by VA, work-study services are limited to those allowed in the educational program under which the individual is receiving benefits.

(2) If the individual is not concurrently receiving educational assistance in a program administered by VA, the individual may perform only those work-study services and activities which are or were open to those students receiving a work-study allowance while pursuing a program of education pursuant to the chapter under which the debt was incurred.

(Authority: 38 U.S.C. 3485(e); Pub. L. 102–16)

(d) *Contract to perform services.* (1) The work-study services performed to reduce indebtedness shall be performed pursuant to a contract between the individual and VA.

(2) The individual shall perform the work-study services required by the contract at the place or places designated by VA.

(3) The number of hours of services to be performed under the contract must be sufficient to enable the individual to become entitled to a sum large enough to liquidate the debt by offset.

(4) The number of weeks in the contract will not exceed the lesser of—

(i) The number of weeks of services the individual needs to perform to liquidate his or her debt; or

(ii) 52.

(5) In determining the number of hours per week and the number of weeks under paragraphs (d)(3) and (d)(4) of this section necessary to liquidate the debt, VA will use the amount of the account receivable, including all accrued interest, administrative costs and marshall fees outstanding on the date the contract is offered to the individual and all accrued interest, administrative costs and marshall fees VA estimates will have become outstanding on the debt on the date the debt is to be liquidated.

(6) The contract will automatically terminate after the total amount of the individual's indebtedness described in paragraph (d)(5) of this section has been recouped, waived, or otherwise liquidated. An individual performing work-study services under a contract to liquidate a debt is released from the contract if the debt is liquidated by other means.

(7) The contract to perform work-study services for the purpose of liquidating indebtedness will be terminated if:

(i) The individual is liquidating his or her debt under this section while receiving either an educational assistance allowance for further pursuit of a program of education or a subsistence allowance for further pursuit of a program of rehabilitation;

(ii) The individual terminates or reduces the rate of pursuit of his or her program of education or rehabilitation; and

(iii) The termination or reduction causes an account receivable as a debt owed by the individual.

(8) VA may terminate the contract at any time the individual fails to perform the services required by the contract in a satisfactory manner.

(Authority: 38 U.S.C. 3485(e), 7104(a); Pub. L. 102–16)

(e) *Reduction of indebtedness.* (1) In return for the individual's agreement to perform hours of services totaling not more than 40 times the number of weeks in the contract, VA will reduce the eligible person's outstanding indebtedness by an amount equal to the higher of—

(i) The hourly minimum wage in effect under section 6(a) of the Fair Labor Standards Act of 1938 times the number of hours the individual works; or

(ii) The hourly minimum wage under comparable law of the State in which the services are performed times the number of hours the individual works.

(2) VA will reduce the individual's debt by the amount of the money earned for the performance of work-study services after the completion of each 50 hours of services (or in the case of any remaining hours required by the contract, the amount for those hours).

(Authority: 38 U.S.C. 3485(e); Pub. L. 102–16)

(f) *Suspension of collections by offset.* Notwithstanding the provisions of §1.912a, during the period covered by the work-study debt-liquidation contract with the individual, VA will ordinarily suspend the collection by offset of a debt described in paragraph (a)(1) of this section. However, the individual may voluntarily permit VA to collect part of the debt through offset against other benefits payable while the individual is performing work-study services. If the contract is terminated before its scheduled completion date, and the debt has not been liquidated, collection through offset against other benefits payable will resume on the date the contract terminates.

(Authority: 38 U.S.C. 3485(e); Pub. L. 102–16)

(g) *Payment for additional hours.* (1) If an individual, without fault on his or her part, performs work-study services for which payment may not be authorized, including services performed after termination of the contract, VA will pay the individual at the applicable hourly minimum wage for such services as the Director of the VA field station of jurisdiction determines were satisfactorily performed.

(2) The Director of the VA field station of jurisdiction shall determine whether the individual was without fault. In making this decision he or she shall consider all evidence of record

and any additional evidence which the individual wishes to submit.

(Authority: 38 U.S.C. 3485(e); Pub. L. 102–16)

[62 FR 15401, Apr. 1, 1997]

STANDARDS FOR COMPROMISE OF CLAIMS

AUTHORITY: Sections 1.900 through 1.953 are issued under the authority of 31 U.S.C. 3711 through 3720E; 38 U.S.C. 501, and as noted in specific sections.

SOURCE: 32 FR 2614, Feb. 8, 1967, unless otherwise noted.

§ 1.930 Scope and application.

(a) The standards set forth in §§ 1.930 through 1.936 of this part apply to the compromise of debts pursuant to 31 U.S.C. 3711. VA may exercise such compromise authority when the amount of the debt due, exclusive of interest, penalties, and administrative costs, does not exceed $100,000 or any higher amount authorized by the Attorney General.

(b) Unless otherwise provided by law, when the principal balance of a debt, exclusive of interest, penalties, and administrative costs, exceeds $100,000 or any higher amount authorized by the Attorney General, the authority to accept the compromise rests with the Department of Justice (DOJ). If VA receives an offer to compromise any debt in excess of $100,000, VA should evaluate the compromise offer using the same factors as set forth in § 1.931 of this part. If VA believes the offer has merit, it shall refer the debt to the Civil Division or other appropriate division in DOJ using a Claims Collection Litigation Report (CCLR). The referral shall include appropriate financial information and a recommendation for the acceptance of the compromise offer. DOJ approval is not required if VA decides to reject a compromise offer.

(c) The $100,000 limit in paragraph (b) of this section does not apply to debts that arise out of participation in a VA loan program under Chapter 37 of Title 38 of the U.S. Code. VA has unlimited authority to compromise debts arising out of participation in a Chapter 37 loan program, regardless of the amount of the debt.

(Authority: 31 U.S.C. 3711; 38 U.S.C 501, 3720)

[69 FR 62198, Oct. 25, 2004]

§ 1.931 Bases for compromise.

(a) VA may compromise a debt if it cannot collect the full amount because:

(1) The debtor is unable to pay the full amount in a reasonable time, as verified through credit reports or other financial information;

(2) VA is unable to collect the debt in full within a reasonable time by enforced collection proceedings;

(3) The cost of collecting the debt does not justify the enforced collection of the full amount; or

(4) There is significant doubt concerning VA's ability to prove its case in court.

(b) In determining the debtor's inability to pay, VA will consider relevant factors such as the following:

(1) Age and health of the debtor;

(2) Present and potential income;

(3) Inheritance prospects;

(4) The possibility that assets have been concealed or improperly transferred by the debtor; and

(5) The availability of assets or income that may be realized by enforced collection proceedings.

(c) VA will verify the debtor's claim of inability to pay by using a credit report and other financial information as provided in paragraph (g) of this section. VA should consider the applicable exemptions available to the debtor under State and Federal law in determining the ability to enforce collection. VA also may consider uncertainty as to the price that collateral or other property will bring at a forced sale in determining the ability to enforce collection. A compromise effected under this section should be for an amount that bears a reasonable relation to the amount that can be recovered by enforced collection procedures, with regard to the exemptions available to the debtor and the time that collection will take.

(d) If there is significant doubt concerning VA's ability to prove its case in court for the full amount claimed, either because of the legal issues involved or because of a bona fide dispute

as to the facts, then the amount accepted in compromise of such cases should fairly reflect the probabilities of successful prosecution to judgment, with due regard given to the availability of witnesses and other evidentiary support for VA's claim. In determining the risks involved in litigation, VA will consider the probable amount of court costs and attorney fees pursuant to the Equal Access to Justice Act, 28 U.S.C. 2412, that may be imposed against the Government if it is unsuccessful in litigation.

(e) VA may compromise a debt if the cost of collecting the debt does not justify the enforced collection of the full amount. The amount accepted in compromise in such cases may reflect an appropriate discount for the administrative and litigative costs of collection, with consideration given to the time it will take to effect collection. Collection costs may be a substantial factor in the settlement of small debts. In determining whether the cost of collecting justifies enforced collection of the full amount, VA will consider whether continued collection of the debt, regardless of cost, is necessary to further an enforcement principle.

(f) VA generally will not accept compromises payable in installments. If, however, payment of a compromise in installments is necessary, VA will obtain a legally enforceable written agreement providing that, in the event of default, the full original principal balance of the debt prior to compromise, less sums paid thereon, is reinstated. Whenever possible, VA will also obtain security for repayment.

(g) To assess the merits of a compromise offer based in whole or in part on the debtor's inability to pay the full amount of a debt within a reasonable time, VA will obtain a current financial statement from the debtor showing the debtor's assets, liabilities, income, and expenses. Agencies also may obtain credit reports or other financial information to assess compromise offers.

(Authority: 31 U.S.C. 3711; 38 U.S.C. 501, 3720)

[69 FR 62198, Oct. 25, 2004]

§ 1.932 Enforcement policy.

VA may compromise statutory penalties, forfeitures, or claims established as an aid to enforcement and to compel compliance, if VA's enforcement policy in terms of deterrence and securing compliance, present and future, will be adequately served by VA's acceptance of the sum to be agreed upon.

(Authority: 31 U.S.C. 3711; 38 U.S.C. 501, 3720)

[69 FR 62198, Oct. 25, 2004]

§ 1.933 Joint and several liability.

(a) When two or more debtors are jointly and severally liable, VA will pursue collection activity against all debtors, as appropriate. VA will not attempt to allocate the burden of payment between the debtors but should proceed to liquidate the indebtedness as quickly as possible.

(b) VA will ensure that a compromise agreement with one debtor does not release VA's claim against the remaining debtors. The amount of a compromise with one debtor shall not be considered a precedent or binding in determining the amount that will be required from other debtors jointly and severally liable on the claim.

(Authority: 31 U.S.C. 3711; 38 U.S.C. 501, 3720)

[69 FR 62198, Oct. 25, 2004]

§ 1.934 Further review of compromise offers.

If VA is uncertain whether to accept a firm, written, substantive compromise offer on a debt that is within its delegated compromise authority, it may refer the offer to VA General Counsel or Regional Counsel or to the Civil Division or other appropriate division in the Department of Justice (DOJ), using a Claims Collection Litigation Report (CCLR) accompanied by supporting data and particulars concerning the debt. DOJ may act upon such an offer or return it to the agency with instructions or advice.

(Authority: 31 U.S.C. 3711; 38 U.S.C. 501, 3720)

[69 FR 62198, Oct. 25, 2004]

§ 1.935 Consideration of tax consequences to the Government.

In negotiating a compromise, VA will consider the tax consequences to the Government. In particular, VA will consider requiring a waiver of tax-loss-

carry-forward and tax-loss-carry-back rights of the debtor.

(Authority: 31 U.S.C. 3711; 38 U.S.C. 501, 3720)

[69 FR 62198, Oct. 25, 2004]

§ 1.936 Mutual releases of the debtor and VA.

In all appropriate instances, a compromise that is accepted by VA shall be implemented by means of a mutual release, in which the debtor is released from further non-tax liability on the compromised debt in consideration of payment in full of the compromise amount, and VA and its officials, past and present, are released and discharged from any and all claims and causes of action that the debtor may have arising from the same transaction. In the event a mutual release is not executed when a debt is compromised, unless prohibited by law, the debtor is still deemed to have waived any and all claims and causes of action against VA and its officials related to the transaction giving rise to the compromised debt.

(Authority: 31 U.S.C. 3711; 38 U.S.C. 501, 3720)

[69 FR 62198, Oct. 25, 2004]

STANDARDS FOR SUSPENDING OR TERMINATING COLLECTION ACTION

AUTHORITY: Sections 1.900 through 1.953 are issued under the authority of 31 U.S.C. 3711 through 3720E; 38 U.S.C. 501, and as noted in specific sections.

SOURCE: 32 FR 2615, Feb. 8, 1967, unless otherwise noted.

§ 1.940 Scope and application.

Except as otherwise provided in § 1.945:

(a) The standards set forth in §§ 1.940 through 1.944 apply to the suspension or termination of collection activity pursuant to 31 U.S.C. 3711 on debts that do not exceed $100,000, or such other amount as the Attorney General may direct, exclusive of interest, penalties, and administrative costs, after deducting the amount of partial payments or collections, if any. Prior to referring a debt to the Department of Justice (DOJ) for litigation, VA may suspend or terminate collection under this part with respect to the debt.

(b) If, after deducting the amount of any partial payments or collections, the principal amount of a debt exceeds $100,000, or such other amount as the Attorney General may direct, exclusive of interest, penalties, and administrative costs, the authority to suspend or terminate rests solely with DOJ. If VA believes that suspension or termination of any debt in excess of $100,000 may be appropriate, it shall refer the debt to the Civil Division or other appropriate division in DOJ, using the Claims Collection Litigation Report (CCLR). The referral should specify the reasons for VA's recommendation. If, prior to referral to DOJ, VA determines that a debt is plainly erroneous or clearly without legal merit, VA may terminate collection activity regardless of the amount involved without obtaining DOJ concurrence.

(Authority: 31 U.S.C. 3711; 38 U.S.C. 501)

[69 FR 62199, Oct. 25, 2004, as amended at 75 FR 53201, Aug. 31, 2010]

§ 1.941 Suspension of collection activity.

(a) VA may suspend collection activity on a debt when:

(1) It cannot locate the debtor;

(2) The debtor's financial condition is expected to improve; or

(3) The debtor has requested a waiver or review of the debt.

(b) Based on the current financial condition of the debtor, VA may suspend collection activity on a debt when the debtor's future prospects justify retention of the debt for periodic review and collection activity and:

(1) The applicable statute of limitations has not expired; or

(2) Future collection can be effected by administrative offset, notwithstanding the expiration of the applicable statute of limitations for litigation of claims, and with due regard to the 10-year limitation for administrative offset prescribed by 31 U.S.C. 3716(e)(1); or

(3) The debtor agrees to pay interest on the amount of the debt on which collection will be suspended, and such suspension is likely to enhance the debtor's ability to pay the full amount of the principal of the debt with interest at a later date.

(c) Collection action may also be suspended, in accordance with §§1.911, 1.911a, 1.912, and 1.912a, pending VA action on requests for administrative review of the existence or amount of the debt or a request for waiver of collection of the debt. However, collection action will be resumed once VA issues an initial decision on the administrative review or waiver request.

(d) When VA learns that a bankruptcy petition has been filed with respect to a debtor, in most cases the collection activity on a debt must be suspended, pursuant to the provisions of 11 U.S.C. 362, 1201, and 1301, unless VA can clearly establish that the automatic stay does not apply, has been lifted, or is no longer in effect. VA shall seek legal advice immediately from either the VA General Counsel or Regional Counsel and, if legally permitted, take the necessary steps to ensure that no funds or money are paid by VA to the debtor until relief from the automatic stay is obtained.

(Authority: 31 U.S.C. 3711; 38 U.S.C. 501)

[69 FR 62199, Oct. 25, 2004]

§ 1.942 Termination of collection activity.

Termination of collection activity involves a final determination. Collection activity may be terminated on cases previously suspended. The Department of Veterans Affairs may terminate collection activity and consider closing the agency file on a claim which meets any one of the following standards:

(a) *Inability to collect any substantial amount.* Collection action may be terminated on a claim when it becomes clear that VA cannot collect or enforce collection of any significant amount from the debtor, having due regard for the judicial remedies available to the agency, the debtor's future financial prospects, and the exemptions available to the debtor under State and Federal law. In determining the debtor's inability to pay, the following factors, among others, shall be considered: Age and health of the debtor, present and potential income, inheritance prospects, the possibility that assets have been concealed or improperly transferred by the debtor, the availability of assets or income which may be realized by means of enforced collection proceedings.

(b) *Inability to locate debtor.* The debtor cannot be located, no security remains to be liquidated, the applicable statute of limitations has run, and the prospects of collecting by offset are too remote.

(c) *Death of debtor.* The debtor is determined to be deceased and the Government has no prospect of collection from his/her estate.

(d) *Cost will exceed recovery.* The cost of further collection effort is likely to exceed the amount recoverable.

(e) *Claim legally without merit.* Collection action should be terminated on a claim whenever it is determined that the claim is legally without merit.

(f) *Claim cannot be substantiated by evidence.* VA will terminate collection action on once asserted claims because of lack of evidence or unavailability of witnesses only in cases where efforts to induce voluntary payment are unsuccessful.

(g) *Discharge in bankruptcy.* Generally, VA shall terminate collection activity on a debt that has been discharged in bankruptcy, regardless of the amount. VA may continue collection activity, subject to the provisions of the Bankruptcy Code, for any payments provided under a plan of reorganization. Offset and recoupment rights may survive the discharge of the debtor in bankruptcy and, under some circumstances, claims also may survive the discharge.

(h) Before terminating collection activity, VA should have pursued all appropriate means of collection and determined, based upon the results of the collection activity, that the debt is uncollectible. Termination of collection activity ceases active collection of the debt. The termination of collection activity does not preclude VA from retaining a record of the account for purposes of:

(1) Selling the debt, if the Secretary of the Treasury determines that such sale is in the best interests of the United States;

(2) Pursuing collection at a subsequent date in the event there is a change in the debtor's status or a new collection tool becomes available;

(3) Offsetting against future income or assets not available at the time of termination of collection activity; or

(4) Screening future applicants for prior indebtedness.

(Authority: 31 U.S.C. 3711; 38 U.S.C. 501)

[32 FR 2615, Feb. 8, 1967, as amended at 52 FR 42111, Nov. 3, 1987; 69 FR 62200, Oct. 25, 2004]

§ 1.943 Exception to termination.

When a significant enforcement policy is involved, or recovery of a judgment is a prerequisite to the imposition of administrative sanctions, VA may refer debts for litigation even though termination of collection activity may otherwise be appropriate.

(Authority: 31 U.S.C. 3711; 38 U.S.C. 501)

[69 FR 62200, Oct. 25, 2004]

§ 1.944 Discharge of indebtedness; reporting requirements.

(a) Before discharging a delinquent debt (also referred to as a close out of the debt), VA shall take all appropriate steps to collect the debt in accordance with 31 U.S.C. 3711(g), including, as applicable, administrative offset, tax refund offset, Federal salary offset, referral to Treasury or Treasury-designated debt collection centers or private collection contractors, credit bureau reporting, wage garnishment, litigation, and foreclosure. Discharge of indebtedness is distinct from termination or suspension of collection activity under §§ 1.940 through 1.943 and is governed by the Internal Revenue Code (see 26 U.S.C. 6050P). When collection action on a debt is suspended or terminated, the debt remains delinquent and further collection action may be pursued at a later date in accordance with the standards set forth in §§ 1.900 through 1.953. When VA discharges a debt in full or in part, further collection action is prohibited. Therefore, VA should make the determination that collection action is no longer warranted before discharging a debt. Before discharging a debt, VA must terminate debt collection action.

(b) Upon discharge of an indebtedness, VA must report the discharge to the Internal Revenue Service (IRS) in accordance with the requirements of 26 U.S.C. 6050P and 26 CFR 1.6050P–1. VA may request Treasury or Treasury-designated debt collection centers to file such a discharge report to the IRS on VA's behalf.

(c) When discharging a debt, VA must request that any liens of record securing the debt be released.

(d) 31 U.S.C. 3711(i)(2) requires agencies to sell a delinquent nontax debt upon termination of collection action if the Secretary of the Treasury determines such a sale is in the best interests of the United States. Since the discharge of a debt precludes any further collection action (including the sale of a delinquent debt), VA may not discharge a debt until the requirements of § 3711(i)(2) have been met.

(Authority: 31 U.S.C. 3711; 38 U.S.C. 501)

[69 FR 62200, Oct. 25, 2004]

§ 1.945 Authority to suspend or terminate collection action on certain benefit indebtedness; authority for refunds.

(a) The Secretary of Veterans Affairs (Secretary) may suspend or terminate collection action on all or any part of an indebtedness owed to VA by a member of the Armed Forces who dies while on active duty, if the Secretary determines that such suspension or termination of collection is appropriate and in the best interest of the United States.

(b) The Secretary may terminate collection action on all or any part of an amount owed to the United States for an indebtedness resulting from an individual's participation in a benefits program administered by the Secretary, other than a program as described in paragraph (h) of this section, if the Secretary determines that such termination of collection is in the best interest of the United States. For purposes of this paragraph, an *individual* is any member of the Armed Forces or veteran who dies as a result of an injury incurred or aggravated in the line of duty while serving in a theater of combat operations in a war or in combat against a hostile force during a period of hostilities on or after September 11, 2001.

(c) For purposes of this section:

(1) *Theater of combat operations* means the geographic area of operations where the Secretary in consultation

with the Secretary of Defense determines that combat occurred.

(2) *Period of hostilities* means an armed conflict in which members of the United States Armed Forces are subjected to danger comparable to danger to which members of the Armed Forces have been subjected in combat with enemy armed forces during a period of war, as determined by the Secretary in consultation with the Secretary of Defense.

(d) The Secretary may refund amounts collected after the death of a member of the Armed Forces or veteran in accordance with this paragraph and paragraph (e) of this section.

(1) In any case where all or any part of a debt of a member of the Armed Forces, as described under paragraph (a) of this section, was collected, the Secretary may refund the amount collected if, in the Secretary's determination, the indebtedness would have been suspended or terminated under authority of 31 U.S.C. 3711(f). The member of the Armed Services must have been serving on active duty on or after September 11, 2001. In any case where all or any part of a debt of a covered member of the Armed Forces was collected, the Secretary may refund the amount collected, but only if the Secretary determines that, under the circumstances applicable with respect to the deceased member of the Armed Forces, it is appropriate to do so.

(2) In any case where all or any part of a debt of a covered member of the Armed Forces or veteran, as described under paragraph (b) of this section, was collected on or after September 11, 2001, the Secretary may refund the amount collected if, in the Secretary's determination, the indebtedness would have been terminated under authority of 38 U.S.C. 5302A. In addition, the Secretary may refund the amount only if he or she determines that the deceased individual is equitably entitled to the refund.

(e) Refunds under paragraph (d) of this section will be made to the estate of the decedent or, in its absence, to the decedent's next-of-kin in the order listed below.

(1) The decedent's spouse.

(2) The decedent's children (in equal shares).

(3) The decedent's parents (in equal shares).

(f) The authority exercised by the Secretary to suspend or terminate collection action and/or refund amounts collected on certain indebtedness is reserved to the Secretary and will not be delegated.

(g) Requests for a determination to suspend or terminate collection action and/or refund amounts previously collected as described in this section will be submitted to the Office of the Secretary through the Office of the General Counsel. Such requests for suspension or termination and/or refund may be initiated by the head of the VA administration having responsibility for the program that gave rise to the indebtedness, or any concerned staff office, or by the Chairman of the Board of Veterans' Appeals. When a recommendation for refund under this section is initiated by the head of a staff office, or by the Chairman, Board of Veterans' Appeals, the views of the head of the administration that administers the program that gave rise to the indebtedness will be obtained and transmitted with the recommendation of the initiating office.

(h) The provisions of this section concerning suspension or termination of collection actions and the refunding of moneys previously collected do not apply to any amounts owed the United States under any program carried out under 38 U.S.C. chapter 37.

(Authority: 38 U.S.C. 501, 5302A; 31 U.S.C. 3711(f)).

[75 FR 53201, Aug. 31, 2010]

REFERRALS TO GAO, DEPARTMENT OF JUSTICE, OR IRS

AUTHORITY: Sections 1.900 through 1.953 are issued under the authority of 31 U.S.C. 3711 through 3720E; 38 U.S.C. 501, and as noted in specific sections.

SOURCE: 52 FR 42111, 42112, Nov. 3, 1987, unless otherwise noted.

§ 1.950 Prompt referral.

(a) VA shall promptly refer debts to Department of Justice (DOJ) for litigation where aggressive collection activity has been taken in accordance with §§ 1.900 through 1.953, and such debts cannot be compromised, or on which

collection activity cannot be suspended or terminated, in accordance with §§ 1.930 through 1.936 and §§ 1.940 through 1.944. Debts for which the principal amount is over $1,000,000, or such other amount as the Attorney General may direct, exclusive of interest and other late payment charges, shall be referred to the Civil Division or other division responsible for litigating such debts at DOJ. Debts for which the principal amount is $1,000,000, or less, or such other amount as the Attorney General may direct, exclusive of interest or penalties, shall be referred to DOJ's Nationwide Central Intake Facility as required by the Claims Collection Litigation Report (CCLR) instructions. Debts should be referred as early as possible, consistent with aggressive agency collection activity and the observance of the standards contained in §§ 1.900 through 1.953, and, in any event, well within the period for initiating timely lawsuits against the debtors. VA shall make every effort to refer delinquent debts to DOJ for litigation within 1 year of the date such debts last became delinquent. In the case of guaranteed or insured loans, VA should make every effort to refer these delinquent debts to DOJ for litigation within 1 year from the date the loan was presented to VA for payment or reinsurance.

(b) DOJ has exclusive jurisdiction over the debts referred to it pursuant to this section. VA shall immediately terminate the use of any administrative collection activities to collect a debt at the time of the referral of that debt to DOJ. VA should advise DOJ of the collection activities that have been utilized to date, and their result. VA shall refrain from having any contact with the debtor and shall direct all debtor inquiries concerning the debt to DOJ. VA shall immediately notify DOJ of any payments credited to the debtor's account after referral of a debt under this section. DOJ shall notify VA, in a timely manner, of any payments it receives from the debtor.

(Authority: 31 U.S.C. 3711; 38 U.S.C. 501)

[69 FR 62200, Oct. 25, 2004]

§ 1.951 Claims Collection Litigation Report (CCLR).

(a) Unless excepted by the Department of Justice (DOJ), VA shall complete the CCLR, accompanied by a signed Certificate of Indebtedness, to refer all administratively uncollectible claims to DOJ for litigation. VA shall complete all of the sections of the CCLR appropriate to each claim as required by the CCLR instructions and furnish such other information as may be required in specific cases.

(b) VA shall indicate clearly on the CCLR the actions it wishes DOJ to take with respect to the referred claim.

(c) VA shall also use the CCLR to refer claims to DOJ to obtain approval of any proposals to compromise the claims or to suspend or terminate agency collection activity.

(Authority: 31 U.S.C. 3711; 38 U.S.C. 501)

[69 FR 62200, Oct. 25, 2004]

§ 1.952 Preservation of evidence.

VA must take care to preserve all files and records that may be needed by the Department of Justice (DOJ) to prove its claims in court. VA ordinarily should include certified copies of the documents that form the basis for the claim when referring such claims to DOJ for litigation. VA shall provide originals of such documents immediately upon request by DOJ.

(Authority: 31 U.S.C. 3711; 38 U.S.C. 501)

[69 FR 62200, Oct. 25, 2004]

§ 1.953 Minimum amount of referrals to the Department of Justice.

(a) Except as otherwise provided in paragraphs (b) and (c) of this section, VA shall not refer for litigation claims of less than $2,500, exclusive of interest, penalties, and administrative costs, or such other minimum amount as the Attorney General shall from time to time prescribe. The Department of Justice (DOJ) shall promptly notify referring agencies if the Attorney General changes this minimum amount.

(b) VA shall not refer claims of less than the minimum amount prescribed by the Attorney General unless:

(1) Litigation to collect such smaller claims is important to ensure compliance with VA's policies or programs;

(2) The claim is being referred solely for the purpose of securing a judgment against the debtor, which will be filed as a lien against the debtor's property pursuant to 28 U.S.C. 3201 and returned to VA for enforcement; or

(3) The debtor has the clear ability to pay the claim and the Government effectively can enforce payment, with due regard for the exemptions available to the debtor under State and Federal law and the judicial remedies available to the Government.

(c) VA should consult with the Financial Litigation Staff of the Executive Office for United States Attorneys, in DOJ, prior to referring claims valued at less than the minimum amount.

(Authority: 31 U.S.C. 3711; 38 U.S.C. 501)

[69 FR 62200, Oct. 25, 2004]

§ 1.955 Regional office Committees on Waivers and Compromises.

(a) *Delegation of authority and establishment.* (1) Sections 1.955 *et seq.* are issued to implement the authority for waiver consideration found in 38 U.S.C. 5302 and 5 U.S.C. 5584 and the compromise authority found 38 U.S.C. 3720(a) and 31 U.S.C. 3711. The duties, delegations of authority, and all actions required of the Committees on Waivers and Compromises are to be accomplished under the direction of, and authority vested in, the Director of the regional office. Delegations of authority and limitations for waiver actions under 5 U.S.C. 5584 are set forth in § 1.963a of this part.

(2) There is established in each regional office, a Committee on Waivers and Compromises to perform the duties and assume the responsibilities delegated by §§ 1.956 and 1.957. The term *regional office,* as used in § 1.955 *et seq.*, includes VA Medical and Regional Office Centers and VA Centers where such are established.

(b) *Selection.* The Director shall designate the employees to serve as Chairperson, members, and alternates. Except upon specific authorization of the Under Secretary for Benefits, when workload warrants a full-time committee, such designation will be part-time additional duty upon call of the Chairperson.

(c) *Control and staff.* The administrative control of each Committee on Waivers and Compromises is the responsibility of the station's Fiscal Officer. However, the station Director has the authority to reassign the administrative control function to another station activity, rather than the Fiscal Officer, whenever the Director determines that such reassignment is appropriate. The quality control of the professional and clerical staff of the Committee is the responsibility of the Chairperson.

(d) *Overall control.* The Assistant Secretary for Management is delegated complete management authority, including planning, policy formulation, control, coordination, supervision, and evaluation of Committee operations.

(e) *Committee composition.* (1) The Committee shall consist of a Chairperson and Alternate Chairperson and as many Committee members and alternate members as the Director may appoint. Members and alternates shall be selected so that in each of the debt claim areas (*i.e.*, compensation, pension, education, insurance, loan guaranty, etc.) there are members and alternates with special competence and familiarity with the program area.

(2) When a claim is properly referred to the Committee for either waiver consideration or the consideration of a compromise offer, the Chairperson shall designate a panel from the available Committee members to consider the waiver request or compromise offer. If the debt for which the waiver request or compromise offer is made is $20,000 or less (exclusive or interest and administrative costs), the Chairperson will assign one Committee member as the panel. This one Committee member should have experience in the program area where the debt is located. The single panel member's decision shall stand as the decision of the Committee. If the debt for which the waiver request or compromise offer is made is more than $20,000 (exclusive of interest and administrative costs), the Chairperson shall assign two Committee members. One of the two members should be knowledgeable in the program area where the debt arose. If the two member panel cannot reach a unanimous decision, the Chairperson shall assign a

third member of the Committee to the panel, or assign the case to three new members, and the majority vote shall determine the Committee decision.

(3) The assignment of a one or two member panel as described in paragraph (e)(2) of this section is applicable if the debtor files a Notice of Disagreement with a Committee decision to deny waiver. That is, if the Notice of Disagreement is filed with a decision by a one member panel to deny waiver of collection of a debt of $20,000 or less, then the Notice of Disagreement should also be assigned to one panel member. Likewise, a Notice of Disagreement filed with a decision by a two or three member panel to deny waiver of collection of a debt of more than $20,000 should also be assigned to a Committee panel of two members (three if these two members cannot agree). However, a Chairperson must assign the Notice of Disagreement to a different one, two, or three member panel than the panel that made the original Committee decision that is now the subject of the Notice of Disagreement.

(Authority: 5 U.S.C. 5584, 31 U.S.C. 3711, 38 U.S.C. 3720(a), 5302)

[44 FR 59905, Oct. 17, 1979, as amended at 48 FR 1056, Jan. 10, 1983; 54 FR 40871, Oct. 4, 1989; 57 FR 47264, Oct. 15, 1992; 60 FR 53276, Oct. 13, 1995; 69 FR 62201, Oct. 25, 2004]

§ 1.956 Jurisdiction.

(a) The regional office Committees are authorized, except as to determinations under § 2.6(e)(4)(i) of this chapter where applicable, to consider and determine as limited in §§ 1.955 *et seq.*, settlement, compromise and/or waiver concerning the following debts and overpayments:

(1) Arising out of operations of the Veterans Benefits Administration:

(i) Overpayment or erroneous payments of pension, compensation, dependency and indemnity compensation, burial allowances, plot allowance, subsistence allowance, education (includes debts from work study and education loan defaults as well as from other overpayments of educational assistance benefits) or insurance benefits, clothing allowance and automobile or other conveyance and adaptive equipment allowances.

(ii) Debts arising out of the loan program under 38 U.S.C. ch. 37 after liquidation of security, if any.

(iii) Such other debts as may be specifically designated by the Under Secretary for Benefits.

(2) Arising out of operations of the Veterans Health Services and Research Administration:

(i) Debts resulting from services furnished in error (§ 17.101(a) of this chapter).

(ii) Debts resulting from services furnished in a medical emergency (§ 17.101(b) of this chapter).

(iii) Other claims arising in connection with transactions of the Veterans Health Administration (§ 17.103(c) of this chapter).

(iv) The Chief Financial Officer of the Consolidated Patient Account Center is authorized to waive veterans' debts arising from medical care copayments (§ 17.105(c) of this chapter).

(3) Claims for erroneous payments of pay and allowances, and erroneous payments of travel, transportation, and relocation expenses and allowances, made to or on behalf of employees (5 U.S.C. 5584).

(b) The Under Secretary for Benefits may, at his or her discretion, assume original jurisdiction and establish an ad hoc Board to determine a particular issue arising within this section.

(Authority: 38 U.S.C. 501)

[39 FR 26400, July 19, 1974, as amended at 44 FR 59905, Oct. 17, 1979; 60 FR 53276, Oct. 13, 1995; 69 FR 62201, Oct. 25, 2004; 80 FR 23241, Apr. 27, 2015]

§ 1.957 Committee authority.

(a) *Regional office committee.* On matters covered in § 1.956, the regional office Committee is authorized to determine the following issues:

(1) *Waivers.* A decision may be rendered to grant or deny waiver of collection of a debt in the following debt categories:

(i) Loan guaranty program (38 U.S.C. 5302(b)). Committees may consider waiver of the indebtedness of a veteran or spouse resulting from: (A) The payment of a claim under the guaranty or insurance of loans, (B) the liquidation of direct loans, (C) the liquidation of loans acquired under § 36.4318, and (D) the liquidation of vendee accounts. The

phrase *veteran or spouse* includes a veteran-borrower, veteran-transferee, a veteran-purchaser on a vendee account, a former spouse or surviving spouse of a veteran.

(ii) Other than loan guaranty program. (38 U.S.C. 5302(a))

(iii) Services erroneously furnished (§ 17.101(a)).

(2) *Compromises*—(i) *Loan program debts* (38 U.S.C. 3720(a)). Accept or reject a compromise offer irrespective of the amount of the debt (loan program matters under 38 U.S.C. chapter 37 are unlimited as to amount).

(ii) Other than loan program debts (31 U.S.C. 3711).

(A) Accept or reject a compromise offer on a debt which exceeds $1,000 but which is not over $100,000 (both amounts exclusive of interest and other late payment charges).

(B) Accept or reject a compromise offer on a debt of a $1,000 or less, exclusive of interest and other late payment charges, which is not disposed of by the Chief, Fiscal activity, pursuant to paragraph (b) of this section.

(C) Reject a compromise offer on a debt which exceeds $100,000, exclusive of interest and other late payment charges.

(D) Recommend approval of a compromise offer on a debt which exceeds $100,000, exclusive of interest and other late payment charges. The authority to accept a compromise offer on such a debt rests solely within the jurisdiction of the Department of Justice. The Committee should evaluate a compromise offer on a debt in excess of $100,000, using the factors set forth in §§ 1.930 through 1.938. If the Committee believes that the compromise offer is advantageous to the government, then the Committee members shall so state this conclusion in a written memorandum of recommendation of approval to the Chairperson. This recommendation, along with a Claims Collection Litigation Report (CCLR) completed in accordance with § 1.951, will be referred to VA Central Office, Office of Financial Management (047G7), for submission to the Department of Justice for final approval.

(Authority: 31 U.S.C. 3711)

(b) *Chief of Fiscal activity*. The Chief of the Fiscal activity at both VBA and VHA offices has the authority, as to debts within his/her jurisdiction, to:

(1) On other than loan program debts under 38 U.S.C. chapter 37, accept compromise offers of 50% or more of a total debt not in excess of $1,000, exclusive of interest and other late payment charges, regardless of whether or not there has been a prior denial of waiver.

(2) On other than loan program debts under 38 U.S.C. chapter 37, reject any offer of compromise of a total debt not in excess of $1,000, exclusive of interest and other late payment charges, regardless of whether or not there has been a prior denial of waiver.

(3) On other than loan guaranty program debts under 38 U.S.C. chapter 37, reject any offer of compromise of a total debt not in excess of $1,000, exclusive of interest, regardless of whether or not there has been a prior denial of waiver.

(Authority: 31 U.S.C. 3711 and 38 U.S.C. 3720(a))

[44 FR 59906, Oct. 17, 1979, as amended at 51 FR 38803, Sept. 25, 1985; 52 FR 42112, Nov. 3, 1987; 57 FR 47264, Oct. 15, 1992; 60 FR 53276, Oct. 13, 1995; 69 FR 62201, Oct. 25, 2004]

§ 1.958 Finality of decisions.

A decision by the regional office Committee, operating within the scope of its authority, denying waiver of all or part of a debt arising out of participation in a VA benefit or home loan program, is subject to appeal in accordance with 38 CFR parts 19 and 20. A denial of waiver of an erroneous payment of pay and allowances is subject to appeal in accordance with § 1.963a(a). There is no right of appeal from a decision rejecting a compromise offer.

(Authority: 38 U.S.C. 501 and 7104).

[69 FR 62201, Oct. 25, 2004]

§ 1.959 Records and certificates.

The Chairperson of the Committee shall execute or certify any documents pertaining to its proceedings. He/she will be responsible for maintaining needed records of the transactions of the Committee and preparation of any

administrative or other reports which may be required.

(Authority: 38 U.S.C. 501)

[44 FR 59906, Oct. 17, 1979]

§ 1.960 Legal and technical assistance.

Legal questions involving a determination under § 2.6(e)(4) of this chapter will be referred to the Regional Counsel for action in accordance with delegations of the General Counsel, unless there is an existence a General Counsel's opinion or an approved Regional Counsel's opinion dispositive of the controlling legal principle. As to matters not controlled by § 2.6(e)(4) of this chapter, the Chairperson of the regional office Committee or at his/her instance, a member, may seek and obtain advice from the Regional Counsel on legal matters within his/her jurisdiction and from other division chiefs in their areas of responsibility, on any matter properly before the Committee. Guidance may also be requested from the Central Office staff.

(Authority: 38 U.S.C. 501)

[44 FR 59906, Oct. 17, 1979]

§ 1.961 Releases.

On matters within its jurisdiction, the Committee may authorize the release of any right, title, claim, lien or demand, however acquired, against any person obligated on a loan guaranteed, insured, or made by the Department of Veterans Affairs under the provisions of 38 U.S.C. ch. 37, or on an acquired loan, or on a vendee account.

[39 FR 26400, July 19, 1974]

§ 1.962 Waiver of overpayments.

There shall be no collection of an overpayment, or any interest thereon, which results from participation in a benefit program administered under any law by VA when it is determined by a regional office Committee on Waivers and Compromises that collection would be against equity and good conscience. For the purpose of this regulation, the term *overpayment* refers only to those benefit payments made to a designated living payee or beneficiary in excess of the amount due or to which such payee or beneficiary is entitled. The death of an indebted payee, either prior to a request for waiver of the indebtedness or during Committee consideration of the waiver request, shall not preclude waiver consideration. There shall be no waiver consideration of an indebtedness that results from the receipt of a benefit payment by a non-payee who has no claim or entitlement to such payment.

(a) Waiver consideration is applicable in an indebtedness resulting from work study and education loan default, as well as indebtedness of a veteran-borrower, veteran transferee, or indebted spouse of either, arising out of participation in the loan program administered under 38 U.S.C. ch. 37. Also subject to waiver consideration is an indebtedness which is the result of VA hospitalization, domiciliary care, or treatment of a veteran, either furnished in error or on the basis of tentative eligibility.

(b) In any case where there is an indication of fraud or misrepresentation of a material fact on the part of the debtor or any other party having an interest in the claim, action on a request for waiver will be deferred pending appropriate disposition of the matter. However, the existence of a prima facie case of fraud shall, nevertheless, entitle a claimant to an opportunity to make a rebuttal with countervailing evidence; similiarly, the misrepresentation must be more than non-willful or mere inadvertence. The Committee may act on a request for waiver concerning such debts, after the Inspector General or the Regional Counsel has determined that prosecution is not indicated, or the Department of Justice has notified VA that the alleged fraud or misrepresentation does not warrant action by that department, or the Department of Justice or the appropriate United States Attorney, specifically authorized action on the request for waiver.

(Authority: 38 U.S.C. 501)

[39 FR 26400, July 19, 1974, as amended at 44 FR 59906, Oct. 17, 1979; 50 FR 38803, Sept. 25, 1985; 52 FR 42112, Nov. 3, 1987]

§ 1.963 Waiver; other than loan guaranty.

(a) *General.* Recovery of overpayments of any benefits made under laws administered by the VA shall be waived

if there is no indication of fraud, misrepresentation, or bad faith on the part of the person or persons having an interest in obtaining the waiver and recovery of the indebtedness from the payee who received such benefits would be against equity and good conscience.

(b) *Application*. A request for waiver of an indebtedness under this section shall only be considered:

(1) If made within 2 years following the date of a notice of indebtedness issued on or before March 31, 1983, by the Department of Veterans Affairs to the debtor, or

(2) Except as otherwise provided herein, if made within 180 days following the date of a notice of indebtedness issued on or after April 1, 1983, by the Department of Veterans Affairs to the debtor. The 180 day period may be extended if the individual requesting waiver demonstrated to the Chairperson of the Committee on Waivers and Compromises that, as a result of an error by either the Department of Veterans Affairs or the postal authorities, or due to other circumstances beyond the debtor's control, there was a delay in such individual's receipt of the notification of indebtedness beyond the time customarily required for mailing (including forwarding). If the requester does substantiate that there was such a delay in the receipt of the notice of indebtedness, the Chairperson shall direct that the 180 day period be computed from the date of the requester's actual receipt of the notice of indebtedness.

(Authority: 38 U.S.C. 5302 (a) & (c))

[39 FR 26400, July 19, 1974, as amended at 44 FR 59906, Oct. 17, 1979; 48 FR 27400, June 15, 1983; 50 FR 38803, Sept. 25, 1985; 58 FR 3840, Jan. 12, 1993]

§ 1.963a Waiver; erroneous payments of pay and allowances.

(a) The provisions applicable to VA (including refunds) concerning waiver actions relating to erroneous payments to VA employees of pay and allowances, and travel, transportation, and relocation expenses and allowances, are set forth in 5 U.S.C. 5584. The members of Committees on Waivers and Compromises assigned to waiver actions under § 1.955 of this part are delegated all authority granted the Secretary under 5 U.S.C. 5584 to deny waiver or to grant waiver in whole or in part of any debt regardless of the amount of the indebtedness. Committee members also have exclusive authority to consider and render a decision on the appeal of a waiver denial or the granting of a partial waiver. However, the Chairperson of the Committee must assign the appeal to a different Committee member or members than the member or members who made the original decision that is now the subject of the appeal. The following are the only provisions of §§ 1.955 through 1.970 of this part applicable to waiver actions concerning erroneous payments of pay and allowances, and travel, transportation, and relocation expenses and allowances, under 5 U.S.C. 5584: §§ 1.955(a) through (e)(2), 1.956(a)(introductory text) and (a)(3), 1.959, 1.960, 1.963a, and 1.967(c).

(b) Waiver may be granted under this section and 5 U.S.C. 5584 when collection would be against equity and good conscience and not in the best interest of the United States. Generally, these criteria will be met by a finding that the erroneous payment occurred through administrative error and that there is no indication of fraud, misrepresentation, fault, or lack of good faith on the part of the employee or other person having an interest in obtaining a waiver of the claim, and waiver would not otherwise be inequitable. Generally, waiver is precluded when an employee receives a significant unexplained increase in pay or allowances, or otherwise knows, or reasonably should know, that an erroneous payment has occurred, and fails to make inquiries or bring the matter to the attention of the appropriate officials. Waiver under this standard will depend upon the facts existing in each case.

(c) An application for waiver must be received within 3 years immediately following the date on which the erroneous payment was discovered.

(Authority: 5 U.S.C. 5584; 38 U.S.C. 501).

[69 FR 62202, Oct. 25, 2004]

§ 1.964 Waiver; loan guaranty.

(a) *General*. Any indebtedness of a veteran or the indebtedness of the

spouse shall be waived only when the following factors are determined to exist:

(1) Following default there was a loss of the property which constituted security for the loan guaranteed, insured or made under chapter 37 of title 38 United States Code;

(2) There is no indication of fraud, misrepresentation, or bad faith on the part of the person or persons having an interest in obtaining the waiver; and

(3) Collection of such indebtedness would be against equity and good conscience.

(b) *Spouse*. The waiver of a veteran's indebtedness shall inure to the spouse of such veteran insofar as concerns said indebtedness, unless the obligation of the spouse is specifically excepted. However, the waiver of the indebtedness of the veteran's spouse shall not inure to the benefit of the veteran unless specifically provided for in the waiver decision.

(c) *Surviving spouse or former spouse*. A surviving spouse of a veteran or the former spouse of a veteran may be granted a waiver of the indebtedness provided the requirements of paragraph (a) of this section are met.

(d) *Preservation of Government rights*. In cases in which it is determined that waiver may be granted, the action will take such form (covenant not to sue, or otherwise) as will preserve the rights of the Government against obligors other than the veteran or the spouse.

(e) *Application*. A request for waiver of an indebtedness under this section shall be made within one year after the date on which the debtor receives, by Certified Mail-Return Receipt Requested, written notice from VA of the indebtedness. If written notice of indebtedness is sent by means other than Certified Mail-Return Receipt Requested, then there is no time limit for filing a request for waiver of indebtedness under this section.

(Authority: 38 U.S.C. 5302(b))

(f) *Exclusion*. Except as otherwise provided in this section, the indebtedness of a nonveteran obligor under the loan program is excluded from waiver.

(Authority: 38 U.S.C. 5302 (b) and (c))

[39 FR 26400, July 19, 1974, as amended at 44 FR 59907, Oct. 17, 1979; 57 FR 33875, July 31, 1992; 58 FR 3840, Jan. 12, 1993]

§ 1.965 Application of standard.

(a) The standard ''Equity and Good Conscience'', will be applied when the facts and circumstances in a particular case indicate a need for reasonableness and moderation in the exercise of the Government's rights. The decision reached should not be unduly favorable or adverse to either side. The phrase *equity and good conscience* means arriving at a fair decision between the obligor and the Government. In making this determination, consideration will be given to the following elements, which are not intended to be all inclusive:

(1) *Fault of debtor*. Where actions of the debtor contribute to creation of the debt.

(2) *Balancing of faults*. Weighing fault of debtor against Department of Veterans Affairs fault.

(3) *Undue hardship*. Whether collection would deprive debtor or family of basic necessities.

(4) *Defeat the purpose*. Whether withholding of benefits or recovery would nullify the objective for which benefits were intended.

(5) *Unjust enrichment*. Failure to make restitution would result in unfair gain to the debtor.

(6) *Changing position to one's detriment*. Reliance on Department of Veterans Affairs benefits results in relinquishment of a valuable right or incurrence of a legal obligation.

(b) In applying this single standard for all areas of indebtedness, the following elements will be considered, any indication of which, if found, will preclude the granting of waiver:

(1) Fraud or misrepresentation of a material fact (see § 1.962(b)).

(2) *Bad faith*. This term generally describes unfair or deceptive dealing by one who seeks to gain thereby at another's expense. Thus, a debtor's conduct in connection with a debt arising from participation in a VA benefits/services program exhibits bad faith if such conduct, although not undertaken

with actual fraudulent intent, is undertaken with intent to seek an unfair advantage, with knowledge of the likely consequences, and results in a loss to the government.

(Authority: 38 U.S.C. 5302(c))

[39 FR 26400, July 19, 1974, as amended at 58 FR 3841, Jan. 12, 1993; 58 FR 7296, Feb. 5, 1993; 69 FR 62202, Oct. 25, 2004]

§ 1.966 Scope of waiver decisions.

(a) Decisions will be based on the evidence of record. A hearing may be held at the request of the claimant or his/her representative. No expenses incurred by a claimant, his representative, or any witness incident to a hearing will be paid by the Department of Veterans Affairs.

(b) A regional office Committee may:

(1) Waive recovery as to certain persons and decline to waive as to other persons whose claims are based on the same veteran's service.

(2) Waive or decline to waive recovery from specific benefits or sources, except that:

(i) There shall be no waiver of recovery out of insurance of an indebtedness secured thereby; *i.e.*, an insurance overpayment to an insured. However, recovery may be waived of any or all of such indebtedness out of benefits other than insurance then or thereafter payable to the insured.

(Authority: 38 U.S.C. 501, 5302)

[39 FR 26400, July 19, 1974, as amended at 44 FR 59907, Oct. 17, 1979; 48 FR 1056, Jan. 10, 1983; 69 FR 62202, Oct. 25, 2004]

§ 1.967 Refunds.

(a) Except as provided in paragraph (c) of this section, any portion of an indebtedness resulting from participation in benefits programs administered by the Department of Veterans Affairs which has been recovered by the U.S. Government from the debtor may be considered for waiver, provided the debtor requests waiver in accordance with the time limits of § 1.963(b). If collection of an indebtness is waived as to the debtor, such portions of the indebtedness previously collected by the Department of Veterans Affairs will be refunded. In the event that waiver of collection is granted for either an education, loan guaranty, or direct loan debt, there will be a reduction in the debtor's entitlement to future benefits in the program in which the debt originated.

(b) The Department of Veterans Affairs may not waive collection of the indebtedness of an educational institution found liable under 38 U.S.C. 3685. Waiver of collection of educational benefit overpayments from all or a portion of the eligible persons attending an educational institution which has been found liable under 38 U.S.C. 3685 shall not relieve the institution of its assessed liability. (See 38 CFR 21.4009(f)).

(c) The regulatory provisions concerning refunds of indebtedness collected by the Department of Veterans Affairs arising from erroneous payments of pay and allowances and travel, transportation, and relocation expenses and allowances are set forth in 4 CFR Parts 91 and 92.

(d) Refund of the entire amount collected may not be made when only a part of the debt is waived or when collection of the balance of a loan guaranty indebtedness by the Department of Veterans Affairs from obligors, other than a husband or wife of the person requesting waiver, will be adversely affected. Only where the amount collected exceeds the balance of the indebtedness still in existence will a refund be made in the amount of the difference between the two. Otherwise, refunds will be made in accordance with paragraph (a) of this section.

(Authority: 38 U.S.C. 3685, 5302; 5 U.S.C. 5584)

[48 FR 1056, Jan. 10, 1983, as amended at 60 FR 53276, Oct. 13, 1995]

§ 1.968 [Reserved]

§ 1.969 Revision of waiver decisions.

(a) *Jurisdiction*. A decision involving waiver may be reversed or modified on the basis of new and material evidence, fraud, a change in law or interpretation of law specifically stated in a Department of Veterans Affairs issue, or clear and unmistakable error shown by the evidence in file at the time the prior decision was rendered by the same or any other regional office Committee.

(b) *Finality of decisions*. Except as provided in paragraph (a) of this section, a

decision involving waiver rendered by the Committee having jurisdiction is final, subject to the provisions of:

(1) Sections 3.104(a), 19.153 and 19.154 of this chapter as to finality of decisions;

(2) Section 3.105 (a) and (b) of this chapter as to revision of decisions, except that the Central Office staff may postaudit or make an administrative review of any decision of a regional office Committee;

(3) Sections 3.103, 19.113 and 19.114 of this chapter as to notice of disagreement and the right of appeal;

(4) Section 19.124 of this chapter as to the filing of administrative appeals and the time limits for filing such appeals.

(c) *Difference of opinion.* Where reversal or amendment of a decision involving waiver is authorized under § 3.105(b) of this chapter because of a difference of opinion, the effective date of waiver will be governed by the principle contained in § 3.400(h) of this chapter.

(Authority: 38 U.S.C. 501)

[44 FR 59907, Oct. 17, 1979]

§ 1.970 Standards for compromise.

Decisions of the Committee respecting acceptance or rejection of a compromise offer shall be in conformity with the standards in §§ 1.930 through 1.936. In loan guaranty cases the offer of a veteran or other obligor to effect a compromise must relate to an indebtedness established after the liquidation of the security, if any, and shall be reviewed by the Committee. An offer to effect a compromise may be accepted if it is deemed advantageous to the Government. A decision on an offer of compromise may be revised or modified on the basis of any information which would warrant a change in the original decision.

(Authority: 31 U.S.C. 3711; 38 U.S.C. 501, 3720)

[44 FR 59907, Oct. 17, 1979, as amended at 69 FR 62202, Oct. 25, 2004]

SALARY OFFSET PROVISIONS

SOURCE: 52 FR 1905, Jan. 16, 1987, unless otherwise noted.

§ 1.980 Scope.

(a) In accordance with 5 CFR part 550, subpart K, the provisions set forth in §§ 1.980 through 1.995 implement VA's authority for the use of salary offset to satisfy certain debts owed to VA.

(b) These regulations apply to offsets from the salaries of current employees of VA, or any other agency, who owe debts to VA. Offsets by VA from salaries of current VA employees who owe debts to other agencies shall be processed in accordance with procedures set forth in 5 CFR part 550, subpart K.

(c) These regulations do not apply to debts or claims arising under the Internal Revenue Code of 1954, as amended, the Social Security Act, the tariff laws of the United States, or to any case where collection of a debt by salary offset is explicitly provided for (e.g., travel advances in 5 U.S.C. 5705 and employee training expenses in 5 U.S.C. 4108) or prohibited by another statute.

(d) These regulations do not preclude an employee from requesting waiver of an overpayment under 38 U.S.C. 5302, 5 U.S.C. 5584, or any other similar provision of law, or in any way questioning the amount or validity of a debt not involving benefits under the laws administered by VA by submitting a subsequent claim to the General Accounting Office in accordance with procedures prescribed by that office.

(e) These regulations do not apply to any adjustment to pay arising out of an employee's election of coverage or a change in coverage under a Federal benefits program requiring periodic deductions from pay if the amount to be recovered was accumulated over four pay periods or less.

(f) These regulations do not apply to a routine intra-agency adjustment of pay that is made to correct an overpayment of pay attributable to clerical or administrative errors or delays in processing pay documents, if the overpayment occurred within the four pay periods preceding the adjustment and, at the time of such adjustment, or as soon thereafter as practicable, the individual is provided written notice of the nature and amount of the adjustment and a point of contact for contesting such adjustment.

(g) These regulations do not apply to any adjustment to collect a debt amounting to $50 or less, if at the time of such adjustment, or as soon thereafter as practicable, the individual is

provided with written notice of the nature and amount of the adjustment and a point of contact for contesting such adjustment.

(h) These regulations do not preclude the compromise, suspension, or termination of collection action under the Federal Claims Collection Standards (FCCS) (31 CFR parts 900–904) and VA regulations 38 CFR 1.930 through 1.944.

(i) The procedures and requirements of these regulations do not apply to salary offset used to recoup a Federal employee's debt where a judgment has been obtained against the employee for the debt.

(Authority: 5 U.S.C. 5514)

[52 FR 1905, Jan. 16, 1987; 52 FR 23824, June 25, 1987, as amended at 54 FR 34980, Aug. 23, 1989; 69 FR 62202, Oct. 25, 2004]

§ 1.981 Definitions.

(a) *Agency* means:

(1) An executive agency as defined in 5 U.S.C. 105, including the U.S. Postal Service, and the U.S. Postal Rate Commission, and

(2) A military department as defined in 5 U.S.C. 102.

(3) An agency or court of the judicial branch, including a court as defined in 28 U.S.C. 610, the District Court for the Northern Mariana Islands, and the Judicial Panel on Multidistrict Litigation;

(4) An agency of the legislative branch, including the U.S. Senate and the U.S. House of Representatives; and

(5) Other independent establishments that are entities of the Federal Government.

(b) *Debt* means an amount owed to the United States from sources which include loans insured or guaranteed by the United States and all other amounts due the United States from fees, leases, rents, royalties, services, sales of real or personal property, overpayments, penalties, damages, interest, fines and forfeitures (except those arising under the Uniform Code of Military Justice), and all other similar sources.

(c) *Disposable pay* means that part of current basic pay, special pay, incentive pay, retired pay, retainer pay, or in the case of an employee not entitled to basic pay, other authorized pay remaining after the deduction of any amount required by law to be withheld. Excluded from this definition are deductions described in 5 CFR 581.105(b) through (f).

(d) *Employee* means a current employee of VA or other Federal agency including a current member of the Armed Forces or a Reserve of the Armed Forces (Reserves).

(e) *Salary offset* means an attempt to collect a debt under 5 U.S.C. 5514 by deduction(s) at one or more officially estabilished pay intervals from the current pay account of an employee without his or her consent.

(f) *Waiver* means the cancellation, remission, forgiveness, or non-recovery of a debt owed by an employee to VA or another Federal agency as permitted or required by 5 U.S.C. 5584 or 38 U.S.C. 5302, or other similar statutes.

(g) *Extreme hardship to an employee* means an employee's inability to provide himself or herself and his or her dependents with the necessities of life such as food, housing, clothing, transportation, and medical care.

(Authority: 5 U.S.C. 5514)

[52 FR 1905, Jan. 16, 1987; 52 FR 23824, June 25, 1987]

§ 1.982 Salary offsets of debts involving benefits under the laws administered by VA.

(a) VA will not collect a debt involving benefits under the laws administered by VA by salary offset unless the Secretary or appropriate designee first provides the employee with a minimum of 30 calendar days written notice.

(b) If the employee has not previously appealed the amount or existence of the debt under 38 CFR parts 19 and 20 and the time for pursuing such an appeal has not expired (§ 20.302), the Secretary or appropriate designee will provide the employee with written notice of the debt. The written notice will state that the employee may appeal the amount and existence of the debt in accordance with the procedures set forth in 38 CFR parts 19 and 20 and will contain the determination and information required by § 1.983(b)(1) through (5), (7), (9), (10), and (12) though (14). The notice will also state that the employee may request a hearing on the offset schedule under the procedures set forth in § 1.984 and such a request

will stay the commencement of salary offset.

(c) If the employee previously appealed the amount or existence of the debt and the Board of Veterans Appeals decided the appeal on the merits or if the employee failed to pursue an appeal within the time provided by regulations, the Secretary or designee shall provide the employee with written notice prior to collecting the debt by salary offset. The notice will state:

(1) The determinations and information required by §1.983(b)(1)–(5), (7), and (12)–(14);

(2) That the employee's appeal of the existence or amount of the debt was determined on the merits or that the employee failed to pursue an appeal within the time provided, and VA's decision is final except as otherwise provided in agency regulations;

(3) That the employee may request a waiver of the debt pursuant to 38 CFR 1.911(c)(2) subject to the time limits of 38 U.S.C. 5302.

(4) That the employee may request an oral or paper hearing on the offset schedule and receive a decision within 60 days of such request under the procedures and time limit set forth in §1.984 and that such a request will stay the commencement of salary offset.

(d) If the employee has appealed the existence or amount of the debt and the Board of Veterans Appeals has not decided the appeal on the merits, collection of the debt by salary offset will be suspended until the appeal is decided or the employee ceases to pursue the appeal.

(Authority: 5 U.S.C. 5514)

[52 FR 1905, Jan. 16, 1987, as amended at 69 FR 62202, Oct. 25, 2004]

§ 1.983 Notice requirements before salary offsets of debts not involving benefits under the laws administered by VA.

(a) For a debt not involving benefits under the laws administered by VA, the Secretary or designee will review the records relating to the debt to assure that it is owed prior to providing the employee with a notice of the debt.

(b) Except as provided in §1.980(e), salary offset of debts not involving benefits under the laws administered by VA will not be made unless the Secretary or designee first provides the employee with a minimum of 30 calendar days written notice. This notice will state:

(1) The Secretary or designee's determination that a debt is owed;

(2) The amount of the debt owed and the facts giving rise to the debt;

(3) The Secretary or designee's intention to collect the debt by means of deduction from the employee's current disposable pay account until the debt and all accumulated interest and associated costs are paid in full;

(4) The amount, frequency, approximate beginning date, and duration of the intended deductions;

(5) An explanation of VA's requirements concerning interest, administrative costs, and penalties;

(6) The employee's right to inspect and copy VA records relating to the debt or, if the employee or his or her representative cannot personally inspect the records, to request and receive a copy of such records;

(7) The employee's right to enter into a written agreement with the Secretary or designee for a repayment schedule differing from that proposed by the Secretary or designee, so long as the terms of the repayment schedule proposed by the employee are agreeable to the Secretary or designee;

(8) The VA employee's right to request an oral or paper hearing on the Secretary or appropriate designee's determination of the existence or amount of the debt, or the percentage of disposable pay to be deducted each pay period, so long as a request is filed by the employee as prescribed by the Secretary. The hearing official for the hearing requested by a VA employee must be either a VA administrative law judge or a hearing official from an agency other than VA. Any VA hearing official may conduct an oral or paper hearing at the request of a non-VA employee on the determination by an appropriately designated official of the employing agency of the existence or amount of the debt, or the percentage of disposable pay to be deducted each pay period, so long as a hearing request is filed by the non-VA employee as prescribed by the employing agency.

(9) The method and time period for requesting a hearing;

(10) That the timely filing of a request for a hearing (oral or paper) will stay the commencement of salary offset;

(11) That a final decision after the hearing will be issued at the earliest practical date, but no later than 60 calendar days after the filing of the request for the hearing, unless the employee requests and the hearing officer grants a delay in the proceedings;

(12) That any knowingly false or frivolous statements, representations, or evidence may subject the employee to:

(i) Disciplinary procedures appropriate under 5 U.S.C. ch. 75, 5 CFR part 752, or any other applicable statutes or regulations;

(ii) Penalties under the False Claims Act, 31 U.S.C. 3729–3731, or any other applicable statutory authority; or

(iii) Criminal penalties under 18 U.S.C. 286, 287, 1001, and 1002 or any other applicable statutory authority.

(13) The employee's right, if applicable, to request waiver under 5 U.S.C. 5584 and 38 CFR 1.963a and any other rights and remedies available to the employee under statutes or regulations governing the program for which the collection is being made; and

(14) Unless there are applicable contractual or statutory provisions to the contrary, that amounts paid on or deducted for the debt which are later waived or found not owed to the United States will be promptly refunded to the employee.

(Authority: 5 U.S.C. 5514)

[52 FR 1905, Jan. 16, 1987, as amended at 69 FR 62202, Oct. 25, 2004; 72 FR 65462, Nov. 21, 2007]

§ 1.984 Request for a hearing.

(a) Except as provided in paragraph (b) of this section and in § 1.982, an employee wishing a hearing on the existence or amount of the debt or on the proposed offset schedule must send such a request to the office which sent the notice of the debt. The employee must also specify whether an oral or paper hearing is requested. If an oral hearing is requested, the request should explain why the matter cannot be resolved by review of the documentary evidence. The request must be received by the office which sent the notice of the debt not later than 30 calendar days from the date of the notice.

(b) If the employee files a request for a hearing after the expiration of the 30 day period provided for in paragraph (a) of this section, VA may accept the request if the employee shows that the delay was because of circumstances beyond his or her control or because of failure to receive the written notice of the filing deadline (unless the employee has actual notice of the filing deadline).

(Authority: 5 U.S.C. 5514)

[52 FR 1905, Jan. 16, 1987, as amended at 69 FR 62203, Oct. 25, 2004]

§ 1.985 Form, notice of, and conduct of hearing.

(a) After an employee requests a hearing, the hearing official or administrative law judge shall notify the employee of the form of the hearing to be provided. If the hearing will be oral, the notice shall set forth the date, time, and location for the hearing. If the hearing will be paper, the employee shall be notified that he or she should submit his or her position and arguments in writing to the hearing official or administrative law judge by a specified date after which the record shall be closed. This date shall give the employee reasonable time to submit this information.

(b) An employee who requests an oral hearing shall be provided an oral hearing if the hearing official or administrative law judge determines that the matter cannot be resolved by review of documentary evidence, for example, when an issue of credibility or veracity is involved. If a determination is made to provide an oral hearing, the hearing official or administrative law judge may offer the employee the opportunity for a hearing by telephone conference call. If this offer is rejected or if the hearing official or administrative law judge declines to offer a telephone conference call hearing, the employee shall be provided an oral hearing permitting the personal appearance of the employee, his or her personal representative, and witnesses. A record or transcript of every oral hearing shall be made. Witnesses shall testify under

oath or affirmation. VA shall not be responsible for the payment of any expenses incident to attendance at the hearing which are incurred by either the employee, his or her representative or Counsel, or witnesses.

(c) In all other cases where an employee requests a hearing, a paper hearing shall be provided. A paper hearing shall consist of a review of the written evidence of record by the administrative law judge or hearing official.

(d) In any hearing under this section, the administrative law judge or hearing official may exclude from consideration evidence or testimony which is irrelevant, immaterial, or unduly repetitious.

(Authority: 5 U.S.C. 5514)

§ 1.986 Result if employee fails to meet deadlines.

An employee waives the right to a hearing, and will have his or her disposable pay offset in accordance with the offset schedule, if the employee:

(a) Fails to file a request for a hearing as prescribed in § 1.982, § 1.984, or §§ 19.1 through 19.200, whichever is applicable, unless such failure is excused as provided in § 1.984(b); or

(b) Fails to appear at an oral hearing of which he or she had been notified unless the administrative law judge or hearing official determines that failure to appear was due to circumstances beyond the employee's control.

(Authority: 5 U.S.C. 5514)

§ 1.987 Review by the hearing official or administrative law judge.

(a) The hearing official or administrative law judge shall uphold VA's determination of the existence and amount of the debt unless determined to be erroneous by a preponderance of the evidence.

(b) The hearing official or administrative law judge shall uphold VA's offset schedule unless the schedule would result in extreme hardship to the employee.

(Authority: 5 U.S.C. 5514)

[52 FR 1905, Jan. 16, 1987; 52 FR 23824, June 25, 1987]

§ 1.988 Written decision following a hearing requested under § 1.984.

(a) The hearing official or administrative law judge must issue a written decision not later than 60 days after the employee files a request for the hearing.

(b) Written decisions provided after a hearing requested under § 1.984 will include:

(1) A statement of the facts presented to support the nature and origin of the alleged debt;

(2) The hearing official or administrative law judge's analysis, findings and conclusions concerning as applicable:

(i) The employee's or VA's grounds;

(ii) The amount and validity of the alleged debt; and

(iii) The repayment schedule.

(c) The decision in a case where a paper hearing was provided shall be based upon a review of the written record. The decision in a case where an oral hearing was provided shall be based upon the hearing and the written record.

(Authority: 5 U.S.C. 5514)

§ 1.989 Review of VA records related to the debt.

(a) *Notification by employee.* An employee who intends to inspect or copy VA records related to the debt as permitted by a notice provided under § 1.983 must send a letter to the office which sent the notice of the debt stating his or her intention. The letter must be received by that office within 30 calendar days of the date of the notice.

(b) *VA response.* In response to timely notice submitted by the debtor as described in paragraph (a) of this section, VA will notify the employee of the location and time when the employee may inspect and copy records related to the debt.

(Authority: 5 U.S.C. 5514)

[52 FR 1905, Jan. 16, 1987, as amended at 69 FR 62203, Oct. 25, 2004]

§ 1.990 Written agreement to repay debt as alternative to salary offset.

(a) *Notification by employee.* The employee may propose, in response to a

notice under § 1.983, a written agreement to repay the debt as an alternative to salary offset. Any employee who wishes to do this must submit a proposed written agreement to repay the debt which is received by the office which sent the notice of the debt within 30 calendar days of the date of the notice.

(b) *VA response*. In response to timely notice by the debtor as described in paragraph (a) of this section, VA will notify the employee whether the employee's proposed written agreement for repayment is acceptable. It is within VA's discretion to accept a repayment agreement instead of proceeding by offset. In making this determination, VA will balance its interest in collecting the debt against the hardship to the employee. VA will accept a repayment agreement instead of offset only if the employee is able to establish that offset would result in extreme hardship.

(Authority: 5 U.S.C. 5514)

[52 FR 1905, Jan. 16, 1987, as amended at 69 FR 62203, Oct. 25, 2004]

§ 1.991 Procedures for salary offset: when deductions may begin.

(a) Deductions to liquidate an employee's debt will be by the method and in the amount stated in the notice to collect from the employee's current pay as modified by a written decision issued under § 1.982 or § 1.988, or parts 19 and 20 or by written agreement between the employee and the VA under § 1.990.

(b) If the employee filed a request for a hearing as provided by § 1.984 before the expiration of the period provided for in that section, deductions will not begin until after the hearing official or administrative law judge has provided the employee with a hearing, and has rendered a final written decision.

(c) If the employee failed to file a timely request for a hearing, deductions will begin on the date specified in the notice of intention to offset, unless a hearing is granted pursuant to § 1.984(b).

(d) If an employee retires, resigns, or his or her employment ends before collection of the amount of the indebtedness is completed, the remaining indebtedness will be collected according to procedures for administrative offset (*see* 5 CFR 831.1801 through 831.1808, 31 CFR 901.3, and 38 CFR 1.912).

(Authority: 5 U.S.C. 5514)

[52 FR 1905, Jan. 16, 1987, as amended at 69 FR 62203, Oct. 25, 2004]

§ 1.992 Procedures for salary offset.

(a) *Types of collection*. A debt will be collected in a lump-sum or in installments. Collection will be in a lump-sum unless the employee is financially unable to pay in one lump-sum, or if the amount of the debt exceeds 15 percent of the employee's disposable pay. In these cases, deduction will be by installments.

(b) *Installment deductions*. (1) A debt to be collected in installments will be deducted at officially established pay intervals from an employee's current pay account unless the employee and the Secretary agree to alternative arrangements for repayment. The alternative arrangement must be in writing and signed by both the employee and Secretary or designee.

(2) Installment deductions will be made over a period not greater than the anticipated period of employment. The size and frequency of installment deductions will bear a reasonable relation to the size of the debt and the employee's ability to pay. However, the amount deducted for any period will not exceed 15 percent of the disposable pay from which the deduction is made, unless the employee has agreed in writing to the deduction of a greater amount. If possible, the installment payment will be sufficient in size and frequency to liquidate the debt in three years. Installment payments of less than $25 per pay period or $50 a month will be acceptable only in the most unusual circumstances.

(c) Imposition of interest, penalties, and administrative costs. Interest, penalties, and administrative costs shall be charged in accordance with 31 CFR 901.9 and 38 CFR 1.915.

(Authority: 5 U.S.C. 5514; 38 U.S.C. 501)

[52 FR 1905, Jan. 16, 1987, as amended at 54 FR 34980, Aug. 23, 1989; 69 FR 62203, Oct. 25, 2004]

§ 1.993 Non-waiver of rights.

So long as there are not statutory or contractual provisions to the contrary, an employee's involuntary payment (of all or a portion of a debt) under these regulations will not be interpreted as a waiver of any rights that the employee may have under 5 U.S.C. 5514.

(Authority: 5 U.S.C. 5514)

VA will refund promptly to the appropriate individual amounts offset under these regulations when:

(a) A debt is waived or otherwise found not owed the United States (unless expressly prohibited by statute or regulation); or

(b) VA is directed by an administrative or judicial order to refund amounts deducted from the employee's current pay.

(Authority: 5 U.S.C. 5514)

§ 1.995 Requesting recovery through centralized administrative offset.

(a) Under 31 U.S.C. 3716, VA and other creditor agencies must notify Treasury of all debts over 180 days delinquent so that recovery of such debts may be made by centralized administrative offset. This includes those debts that VA and other agencies seek from the pay account of an employee of another Federal agency via salary offset. Treasury and other disbursing officials will match payments, including Federal salary payments, against these debts. Where a match occurs, and all the requirements for offset have been met, the payment will be offset to satisfy the debt in whole or part.

(b) Prior to submitting a debt to Treasury for the purpose of collection by offset, including salary offset, VA shall provide written certification to Treasury that:

(1) The debt is past due and legally enforceable in the amount submitted to Treasury and that VA will ensure that any subsequent collections are credited to the debt and that Treasury shall be notified of such;

(2) Except in the case of a judgment debt or as otherwise allowed by law, the debt is referred to Treasury for offset within 10 years after VA's right of action accrues;

(3) VA has complied with the provisions of 31 U.S.C. 3716 and 38 CFR 1.912 and 1.912a including, but not limited to, those provisions requiring that VA provide the debtor with applicable notices and opportunities for a review of the debt; and

(4) VA has complied with the provisions of 5 U.S.C. 5514 (salary offset) and 38 CFR 1.980 through 1.994 including, but not limited to, those provisions requiring that VA provide the debtor with applicable notices and opportunities for a hearing.

(c) Specific procedures for notifying Treasury of debts for purposes of collection by centralized administrative offset are contained in the 31 CFR 285.7. VA and other creditor agencies may notify Treasury of debts that have been delinquent for 180 days or less, including debts that VA and other creditor agencies seek to recover from the pay of an employee via salary offset.

(Authority: 31 U.S.C. 3716; 38 U.S.C. 501)

[69 FR 62203, Oct. 25, 2004]

PROCEDURES FOR FINANCIAL INSTITUTIONS REGARDING GARNISHMENT OF BENEFIT PAYMENTS AFTER DISBURSEMENT

§ 1.1000 Garnishment of payments after disbursement.

(a) Payments of benefits due under any law administered by the Secretary that are protected by 38 U.S.C. 5301(a) and made by direct deposit to a financial institution are subject to 31 CFR part 212, Garnishment of Accounts Containing Federal Benefit Payments.

(b) This section may be amended only by a rulemaking issued jointly by the Department of the Treasury and the agencies defined as a ''benefit agency'' in 31 CFR 212.3.

[76 FR 9961, Feb. 23, 2011]

PART 2—DELEGATIONS OF AUTHORITY

Sec.
2.1 General provisions.
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2.8 Delegation of authority to authorize allowances for Department of Veterans Affairs employees who are notaries public.

AUTHORITY: 5 U.S.C. 302, 552a; 38 U.S.C. 501, 512, 515, 1729, 1729A, 5711; 44 U.S.C. 3702, and as noted in specific sections.

§ 2.1 General provisions.

In addition to the delegations of authority in this part, numerous delegations of authority are set forth throughout this title.

(Authority: 38 U.S.C. 512)

[64 FR 47111, Aug. 30, 1999]

§ 2.2 Delegation of authority to employees to issue subpoenas, etc.

(a) *Authority to issue subpoenas.* Employees occupying or acting in the positions designated in paragraph (b) of this section shall have the power to issue subpoenas for (by countersigning VA Form 2–4003) and compel the attendance of witnesses within a radius of 100 miles from the place of hearing and to require the production of books, papers, documents, and other evidence. Issuing officials shall use discretion when exercising this power.

(b) *Designated positions.* The positions designated pursuant to paragraph (a) of this section are: General Counsel, Deputy General Counsel, Chairman, Board of Veterans' Appeals, Heads of Regional Offices and Centers having insurance or regional office activities, Under Secretary for Health (for income matching programs), Director, Income Verification Match Center (for income matching programs), and the Associate Director for Operations, Income Verification Match Center (for income matching programs).

(c) *Means of service.* Subpoenas issued pursuant to this section may be served by registered or certified mail, return receipt requested, addressed to the witness only. Personal service by any VA employee or other authorized person may be made where authorized in writing by the issuing official.

(d) *Fees and mileage; district courts of the United States.* Any person required by such subpoena to attend as a witness shall be allowed and paid the same fees and mileage as are paid witnesses in the district courts of the United States. In case of disobedience to any such subpoena, the aid of any district court of the United States may be invoked in requiring attendance and testimony of witnesses and the production of documentary evidence, and such court within the jurisdiction in which the inquiry is carried on may, in the case of contumacy or refusal to obey a subpoena issued to any officer, agent, or employee of any corporation or to any other person, issue an order requiring such corporation or other person to appear or to give evidence touching the matter in question, and any failure to obey such order of the court may be punished by such court as a contempt thereof.

(Authority: 38 U.S.C.A. 501, 5711)

[60 FR 40757, Aug. 10, 1995. Redesignated at 64 FR 47111, Aug. 30, 1999]

§ 2.3 Delegation of authority to employees to take affidavits, to administer oaths, etc.

(a) An employee to whom authority is delegated by the Secretary in accordance with 38 U.S.C. 5711, or to whom authority was delegated by the Secretary in accordance with title III, Pub. L. 844, 74th Congress, section 616, Pub. L. 801, 76th Congress, and section 1211, Pub. L. 85–56, is by virtue of such delegated authority, until such authority is revoked or otherwise terminated, empowered to take affidavits, to administer oaths and affirmations, to aid claimants in the preparation and presentation of claims, and to make investigations, examine witnesses, and certify to the correctness of papers and documents upon any matter within the jurisdiction of the Department of Veterans Affairs. Such employee is not authorized to administer oaths in connection with the execution of affidavits relative to fiscal vouchers and is not authorized to take acknowledgments to policy loan agreements and applications for cash surrender value to United States Government life insurance and National Service life insurance.

(b) Any such oath, affirmation, affidavit, or examination, when certified under the hand of any such employee by whom it was administered or taken and authenticated by the seal of the Department of Veterans Affairs, may be offered or used in any court of the United States and, without further proof of the identity or authority of such employee, shall have like force and effect as if administered or taken before a clerk of such court.

(c) The delegated authority from the Secretary to employees to take affidavits, to administer oaths, etc., will be evidenced by VA Form 4505 series.

[24 FR 10018, Dec. 11, 1959. Redesignated at 64 FR 47111, Aug. 30, 1999]

§ 2.4 Delegation of authority to order paid advertising for use in recruitment.

Paid advertisements may be used in recruitment for VA competitive and excepted service positions. Authority to order such advertisements is hereby delegated to Administration Heads, Assistant Secretaries, Other Key Officials (the General Counsel; the Inspector General; the Chairman, Board of Veterans' Appeals; and the Director, Office of Small and Disadvantaged Business Utilization), Deputy Assistant Secretaries, to the deputies of such officials, to the Deputy Assistant Secretary and Associate Deputy Assistant Secretary for Human Resources Management, and to field facility Directors.

(Authority: 5 U.S.C. 302(b)(2); 44 U.S.C. 3702)

[61 FR 20134, May 6, 1996, as amended at 72 FR 65462, Nov. 21, 2007]

§ 2.5 Delegation of authority to certify copies of documents, records, or papers in Department of Veterans Affairs files.

(a) Persons occupying or acting for the following positions in the Office of the General Counsel are authorized to certify copies of public documents, records, or papers belonging to or in the files of the Department of Veterans Affairs for the purposes of 38 U.S.C. 302: General Counsel, Deputy General Counsel, Assistant General Counsel, Deputy Assistant General Counsel, and the Regional Counsel for Puerto Rico.

(b) The person occupying or acting in the position of Chairman, Board of Veterans Apeals, is authorized to certify copies of decisions, orders, subpoenas, and other documents, records, or papers issued by, belonging to, or in the files of the Board for the purposes of 38 U.S.C. 302.

(Authority: 38 U.S.C. 302, 501, 512)

[46 FR 18978, Mar. 27, 1981, as amended at 49 FR 30692, Aug. 1, 1984; 60 FR 48029, Sept. 18, 1995; 72 FR 65462, Nov. 21, 2007]

§ 2.6 Secretary's delegations of authority to certain officials (38 U.S.C. 512).

Employees occupying or acting in the positions designated below are delegated authority as indicated:

(a) *Veterans Health Administration.* The Under Secretary for Health is delegated authority:

(1) To act on all matters assigned to the Veterans Health Administration by statute (38 U.S.C. Ch. 73) and by regulation, except such matters as require the personal attention or action of the Secretary.

(2) To revise, exceed, delete, increase, or decrease fees contained in Department of Veterans Affairs Veterans Health Services and Research Administration Manual M–1, part I, appendix A (following agreement therefor as provided in the contract with the intermediary involved), in an approved State fee schedule, and to add additional fees when found to be necessary, provided such fees are not in excess of those customarily charged the general public, in the community concerned, for the same service.

(3) To designate the Deputy Under Secretary for Health, or other physician of the Veterans Health Administration, and authority is hereby delegated such designee to perform the functions prescribed in paragraph (a)(2) of this section.

(4) To revise, exceed, delete, increase or decrease dental fees established in Department of Veterans Affairs Veterans Health Services and Research Administration Manual M–4, chapter 6, and any amendments thereto, and to add additional fees when found to be necessary, provided: such fees are not in excess of those customarily charged the general public, in the community concerned, for the same service.

(5) To designate the Assistant Chief Medical Director for Dentistry, and authority is hereby delegated such designee, to perform the functions prescribed in paragraph (a)(4) of this section.

(6) To supervise programs for grants to the Republic of the Philippines and medical care for Commonwealth Army veterans and Philippine Scouts in Veterans Memorial Medical Center, Manila, pursuant to the provisions of 38 U.S.C. ch. 17, subch. IV.

(7) To designate the Deputy Under Secretary for Health of the Veterans Health Administration and authority is hereby delegated such designee to designate a Department of Veterans Affairs full-time physician or nonmedical Director to serve *as an ex officio member* on advisory bodies to State Comprehensive Health Planning agencies and to individual Regional Medical Programs in those areas in which there is located one or more Department of Veterans Affairs hospitals or other health facilities, who shall serve on such advisory group as the representative of the Department of Veterans Affairs health facilities located in that area.

(8) To authorize Directors of Department of Veterans Affairs property and facilities under the charge and control of the Department of Veterans Affairs to appoint police officers with the power to enforce Federal laws and Department of Veterans Affairs regulations, to investigate violations of those laws and to arrest for crimes committed on Department of Veterans Affairs property to the full extent provided by Department policies and procedures.

(Authority: 38 U.S.C. 501 and 512)

(9) To develop and establish minimum safety and quality standards for adaptive equipment provided under chapter 39 of title 38, United States Code, or to appoint a designee to perform these functions.

(b) *Veterans Benefits Administration*—(1) *General*. The Under Secretary for Benefits is delegated authority to act on all matters assigned to the Veterans Benefits Administration except as provided in §1.771 of this chapter and to authorize supervisory or adjudicative personnel within his/her jurisdiction to perform such functions as may be assigned.

(2) *Philippines*. The Director, Department of Veterans Affairs Regional Office, Manila, Philippines, is delegated authority to exercise such authorities as are delegated to directors of regional offices in the United States, which are appropriate to the administration in the Republic of the Philippines of the laws administered by the Department of Veterans Affairs.

(c) *Office of Management*. (1) The Assistant Secretary for Management (Chief Financial Officer) is delegated authority to act on all matters assigned to his/her office, and to authorize supervisory personnel within his/her jurisdiction to perform such functions as may be assigned. Appropriate written notification will be furnished other Federal agencies concerning such authorizations.

(2) The Assistant Secretary for Management (Chief Financial Officer) is delegated authority under 31 U.S.C. 1553(c)(1), to approve, in a fixed appropriation account to which the period of availability for obligation has expired, obligational increases related to contract changes when such transaction will cause cumulative obligational increase for contract changes during a fiscal year to exceed $4 million but not more than $25 million; for this responsibility the Assistant Secretary for Management (Chief Financial Officer) shall act as a member of the Office of the Secretary and shall report to and consult with the Secretary on these matters.

(d) *Assistant Secretary for Management (Chief Financial Officer); administration heads and staff office directors*. The Assistant Secretary for Management (Chief Financial Officer) is delegated authority to take appropriate action (other than provided for in paragraphs (e)(3) and (e)(4) of this section) in connection with the collection of civil claims by VA for money or property, as authorized in §1.900, *et seq*. The Assistant Secretary for Management (Chief Financial Officer) may redelegate such authority as he/she deems appropriate

to administration heads and staff office directors.

(Authority: 38 U.S.C. 501, 512)

(e) *General Counsel.* (1) The General Counsel is delegated authority to serve as the Regulatory Policy Officer for the Department in accordance with Executive Order 12866. The General Counsel, the Principal Deputy General Counsel, the Deputy General Counsel, Central Office, and the Director of the Office of Regulation Policy and Management are delegated authority to manage, direct, and coordinate the Department's rulemaking activities, including the revision and reorganization of regulations, and to perform all functions necessary or appropriate under Executive Order 12866 and other rulemaking requirements.

(Authority: 38 U.S.C. 501, 512)

(2) Under the provisions of 38 U.S.C. 515(b), the General Counsel, Deputy General Counsel, Assistant General Counsel and Regional Counsel, or those authorized to act for them, are authorized to consider, ascertain, adjust, determine, and settle tort claims cognizable thereunder and to execute an appropriate voucher and other necessary instruments in connection with the final disposition of such claims.

(3) Under the provisions of ''The Federal Medical Care Recovery Act,'' 42 U.S.C. 2651, *et seq.* (as implemented by part 43, title 28, Code of Federal Regulations), authority is delegated to the General Counsel, Deputy General Counsel, Assistant General Counsel (Professional Staff Group I), Deputy Assistant General Counsel of said staff group, and Regional Counsels or those authorized to act for them, to collect in full, compromise, settle, or waive any claim and execute the release thereof; however, claims in excess of $100,000 may be compromised, settled, or waived only with the prior approval of the Department of Justice.

(4) Under the Federal Claims Collection Act of 1966, 31 U.S.C. 3711, *et seq.*, authority is delegated to the General Counsel, Deputy General Counsel, Assistant General Counsel, Deputy Assistant General Counsel and Regional Counsel, or those authorized to act for them, to:

(i) Make appropriate determinations with respect to the litigative probabilities of a claim (§ 1.932 of this chapter), the legal merits of a claim (§ 1.942(e) of this chapter), and any other legal considerations of a claim.

(ii) Collect in full a claim involving damage to or loss of government property under the jurisdiction of the Department of Veterans Affairs resulting from negligence or other legal wrong of a person (other than an employee of the Government while acting within the scope of his or her employment) and to compromise, suspend, or terminate any such claim not exceeding $100,000.

(iii) Collect a claim in full from an individual or legal entity who is liable for the cost of hospital, medical, surgical, or dental care and treatment of a person, and to compromise, suspend, or terminate any such claim not exceeding $100,000.

(Authority: 31 U.S.C. 3711(a)(2); 38 U.S.C. 501, 512)

(iv) The delegations of authority set forth in paragraphs (e)(4)(ii) and (iii) of this section do not apply to the handling of any claim as to which there is an indication of fraud, the presentation of a false claim or misrepresentation on the part of the debtor or any other party having an interest in the claim, or to any claim based in whole or in part on conduct in violation of the antitrust laws. Such cases will be considered by the General Counsel, who will make the determination in all instances as to whether the case warrants referral to the Department of Justice. The delegations of authority are applicable to those claims where the Department of Justice determines that action based upon the alleged fraud, false claim, or misrepresentation is not warranted.

(5) Pursuant to the provisions of the Military Personnel and Civilian Employees' Claim Act of 1964, 31 U.S.C. 3721, as amended, the General Counsel, Deputy General Counsel, Assistant General Counsel (Professional Staff Group III), Deputy Assistant General Counsel of said staff group, and Regional Counsel or those authorized to act for them, are authorized to settle and pay a claim for not more than

$40,000 made by a civilian officer or employee of the Department of Veterans Affairs for damage to, or loss of, personal property incident to his or her service. (Pub. L. 97–226)

(6) Under the provisions of 38 U.S.C. 7316(e), authority is delegated to the General Counsel, Deputy General Counsel, and the Assistant General Counsel (Professional Staff Group I) to hold harmless or provide liability insurance for any person to whom the immunity provisions of section 7316 apply, for damage for personal injury or death, or for property damage, negligently caused by such person while furnishing medical care or treatment in the exercise of his or her duties in or for the Veterans Health Administration, if such person is assigned to a foreign country, detailed to State or political division thereof, or is acting under any other circumstances which would preclude the remedies of an injured third person against the United States, provided by sections 1346(b) and 2672 of title 28, United States Code, for such damage or injury.

(7) The General Counsel, Deputy General Counsel, and those authorized to act for them, are authorized to conduct investigations, examine witnesses, take affidavits, administer oaths and affirmations, and certify copies of public or private documents on all matters within the jurisdiction of the General Counsel. Pursuant to the provisions of §2.2(c), the General Counsel, Deputy General Counsel, and those authorized to act for them, are authorized to countersign VA Form 4505.

(8) The General Counsel, or the Deputy General Counsel acting as or for the General Counsel, is authorized to designate, in accordance with established standards, those legal opinions of the General Counsel which will be considered precedent opinions involving veterans' benefits under laws administered by the Department of Veterans Affairs.

(Authority: 38 U.S.C. 501, 512)

(9) Under the provisions of 38 U.S.C. 1729(c)(1), authority is delegated to the General Counsel, Deputy General Counsel, Assistant General Counsel (Professional Staff Group I), Deputy Assistant General Counsel of said staff group, and Regional Counsel, or those authorized to act for them, to collect in full, compromise, settle, or waive any claim and execute the release thereof; however, claims in excess of $100,000 may only be compromised, settled, or waived with the prior approval of the General Counsel, Deputy General Counsel, Assistant General Counsel (Professional Staff Group I), or Deputy Assistant General Counsel of said staff group, or those authorized to act for them.

(Authority: 31 U.S.C. 3711(a)(2); 38 U.S.C. 501, 512).

(10) Except as prescribed in paragraph (g)(3) of this section, the General Counsel, Deputy General Counsel, and the Assistant General Counsel for Professional Staff Group IV are authorized to make final Departmental decisions on appeals under the Freedom of Information Act, the Privacy Act, and 38 U.S.C. 5701, 5705 and 7332.

(Authority: 38 U.S.C. 512)

(11) All authority delegated in this paragraph to Regional Counsels will be exercised by them under the supervision of and in accordance with instructions issued by the General Counsel.

(f) *National Cemetery Administration.* Under Secretary for Memorial Affairs is delegated authority:

(1) To act on all matters assigned to the National Cemetery Administration by statute (38 U.S.C. chapter 24) and by regulation except where specifically requiring the personal attention or action of the Secretary and to authorize supervisory personnel within the jurisdiction of the Under Secretary for Memorial Affairs, to perform such functions as may be assigned.

(2) To designate, as deemed necessary, Superintendents of National Cemeteries as special investigators under 38 U.S.C. 901, however, such law enforcement authority is limited to enforcement of rules and regulations governing conduct on property under the charge and control of the Department of Veterans Affairs, as those rules and regulations apply to the cemetery over which the individual Superintendent exercises control and jurisdiction. Such

designation will not authorize the carrying of firearms by any Superintendent.

(3) To accept donations, except offers of land, made in any manner, for the beautification or benefit of national cemeteries.

(4) To name features in national cemeteries, such as, roads, walks, and special structures.

(5) To establish policies and specifications for inscriptions on Government headstones, markers, and private monuments.

(Authority: 38 U.S.C. 501, 512, 2404)

(g) *Inspector General.* (1) The Secretary delegates to the Inspector General, the authority, as head of the Department of Veterans Affairs, to make written requests under the Privacy Act of 1974, 5 U.S.C. 552a(b)(7), for the transfer of records or copies of records maintained by other agencies which are necessary to carry out an authorized law enforcement activity of the Office of Inspector General. This delegation is made pursuant to 38 U.S.C. 512. The Inspector General may redelegate the foregoing authority within the Office of Inspector General, but the delegation may only be to an official of sufficient rank to ensure that the request for the records has been the subject of a high level evaluation of the need for the information.

(2) The Inspector General delegates the authority under the Inspector General Act of 1978, and redelegates the authority under paragraph (a) of this section, to request Privacy Act-protected records from Federal agencies pursuant to subsection (b)(7) of the Privacy Act to each of the following Office of Inspector General officials: (i) Deputy Inspector General, (ii) Assistant Inspector General for Investigations, (iii) Deputy Assistant Inspector General for Investigations, (iv) Chief of Operations, and (v) Special Agents in Charge of Field Offices of Investigations. These officials may not redelegate this authority.

(3) The Office of Inspector General is authorized to make final decisions on appeals submitted pursuant to the Freedom of Information Act concerning any Office of Inspector General records.

(Authority: 38 U.S.C. 512)

(h) *Delegations to Office Resolution Management Officials (ORM).* (1) The Deputy Assistant Secretary for Resolution Management is delegated authority to supervise and control the operation of the administrative EEO Discrimination Complaint Processing System within the Department.

(2) The Deputy Assistant Secretary for Resolution Management, the Chief Operating Officer, and all Regional EEO Officers/Field Managers are delegated authority to make procedural agency decisions to either accept or dismiss, in whole or in part, EEO discrimination complaints based upon race, color, national origin, sex, religion, age, disability, or reprisal filed by employees, former employees, or applicants for employment.

(3) The Deputy Assistant Secretary for Resolution Management, the Chief Operating Officer, and the Chief, Policy and Compliance are delegated authority to make agency decisions on all breach of settlement claims raised by employees, former employees, and applicants for employment.

(4) The Deputy Assistant Secretary for Resolution Management, the Chief Operating Officer, and the Chief, Policy and Compliance are delegated authority to consider and resolve all claims raised by employees, former employees, and applicants for employment that allege dissatisfaction with the processing of a previously filed EEO discrimination complaint.

(5) The Deputy Assistant Secretary for Resolution Management, the Chief Operating Officer, and the Chief, Policy and Compliance are delegated authority to monitor compliance by Department organizational components with orders and decisions of the OEDCA and the EEOC.

(i) *Delegations to officials of the Office of Employment Discrimination Complaint Adjudication (OEDCA).* (1) The Director and Associate Director, OEDCA, are delegated authority to make procedural decisions to dismiss, in whole or in part, any EEO discrimination complaint filed by any employee, former employee, or applicant for employment

that may be pending before OEDCA, where administrative complaint processing efficiency may be best served by doing so.

(2) The Director and Associate Director, OEDCA, are delegated authority to dismiss, in whole or in part any EEO discrimination complaint based upon race, color, religion, sex, national origin, age, disability, or reprisal filed by any ORM employee, former employee, or applicant for employment.

(3) The Director and Associate Director, OEDCA, are delegated authority to make the agency decision on all breach of settlement claims raised by ORM employees, former employees, and applicants for employment.

(4) The Director and Associate Director, OEDCA, are delegated authority to consider and resolve all claims raised by ORM employees, former employees, and applicants for employment that allege dissatisfaction with the processing of a previously filed EEO discrimination complaint.

(5) The Director and Associate Director, OEDCA, are delegated authority to make procedural agency decisions to either accept or dismiss, in whole or in part, EEO discrimination complaints filed by employees, former employees, or applicants for employment where the ORM must recuse itself from a case due to an actual, apparent, or potential conflict of interest.

(j) *Delegation to the Chairman, Board of Veterans' Appeals.* In cases where OEDCA has recused itself from a case due to an actual, apparent, or potential conflict of interest, the Chairman, Board of Veterans' Appeals, is delegated authority to make procedural agency decisions to dismiss, in whole or in part, EEO discrimination complaints filed by agency employees, former employees, and applicants for employment; to make substantive final agency decisions where complainants do not request an EEOC hearing; to take final agency action following a decision by an EEOC Administrative Judge; and to make final agency decisions ordering appropriate remedies and relief where there is a finding of discrimination.

(k) *Processing complaints involving certain officials.* A complaint alleging that the Secretary or the Deputy Secretary personally made a decision directly related to matters in dispute, or are otherwise personally involved in such matters, will be referred for procedural acceptability review, investigation, and substantive decisionmaking to another Federal agency (e.g., The Department of Justice) pursuant to a cost reimbursement agreement. Referral will not be made when the action complained of relates merely to ministerial involvement in such matters (e.g., ministerial approval of selection recommendations submitted to the Secretary by the Under Secretary for Health, the Under Secretary for Benefits, the Under Secretary for Memorial Affairs, assistant secretaries, or staff office heads).

(Authority: 38 U.S.C. 501, 512)

[25 FR 11095, Nov. 23, 1960]

EDITORIAL NOTE: For FEDERAL REGISTER citations affecting §2.6, see the List of CFR Sections Affected, which appears in the Finding Aids section of the printed volume and at *www.fdsys.gov*.

§2.7 Delegation of authority to provide relief on account of administrative error.

(a) Section 503(a) of title 38 U.S.C., provides that if the Secretary determines that benefits administered by the Department of Veterans Affairs have not been provided by reason of administrative error on the part of the Federal Government or any of its employees, the Secretary is authorized to provide such relief on account of such error as the Secretary determines equitable, including the payment of moneys to any person whom he determines equitably entitled thereto.

(b) Section 503(b) of title 38 U.S.C., provides that if the Secretary determines that any veteran, surviving spouse, child of a veteran, or other person, has suffered loss, as a consequence of reliance upon a determination by the Department of Veterans Affairs of eligibility or entitlement to benefits, without knowledge that it was erroneously made, the Secretary is authorized to provide such relief as the Secretary determines equitable, including the payment of moneys to any person equitably entitled thereto. The Secretary is also required to submit an annual report to the Congress, containing

a brief summary of each recommendation for relief and its disposition. Preparation of the report shall be the responsibility of the General Counsel.

(c) The authority to grant the equitable relief, referred to in paragraphs (a) and (b) of this section, has not been delegated and is reserved to the Secretary. Recommendation for the correction of administrative error and for appropriate equitable relief therefrom will be submitted to the Secretary, through the General Counsel. Such recommendation may be initiated by the head of the administration having responsibility for the benefit, or of any concerned staff office, or by the Chairman, Board of Veterans Appeals. When a recommendation for relief under paragraph (a) or (b) of this section is initiated by the head of a staff office, or the Chairman, Board of Veterans Appeals, the views of the head of the administration having responsibility for the benefit will be obtained and transmitted with the recommendation of the initiating office.

(Authority: 38 U.S.C. 503, 512)

[37 FR 22864, Oct. 26, 1972, as amended at 49 FR 30693, Aug. 1, 1984; 54 FR 34981, Aug. 23, 1989; 68 FR 25504, May 13, 2003]

§ 2.8 Delegation of authority to authorize allowances for Department of Veterans Affairs employees who are notaries public.

(a) Employees occupying or acting in the positions designated in paragraph (b) of this section are authorized to designate those employees who are required to serve as notaries public in connection with the performance of official business and to pay an allowance for the costs therefor not to exceed the expense required to be incurred by them in order to obtain their commission.

(Authority: 5 U.S.C. 5945)

(b) Designated positions: Deputy Secretary, Under Secretary for Benefits, Director, Office of Data Management and Telecommunications, Chief Medical Director, General Counsel, Directors of regional offices, hospitals, domiciliaries, and centers.

[35 FR 13771, Aug. 29, 1970, as amended at 49 FR 30693, Aug. 1, 1984]

PART 3—ADJUDICATION

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EDITORIAL NOTE: Nomenclature changes to part 3 appear at 61 FR 7216, Feb. 27, 1996; 62 FR 35970, July 3, 1997; 62 FR 47532, Sept. 9, 1997; and 67 FR 46868, July 17, 2002.

Subpart A—Pension, Compensation, and Dependency and Indemnity Compensation

AUTHORITY: 38 U.S.C. 501(a), unless otherwise noted.

GENERAL

§ 3.1 Definitions.

(a) *Armed Forces* means the United States Army, Navy, Marine Corps, Air Force, and Coast Guard, including their Reserve components.

(b) *Reserve component* means the Army, Naval, Marine Corps, Air Force, and Coast Guard Reserves and the National and Air National Guard of the United States.

(c) *Reserves* means members of a Reserve component of one of the Armed Forces.

(d) *Veteran* means a person who served in the active military, naval, or air service and who was discharged or released under conditions other than dishonorable.

(1) For compensation and dependency and indemnity compensation the term *veteran* includes a person who died in active service and whose death was not due to willful misconduct.

(2) For death pension the term *veteran* includes a person who died in active service under conditions which preclude payment of service-connected death benefits, provided such person had completed at least 2 years honorable military, naval or air service, as certified by the Secretary concerned. (See §§3.3(b)(3)(i) and 3.3(b)(4)(i))

(Authority: 38 U.S.C. 501)

(e) *Veteran of any war* means any veteran who served in the active military, naval or air service during a period of war as set forth in §3.2.

(f) *Period of war* means the periods described in §3.2.

(g) *Secretary concerned* means:

(1) The Secretary of the Army, with respect to matters concerning the Army;

(2) The Secretary of the Navy, with respect to matters concerning the Navy or the Marine Corps;

(3) The Secretary of the Air Force, with respect to matters concerning the Air Force;

(4) The Secretary of Homeland Security, with respect to matters concerning the Coast Guard;

(5) The Secretary of Health and Human Services, with respect to matters concerning the Public Health Service; and

(6) The Secretary of Commerce, with respect to matters concerning the Coast and Geodetic Survey, the Environmental Science Services Administration, and the National Oceanic and Atmospheric Administration.

(h) *Discharge or release* includes retirement from the active military, naval, or air service.

(i) *State* means each of the several States, Territories and possessions of the United States, the District of Columbia, and Commonwealth of Puerto Rico.

(j) *Marriage* means a marriage valid under the law of the place where the parties resided at the time of marriage, or the law of the place where the parties resided when the right to benefits accrued.

(Authority: 38 U.S.C. 103(c))

(k) *Service-connected* means, with respect to disability or death, that such disability was incurred or aggravated, or that the death resulted from a disability incurred or aggravated, in line of duty in the active military, naval, or air service.

(l) *Nonservice-connected* means, with respect to disability or death, that such disability was not incurred or aggravated, or that the death did not result from a disability incurred or aggravated, in line of duty in the active military, naval, or air service.

(m) *In line of duty* means an injury or disease incurred or aggravated during a period of active military, naval, or air service unless such injury or disease was the result of the veteran's own willful misconduct or, for claims filed after October 31, 1990, was a result of his or her abuse of alcohol or drugs. A service department finding that injury, disease or death occurred in line of duty will be binding on the Department of Veterans Affairs unless it is patently inconsistent with the requirements of laws administered by the Department of Veterans Affairs. Requirements as to line of duty are not met if at the time the injury was suffered or disease contracted the veteran was:

(1) Avoiding duty by desertion, or was absent without leave which materially interfered with the performance of military duty.

(2) Confined under a sentence of court-martial involving an unremitted dishonorable discharge.

(3) Confined under sentence of a civil court for a felony as determined under the laws of the jurisdiction where the person was convicted by such court.

(Authority: 38 U.S.C. 105)

NOTE: See §3.1(y)(2)(iii) for applicability of *in line of duty* in determining former prisoner of war status.

(n) *Willful misconduct* means an act involving conscious wrongdoing or known prohibited action. A service department finding that injury, disease or death was not due to misconduct will be binding on the Department of

Veterans Affairs unless it is patently inconsistent with the facts and the requirements of laws administered by the Department of Veterans Affairs.

(1) It involves deliberate or intentional wrongdoing with knowledge of or wanton and reckless disregard of its probable consequences.

(2) Mere technical violation of police regulations or ordinances will not per se constitute willful misconduct.

(3) Willful misconduct will not be determinative unless it is the proximate cause of injury, disease or death. (See §§ 3.301, 3.302.)

(o) *Political subdivision of the United States* includes the jurisdiction defined as a State in paragraph (i) of this section, and the counties, cities or municipalities of each.

(p) *Claim* means a written or electronic communication requesting a determination of entitlement or evidencing a belief in entitlement, to a specific benefit under the laws administered by the Department of Veterans Affairs submitted on an application form prescribed by the Secretary. (See scope of claim, § 3.155(d)(2); complete claim, § 3.160(a); issues within a claim, § 3.151(c)).

(1) *Initial claim.* An initial claim is any complete claim, other than a supplemental claim, for a benefit on a form prescribed by the Secretary. The first initial claim for one or more benefits received by VA is further defined as an original claim. (See original claim, § 3.160(b)). Initial claims include:

(i) A new claim requesting service connection for a disability or grant of a new benefit, and

(ii) A claim for increase in a disability evaluation rating or rate of a benefit paid based on a change or worsening in condition or circumstance since the last decision issued by VA for the benefit.

(2) *Supplemental claim.* A supplemental claim is any complete claim for a VA benefit on an application form prescribed by the Secretary where an initial or supplemental claim for the same or similar benefit on the same or similar basis was previously decided. (See supplemental claim; § 3.2501.)

(q) *Notice* means written notice sent to a claimant or payee at his or her latest address of record.

(r) *Date of receipt* means the date on which a claim, information or evidence was received in the Department of Veterans Affairs, except as to specific provisions for claims or evidence received in the State Department (§ 3.108), or in the Social Security Administration (§§ 3.153, 3.201), or Department of Defense as to initial claims filed at or prior to separation. However, the Under Secretary for Benefits may establish, by notice published in the FEDERAL REGISTER, exceptions to this rule, using factors such as postmark or the date the claimant signed the correspondence, when he or she determines that a natural or man-made interference with the normal channels through which the Veterans Benefits Administration ordinarily receives correspondence has resulted in one or more Veterans Benefits Administration offices experiencing extended delays in receipt of claims, information, or evidence from claimants served by the affected office or offices to an extent that, if not addressed, would adversely affect such claimants through no fault of their own.

(Authority: 38 U.S.C. 501(a), 512(a), 5110)

(s) *On the borders thereof* means, with regard to service during the Mexican border period, the States of Arizona, California, New Mexico, and Texas, and the nations of Guatemala and British Honduras.

(Authority: 38 U.S.C. 101(30))

(t) *In the waters adjacent thereto* means, with regard to service during the Mexican border period, the waters (including the islands therein) which are within 750 nautical miles (863 statute miles) of the coast of the mainland of Mexico.

(Authority: 38 U.S.C. 101(30)

(u) *Section 306 pension* means those disability and death pension programs in effect on December 31, 1978, which arose out of Pub. L. 86–211; 73 Stat. 432.

(v) *Old-Law pension* means the disability and death pension programs that were in effect on June 30, 1960. Also known as protected pension, *i.e.*,

protected under section 9(b) of the Veteran's Pension Act of 1959 (Pub. L. 86–211; 73 Stat. 432).

(w) *Improved pension* means the disability and death pension programs becoming effective January 1, 1979, under authority of Pub. L. 95–588; 92 Stat. 2497.

(x) *Service pension* is the name given to Spanish-American War pension. It is referred to as a service pension because entitlement is based solely on service without regard to nonservice-connected disability, income and net worth.

(Authority: 38 U.S.C. 1512, 1536)

(y) *Former prisoner of war*. The term *former prisoner of war* means a person who, while serving in the active military, naval or air service, was forcibly detained or interned in the line of duty by an enemy or foreign government, the agents of either, or a hostile force.

(1) *Decisions based on service department findings*. The Department of Veterans Affairs shall accept the findings of the appropriate service department that a person was a prisoner of war during a period of war unless a reasonable basis exists for questioning it. Such findings shall be accepted only when detention or internment is by an enemy government or its agents.

(2) *Other decisions*. In all other situations, including those in which the Department of Veterans Affairs cannot accept the service department findings, the following factors shall be used to determine prisoner of war status:

(i) *Circumstances of detention or internment*. To be considered a former prisoner of war, a serviceperson must have been forcibly detained or interned under circumstances comparable to those under which persons generally have been forcibly detained or interned by enemy governments during periods of war. Such circumstances include, but are not limited to, physical hardships or abuse, psychological hardships or abuse, malnutrition, and unsanitary conditions. Each individual member of a particular group of detainees or internees shall, in the absence of evidence to the contrary, be considered to have experienced the same circumstances as those experienced by the group.

(ii) *Reason for detainment or internment*. The reason for which a serviceperson was detained or interned is immaterial in determining POW status, except that a serviceperson who is detained or interned by a foreign government for an alleged violation of its laws is not entitled to be considered a former POW on the basis of that period of detention or internment, unless the charges are a sham intended to legitimize the period of detention or internment.

(3) *Central Office approval*. The Director of the Compensation Service, VA Central Office, shall approve all VA regional office determinations establishing or denying POW status, with the exception of those service department determinations accepted under paragraph (y)(1) of this section.

(4) *In line of duty*. The Department of Veterans Affairs shall consider that a serviceperson was forcibly detained or interned in line of duty unless the evidence of record discloses that forcible detainment or internment was the proximate result of the serviceperson's own willful misconduct.

(5) *Hostile force*. The term *hostile force* means any entity other than an enemy or foreign government or the agents of either whose actions are taken to further or enhance anti-American military, political or economic objectives or views, or to attempt to embarrass the United States.

(Authority: 38 U.S.C. 101(32))

(z) *Nursing home* means

(1) Any extended care facility which is licensed by a State to provide skilled or intermediate-level nursing care,

(2) A nursing home care unit in a State veterans' home which is approved for payment under 38 U.S.C. 1742, or

(3) A Department of Veterans Affairs Nursing Home Care Unit.

(aa) *Fraud:*

(1) As used in 38 U.S.C. 103 and implementing regulations, fraud means an intentional misrepresentation of fact, or the intentional failure to disclose pertinent facts, for the purpose of obtaining, or assisting an individual to obtain an annulment or divorce, with knowledge that the misrepresentation or failure to disclose may result in the

erroneous granting of an annulment or divorce; and

(Authority: 38 U.S.C. 501)

(2) As used in 38 U.S.C. 110 and 1159 and implementing regulations, fraud means an intentional misrepresentation of fact, or the intentional failure to disclose pertinent facts, for the purpose of obtaining or retaining, or assisting an individual to obtain or retain, eligibility for Department of Veterans Affairs benefits, with knowledge that the misrepresentation or failure to disclose may result in the erroneous award or retention of such benefits.

(Authority: 38 U.S.C. 501)

CROSS REFERENCES: Pension. See § 3.3. Compensation. See § 3.4. Dependency and indemnity compensation. See § 3.5. Preservation of disability ratings. See § 3.951. Service-connection. See § 3.957.

[26 FR 1563, Feb. 24, 1961]

EDITORIAL NOTE: For FEDERAL REGISTER citations affecting § 3.1, see the List of CFR Sections Affected, which appears in the Finding Aids section of the printed volume and at *www.fdsys.gov*.

§ 3.2 Periods of war.

This section sets forth the beginning and ending dates of each war period beginning with the Indian wars. Note that the term *period of war* in reference to pension entitlement under 38 U.S.C. 1521, 1541 and 1542 means all of the war periods listed in this section except the Indian wars and the Spanish-American War. See § 3.3(a)(3) and (b)(4)(i).

(a) *Indian wars*. January 1, 1817, through December 31, 1898, inclusive. Service must have been rendered with the United States military forces against Indian tribes or nations.

(b) *Spanish-American War*. April 21, 1898, through July 4, 1902, inclusive. If the veteran served with the United States military forces engaged in hostilities in the Moro Province, the ending date is July 15, 1903. The Philippine Insurrection and the Boxer Rebellion are included.

(c) *World War I*. April 6, 1917, through November 11, 1918, inclusive. If the veteran served with the United States military forces in Russia, the ending date is April 1, 1920. Service after November 11, 1918 and before July 2, 1921 is considered World War I service if the veteran served in the active military, naval, or air service after April 5, 1917 and before November 12, 1918.

(d) *World War II*. December 7, 1941, through December 31, 1946, inclusive. If the veteran was in service on December 31, 1946, continuous service before July 26, 1947, is considered World War II service.

(e) *Korean conflict*. June 27, 1950, through January 31, 1955, inclusive.

(f) *Vietnam era*. The period beginning on February 28, 1961, and ending on May 7, 1975, inclusive, in the case of a veteran who served in the Republic of Vietnam during that period. The period beginning on August 5, 1964, and ending on May 7, 1975, inclusive, in all other cases.

(Authority: 38 U.S.C. 101(29))

(g) *Future dates*. The period beginning on the date of any future declaration of war by the Congress and ending on a date prescribed by Presidential proclamation or concurrent resolution of the Congress.

(Authority: 38 U.S.C. 101)

(h) *Mexican border period*. May 9, 1916, through April 5, 1917, in the case of a veteran who during such period served in Mexico, on the borders thereof, or in the waters adjacent thereto.

(Authority: 38 U.S.C. 101(30))

(i) *Persian Gulf War*. August 2, 1990, through date to be prescribed by Presidential proclamation or law.

(Authority: 38 U.S.C. 101(33))

[26 FR 1563, Feb. 24, 1961, as amended at 32 FR 13223, Sept. 19, 1967; 36 FR 8445, May 6, 1971; 37 FR 6676, Apr. 1, 1972; 40 FR 27030, June 26, 1975; 44 FR 45931, Aug. 6, 1979; 56 FR 57986, Nov. 15, 1991; 62 FR 35422, July 1, 1997]

§ 3.3 Pension.

(a) *Pension for veterans*—(1) *Service pension; Spanish-American War*. A benefit payable monthly by the Department of Veterans Affairs because of service in the Spanish-American War. Basic entitlement exists if a veteran:

(i) Had 70 (or 90) days or more active service during the Spanish-American War; or

(ii) Was discharged or released from such service for a disability adjudged service connected without benefit of presumptive provisions of law, or at the time of discharge had such a service-connected disability, shown by official service records, which in medical judgment would have justified a discharge for disability.

(Authority: 38 U.S.C. 1512)

(2) *Section 306 pension.* A benefit payable monthly by the Department of Veterans Affairs because of nonservice-connected disability or age. Basic entitlement exists if a veteran:

(i) Served 90 days or more in either the Mexican border period, World War I, World War II, the Korean conflict, or the Vietnam era, or served an aggregate of 90 days or more in separate periods of service during the same or during different war periods, including service during the Spanish-American War (Pub. L. 87–101, 75 Stat. 218; Pub. L. 90–77, 81 Stat. 178; Pub. L. 92–198, 85 Stat. 663); or

(ii) Served continuously for a period of 90 consecutive days or more and such period ended during the Mexican border period or World War I, or began or ended during World War II, the Korean conflict or the Vietnam era (Pub. L. 87–101, 75 Stat. 218; Pub. L. 88–664, 78 Stat. 1094; Pub. L. 90–77, 81 Stat. 178; Pub. L. 91–588, 84 Stat. 1580; Pub. L. 92–198, 85 Stat. 663; Pub. L. 94–169, 89 Stat. 1013; Pub. L. 95–204, 91 Stat. 1455); or

(iii) Was discharged or released from such wartime service, before having served 90 days, for a disability adjudged service connected without the benefit of presumptive provisions of law, or at the time of discharge had such a service-connected disability, shown by official service records, which in medical judgment would have justified a discharge for disability; and

(iv) Is permanently and totally disabled (*a*) from nonservice-connected disability not due to the veteran's own willful misconduct or vicious habits, or (*b*) by reason of having attained the age of 65 years or by reason of having become unemployable after age 65; and

(v)(*a*) Is in receipt of section 306 pension or (*b*) has an application for pension pending on December 31, 1978, or (*c*) meets the age or disability requirements for such pension on December 31, 1978, and files a claim within 1 year of that date and also within 1 year after meeting the age or disability requirements.

(vi) Meets the income and net worth requirements of 38 U.S.C. 1521 and 1522 as in effect on December 31, 1978, and all other provisions of title 38, United States Code, in effect on December 31, 1978, applicable to section 306 pension.

NOTE: The pension provisions of title 38 U.S.C., as in effect on December 31, 1978, are available in any VA regional office.

(3) *Improved pension; Pub. L. 95–588 (92 Stat. 2497).* A benefit payable by the Department of Veterans Affairs to veterans of a period or periods of war because of nonservice-connected disability or age. The qualifying periods of war for this benefit are the Mexican border period, World War I, World War II, the Korean conflict, the Vietnam era and the Persian Gulf War. Payments are made monthly unless the amount of the annual benefit is less than 4 percent of the maximum annual rate payable to a veteran under 38 U.S.C. 1521(b), in which case payments may be made less frequently than monthly. Basic entitlement exists if a veteran:

(i) Served in the active military, naval or air service for 90 days or more during a period of war (38 U.S.C. 1521(j)); or

(ii) Served in the active military, naval or air service during a period of war and was discharged or released from such service for a disability adjudged service-connected without presumptive provisions of law, or at time of discharge had such a service-connected disability, shown by official service records, which in medical judgment would have justified a discharge for disability (38 U.S.C. 1521(j)); or

(iii) Served in the active military, naval or air service for a period of 90 consecutive days or more and such period began or ended during a period of war (38 U.S.C. 1521(j)); or

(iv) Served in the active military, naval or air service for an aggregate of 90 days or more in two or more separate periods of service during more than one period of war (38 U.S.C. 1521(j)); and

(v) Meets the net worth requirements under § 3.274 and does not have an annual income in excess of the applicable maximum annual pension rate specified in § 3.23; and

(vi)(A) Is age 65 or older; or

(B) Is permanently and totally disabled from nonservice-connected disability not due to the veteran's own willfull misconduct. For purposes of this paragraph, a veteran is considered permanently and totally disabled if the veteran is any of the following:

(*1*) A patient in a nursing home for long-term care because of disability; or

(*2*) Disabled, as determined by the Commissioner of Social Security for purposes of any benefits administered by the Commissioner; or

(*3*) Unemployable as a result of disability reasonably certain to continue throughout the life of the person; or

(*4*) Suffering from:

(*i*) Any disability which is sufficient to render it impossible for the average person to follow a substantially gainful occupation, but only if it is reasonably certain that such disability will continue throughout the life of the person; or

(*ii*) Any disease or disorder determined by VA to be of such a nature or extent as to justify a determination that persons suffering from that disease or disorder are permanently and totally disabled.

(Authority: 38 U.S.C. 1502(a), 1513, 1521, 1522)

(b) *Pension for survivors*—(1) *Indian war death pension*. A monthly benefit payable by the Department of Veterans Affairs to the surviving spouse or child of a deceased veteran of an Indian war. Basic entitlement exists if a veteran had qualifying service as specified in 38 U.S.C. 1511. Indian war death pension rates are set forth in 38 U.S.C. 1534 and 1535.

(2) *Spanish-American War death pension*. A monthly benefit payable by the Department of Veterans Affairs to the surviving spouse or child of a deceased veteran of the Spanish-American War, if the veteran:

(i) Had 90 days or more active service during the Spanish-American War; or

(ii) Was discharged or released from such service for a disability service-connected without benefit of presumptive provisions of law, or at time of discharge had such a service-connected disability, as shown by official service records, which in medical judgment would have justified a discharge for disability.

(Authority: 38 U.S.C. 1536, 1537)

(3) *Section 306 death pension*. A monthly benefit payable by the Department of Veterans Affairs to a surviving spouse or child because of a veteran's nonservice-connected death. Basic entitlement exists if:

(i) The veteran (as defined in § 3.1(d) and (d)(2)) had qualifying service as specified in paragraph (a)(2)(i), (ii), or (iii) of this section; or

(ii) The veteran was, at time of death, receiving or entitled to receive compensation or retired pay for service-connected disability based on wartime service; and

(iii) The surviving spouse or child (A) was in receipt of section 306 pension on December 31, 1978, or (B) had a claim for pension pending on that date, or (C) filed a claim for pension after that date but within 1 year after the veteran's death, if the veteran died before January 1, 1979; and

(iv) The surviving spouse or child meets the income and net worth requirements of 38 U.S.C. 1541, 1542 or 1543 as in effect on December 31, 1978, and all other provisions of title 38, United States Code in effect on December 31, 1978, applicable to section 306 pension.

NOTE: The pension provisions of title 38, United States Code, as in effect on December 31, 1978, are available in any VA regional office.)

(4) *Improved death pension, Public Law 95–588*. A benefit payable by the Department of Veterans Affairs to a veteran's surviving spouse or child because of the veteran's nonservice-connected death. Payments are made monthly unless the amount of the annual benefit is less than 4 percent of the maximum annual rate payable to a veteran under 38 U.S.C. 1521(b), in which case payments may be made less frequently than monthly. Basic entitlement exists if:

(i) The veteran (as defined in § 3.1(d) and (d)(2)) had qualifying service as specified in paragraph (a)(3)(i), (ii),

(iii), or (iv) of this section (38 U.S.C. 1541(a)); or

(ii) The veteran was, at time of death, receiving or entitled to receive compensation or retired pay for a service-connected disability based on service during a period of war. (The qualifying periods of war are specified in paragraph (a)(3) of this section.) (38 U.S.C. 1541(a)); and

(iii) The surviving spouse or child meets the net worth requirements of §3.274 and has an annual income not in excess of the applicable maximum annual pension rate specified in §§3.23 and 3.24.

(Authority: 38 U.S.C. 1541 and 1542)

CROSS REFERENCES: Section 306 pension. See §3.1(u). Improved pension. See §3.1(w). Improved pension rates. See §3.23. Improved pension rates; surviving children. See §3.24. Frequency of payment of improved pension. See §3.30. Relationship of net worth to pension entitlement. See §3.274.

[44 FR 45931, Aug. 6, 1979, as amended at 56 FR 19579, Apr. 29, 1991; 56 FR 22910, May 17, 1991; 56 FR 25044, June 3, 1991; 56 FR 57986, Nov. 15, 1991; 68 FR 34541, June 10, 2003]

§3.4 Compensation.

(a) *Compensation*. This term means a monthly payment made by the Department of Veterans Affairs to a veteran because of service-connected disability, or to a surviving spouse, child, or parent of a veteran because of the service-connected death of the veteran occurring before January 1, 1957, or under the circumstances outlined in paragraph (c)(2) of this section. If the veteran was discharged or released from service, the discharge or release must have been under conditions other than dishonorable.

(Authority: 38 U.S.C. 101(2), (13))

(b) *Disability compensation*. (1) Basic entitlement for a veteran exists if the veteran is disabled as the result of a personal injury or disease (including aggravation of a condition existing prior to service) while in active service if the injury or the disease was incurred or aggravated in line of duty.

(Authority: 38 U.S.C. 1110, 1131)

(2) An additional amount of compensation may be payable for a spouse, child, and/or dependent parent where a veteran is entitled to compensation based on disability evaluated as 30 per centum or more disabling.

(Authority: 38 U.S.C. 1115)

(c) *Death compensation*. Basic entitlement exists for a surviving spouse, child or children, and dependent parent or parents if:

(1) The veteran died before January 1, 1957; or

(2) The veteran died on or after May 1, 1957, and before January 1, 1972, if at the time of death a policy of United States Government Life Insurance or National Service Life Insurance was in effect under waiver of premiums under 38 U.S.C. 1924 unless the waiver was granted under the first proviso of section 622(a) of the National Service Life Insurance Act of 1940, and the veteran died before return to military jurisdiction or within 120 days thereafter. (See §3.5(d) as to Public Health Service.)

(Authority: 38 U.S.C. 1121, 1141)

[26 FR 1564, Feb. 24, 1961, as amended at 38 FR 21923, Aug. 14, 1973; 39 FR 34529, Sept. 26, 1974; 44 FR 22717, Apr. 17, 1979]

§3.5 Dependency and indemnity compensation.

(a) *Dependency and indemnity compensation*. This term means a monthly payment made by the Department of Veterans Affairs to a surviving spouse, child, or parent:

(1) Because of a service-connected death occurring after December 31, 1956, or

(2) Pursuant to the election of a surviving spouse, child, or parent, in the case of such a death occurring before January 1, 1957.

(Authority: 38 U.S.C. 101 (14))

(b) *Entitlement*. Basic entitlement for a surviving spouse, child or children, and parent or parents of a veteran exists, if:

(1) Death occurred on or after January 1, 1957, except in the situation specified in §3.4(c)(2); or

(2) Death occurred prior to January 1, 1957, and the claimant was receiving or eligible to receive death compensation on December 31, 1956 (or, as to a parent, would have been eligible except

for income), under laws in effect on that date or who subsequently becomes eligible by reason of a death which occurred prior to January 1, 1957; or

(3) Death occurred on or after May 1, 1957, and before January 1, 1972, and the claimant had been ineligible to receive dependency and indemnity compensation because of the exception in subparagraph (1) of this paragraph. In such case dependency and indemnity compensation is payable upon election.

(38 U.S.C. 1310, 1316, 1317, Public Law 92–197, 85 Stat. 660)

(c) *Exclusiveness of remedy*. No person eligible for dependency and indemnity compensation by reason of a death occurring on or after January 1, 1957, shall be eligible by reason of such death for death pension or compensation under any other law administered by the Department of Veterans Affairs, except that, effective November 2, 1994, a surviving spouse who is receiving dependency and indemnity compensation may elect to receive death pension instead of such compensation.

(Authority: 38 U.S.C. 1317)

(d) *Group life insurance*. No dependency and indemnity compensation or death compensation shall be paid to any surviving spouse, child or parent based on the death of a commissioned officer of the Public Health Service, the Coast and Geodetic Survey, the Environmental Science Services Administration, or the National Oceanic and Atmospheric Administration occuring on or after May 1, 1957, if any amounts are payable under the Federal Employees' Group Life Insurance Act of 1954 (Pub. L. 598, 83d Cong., as amended) based on the same death.

(Authority: Sec. 501(c)(2), Pub. L. 881, 84th Cong. (70 Stat. 857), as amended by Sec. 13(u), Pub. L. 85–857; (72 Stat. 1266); Sec. 5, Pub. L. 91–621 (84 Stat. 1863))

[29 FR 10396, July 25, 1964, as amended at 35 FR 18661, Dec. 9, 1970; 37 FR 6676, Apr. 1, 1972; 39 FR 34529, Sept. 26, 1974; 44 FR 22717, Apr. 17, 1979; 58 FR 25561, Apr. 27, 1993; 58 FR 27622, May 10, 1993; 60 FR 18355, Apr. 11, 1995; 70 FR 72220, Dec. 2, 2005; 73 FR 23356, Apr. 30, 2008]

§ 3.6 Duty periods.

(a) *Active military, naval, and air service*. This includes active duty, any period of active duty for training during which the individual concerned was disabled or died from a disease or injury incurred or aggravated in line of duty, and any period of inactive duty training during which the individual concerned was disabled or died from an injury incurred or aggravated in line of duty or from an acute myocardial infarction, a cardiac arrest, or a cerebrovascular accident which occurred during such training.

(Authority: 38 U.S.C. 101(24))

(b) *Active duty*. This 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:

(i) On or after July 29, 1945, or

(ii) Before that date under circumstances affording entitlement to *full military benefits*, or

(iii) At any time, for the purposes of dependency and indemnity compensation.

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

(i) On or after July 29, 1945, or

(ii) Before that date:

(*a*) While on transfer to one of the Armed Forces, or

(*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

(iii) At any time, for the purposes of dependency and indemnity compensation.

(4) Service at any time as a cadet at the United States Military, Air Force, or Coast Guard Academy, or as a midshipman at the United States Naval Academy;

(5) Attendance at the preparatory schools of the United States Air Force Academy, the United States Military Academy, or the United States Naval Academy for enlisted active-duty members who are reassigned to a preparatory school without a release from active duty, and for other individuals who have a commitment to active duty in the Armed Forces that would be binding upon disenrollment from the preparatory school;

(6) Authorized travel to or from such duty or service; and

(7) A person discharged or released from a period of active duty, shall be deemed to have continued on active duty during the period of time immediately following the date of such discharge or release from such duty determined by the Secretary concerned to have been required for him or her to proceed to his or her home by the most direct route, and, in all instances, until midnight of the date of such discharge or release.

(Authority: 38 U.S.C. 106(c))

(c) *Active duty for training.* (1) Full-time duty in the Armed Forces performed by Reserves for training purposes;

(2) Full-time duty for training purposes performed as a commissioned officer of the Reserve Corps of the Public Health Service:

(i) On or after July 29, 1945, or

(ii) Before that date under circumstances affording entitlement to *full military benefits*, or

(iii) At any time, for the purposes of dependency and indemnity compensation:

(3) Full-time duty performed by members of the National Guard of any State, under 32 U.S.C. 316, 502, 503, 504, or 505, or the prior corresponding provisions of law or full-time duty by such members while participating in the reenactment of the Battle of First Manassas in July 1961;

(4) Duty performed by a member of a Senior Reserve Officers' Training Corps program when ordered to such duty for the purpose of training or a practice cruise under chapter 103 of title 10 U.S.C.

(i) The requirements of this paragraph are effective—

(A) On or after October 1, 1982, with respect to deaths and disabilities resulting from diseases or injuries incurred or aggravated after September 30, 1982, and

(B) October 1, 1983, with respect to deaths and disabilities resulting from diseases or injuries incurred or aggravated before October 1, 1982.

(ii) Effective on or after October 1, 1988, such duty must be prerequisite to the member being commissioned and must be for a period of at least four continuous weeks.

(Authority: 38 U.S.C. 101(22)(D) as amended by Pub. L. 100–456)

(5) Attendance at the preparatory schools of the United States Air Force Academy, the United States Military Academy, or the United States Naval Academy by an individual who enters the preparatory school directly from the Reserves, National Guard or civilian life, unless the individual has a commitment to service on active duty which would be binding upon disenrollment from the preparatory school.

(6) Authorized travel to or from such duty.

(Authority: 38 U.S.C. 101(22))

The term does not include duty performed as a temporary member of the Coast Guard Reserve.

(d) *Inactive duty training.* This means: (1) Duty (other than full-time duty) prescribed for Reserves (including commissioned officers of the Reserve Corps of the Public Health Service) by the Secretary concerned under 37 U.S.C. 206 or any other provision of law;

(2) Special additional duties authorized for Reserves (including commissioned officers of the Reserve Corps of the Public Health Service) by an authority designated by the Secretary concerned and performed by them on a voluntary basis in connection with the prescribed training or maintenance activities of the units to which they are assigned; and

(3) Training (other than active duty for training) by a member of, or applicant for membership (as defined in 5 U.S.C. 8140(g)) in, the Senior Reserve

Officers' Training Corps prescribed under chapter 103 of title 10 U.S.C.

(4) Duty (other than full-time duty) performed by a member of the National Guard of any State, under 32 U.S.C. 316, 502, 503, 504, or 505, or the prior corresponding provisions of law. The term *inactive duty training* does not include:

(i) Work or study performed in connection with correspondence courses,

(ii) Attendance at an educational institution in an inactive status, or

(iii) Duty performed as a temporary member of the Coast Guard Reserve.

(Authority: 38 U.S.C. 101(23))

(e) *Travel status—training duty (disability or death from injury or covered disease)*. Any individual:

(1) Who, when authorized or required by competent authority, assumes an obligation to perform active duty for training or inactive duty training; and

(2) Who is disabled or dies from an injury or covered disease incurred while proceeding directly to or returning directly from such active duty for training or inactive duty training shall be deemed to have been on active duty for training or inactive duty training, as the case may be. The Department of Veterans Affairs will determine whether such individual was so authorized or required to perform such duty, and whether the individual was disabled or died from an injury or covered disease so incurred. In making such determinations, there shall be taken into consideration the hour on which the individual began to proceed or return; the hour on which the individual was scheduled to arrive for, or on which the individual ceased to perform, such duty; the method of travel performed; the itinerary; the manner in which the travel was performed; and the immediate cause of disability or death. Whenever any claim is filed alleging that the claimant is entitled to benefits by reason of this paragraph, the burden of proof shall be on the claimant.

(3) For purposes of this section, the term *covered disease* means any of the following:

(i) An acute myocardial infarction.

(ii) A cardiac arrest.

(iii) A cerebrovascular accident.

(Authority: 38 U.S.C. 106(d))

[26 FR 1564, Feb. 24, 1961, as amended at 26 FR 6767, July 28, 1961; 27 FR 4023, Apr. 27, 1962; 29 FR 14171, Oct. 15, 1964; 36 FR 5341, Mar. 20, 1971; 41 FR 26881, June 29, 1976; 49 FR 47003, Nov. 30, 1984; 54 FR 51200, Dec. 13, 1989; 55 FR 23931, June 13, 1990; 60 FR 57179, Nov. 14, 1995; 61 FR 11731, Mar. 22, 1996; 66 FR 48560, Sept. 21, 2001; 67 FR 49585, July 31, 2002]

§ 3.7 Individuals and groups considered to have performed active military, naval, or air service.

The following individuals and groups are considered to have performed active military, naval, or air service:

(a) *Aerial transportation of mail* (*Pub. L. 140, 73d Congress*). Persons who were injured or died while serving under conditions set forth in Pub. L. 140, 73d Congress.

(b) *Aliens*. Effective July 28, 1959, a veteran discharged for alienage during a period of hostilities unless evidence affirmatively shows he or she was discharged at his or her own request. A veteran who was discharged for alienage after a period of hostilities and whose service was honest and faithful is not barred from benefits if he or she is otherwise entitled. A discharge changed prior to January 7, 1957, to honorable by a board established under authority of section 301, Pub. L. 346, 78th Congress, as amended, or section 207, Pub. L. 601, 79th Congress, as amended (now 10 U.S.C. 1552 and 1553), will be considered as evidence that the discharge was not at the alien's request. (See § 3.12.)

(Authority: 38 U.S.C. 5303(c))

(c) *Army field clerks*. Included as enlisted men.

(d) *Army Nurse Corps, Navy Nurse Corps, and female dietetic and physical therapy personnel*. (1) Army and Navy nurses (female) on active service under order of the service department.

(2) Dietetic and physical therapy (female) personnel, excluding students and apprentices, appointed with relative rank on or after December 22, 1942, or commissioned on or after June 22, 1944.

(e) *Aviation camps*. Students who were enlisted men during World War I.

(f) *Cadets and midshipmen.* See §3.6(b)(4).

(g) *Coast and Geodetic Survey, and its successor agencies, the Environmental Science Services Administration and the National Oceanic and Atmospheric Administration.* See §3.6(b)(3).

(h) *Coast Guard.* Active service in Coast Guard on or after January 29, 1915, while under jurisdiction of the Treasury Department, Navy Department, or the Department of Transportation. (See §3.6 (c) and (d) as to temporary members of the Coast Guard Reserves.)

(i) *Contract surgeons.* For compensation and dependency and indemnity compensation, if the disability or death was the result of disease or injury contracted in line of duty during a war period while actually performing the duties of assistant surgeon or acting assistant surgeon with any military force in the field, or in transit or in hospital.

(j) *Field clerks, Quartermaster Corps.* Included as enlisted men.

(k) *Lighthouse service personnel.* Transferred to the service and jurisdiction of War or Navy Departments by Executive order under the Act of August 29, 1916. Effective July 1, 1939, service was consolidated with the Coast Guard.

(l) *Male nurses.* Persons who were enlisted men of Medical Corps.

(m) *National Guard.* Members of the National Guard of the United States and Air National Guard of the United States are included as Reserves. See §3.6 (c) and (d) as to training duty performed by members of a State National Guard and paragraph (o) of this section as to disability suffered after being called into Federal service and before enrollment.

(n) *Persons heretofore having a pensionable or compensable status.*

(Authority: 38 U.S.C. 1152, 1504)

(o) *Persons ordered to service.* (1) Any person who has:

(i) Applied for enlistment or enrollment in the active military, naval, or air service and who is provisionally accepted and directed, or ordered, to report to a place for final acceptance into the service, or

(ii) Been selected or drafted for such service, and has reported according to a call from the person's local draft board and before final rejection, or

(iii) Been called into Federal service as a member of the National Guard, but has not been enrolled for Federal service, and

(iv) Suffered injury or disease in line of duty while going to, or coming from, or at such place for final acceptance or entry upon active duty,

is considered to have been on active duty and therefore to have incurred such disability in active service.

(2) The injury or disease must be due to some factor relating to compliance with proper orders. Draftees and selectees are included when reporting for preinduction examination or for final induction on active duty. Such persons are not included for injury or disease suffered during the period of inactive duty, or period of waiting, after a final physical examination and prior to beginning the trip to report for induction. Members of the National Guard are included when reporting to a designated rendezvous.

(p) *Philippine Scouts and others.* See §3.40.

(q) *Public Health Service.* See §3.6 (a) and (b).

(r) *Reserves.* See §3.6 (a), (b), and (c).

(s) *Revenue Cutter Service.* While serving under direction of Secretary of the Navy in cooperation with the Navy.

(t) *Training camps.* Members of training camps authorized by section 54 of the National Defense Act, except members of Student Army Training Corps Camps at the Presidio of San Francisco, Plattsburg, New York, Fort Sheridan, Illinois, Howard University, Washington, D.C., Camp Perry, Ohio, and Camp Hancock, Georgia, from July 18, 1918, to September 16, 1918.

(u) *Women's Army Corps (WAC).* Service on or after July 1, 1943.

(v) *Women's Reserve of Navy, Marine Corps, and Coast Guard.* Same benefits as members of the Officers Reserve Corps or enlisted men of the United States Navy, Marine Corps or Coast Guard.

(w) *Russian Railway Service Corps.* Service during World War I as certified by the Secretary of the Army.

(x) *Active military service certified as such under section 401 of Pub. L. 95–202.*

Such service if certified by the Secretary of Defense as active military service and if a discharge under honorable conditions is issued by the Secretary. The effective dates for an award based upon such service shall be as provided by § 3.400(z) and 38 U.S.C. 5110, except that in no event shall such an award be made effective earlier than November 23, 1977. Service in the following groups has been certified as active military service.

(1) Women's Air Forces Service Pilots (WASP).

(2) Signal Corps Female Telephone Operators Unit of World War I.

(3) Engineer Field Clerks (WWI).

(4) Women's Army Auxiliary Corps (WAAC).

(5) Quartermaster Corps Female Clerical Employees serving with the AEF (American Expeditionary Forces) in World War I.

(6) Civilian Employees of Pacific Naval Air Bases Who Actively Participated in Defense of Wake Island During World War II.

(7) Reconstruction Aides and Dietitians in World War I.

(8) Male Civilian Ferry Pilots.

(9) Wake Island Defenders from Guam.

(10) Civilian Personnel Assigned to the Secret Intelligence Element of the OSS.

(11) Guam Combat Patrol.

(12) Quartermaster Corps *Keswick* Crew on Corregidor (WWII).

(13) U.S. Civilian Volunteers Who Actively Participated in the Defense of Bataan.

(14) United States Merchant Seamen Who Served on Blockships in Support of Operation Mulberry.

(15) American Merchant Marine in Oceangoing Service during the Period of Armed Conflict, December 7, 1941, to August 15, 1945.

(16) Civilian Navy IFF Technicians Who Served in the Combat Areas of the Pacific during World War II (December 7, 1941 to August 15, 1945). As used in the official name of this group, the acronym *IFF* stands for Identification Friend or Foe.

(17) U.S. Civilians of the American Field Service (AFS) Who Served Overseas Operationally in World War I during the Period August 31, 1917 to January 1, 1918.

(18) U.S. Civilians of the American Field Service (AFS) Who Served Overseas Under U.S. Armies and U.S. Army Groups in World War II during the Period December 7, 1941 through May 8, 1945.

(19) U.S. Civilian Employees of American Airlines Who Served Overseas as a Result of American Airlines' Contract with the Air Transport Command During the Period December 14, 1941 through August 14, 1945.

(20) Civilian Crewmen of United States Coast and Geodetic Survey (USCGS) Vessels Who Performed Their Service in Areas of Immediate Military Hazard While Conducting Cooperative Operations with and for the United States Armed Forces Within a Time Frame of December 7, 1941, to August 15, 1945 on a qualifying USCGS vessel. Qualifying USCGS vessels are the Derickson, Explorer, Gilbert, Hilgard, E. Lester Jones, Lydonia, Patton, Surveyor, Wainwright, Westdahl, Oceanographer, Hydrographer, and Pathfinder.

(21) Honorably Discharged Members of the American Volunteer Group (Flying Tigers) Who Served During the Period December 7, 1941 to July 18, 1942.

(22) U.S. Civilian Flight Crew and Aviation Ground Support Employees of United Air Lines (UAL), Who Served Overseas as a Result of UAL's Contract With the Air Transport Command During the Period December 14, 1941, through August 14, 1945.

(23) U.S. Civilian Flight Crew and Aviation Ground Support Employees of Transcontinental and Western Air (TWA), Inc., Who Served Overseas as a Result of TWA's Contract with the Air Transport Command During the Period December 14, 1941, through August 14, 1945. The ''Flight Crew'' includes pursers.

(24) U.S. Civilian Flight Crew and Aviation Ground Support Employees of Consolidated Vultree Aircraft Corporation (Consairway Division) Who Served Overseas as a Result of a Contract With the Air Transport Command During the Period December 14, 1941, through August 14, 1945.

(25) U.S. Civilian Flight Crew and Aviation Ground Support Employees of Pan American World Airways and Its

Subsidiaries and Affiliates, Who Served Overseas as a Result of Pan American's Contract With the Air Transport Command and Naval Air Transport Service During the Period December 14, 1941 through August 14, 1945.

(26) Honorably Discharged Members of the American Volunteer Guard, Eritrea Service Command During the Period June 21, 1942 to March 31, 1943.

(27) U.S. Civilian Flight Crew and Aviation Ground Support Employees of Northwest Airlines, Who Served Overseas as a Result of Northwest Airline's Contract with the Air Transport Command during the Period December 14, 1941 through August 14, 1945.

(28) U.S. Civilian Female Employees of the U.S. Army Nurse Corps While Serving in the Defense of Bataan and Corregidor During the Period January 2, 1942 to February 3, 1945.

(29) U.S. Flight Crew and Aviation Ground Support Employees of Northeast Airlines Atlantic Division, Who Served Overseas as a Result of Northeast Airlines' Contract With the Air Transport Command During the Period December 7, 1941, Through August 14, 1945.

(30) U.S. Civilian Flight Crew and Aviation Ground Support Employees of Braniff Airways, Who Served Overseas in the North Atlantic or Under the Jurisdiction of the North Atlantic Wing, Air Transport Command (ATC), as a Result of a Contract With the ATC During the Period February 26, 1942, Through August 14, 1945.

(31) The approximately 50 Chamorro and Carolinian former native policemen who received military training in the Donnal area of central Saipan and were placed under the command of Lt. Casino of the 6th Provisional Military Police Battalion to accompany United States Marines on active, combat-patrol activity from August 19, 1945, to September 2, 1945.

(32) Three scouts/guides, Miguel Tenorio, Penedicto Taisacan, and Cristino Dela Cruz, who assisted the United States Marines in the offensive operations against the Japanese on the Northern Mariana Islands from June 19, 1944, through September 2, 1945.

(33) The Operational Analysis Group of the Office of Scientific Research and Development, Office of Emergency Management, which served overseas with the U.S. Army Air Corps from December 7, 1941, through August 15, 1945.

(Authority: Sec. 401, Pub. L. 95–202, 91 Stat. 1449)

(y) *Alaska Territorial Guard:* Members of the Alaska Territorial Guard during World War II who were honorably discharged from such service as determined by the Secretary of Defense.

(Authority: 38 U.S.C. 106(f))

CROSS REFERENCE: Office of Workers' Compensation Programs. See §3.708.

[26 FR 1565, Feb. 24, 1961]

EDITORIAL NOTE: For FEDERAL REGISTER citations affecting §3.7, see the List of CFR Sections Affected, which appears in the Finding Aids section of the printed volume and at *www.fdsys.gov*.

§3.10 Dependency and indemnity compensation rate for a surviving spouse.

(a) *General determination of rate.* When VA grants a surviving spouse entitlement to DIC, VA will determine the rate of the benefit it will award. The rate of the benefit will be the total of the basic monthly rate specified in paragraph (b) or (d) of this section and any applicable increases specified in paragraph (c) or (e) of this section.

(b) *Basic monthly rate.* Except as provided in paragraph (d) of this section, the basic monthly rate of DIC for a surviving spouse will be the amount set forth in 38 U.S.C. 1311(a)(1).

(c) *Section 1311(a)(2) increase.* The basic monthly rate under paragraph (b) of this section shall be increased by the amount specified in 38 U.S.C. 1311(a)(2) if the veteran, at the time of death, was receiving, or was entitled to receive, compensation for service-connected disability that was rated by VA as totally disabling for a continuous period of at least eight years immediately preceding death. Determinations of entitlement to this increase shall be made in accordance with paragraph (f) of this section.

(d) *Alternative basic monthly rate for death occurring prior to January 1, 1993.* The basic monthly rate of DIC for a surviving spouse when the death of the veteran occurred prior to January 1, 1993, will be the amount specified in 38

U.S.C. 1311(a)(3) corresponding to the veteran's pay grade in service, but only if such rate is greater than the total of the basic monthly rate and the section 1311(a)(2) increase (if applicable) the surviving spouse is entitled to receive under paragraphs (b) and (c) of this section. The Secretary of the concerned service department will certify the veteran's pay grade and the certification will be binding on VA. DIC paid pursuant to this paragraph may not be increased by the section 1311(a)(2) increase under paragraph (c) of this section.

(e) *Additional increases.* One or more of the following increases may be paid in addition to the basic monthly rate and the section 1311(a)(2) increase.

(1) *Increase for children.* If the surviving spouse has one or more children under the age of 18 of the deceased veteran (including a child not in the surviving spouse's actual or constructive custody, or a child who is in active military service), the monthly DIC rate will be increased by the amount set forth in 38 U.S.C. 1311(b) for each child.

(2) *Increase for regular aid and attendance.* If the surviving spouse is determined to be in need of regular aid and attendance under the criteria in § 3.352 or is a patient in a nursing home, the monthly DIC rate will be increased by the amount set forth in 38 U.S.C. 1311(c).

(3) *Increase for housebound status.* If the surviving spouse does not qualify for the regular aid and attendance allowance but is housebound under the criteria in § 3.351(e), the monthly DIC rate will be increased by the amount set forth in 38 U.S.C. 1311(d).

(4) For a two-year period beginning on the date entitlement to dependency and indemnity compensation commenced, the dependency and indemnity compensation paid monthly to a surviving spouse with one or more children below the age of 18 shall be increased by the amount set forth in 38 U.S.C. 1311(f), regardless of the number of such children. The dependency and indemnity compensation payable under this paragraph is in addition to any other dependency and indemnity compensation payable. The increase in dependency and indemnity compensation of a surviving spouse under this paragraph shall cease beginning with the first month commencing after the month in which all children of the surviving spouse have attained the age of 18.

(f) *Criteria governing section 1311(a)(2) increase.* In determining whether a surviving spouse qualifies for the section 1311(a)(2) increase under paragraph (c) of this section, the following standards shall apply.

(1) *Marriage requirement.* The surviving spouse must have been married to the veteran for the entire eight-year period referenced in paragraph (c) of this section in order to qualify for the section 1311(a)(2) increase.

(2) *Determination of total disability.* As used in paragraph (c) of this section, the phrase ''rated by VA as totally disabling'' includes total disability ratings based on unemployability (§ 4.16 of this chapter).

(3) *Definition of ''entitled to receive''.* As used in paragraph (c) of this section, the phrase ''entitled to receive'' means that the veteran filed a claim for disability compensation during his or her lifetime and one of the following circumstances is satisfied:

(i) The veteran would have received total disability compensation for the period specified in paragraph (c) of this section but for clear and unmistakable error committed by VA in a decision on a claim filed during the veteran's lifetime; or

(ii) Additional evidence submitted to VA before or after the veteran's death, consisting solely of service department records that existed at the time of a prior VA decision but were not previously considered by VA, provides a basis for reopening a claim finally decided during the veteran's lifetime and for awarding a total service-connected disability rating retroactively in accordance with §§ 3.156(c) and 3.400(q)(2) of this part for the period specified in paragraph (c) of this section; or

(iii) At the time of death, the veteran had a service-connected disability that was continuously rated totally disabling by VA for the period specified in paragraph (c) of this section, but was not receiving compensation because:

(A) VA was paying the compensation to the veteran's dependents;

(B) VA was withholding the compensation under the authority of 38 U.S.C. 5314 to offset an indebtedness of the veteran;

(C) The veteran had not waived retired or retirement pay in order to receive compensation;

(D) VA was withholding payments under the provisions of 10 U.S.C. 1174(h)(2);

(E) VA was withholding payments because the veteran's whereabouts were unknown, but the veteran was otherwise entitled to continued payments based on a total service-connected disability rating; or

(F) VA was withholding payments under 38 U.S.C. 5308 but determines that benefits were payable under 38 U.S.C. 5309.

(Authority: 38 U.S.C. 501(a), 1311, 1314, and 1321)

[70 FR 72220, Dec. 2, 2005, as amended at 71 FR 44918, Aug. 8, 2006; 77 FR 40525, July 10, 2012; 80 FR 18117, Apr. 3, 2015]

§3.11 Homicide.

Any person who has intentionally and wrongfully caused the death of another person is not entitled to pension, compensation, or dependency and indemnity compensation or increased pension, compensation, or dependency and indemnity compensation by reason of such death. For the purpose of this section the term *dependency and indemnity compensation* includes benefits at dependency and indemnity compensation rates paid under 38 U.S.C. 1318.

[44 FR 22718, Apr. 17, 1979, as amended at 54 FR 31829, Aug. 2, 1989]

§3.12 Character of discharge.

(a) If the former service member did not die in service, pension, compensation, or dependency and indemnity compensation is not payable unless the period of service on which the claim is based was terminated by discharge or release under conditions other than dishonorable. (38 U.S.C. 101(2)). A discharge under honorable conditions is binding on the Department of Veterans Affairs as to character of discharge.

(b) A discharge or release from service under one of the conditions specified in this section is a bar to the payment of benefits unless it is found that the person was insane at the time of committing the offense causing such discharge or release or unless otherwise specifically provided (38 U.S.C. 5303(b)).

(c) Benefits are not payable where the former service member was discharged or released under one of the following conditions:

(1) As a conscientious objector who refused to perform military duty, wear the uniform, or comply with lawful order of competent military authorities.

(2) By reason of the sentence of a general court-martial.

(3) Resignation by an officer for the good of the service.

(4) As a deserter.

(5) As an alien during a period of hostilities, where it is affirmatively shown that the former service member requested his or her release. See §3.7(b).

(6) By reason of a discharge under other than honorable conditions issued as a result of an absence without official leave (AWOL) for a continuous period of at least 180 days. This bar to benefit entitlement does not apply if there are compelling circumstances to warrant the prolonged unauthorized absence. This bar applies to any person awarded an honorable or general discharge prior to October 8, 1977, under one of the programs listed in paragraph (h) of this section, and to any person who prior to October 8, 1977, had not otherwise established basic eligibility to receive Department of Veterans Affairs benefits. The term *established basic eligibility to receive Department of Veterans Affairs benefits* means either a Department of Veterans Affairs determination that an other than honorable discharge was issued under conditions other than dishonorable, or an upgraded honorable or general discharge issued prior to October 8, 1977, under criteria other than those prescribed by one of the programs listed in paragraph (h) of this section. However, if a person was discharged or released by reason of the sentence of a general court-martial, only a finding of insanity (paragraph (b) of this section) or a decision of a board of correction of records established under 10 U.S.C. 1552 can estalish basic eligibility to receive Department of Veterans Affairs benefits.

The following factors will be considered in determining whether there are compelling circumstances to warrant the prolonged unauthorized absence.

(i) Length and character of service exclusive of the period of prolonged AWOL. Service exclusive of the period of prolonged AWOL should generally be of such quality and length that it can be characterized as honest, faithful and meritorious and of benefit to the Nation.

(ii) Reasons for going AWOL. Reasons which are entitled to be given consideration when offered by the claimant include family emergencies or obligations, or similar types of obligations or duties owed to third parties. The reasons for going AWOL should be evaluated in terms of the person's age, cultural background, educational level and judgmental maturity. Consideration should be given to how the situation appeared to the person himself or herself, and not how the adjudicator might have reacted. Hardship or suffering incurred during overseas service, or as a result of combat wounds of other service-incurred or aggravated disability, is to be carefully and sympathetically considered in evaluating the person's state of mind at the time the prolonged AWOL period began.

(iii) A valid legal defense exists for the absence which would have precluded a conviction for AWOL. Compelling circumstances could occur as a matter of law if the absence could not validly be charged as, or lead to a conviction of, an offense under the Uniform Code of Military Justice. For purposes of this paragraph the defense must go directly to the substantive issue of absence rather than to procedures, technicalities or formalities.

(d) A discharge or release because of one of the offenses specified in this paragraph is considered to have been issued under dishonorable conditions.

(1) Acceptance of an undesirable discharge to escape trial by general court-martial.

(2) Mutiny or spying.

(3) An offense involving moral turpitude. This includes, generally, conviction of a felony.

(4) Willful and persistent misconduct. This includes a discharge under other than honorable conditions, if it is determined that it was issued because of willful and persistent misconduct. A discharge because of a minor offense will not, however, be considered willful and persistent misconduct if service was otherwise honest, faithful and meritorious.

(5) Homosexual acts involving aggravating circumstances or other factors affecting the performance of duty. Examples of homosexual acts involving aggravating circumstances or other factors affecting the performance of duty include child molestation, homosexual prostitution, homosexual acts or conduct accompanied by assault or coercion, and homosexual acts or conduct taking place between service members of disparate rank, grade, or status when a service member has taken advantage of his or her superior rank, grade, or status.

(e) An honorable discharge or discharge under honorable conditions issued through a board for correction of records established under authority of 10 U.S.C. 1552 is final and conclusive on the Department of Veterans Affairs. The action of the board sets aside any prior bar to benefits imposed under paragraph (c) or (d) of this section.

(f) An honorable or general discharge issued prior to October 8, 1977, under authority other than that listed in paragraphs (h) (1), (2) and (3) of this section by a discharge review board established under 10 U.S.C. 1553 set aside any bar to benefits imposed under paragraph (c) or (d) of this section except the bar contained in paragraph (c)(2) of this section.

(g) An honorable or general discharge issued on or after October 8, 1977, by a discharge review board established under 10 U.S.C. 1553, sets aside a bar to benefits imposed under paragraph (d), but not paragraph (c), of this section provided that:

(1) The discharge is upgraded as a result of an individual case review;

(2) The discharge is upgraded under uniform published standards and procedures that generally apply to all persons administratively discharged or released from active military, naval or air service under conditions other than honorable; and

(3) Such standards are consistent with historical standards for determining honorable service and do not contain any provision for automatically granting or denying an upgraded discharge.

(h) Unless a discharge review board established under 10 U.S.C. 1553 determines on an individual case basis that the discharge would be upgraded under uniform standards meeting the requirements set forth in paragraph (g) of this section, an honorable or general discharge awarded under one of the following programs does not remove any bar to benefits imposed under this section:

(1) The President's directive of January 19, 1977, implementing Presidential Proclamation 4313 of September 16, 1974; or

(2) The Department of Defense's special discharge review program effective April 5, 1977; or

(3) Any discharge review program implemented after April 5, 1977, that does not apply to all persons administratively discharged or released from active military service under other than honorable conditions.

(Authority: 38 U.S.C. 5303 (e))

(i) No overpayments shall be created as a result of payments made after October 8, 1977, based on an upgraded honorable or general discharge issued under one of the programs listed in paragraph (h) of this section which would not be awarded under the standards set forth in paragraph (g) of this section. Accounts in payment status on or after October 8, 1977, shall be terminated the end of the month in which it is determined that the original other than honorable discharge was not issued under conditions other than dishonorable following notice from the appropriate discharge review board that the discharge would not have been upgraded under the standards set forth in paragraph (g) of this section, or April 7, 1978, whichever is the earliest. Accounts in suspense (either before or after October 8, 1977) shall be terminated on the date of last payment or April 7, 1978, whichever is the earliest.

(j) No overpayment shall be created as a result of payments made after October 8, 1977, in cases in which the bar contained in paragraph (c)(6) of this section is for application. Accounts in payment status on or after October 8, 1977, shall be terminated at the end of the month in which it is determined that compelling circumstances do not exist, or April 7, 1978, whichever is the earliest. Accounts in suspense (either before or after October 8, 1977) shall be terminated on the date of last payment, or April 7, 1978, whichever is the earliest.

(k) *Uncharacterized separations.* Where enlisted personnel are administratively separated from service on the basis of proceedings initiated on or after October 1, 1982, the separation may be classified as one of the three categories of administrative separation that do not require characterization of service by the military department concerned. In such cases conditions of discharge will be determined by the VA as follows:

(1) *Entry level separation.* Uncharacterized administrative separations of this type shall be considered under conditions other than dishonorable.

(2) *Void enlistment or induction.* Uncharacterized administrative separations of this type shall be reviewed based on facts and circumstances surrounding separation, with reference to the provisions of §3.14 of this part, to determine whether separation was under conditions other than dishonorable.

(3) *Dropped from the rolls.* Uncharacterized administrative separations of this type shall be reviewed based on facts and circumstances surrounding separation to determine whether separation was under conditions other than dishonorable.

(Authority: 38 U.S.C. 501)

CROSS REFERENCES: Validity of enlistments. See §3.14. Revision of decisions. See §3.105. Effective dates. See §3.400(g). Minimum active-duty service requirement. See §3.12a.

[28 FR 123, Jan. 4, 1963, as amended at 41 FR 12656, Mar. 26, 1976; 43 FR 15153, Apr. 11, 1978; 45 FR 2318, Jan. 11, 1980; 49 FR 44099, Nov. 2, 1984; 62 FR 14823, Mar. 28, 1997]

§ 3.12a Minimum active-duty service requirement.

(a) *Definitions.* (1) The term *minimum period of active duty* means, for the purposes of this section, the shorter of the following periods.

(i) Twenty-four months of continuous active duty. Non-duty periods that are excludable in determining the Department of Veterans Affairs benefit entitlement (e.g., see § 3.15) are not considered as a break in service for continuity purposes but are to be subtracted from total time served.

(ii) The full period for which a person was called or ordered to active duty.

(2) The term *benefit* includes a right or privilege but does not include a refund of a participant's contributions under 38 U.S.C. Ch. 32.

(b) *Effect on Department of Veterans Affairs benefits.* Except as provided in paragraph (d) of this section, a person listed in paragraph (c) of this section who does not complete a minimum period of active duty is not eligible for any benefit under title 38, United States Code or under any law administered by the Department of Veterans Affairs based on that period of active service.

(c) *Persons included.* Except as provided in paragraph (d) of this section, the provisions of paragraph (b) of this section apply to the following persons:

(1) A person who originally enlists (enlisted person only) in a regular component of the Armed Forces after September 7, 1980 (a person who signed a delayed-entry contract with one of the service branches prior to September 8, 1980, and under that contract was assigned to a reserve component until entering on active duty after September 7, 1980, shall be considered to have enlisted on the date the person entered on active duty); and

(2) Any other person (officer as well as enlisted) who enters on active duty after October 16, 1981 and who has not previously completed a continuous period of active duty of at least 24 months or been discharged or released from active duty under 10 U.S.C. 1171 (early out).

(d) *Exclusions.* The provisions of paragraph (b) of this section are not applicable to the following cases:

(1) To a person who is discharged or released under 10 U.S.C. 1171 or 1173 (early out or hardship discharge).

(2) To a person who is discharged or released from active duty for a disability adjudged service connected without presumptive provisions of law, or who at time of discharge had such a service-connected disability, shown by official service records, which in medical judgment would have justified a discharge for disability.

(3) To a person with a compensable service-connected disability.

(4) To the provision of a benefit for or in connection with a service-connected disability, condition, or death.

(5) To benefits under chapter 19 of title 38, United States Code.

(e) *Dependent or survivor benefits*—(1) *General.* If a person is, by reason of this section, barred from receiving any benefits under title 38, United States Code (or under any other law administered by the Department of Veterans Affairs based on a period of active duty, the person's dependents or survivors are also barred from receiving benefits based on the same period of active duty.

(2) *Exceptions.* Paragraph (e)(1) of this section does not apply to benefits under chapters 19 and 37 of title 38, United States Code. (38 U.S.C. 5303A)

[47 FR 24549, June 7, 1982]

§ 3.13 Discharge to change status.

(a) A discharge to accept appointment as a commissioned or warrant officer, or to change from a Reserve or Regular commission to accept a commission in the other component, or to reenlist is a conditional discharge if it was issued during one of the following periods:

(1) World War I; prior to November 11, 1918. As to reenlistments, this subparagraph applies only to Army and National Guard. No involuntary extension or other restrictions existed on Navy enlistments.

(2) World War II, the Korean conflict or the Vietnam era; prior to the date the person was eligible for discharge under the point or length of service system, or under any other criteria in effect.

(3) Peacetime service; prior to the date the person was eligible for an unconditional discharge.

(b) Except as provided in paragraph (c) of this section, the entire period of service under the circumstances stated in paragraph (a) of this section constitutes one period of service and entitlement will be determined by the character of the final termination of such period of active service except that, for death pension purposes, §3.3(b)(3) and (4) is controlling as to basic entitlement when the conditions prescribed therein are met.

(c) Despite the fact that no unconditional discharge may have been issued, a person shall be considered to have been unconditionally discharged or released from active military, naval or air service when the following conditions are met:

(1) The person served in the active military, naval or air service for the period of time the person was obligated to serve at the time of entry into service;

(2) The person was not discharged or released from such service at the time of completing that period of obligation due to an intervening enlistment or reenlistment; and

(3) The person would have been eligible for a discharge or release under conditions other than dishonorable at that time except for the intervening enlistment or reenlistment.

[26 FR 1566, Feb. 24, 1961, as amended at 27 FR 4024, Apr. 27, 1962; 32 FR 13224, Sept. 19, 1967; 43 FR 15154, Apr. 11, 1978; 46 FR 23926, Apr. 29, 1981]

§3.14 Validity of enlistments.

Service is valid unless the enlistment is voided by the service department.

(a) *Enlistment not prohibited by statute.* Where an enlistment is voided by the service department for reasons other than those stated in paragraph (b) of this section, service is valid from the date of entry upon active duty to the date of voidance by the service department. Benefits may not be paid, however, unless the discharge is held to have been under conditions other than dishonorable. Generally discharge for concealment of a physical or mental defect except incompetency or insanity which would have prevented enlistment will be held to be under dishonorable conditions.

(b) *Statutory prohibition.* Where an enlistment is voided by the service department because the person did not have legal capacity to contract for a reason other than minority (as in the case of an insane person) or because the enlistment was prohibited by statute (a deserter or person convicted of a felony), benefits may not be paid based on that service even though a disability was incurred during such service. An undesirable discharge by reason of the fraudulent enlistment voids the enlistment from the beginning.

(c) *Misrepresentation of age.* Active service which was terminated because of concealment of minority or misrepresentation of age is honorable if the veteran was released from service under conditions other than dishonorable. Service is valid from the date of entry upon active duty to the date of discharge.

(d) *Honorable discharges.* Determinations as to honorable service will be made by the service departments and the finding shall be binding on the Department of Veterans Affairs, but, in the case of an alien, the effect of the discharge will be governed by §3.7(b).

[26 FR 1567, Feb. 24, 1961, as amended at 27 FR 4024, Apr. 27, 1962]

§3.15 Computation of service.

For nonservice-connected or service-connected benefits, active service is countable exclusive of time spent on an industrial, agricultural, or indefinite furlough, time lost on absence without leave (without pay), under arrest (without acquittal), in desertion, while undergoing sentence of court-martial or a period following release from active duty under the circumstances outlined in §3.41. In claims based on Spanish-American War service, leave authorized under General Order No. 130, War Department, is included.

CROSS REFERENCE: Duty periods. See §3.6(b)(6).

[40 FR 16064, Apr. 9, 1975]

§3.16 Service pension.

In computing the 70 or 90 days required under §3.3(a) active service which began before or extended beyond

the war period will be included if such service was continuous. Broken periods of service during a war period may be added together to meet the requirement for length of service.

[41 FR 18299, May 3, 1976, as amended at 44 FR 45932, Aug. 6, 1979]

§ 3.17 Disability and death pension; Mexican border period and later war periods.

In computing the 90 days' service required for pension entitlement (see § 3.3), there will be included active service which began before and extended into the Mexican border period or ended during World War I, or began or ended during World War II, the Korean conflict, the Vietnam era or the Persian Gulf War, if such service was continuous. Service during different war periods may be combined with service during any other war period to meet the 90 days' service requirement.

(Authority: 38 U.S.C. 1521)

[37 FR 6676, Apr. 1, 1972, as amended at 44 FR 45932, Aug. 6, 1979; 56 FR 57986, Nov. 15, 1991]

§§ 3.18–3.19 [Reserved]

§ 3.20 Surviving spouse's benefit for month of veteran's death.

(a) Where the veteran died on or after December 1, 1962, and before October 1, 1982, the rate of death pension or dependency and indemnity compensation otherwise payable for the surviving spouse for the month in which the death occurred shall be not less than the amount of pension or compensation which would have been payable to or for the veteran for that month but for his or her death.

(Authority: 38 U.S.C. 5310)

(b) Where the veteran dies on or after October 1, 1982, the surviving spouse may be paid death pension or dependency and indemnity compensation for the month in which the veteran died at a rate equal to the amount of compensation or pension which would have been payable to the veteran for that month had death not occurred, but only if such rate is equal to or greater than the monthly rate of death pension or dependency and indemnity compensation to which the surviving spouse is entitled. Otherwise, no payment of death pension or dependency and indemnity compensation may be made for the month in which the veteran died.

(Authority: 38 U.S.C. 5111(c))

(c)(1) Where a veteran receiving compensation or pension dies after December 31, 1996, the surviving spouse, if not entitled to death compensation, dependency and indemnity compensation, or death pension for the month of death, shall be entitled to a benefit for that month in an amount equal to the amount of compensation or pension the veteran would have received for that month but for his or her death.

(2) A payment issued to a deceased veteran as compensation or pension for the month in which death occurred shall be treated as payable to that veteran's surviving spouse, if the surviving spouse is not entitled to death compensation, dependency and indemnity compensation or death pension for that month and, if negotiated or deposited, shall be considered to be the benefit to which the surviving spouse is entitled under paragraph (c)(1) of this section. However, if such payment is in an amount less than the amount of the benefit under paragraph (c)(1) of this section, the unpaid difference shall be treated in the same manner as an accrued benefit under § 3.1000 of this part.

(Authority: 38 U.S.C. 5310(b))

[48 FR 34471, July 29, 1983, as amended at 62 FR 35422, July 1, 1997; 64 FR 30392, June 8, 1999]

§ 3.21 Monetary rates.

The rates of compensation, dependency and indemnity compensation for surviving spouses and children, and section 306 and old-law disability and death pension, are published in tabular form in appendix B of the Veterans Benefits Administration Manual M21–1 and are to be given the same force and effect as if published in the regulations (title 38, Code of Federal Regulations). The maximum annual rates of improved pension payable under Pub. L. 95–588 (92 Stat. 2497) are set forth in §§ 3.23 and 3.24. The monthly rates and annual income limitations applicable

to parents' dependency and indemnity compensation are set forth in §3.25.

CROSS REFERENCES: Section 306 pension. See §3.1(u). Old-law pension. See §3.1(v). Improved pension. See §3.1(w).

[44 FR 45932, Aug. 6, 1979]

§3.22 DIC benefits for survivors of certain veterans rated totally disabled at time of death.

(a) Even though a veteran died of non-service-connected causes, VA will pay death benefits to the surviving spouse or children in the same manner as if the veteran's death were service-connected, if:

(1) The veteran's death was not the result of his or her own willful misconduct, and

(2) At the time of death, the veteran was receiving, or was entitled to receive, compensation for service-connected disability that was:

(i) Rated by VA as totally disabling for a continuous period of at least 10 years immediately preceding death;

(ii) Rated by VA as totally disabling continuously since the veteran's release from active duty and for at least 5 years immediately preceding death; or

(iii) Rated by VA as totally disabling for a continuous period of not less than one year immediately preceding death, if the veteran was a former prisoner of war.

(Authority: 38 U.S.C. 1318(b))

(b) For purposes of this section, ''entitled to receive'' means that the veteran filed a claim for disability compensation during his or her lifetime and one of the following circumstances is satisfied:

(1) The veteran would have received total disability compensation at the time of death for a service-connected disability rated totally disabling for the period specified in paragraph (a)(2) of this section but for clear and unmistakable error committed by VA in a decision on a claim filed during the veteran's lifetime; or

(2) Additional evidence submitted to VA before or after the veteran's death, consisting solely of service department records that existed at the time of a prior VA decision but were not previously considered by VA, provides a basis for reopening a claim finally decided during the veteran's lifetime and for awarding a total service-connected disability rating retroactively in accordance with §§3.156(c) and 3.400(q)(2) of this part for the relevant period specified in paragraph (a)(2) of this section; or

(3) At the time of death, the veteran had a service-connected disability that was continuously rated totally disabling by VA for the period specified in paragraph (a)(2), but was not receiving compensation because:

(i) VA was paying the compensation to the veteran's dependents;

(ii) VA was withholding the compensation under authority of 38 U.S.C. 5314 to offset an indebtedness of the veteran;

(iii) The veteran had not waived retired or retirement pay in order to receive compensation;

(iv) VA was withholding payments under the provisions of 10 U.S.C. 1174(h)(2);

(v) VA was withholding payments because the veteran's whereabouts were unknown, but the veteran was otherwise entitled to continued payments based on a total service-connected disability rating; or

(vi) VA was withholding payments under 38 U.S.C. 5308 but determines that benefits were payable under 38 U.S.C. 5309.

(c) For purposes of this section, ''rated by VA as totally disabling'' includes total disability ratings based on unemployability (§4.16 of this chapter).

(d) To be entitled to benefits under this section, a surviving spouse must have been married to the veteran—

(1) For at least 1 year immediately preceding the date of the veteran's death; or

(2) For any period of time if a child was born of the marriage, or was born to them before the marriage.

(Authority: 38 U.S.C. 1318)

(e) *Effect of judgment or settlement.* If a surviving spouse or child eligible for benefits under paragraph (a) of this section receives any money or property pursuant to a judicial proceeding based upon, or a settlement or compromise of, any cause of action or other right of

recovery for damages for the death of the veteran, benefits payable under paragraph (a) of this section shall not be paid for any month following the month in which such money or property is received until the amount of benefits that would otherwise have been payable under paragraph (a) of this section equals the total of the amount of money received and the fair market value of the property received. The provisions of this paragraph do not apply, however, to any portion of such benefits payable for any period preceding the end of the month in which such money or property of value is received.

(Authority: 38 U.S.C. 501)

(f) *Social security and worker's compensation.* Benefits received under social security or worker's compensation are not subject to recoupment under paragraph (e) of this section even though such benefits may have been awarded pursuant to a judicial proceeding.

(g) *Beneficiary's duty to report.* Any person entitled to benefits under paragraph (a) of this section shall promptly report to the Department of Veterans Affairs the receipt of any money or property received pursuant to a judicial proceeding based upon, or a settlement or compromise of, any cause of action or other right of recovery for damages for the death of the veteran. The amount to be reported is the total of the amount of money received and the fair market value of property received. Expenses incident to recovery, such as attorney's fees, may not be deducted from the amount to be reported.

(h) *Relationship to survivor benefit plan.* For the purpose of 10 U.S.C. 1448(d) and 1450(c) eligibility for benefits under paragraph (a) of this section shall be deemed eligibility for dependency and indemnity compensation under 38 U.S.C. 1311(a).

(Authority: 38 U.S.C. 1318)

CROSS REFERENCES: Marriage dates. See § 3.54. Homicide. See § 3.11.

[44 FR 22718, Apr. 17, 1979, as amended at 48 FR 41161, Sept. 14, 1983; 53 FR 23235, June 21, 1988; 54 FR 31829, Aug. 2, 1989; 65 FR 3391, Jan. 21, 2000; 65 FR 43699, July 14, 2000; 70 FR 72220, Dec. 2, 2005; 77 FR 40526, July 10, 2012]

§ 3.23 Improved pension rates—Veterans and surviving spouses.

(a) *Maximum annual rates of improved pension.* The maximum annual rates of improved pension for the following categories of beneficiaries shall be the amounts specified in 38 U.S.C. 1521 and 1542, as increased from time to time under 38 U.S.C. 5312. Each time there is an increase under 38 U.S.C. 5312, the actual rates will be published in the ''Notices'' section of the FEDERAL REGISTER. (1) Veterans who are permanently and totally disabled.

(Authority: 38 U.S.C. 1521(b) or (c))

(2) Veterans in need of aid and attendance.

(Authority: 38 U.S.C. 1521(d))

(3) Veterans who are housebound.

(Authority: 38 U.S.C. 1521(e))

(4) Two veterans married to one another; combined rates.

(Authority: 38 U.S.C. 1521(f))

(5) Surviving spouse alone or with a child or children of the deceased veteran in custody of the surviving spouse.

(Authority: 38 U.S.C. 1541(b) or (c))

(6) Surviving spouses in need of aid and attendance.

(Authority: 38 U.S.C. 1541(d))

(7) Surviving spouses who are housebound.

(Authority: 38 U.S.C. 1541(e))

(b) *Reduction for income.* The maximum rates of improved pension in paragraph (a) of this section shall be reduced by the amount of the countable annual income of the veteran or surviving spouse.

(Authority: 38 U.S.C. 1521, 1541)

(c) *Mexican border period and World War I veterans.* The applicable maximum annual rate payable to a Mexican border period or World War I veteran under this section shall be increased by the amount specified in 38 U.S.C. 1521(g), as increased from time

to time under 38 U.S.C 5312. Each time there is an increase under 38 U.S.C. 5312, the actual rate will be published in the ''Notices'' section of the FEDERAL REGISTER.

(Authority: 38 U.S.C. 1521(g))

(d) *Definitions of terms used in this section*—(1) *Dependent*. A veteran's spouse or child. A veteran's spouse who resides apart from the veteran and is estranged from the veteran may not be considered the veteran's dependent unless the spouse receives reasonable support contributions from the veteran. (Note that under §3.60 a veteran and spouse who reside apart are considered to be living together unless they are estranged.) A child of a veteran not in custody of the veteran and to whose support the veteran is not reasonably contributing, may not be considered the veteran's dependent.

(Authority: 38 U.S.C. 1521(b))

(2) *In need of aid and attendance*. As defined in §3.351(b).

(3) *Housebound*. As defined in §3.351(d)(2), (f). This term also includes a veteran who has a disability or disabilities evaluated as 60 percent or more disabling in addition to a permanent and totally disabling condition. See §3.351(d)(1).

(4) *Veteran's annual income*. This term includes the veteran's annual income, the annual income of the veteran's dependent spouse, and the annual income of each child of the veteran (other than a child for whom increased pension is not payable under 38 U.S.C. 1522(b)) in the veteran's custody or to whose support the veteran is reasonably contributing (to the extent such child's income is reasonably available to or for the veteran, unless in the judgment of the Department of Veterans Affairs to do so would work a hardship on the veteran.) There is a rebuttable presumption that all of such a child's income is reasonably available to or for the veteran.

(Authority: 38 U.S.C. 1521 (c), (h))

(5) *Surviving spouse's annual income*. This term includes the surviving spouse's annual income and the annual income of each child of the veteran (other than a child for whom increased pension is not payable under 38 U.S.C. 1543(a)(2)) in the custody of the surviving spouse to the extent that such child's income is reasonably available to or for the surviving spouse, unless in the judgment of the Department of Veterans Affairs to do so would work a hardship on the surviving spouse. There is a rebuttable presumption that all of such a child's income is available to or for the surviving spouse.

(Authority: 38 U.S.C. 1541(c), (g))

(6) *Reasonable availability and hardship*. For the purposes of paragraphs (d)(4) and (d)(5) of this section, a child's income shall be considered ''reasonably available'' when it can be readily applied to meet the veteran's or surviving spouse's expenses necessary for reasonable family maintenance, and ''hardship'' shall be held to exist when annual expenses necessary for reasonable family maintenance exceed the sum of countable annual income plus VA pension entitlement. *Expenses necessary for reasonable family maintenance* include expenses for basic necessities (such as food, clothing, shelter, etc.) and other expenses, determined on a case-by-case basis, which are necessary to support a reasonable quality of life.

(Authority: 38 U.S.C. 501)

CROSS REFERENCES: Improved pension. See §3.1(w). Child. See §3.57(d). Definition of *living with*. See §3.60. Exclusions from income. See §3.272.

[44 FR 45933, Aug. 6, 1979, as amended at 52 FR 34907, Sept. 14, 1987; 53 FR 23235, June 21, 1988]

§3.24 Improved pension rates—Surviving children.

(a) *General*. The provisions of this section apply to children of a deceased veteran not in the custody of a surviving spouse who has basic eligibility to receive improved pension. Children in custody of a surviving spouse who has basic eligibility to receive improved pension do not have separate entitlement. Basic eligibility to receive improved pension means that the surviving spouse is in receipt of improved pension or could become entitled to receive improved pension except for the amount of the surviving

spouse's countable annual income or the size of the surviving spouse's estate (See § 3.274(c)). Under § 3.23(d)(5) the countable annual income of a surviving spouse includes the countable annual income of each child of the veteran in custody of the surviving spouse to the extent the child's income is reasonably available to or for the surviving spouse, unless in the judgment of the Department of Veterans Affairs to do so would work a hardship on the surviving spouse.

(b) *Child with no personal custodian or in the custody of an institution.* In cases in which there is no personal custodian, *i.e.*, there is no person who has the legal right to exercise parental control and responsibility for the child's welfare (See § 3.57(d)), or the child is in the custody of an institution, pension shall be paid to the child at the annual rate specified in 38 U.S.C. 1542, as increased from time to time under 38 U.S.C. 5312, reduced by the amount of the child's countable annual income. Each time there is an increase under 38 U.S.C. 5312, the actual rate will be published in the ''Notices'' section of the FEDERAL REGISTER.

(c) *Child in the custody of person legally responsible for support*—(1) *Single child.* Pension shall be paid to a child in the custody of a person legally responsible for the child's support at an annual rate equal to the difference between the rate for a surviving spouse and one child under § 3.23(a)(5), and the sum of the annual income of such child and the annual income of such person or, the maximum annual pension rate under paragraph (b) of this section, whichever is less.

(2) *More than one child.* Pension shall be paid to children in custody of a person legally responsible for the children's support at an annual rate equal to the difference between the rate for a surviving spouse and an equivalent number of children (but not including any child who has countable annual income equal to or greater than the maximum annual pension rate under paragraph (b) of this section) and the sum of the countable annual income of the person legally responsible for support and the combined countable annual income of the children (but not including the income of any child whose countable annual income is equal to or greater than the maximum annual pension rate under paragraph (b) of this section, or the maximum annual pension rate under paragraph (b) of this section times the number of eligible children, whichever is less).

(Authority: 38 U.S.C. 1542)

CROSS REFERENCES: Child. See § 3.57(d). Exclusions from income. See § 3.272.

[44 FR 45933, Aug. 6, 1979, as amended at 52 FR 34907, Sept. 14, 1987; 61 FR 20727, May 8, 1996]

§ 3.25 Parent's dependency and indemnity compensation (DIC)—Method of payment computation.

Monthly payments of parents' DIC shall be computed in accordance with the following formulas:

(a) *One parent.* Except as provided in paragraph (b) of this section, if there is only one parent, the monthly rate specified in 38 U.S.C 1315(b)(1), as increased from time to time under 38 U.S.C. 5312, reduced by $.08 for each dollar of such parent's countable annual income in excess of $800. No payments of DIC may be made under this paragraph, however, if such parent's countable annual income exceeds the amount specified in 38 U.S.C. 1315(b)(3), as increased from time to time under 38 U.S.C. 5312, and no payment of DIC to a parent under this paragraph may be less than $5 a month.

(b) *One parent who has remarried.* If there is only one parent and the parent has remarried and is living with the parent's spouse, DIC shall be paid under paragraph (a) or paragraph (d) of this section, whichever shall result in the greater benefit being paid to the veteran's parent. In the case of remarriage, the total combined annual income of the parent and the parent's spouse shall be counted in determining the monthly rate of DIC.

(c) *Two parents not living together.* The rate computation method in this paragraph applies to:

(1) Two parents who are not living together, or

(2) An unremarried parent when both parents are living and the other parent has remarried.

The monthly rate of DIC paid to such parent shall be the rate sepcified in 38

U.S.C. 1315(c)(1), as increased from time to time under 38 U.S.C. 5312, reduced by an amount no greater than $.08 for each dollar of such parent's countable annual income in excess of $800, except that no payments of DIC may be made under this paragraph if such parent's countable annual income exceeds the amount specified in 38 U.S.C. 1315(c)(3), as increased from time to time under 38 U.S.C. 5312, and no payment of DIC to a parent under this paragraph may be less than $5 monthly. Each time there is a rate increase under 38 U.S.C. 5312, the amount of the reduction under this paragraph shall be recomputed to provide, as nearly as possible, for an equitable distribution of the rate increase. The results of this computation method shall be published in schedular format in the ''Notices'' section of the FEDERAL REGISTER as provided in paragraph (f) of this section.

(d) *Two parents living together or remarried parents living with spouse.* The rate computation method in this paragraph applies to each parent living with another parent and to each remarried parent when both parents are alive. The monthly rate of DIC paid to such parents shall be the rate specified in 38 U.S.C. 1315(d)(1), as increased from time to time under 38 U.S.C. 5312, reduced to an amount no greater than $.08 for each dollar of such parent's and spouse's combined countable annual income in excess of $1,000 except that no payments of DIC to a parent under this paragraph may be less than $5 monthly. Each time there is a rate increase under 38 U.S.C. 5312, the amount of the reduction under this paragraph shall be recomputed to provide, as nearly as possible, for an equitable distribution of the rate increase. The results of this computation method shall be published in schedular format in the ''Notices'' section of the FEDERAL REGISTER as provided in paragraph (f) of this section.

(e) *Aid and attendance.* The monthly rate of DIC payable to a parent under this section shall be increased by the amount specified in 38 U.S.C. 1315(g), as increased from time to time under 38 U.S.C. 5312, if such parent is:

(1) A patient in a nursing home, or

(2) Helpless or blind, or so nearly helpless or blind as to need or require the regular aid and attendance of another person.

(f) *Rate publication.* Each time there is an increase under 38 U.S.C. 5312, the actual rates will be published in the ''Notices'' section of the FEDERAL REGISTER.

(Authority: 38 U.S.C. 501)

[52 FR 34907, Sept. 14, 1987, as amended at 61 FR 20727, May 8, 1996]

§3.26 Section 306 and old-law pension annual income limitations.

(a) The annual income limitations for section 306 pension shall be the amounts specified in section 306(a)(2)(A) of Pub. L. 95–588, as increased from time to time under section 306(a)(3) of Pub. L. 95–588.

(b) If a beneficiary under section 306 pension is in need of aid and attendance, the annual income limitation under paragraph (a) of this section shall be increased in accordance with 38 U.S.C. 1521(d), as in effect on December 31, 1978.

(c) The annual income limitations for old-law pension shall be the amounts specified in section 306(b)(3) of Pub. L. 95–588, as increased from time to time under section 306(b)(4) of Pub. L. 95–588.

(d) Each time there is an increase under section 306 (a)(3) or (b)(4) of Pub. L. 95–588, the actual income limitations will be published in the ''Notices'' section of the FEDERAL REGISTER.

(Authority: 38 U.S.C. 501)

[52 FR 34908, Sept. 14, 1987]

§3.27 Automatic adjustment of benefit rates.

(a) *Improved pension.* Whenever there is a cost-of-living increase in benefit amounts payable under section 215(i) of title II of the Social Security Act, VA shall, effective on the dates such increases become effective, increase by the same percentage each maximum annual rate of pension.

(Authority: 38 U.S.C. 5312(a))

(b) *Parents' dependency and indemnity compensation—maximum annual income limitation and maximum monthly rates.*

Whenever there is a cost-of-living increase in benefit amounts payable under section 215(i) of title II of the Social Security Act, VA shall, effective on the dates such increases become effective, increase by the same percentage the annual income limitations and the maximum monthly rates of dependency indemnity compensation for parents.

(Authority: 38 U.S.C. 5312(b)(1))

(c) *Monetary allowance under 38 U.S.C. chapter 18 for certain individuals who are children of Vietnam veterans or children of veterans with covered service in Korea.* Whenever there is a cost-of-living increase in benefit amounts payable under section 215(i) of Title II of the Social Security Act, VA shall, effective on the dates such increases become effective, increase by the same percentage the monthly allowance rates under 38 U.S.C. chapter 18.

(Authority: 38 U.S.C. 1805(b)(3), 1815(d), 1821, 5312)

(d) *Medal of Honor pension.* Beginning in the year 2004, VA shall, effective December 1 of each year, increase the monthly Medal of Honor pension by the same percentage as the percentage by which benefit amounts payable under section 215(i) of Title II of the Social Security Act are increased effective December 1 of such year.

(Authority: 38 U.S.C. 1562(e))

(e) *Publishing requirements.* Increases in pension rates, parents' dependency and indemnity compensation rates and income limitation, the monthly allowance rates under 38 U.S.C. chapter 18 and the Medal of Honor pension made under this section shall be published in the FEDERAL REGISTER.

(Authority: 38 U.S.C. 1805(b)(3), 1815(d), 5312(c)(1))

[44 FR 45934, Aug. 6, 1979, as amended at 52 FR 34908, Sept. 14, 1987; 62 FR 51278, Sept. 30, 1997; 67 FR 49586, July 31, 2002; 68 FR 55467, Sept. 26, 2003; 76 FR 4247, Jan. 25, 2011]

§ 3.28 Automatic adjustment of section 306 and old-law pension income limitations.

Whenever the maximum annual rates of improved pension are increased by reason of the provisions of 38 U.S.C. 5312, the following will be increased by the same percentage effective the same date:

(a) The maximum annual income limitations applicable to continued receipt of section 306 and old-law pension; and

(b) The dollar amount of a veteran's spouse's income that is excludable in determining the income of a veteran for section 306 pension purposes. (See § 3.262(b)(2))

These increases shall be published in the FEDERAL REGISTER at the same time that increases under § 3.27 are published.

(Authority: Sec. 306, Pub. L. 95–588).

[52 FR 34908, Sept. 14, 1987]

CROSS REFERENCES: Section 306 and old-law pension annual income limitations. See § 3.26.

§ 3.29 Rounding.

(a) *Annual rates.* Where the computation of an increase in improved pension rates under §§ 3.23 and 3.24 would otherwise result in a figure which includes a fraction of a dollar, the benefit rate will be adjusted to the next higher dollar amount. This method of computation will also apply to increases in old-law and section 306 pension annual income limitations under § 3.26, including the income of a spouse which is excluded from a veteran's countable income, and parents' dependency and indemnity compensation benefit rates and annual income limitations under § 3.25.

(Authority: 38 U.S.C. 5312(c)(2))

(b) *Monthly or other periodic pension rates.* After determining the monthly or other periodic rate of improved pension under §§ 3.273 and 3.30 or the rate payable under section 306(a) of Pub. L. 95–588 (92 Stat. 2508), the resulting rate, if not a multiple of one dollar, will be rounded down to the nearest whole dollar amount. The provisions of this paragraph apply with respect to amounts of pension payable for periods beginning on or after June 1, 1983, under the provisions of 38 U.S.C. 1521,

1541 or 1542, or under section 306(a) of Pub. L. 95–588.

(Authority: 38 U.S.C. 5123)

(c) *Monthly rates under 38 U.S.C. chapter 18.* When increasing the monthly monetary allowance rates under 38 U.S.C. chapter 18 for certain individuals who are children of Vietnam veterans or children of veterans with covered service in Korea, VA will round any resulting rate that is not an even dollar amount to the next higher dollar.

(Authority: 38 U.S.C. 1805(b)(3), 1815(d), 1821, 5312)

[48 FR 34471, July 29, 1983, as amended at 65 FR 35282, June 2, 2000; 67 FR 49586, July 31, 2002; 75 FR 4247, Jan. 25, 2011]

§3.30 Frequency of payment of improved pension and parents' dependency and indemnity compensation (DIC).

Payment shall be made as shown in paragraphs (a), (b), (c), (d), (e), and (f) of this section; however, beneficiaries receiving payment less frequently than monthly may elect to receive payment monthly in cases in which other Federal benefits would otherwise be denied.

(Authority: 38 U.S.C. 501)

(a) *Improved pension—Monthly.* Payment shall be made monthly if the annual rate payable is $228 or more.

(b) *Improved pension—Quarterly.* Payment shall be made every 3 months on or about March 1, June 1, September 1, and December 1, if the annual rate payable is at least $144 but less than $228.

(c) *Improved pension—Semiannually.* Payment shall be made every 6 months on or about June 1, and December 1, if the annual rate payable is at least $72 but less than $144.

(d) *Improved pension—Annually.* Payment shall be made annually on or about June 1, if the annual rate payable is less than $72.

(Authority: 38 U.S.C. 1508)

(e) *Parents' DIC—Semiannually.* Benefits shall be paid every 6 months on or about June 1, and December 1, if the amount of the annual benefit is less than 4 percent of the maximum annual rate payable under 38 U.S.C. 1315.

(f) *Payment of less than one dollar.* Payments of less than $1 shall not be made.

CROSS REFERENCE: Pension. See §3.3(a)(3), (b)(4).

[44 FR 45935, Aug. 6, 1979, as amended at 51 FR 1790, Jan. 15, 1986; 53 FR 7903, Mar. 11, 1988; 57 FR 10425, Mar. 26, 1992; 71 FR 52290, Sept. 5, 2006]

§3.31 Commencement of the period of payment.

Regardless of VA regulations concerning effective dates of awards, and except as provided in paragraph (c) of this section, payment of monetary benefits based on original, supplemental, or increased awards of compensation, pension, dependency and indemnity compensation, or a monetary allowance under 38 U.S.C. chapter 18 for an individual who is a child of a Vietnam veteran or a child of a veteran with covered service in Korea may not be made for any period prior to the first day of the calendar month following the month in which the award became effective. However, beneficiaries will be deemed to be in receipt of monetary benefits during the period between the effective date of the award and the date payment commences for the purpose of all laws administered by the Department of Veterans Affairs except that nothing in this section will be construed as preventing the receipt of retired or retirement pay prior to the effective date of waiver of such pay in accordance with 38 U.S.C. 5305.

(a) *Increased award defined.* For the purposes of this section the term *increased award* means an award which is increased because of an added dependent, increase in disability or disability rating, or reduction in income. The term also includes elections of improved pension under section 306 of Pub. L. 95–588 and awards pursuant to paragraphs 29 and 30 of the Schedule for Rating Disabilities except as provided in paragraph (c) of this section.

(b) *General rule of applicability.* The provisions of this section apply to all original, supplemental, or increased awards unless such awards provide only

for continuity of entitlement with no increase in rate of payment.

(c) *Specific exclusions.* The provisions of this section do not apply to the following types of awards.

(1) Surviving spouse's rate for the month of a veteran's death (for exception see § 3.20(b))

(2) In cases where military retired or retirement pay is greater than the amount of compensation payable, compensation will be paid as of the effective date of waiver of such pay. However, in cases where the amount of compensation payable is greater than military retired or retirement pay, payment of the available difference for any period prior to the effective date of total waiver of such pay is subject to the general provisions of this section.

(3) Adjustments of awards—such as in the case of original or increased apportionments or the termination of any withholding, reduction, or suspension by reason of:

(i) Recoupment,

(ii) An offset to collect indebtedness,

(iii) Institutionalization (hospitalization),

(iv) Incompetency,

(v) Incarceration,

(vi) An estate that exceeds the limitation for certain hospitalized incompetent veterans, or

(vii) Discontinuance of apportionments.

(4) Increases resulting solely from the enactment of legislation—such as

(i) Cost-of-living increases in compensation or dependency and indemnity compensation,

(ii) Increases in Improved Pension, parents' dependency and indemnity compensation, or a monetary allowance under 38 U.S.C. chapter 18 pursuant to § 3.27, or

(iii) Changes in the criteria for statutory award designations.

(5) Temporary total ratings pursuant to paragraph 29 of the Schedule for Rating Disabilities when the entire period of hospitalization or treatment, including any period of post-hospitalization convalescence, commences and terminates within the same calendar month. In such cases the period of payment shall commence on the first day of the month in which the hospitalization or treatment began.

(Authority: 38 U.S.C. 1805, 1815, 1821, 1832, 5111)

[48 FR 34472, July 29, 1983; 48 FR 37031, Aug. 16, 1983, as amended at 49 FR 47003, Nov. 30, 1984; 65 FR 35282, June 2, 2000; 67 FR 49586, July 31, 2002; 76 FR 4247, Jan. 25, 2011; 84 FR 166, Jan. 18, 2019]

§ 3.32 Exchange rates for foreign currencies.

When determining the rates of pension or parents' DIC or the amounts of burial, plot or headstone allowances or accrued benefits to which a claimant or beneficiary may be entitled, income received or expenses paid in a foreign currency shall be converted into U.S. dollar equivalents employing quarterly exchange rates established by the Department of the Treasury.

(a) *Pension and parents' DIC.* (1) Because exchange rates for foreign currencies cannot be determined in advance, rates of pension and parents' DIC shall be projected using the most recent quarterly exchange rate and shall be adjusted retroactively based upon actual exchange rates when an annual eligibility verification report is filed.

(2) Retroactive adjustments due to fluctuations in exchange rates shall be calculated using the average of the four most recent quarterly exchange rates. If the claimant reports income and expenses for a prior reporting period, the retroactive adjustment shall be calculated using the average of the four quarterly rates which were the most recent available on the closing date of the twelve-month period for which income and expenses are reported.

(b) *Burial, plot or headstone allowances and accrued benefits.* Payment amounts for burial, plot or headstone allowances and claims for accrued benefits as reimbursement from the person who bore the expenses of a deceased beneficiary's last illness or burial shall be determined using the quarterly exchange rate for the quarter in which the expenses forming the basis of the claim were paid. If the claim is filed by an unpaid creditor, however, the quarterly

rate for the quarter in which the veteran died shall apply. When entitlement originates during a quarter for which the Department of the Treasury has not yet published a quarterly rate, amounts due shall be calculated using the most recent quarterly exchange rate.

CROSS REFERENCES: Accrued benefits. See § 3.1000. Accrued benefits payable to foreign beneficiaries. See § 3.1008.

(Authority: 38 U.S.C. 501)

[55 FR 8140, Mar. 7, 1990; 55 FR 10867, Mar. 23, 1990]

GENERAL

§ 3.40 Philippine and Insular Forces.

(a) *Regular Philippine Scouts.* Service in the Philippine Scouts (except that described in paragraph (b) of this section), the Insular Force of the Navy, Samoan Native Guard, and Samoan Native Band of the Navy is included for pension, compensation, dependency and indemnity compensation, and burial allowance. Benefits are payable in dollars at the full-dollar rate.

(b) *Other Philippine Scouts.* Service of persons enlisted under section 14, Pub. L. 190, 79th Congress (Act of October 6, 1945), is included for compensation and dependency and indemnity compensation. Except as provided in §§ 3.42 and 3.43, benefits based on service described in this paragraph are payable at a rate of $0.50 for each dollar authorized under the law. All enlistments and reenlistments of Philippine Scouts in the Regular Army between October 6, 1945, and June 30, 1947, inclusive, were made under the provisions of Pub. L. 190 as it constituted the sole authority for such enlistments during that period. This paragraph does not apply to officers who were commissioned in connection with the administration of Pub. L. 190.

(Authority: 38 U.S.C. 107)

(c) *Commonwealth Army of the Philippines.* (1) Service is included, for compensation, dependency and indemnity compensation, and burial allowance, from and after the dates and hours, respectively, when they were called into service of the Armed Forces of the United States by orders issued from time to time by the General Officer, U.S. Army, pursuant to the Military Order of the President of the United States dated July 26, 1941. Service as a guerrilla under the circumstances outlined in paragraph (d) of this section is also included. Except as provided in §§ 3.42 and 3.43, benefits based on service described in this paragraph are payable at a rate of $0.50 for each dollar authorized under the law.

(Authority: 38 U.S.C. 107)

(2) Unless the record shows examination at time of entrance into the Armed Forces of the United States, such persons are not entitled to the presumption of soundness. This also applies upon reentering the Armed Forces after a period of inactive service.

(d) *Guerrilla service.* (1) Persons who served as guerrillas under a commissioned officer of the United States Army, Navy or Marine Corps, or under a commissioned officer of the Commonwealth Army recognized by and cooperating with the United States Forces are included. (See paragraph (c) of this section.) Service as a guerrilla by a member of the Philippine Scouts or the Armed Forces of the United States is considered as service in his or her regular status. (See paragraph (a) of this section.)

(2) The following certifications by the service departments will be accepted as establishing guerrilla service:

(i) Recognized guerrilla service;

(ii) Unrecognized guerrilla service under a recognized commissioned officer only if the person was a former member of the United States Armed Forces (including the Philippine Scouts), or the Commonwealth Army. This excludes civilians.

A certification of *Anti-Japanese Activity* will not be accepted as establishing guerrilla service.

(e) *Combined service.* Where a veteran who had Commonwealth Army or guerrilla service and also had other service, wartime or peacetime, in the Armed Forces of the United States, has disabilities which are compensable separately on a dollar and a $0.50 for each dollar authorized basis, and the disabilities are combined under the authority

contained in 38 U.S.C. 1157, the evaluation for which dollars are payable will be first considered and the difference between this evaluation and the combined evaluation will be the basis for computing the amount payable at the rate of $0.50 for each dollar authorized.

CROSS REFERENCE: Computation of service. See § 3.15.

[26 FR 1565, Feb. 24, 1961, as amended at 31 FR 14454, Nov. 10, 1966; 60 FR 18355, Apr. 11, 1995. Redesignated and amended at 66 FR 66767, Dec. 27, 2001; 71 FR 8220, Feb. 16, 2006]

§ 3.41 Philippine service.

(a) For a Regular Philippine Scout or a member of one of the regular components of the Philippine Commonwealth Army while serving with Armed Forces of United States, the period of active service will be from the date certified by the Armed Forces as the date of enlistment or date of report for active duty whichever is later to date of release from active duty, discharge, death, or in the case of a member of the Philippine Commonwealth Army June 30, 1946, whichever was earlier. Release from active duty includes:

(1) Leaving one's organization in anticipation of or due to the capitulation.

(2) Escape from prisoner-of-war status.

(3) Parole by the Japanese.

(4) Beginning of missing-in-action status, except where factually shown at that time he was with his or her unit or death is presumed to have occurred while carried in such status: *Provided, however,* That where there is credible evidence that he was alive after commencement of his or her missing-in-action status, the presumption of death will not apply for Department of Veterans Affairs purposes.

(5) Capitulation on May 6, 1942, except that periods of recognized guerrilla service or unrecognized guerrilla service under a recognized commissioned officer or periods of service in units which continued organized resistance against Japanese prior to formal capitulation will be considered return to active duty for period of such service.

(b) Active service of a Regular Philippine Scout or a member of the Philippine Commonwealth Army serving with the Armed Forces of the United States will include a *prisoner-of-war* status immediately following a period of active duty, or a period of recognized guerrilla service or unrecognized guerrilla service under a recognized commissioned officer. In those cases where following release from active duty as set forth in paragraph (a) of this section, the veteran is factually found by the Department of Veterans Affairs to have been injured or killed by the Japanese because of anti-Japanese activities or his or her former service in the Armed Forces of the United States, such injury or death may be held to have been incurred in active service for Department of Veterans Affairs purposes. Determination shall be based on all available evidence, including service department reports, and consideration shall be given to the character and length of the veteran's former active service in the Armed Forces of the United States.

(c) A prisoner-of-war status based upon arrest during general zonification will not be sufficient of itself to bring a case within the definition of return to military control.

(d) The active service of members of the irregular forces *guerrilla* will be the period certified by the service department.

[26 FR 1566, Feb. 24, 1961, as amended at 26 FR 4612, May 26, 1961Redesignated at 66 FR 66767, Dec. 27, 2001]

§ 3.42 Compensation at the full-dollar rate for certain Filipino veterans residing in the United States.

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

(1) *United States* (U.S.) means the states, territories and possessions of the United States; the District of Columbia, and the Commonwealth of Puerto Rico.

(2) *Residing in the U.S.* means that an individual's principal, actual dwelling place is in the U.S. and that the individual meets the residency requirements of paragraph (c)(4) of this section.

(3) *Citizen of the U.S.* means any individual who acquires U.S. citizenship through birth in the territorial U.S., birth abroad as provided under title 8, United States Code, or through naturalization, and has not renounced his

or her U.S. citizenship, or had such citizenship cancelled, revoked, or otherwise terminated.

(4) *Lawfully admitted for permanent residence* means that an individual has been lawfully accorded the privilege of residing permanently in the U.S. as an immigrant by the U.S. Citizenship and Immigration Services under title 8, United States Code, and still has this status.

(b) *Eligibility requirements*. Compensation and dependency and indemnity compensation is payable at the full-dollar rate, based on service described in §3.40(b), (c), or (d), to a veteran or a veteran's survivor who is residing in the U.S. and is either:

(1) A citizen of the U.S., or

(2) An alien lawfully admitted for permanent residence in the U.S.

(c) *Evidence of eligibility*. (1) A valid original or copy of one of the following documents is required to prove that the veteran or the veteran's survivor is a natural born citizen of the U.S.:

(i) A valid U.S. passport;

(ii) A birth certificate showing that he or she was born in the U.S.; or

(iii) A Report of Birth Abroad of a Citizen of the U.S. issued by a U.S. consulate abroad.

(2) Only verification by the U.S. Citizenship and Immigration Services to VA that a veteran or a veteran's survivor is a naturalized citizen of the U.S., or a valid U.S. passport, will be sufficient proof of such status.

(3) Only verification by the U.S. Citizenship and Immigration Services to VA that a veteran or a veteran's survivor is an alien lawfully admitted for permanent residence in the U.S. will be sufficient proof of such status.

(4) VA will not pay benefits at the full-dollar rate under this section unless the evidence establishes that the veteran or survivor is lawfully residing in the U.S.

(i) Such evidence should identify the veteran's or survivor's name and relevant dates, and may include:

(A) A valid driver's license issued by the state of residence;

(B) Employment records, which may consist of pay stubs, W-2 forms, and certification of the filing of Federal, State, or local income tax returns;

(C) Residential leases, rent receipts, utility bills and receipts, or other relevant documents showing dates of utility service at a leased residence;

(D) Hospital or medical records showing medical treatment or hospitalization, and showing the name of the medical facility or treating physician;

(E) Property tax bills and receipts; and

(F) School records.

(ii) A Post Office box mailing address in the veteran's name or the name of the veteran's survivor does not constitute evidence showing that the veteran or veteran's survivor is lawfully residing in the United States.

(d) *Continued eligibility*. (1) In order to continue receiving benefits at the full-dollar rate under this section, a veteran or a veteran's survivor must be physically present in the U.S. for at least 183 days of each calendar year in which he or she receives payments at the full-dollar rate, and may not be absent from the U.S. for more than 60 consecutive days at a time unless good cause is shown. However, if a veteran or a veteran's survivor becomes eligible for full-dollar rate benefits for the first time on or after July 1 of any calendar year, the 183-day rule will not apply during that calendar year. VA will not consider a veteran or a veteran's survivor to have been absent from the U.S. if he or she left and returned to the U.S. on the same date.

(2) A veteran or a veteran's survivor receiving benefits at the full-dollar rate under this section must notify VA within 30 days of leaving the U.S., or within 30 days of losing either his or her U.S. citizenship or lawful permanent resident alien status. When a veteran or a veteran's survivor no longer meets the eligibility requirements of paragraph (b) of this section, VA will reduce his or her payment to the rate of $0.50 for each dollar authorized under the law, effective on the date determined under §3.505. If such veteran or survivor regains his or her U.S. citizenship or lawful permanent resident alien status, VA will restore full-dollar rate benefits, effective the date the veteran or survivor meets the eligibility requirements in paragraph (b) of this section.

(3) When requested to do so by VA, a veteran or survivor receiving benefits at the full-dollar rate under this section must verify that he or she continues to meet the residency and citizenship or permanent resident alien status requirements of paragraph (b) of this section. VA will advise the veteran or survivor at the time of the request that the verification must be furnished within 60 days and that failure to do so will result in the reduction of benefits. If the veteran or survivor fails to furnish the evidence within 60 days, VA will reduce his or her payment to the rate of $0.50 for each dollar authorized, as provided in § 3.652.

(4) A veteran or survivor receiving benefits at the full-dollar rate under this section must promptly notify VA of any change in his or her address. If mail from VA to the veteran or survivor is returned to VA by the U.S. Postal Service, VA will make reasonable efforts to determine the correct mailing address. If VA is unable to determine the correct mailing address through reasonable efforts, VA will reduce benefit payments to the rate of $0.50 for each dollar authorized under law, effective on the date determined under § 3.505.

(e) *Effective date for restored eligibility.* In the case of a veteran or survivor receiving benefits at the full-dollar rate, if VA reduces his or her payment to the rate of $0.50 for each dollar authorized under the law, VA will resume payments at the full-dollar rate, if otherwise in order, effective the first day of the month following the date on which he or she again meets the requirements. However, such increased payments will be retroactive no more than one year prior to the date on which VA receives evidence that he or she again meets the requirements.

(The Office of Management and Budget has approved the information collection requirements in this section under control number 2900–0655)

[66 FR 66767, Dec. 27, 2001, as amended at 71 FR 8220, Feb. 16, 2006; 72 FR 9, Jan. 3, 2007]

§ 3.43 Burial benefits at the full-dollar rate for certain Filipino veterans residing in the United States on the date of death.

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

(1) *United States* (U.S.) means the states, territories and possessions of the United States, the District of Columbia, and the Commonwealth of Puerto Rico.

(2) *Residing in the U.S.* means an individual's principal, actual dwelling place was in the U.S. When death occurs outside the U.S., VA will consider the deceased individual to have been residing in the U.S. on the date of death if the individual maintained his or her principal actual dwelling place in the U.S. until his or her most recent departure from the U.S., and he or she had been physically absent from the U.S. less than 61 consecutive days when he or she died.

(3) *Citizen of the U.S.* means any individual who acquires U.S. citizenship through birth in the territorial U.S., birth abroad as provided under title 8, United States Code, or through naturalization, and has not renounced his or her U.S. citizenship, or had such citizenship cancelled, revoked, or otherwise terminated.

(4) *Lawfully admitted for permanent residence* means that the individual was lawfully accorded the privilege of residing permanently in the U.S. as an immigrant by the U.S. Citizenship and Immigration Services under title 8, United States Code, and on the date of death, still had this status.

(b) *Eligibility requirements.* VA will pay burial benefits under chapter 23 of title 38, United States Code, at the full-dollar rate, based on service described in § 3.40(c) or (d), when an individual who performed such service dies after November 1, 2000, or based on service described in § 3.40(b) when an individual who performed such service dies after December 15, 2003, and was on the date of death:

(1) Residing in the U.S.; and

(2) Either—

(i) A citizen of the U.S., or

(ii) An alien lawfully admitted for permanent residence in the U.S.; and

(3) Either—

(i) Receiving compensation under chapter 11 of title 38, United States Code; or

(ii) Would have satisfied the disability, income and net worth requirements of §3.3(a)(3) of this part and would have been eligible for pension if the veteran's service had been deemed to be active military, naval, or air service.

(c) *Evidence of eligibility*. (1) In a claim for full-dollar rate burial payments based on the deceased veteran having been a natural born citizen of the U.S., a valid original or copy of one of the following documents is required:

(i) A valid U.S. passport;

(ii) A birth certificate showing that he or she was born in the U.S.; or

(iii) A Report of Birth Abroad of a Citizen of the U.S. issued by a U.S. consulate abroad.

(2) In a claim based on the deceased veteran having been a naturalized citizen of the U.S., only verification of that status by the U.S. Citizenship and Immigration Services to VA, or a valid U.S. passport, will be sufficient proof for purposes of eligibility for full-dollar rate benefits.

(3) In a claim based on the deceased veteran having been an alien lawfully admitted for permanent residence in the U.S., only verification of that status by the U.S. Citizenship and Immigration Services to VA will be sufficient proof for purposes of eligibility for full-dollar rate benefits.

(4) VA will not pay benefits at the full-dollar rate under this section unless the evidence establishes that the veteran was lawfully residing in the U.S. on the date of death.

(i) Such evidence should identify the veteran's name and relevant dates, and may include:

(A) A valid driver's license issued by the state of residence;

(B) Employment records, which may consist of pay stubs, W-2 forms, and certification of the filing of Federal, State, or local income tax returns;

(C) Residential leases, rent receipts, utility bills and receipts, or other relevant documents showing dates of utility service at a leased residence;

(D) Hospital or medical records showing medical treatment or hospitalization of the veteran or survivor, and showing the name of the medical facility or treating physician;

(E) Property tax bills and receipts; and

(F) School records.

(ii) A Post Office box mailing address in the veteran's name does not constitute evidence showing that the veteran was lawfully residing in the United States on the date of death.

(Authority: 38 U.S.C. 107, 501(a))

(The Office of Management and Budget has approved the information collection requirements in this section under control number 2900–0655)

[66 FR 66767, Dec. 27, 2001, as amended at 71 FR 8221, Feb. 16, 2006; 72 FR 9, Jan. 3, 2007]

RELATIONSHIP

§3.50 Spouse and surviving spouse.

(a) *Spouse*. ''Spouse'' means a person of the opposite sex whose marriage to the veteran meets the requirements of §3.1(j).

(b) *Surviving spouse*. Except as provided in §3.52, ''surviving spouse'' means a person of the opposite sex whose marriage to the veteran meets the requirements of §3.1(j) and who was the spouse of the veteran at the time of the veteran's death and:

(1) Who lived with the veteran continuously from the date of marriage to the date of the veteran's death except where there was a separation which was due to the misconduct of, or procured by, the veteran without the fault of the spouse; and

(2) Except as provided in §3.55, has not remarried or has not since the death of the veteran and after September 19, 1962, lived with another person of the opposite sex and held himself or herself out openly to the public to be the spouse of such other person.

[62 FR 5529, Feb. 6, 1997]

§3.52 Marriages deemed valid.

Where an attempted marriage of a claimant to the veteran was invalid by reason of a legal impediment, the marriage will nevertheless be deemed valid if:

(a) The marriage occurred 1 year or more before the veteran died or existed for any period of time if a child was born of the purported marriage or was

born to them before such marriage (see § 3.54(d)), and

(b) The claimant entered into the marriage without knowledge of the impediment, and

(c) The claimant cohabited with the veteran continuously from the date of marriage to the date of his or her death as outlined in § 3.53, and

(d) No claim has been filed by a legal surviving spouse who has been found entitled to gratuitous death benefits other than accrued monthly benefits covering a period prior to the veteran's death.

(Authority: 38 U.S.C. 103(a))

CROSS REFERENCE: Definition, marriage. See § 3.205(c).

[26 FR 1567, Feb. 24, 1961, as amended at 27 FR 1215, Feb. 9, 1962; 32 FR 13224, Sept. 19, 1967; 41 FR 18299, May 3, 1976]

§ 3.53 Continuous cohabitation.

(a) *General*. The requirement that there must be continuous cohabitation from the date of marriage to the date of death of the veteran will be considered as having been met when the evidence shows that any separation was due to the misconduct of, or procured by, the veteran without the fault of the surviving spouse. Temporary separations which ordinarily occur, including those caused for the time being through fault of either party, will not break the continuity of the cohabitation.

(b) *Findings of fact*. The statement of the surviving spouse as to the reason for the separation will be accepted in the absence of contradictory information. If the evidence establishes that the separation was by mutual consent and that the parties lived apart for purposes of convenience, health, business, or any other reason which did not show an intent on the part of the surviving spouse to desert the veteran, the continuity of the cohabitation will not be considered as having been broken. State laws will not control in determining questions of desertion; however, due weight will be given to findings of fact in court decisions made during the life of the veteran on issues subsequently involved in the application of this section.

[41 FR 18300, May 3, 1976, as amended at 59 FR 32659, June 24, 1994]

§ 3.54 Marriage dates.

A surviving spouse may qualify for pension, compensation, or dependency and indemnity compensation if the marriage to the veteran occurred before or during his or her service or, if married to him or her after his or her separation from service, before the applicable date stated in his section.

(a) *Pension*. Death pension may be paid to a surviving spouse who was married to the veteran:

(1) One year or more prior to the veteran's death, or

(2) For any period of time if a child was born of the marriage, or was born to them before the marriage, or

(3) Prior to the applicable delimiting dates, as follows:

(i) Civil War—June 27, 1905.

(ii) Indian wars—March 4, 1917.

(iii) Spanish-American War—January 1, 1938.

(iv) Mexican border period and World War I—December 14, 1944.

(v) World War II—January 1, 1957.

(vi) Korean conflict—February 1, 1965.

(vii) Vietnam era—May 8, 1985.

(viii) Persian Gulf War—January 1, 2001.

(Authority: 38 U.S.C. 532(d), 534(c), 536(c), 541(e), 541(f))

(b) *Compensation*. Death compensation may be paid to a surviving spouse who, with respect to date of marriage, could have qualified as a surviving spouse for death compensation under any law administered by the Department of Veterans Affairs in effect on December 31, 1957, or who was married to the veteran:

(1) Before the expiration of 15 years after termination of the period of service in which the injury or disease which caused the veteran's death was incurred or aggravated, or

(2) One year or more, or

(3) For any period of time if a child was born of the marriage, or was born to them before the marriage.

(Authority: 38 U.S.C. 1102)

(c) *Dependency and indemnity compensation.* Dependency and indemnity compensation payable under 38 U.S.C. 1310(a) may be paid to the surviving spouse of a veteran who died on or after January 1, 1957, who was married to the veteran:

(1) Before the expiration of 15 years after the termination of the period of service in which the injury or disease causing the death of the veteran was incurred or aggravated, or

(2) For 1 year or more, or

(3) For any period of time if a child was born of the marriage, or was born to them before the marriage.

(Authority: 38 U.S.C. 1304)

(d) *Child born.* The term *child born of the marriage* means a birth on or after the date of the marriage on which the surviving spouse's entitlement is predicated. The term *born to them before the marriage* means a birth prior to the date of such marriage. Either term includes a fetus advanced to the point of gestation required to constitute a birth under the law of the jurisdiction in which the fetus was delivered.

(e) *More than one marriage to veteran.* For periods commencing on or after January 1, 1958, where a surviving spouse has been married legally to a veteran more than once, the date of the original marriage will be used in determining whether the statutory requirement as to date of marriage has been met.

(Authority: 38 U.S.C. 103(b))

[26 FR 1567, Feb. 24, 1961, as amended at 27 FR 6498, July 10, 1962; 32 FR 13224, Sept. 19, 1967; 40 FR 16064, Apr. 9, 1975; 40 FR 48680, Oct. 17, 1975; 41 FR 18300, May 3, 1976; 44 FR 22718, Apr. 17, 1979; 54 FR 31829, Aug. 2, 1989; 56 FR 5756, Feb. 13, 1991; 56 FR 57986, Nov. 15, 1991; 65 FR 3392, Jan. 21, 2000]

§ 3.55 Reinstatement of benefits eligibility based upon terminated marital relationships.

(a) *Surviving spouse.* (1) Remarriage of a surviving spouse shall not bar the furnishing of benefits to such surviving spouse if the marriage:

(i) Was void, or

(ii) Has been annulled by a court having basic authority to render annulment decrees, unless it is determined by the Department of Veterans Affairs that the annulment was obtained through fraud by either party or by collusion.

(2) On or after January 1, 1971, remarriage of a surviving spouse terminated prior to November 1, 1990, or terminated by legal proceedings commenced prior to November 1, 1990, by an individual who, but for the remarriage, would be considered the surviving spouse, shall not bar the furnishing of benefits to such surviving spouse provided that the marriage:

(i) Has been terminated by death, or

(ii) Has been dissolved by a court with basic authority to render divorce decrees unless the Department of Veterans Affairs determines that the divorce was secured through fraud by the surviving spouse or by collusion.

(3) On or after October 1, 1998, remarriage of a surviving spouse terminated by death, divorce, or annulment, will not bar the furnishing of dependency and indemnity compensation, unless the Secretary determines that the divorce or annulment was secured through fraud or collusion.

(Authority: 38 U.S.C. 1311(e))

(4) On or after December 1, 1999, remarriage of a surviving spouse terminated by death, divorce, or annulment, will not bar the furnishing of benefits relating to medical care for survivors and dependents under 38 U.S.C. 1781, educational assistance under 38 U.S.C. chapter 35, or housing loans under 38 U.S.C. chapter 37, unless the Secretary determines that the divorce or annulment was secured through fraud or collusion.

(Authority: 38 U.S.C. 103(d))

(5) On or after January 1, 1971, the fact that a surviving spouse has lived with another person and has held himself or herself out openly to the public as the spouse of such other person shall not bar the furnishing of benefits to him or her after he or she terminates the relationship, if the relationship terminated prior to November 1, 1990.

(6) On or after October 1, 1998, the fact that a surviving spouse has lived with another person and has held himself or herself out openly to the public as the spouse of such other person will not bar the furnishing of dependency

and indemnity compensation to the surviving spouse if he or she ceases living with such other person and holding himself or herself out openly to the public as such other person's spouse.

(Authority: 38 U.S.C. 1311(e))

(7) On or after December 1, 1999, the fact that a surviving spouse has lived with another person and has held himself or herself out openly to the public as the spouse of such other person will not bar the furnishing of benefits relating to medical care for survivors and dependents under 38 U.S.C. 1781, educational assistance under 38 U.S.C. chapter 35, or housing loans under 38 U.S.C. chapter 37 to the surviving spouse if he or she ceases living with such other person and holding himself or herself out openly to the public as such other person's spouse.

(Authority: 38 U.S.C. 103(d))

(8) On or after January 1, 1971, the fact that benefits to a surviving spouse may previously have been barred because his or her conduct or a relationship into which he or she had entered had raised an inference or presumption that he or she had remarried or had been determined to be open and notorious adulterous cohabitation, or similar conduct, shall not bar the furnishing of benefits to such surviving spouse after he or she terminates the conduct or relationship, if the relationship terminated prior to November 1, 1990.

(9) *Benefits under 38 U.S.C. 1781 for a surviving spouse who remarries after age 55.* (i) On or after February 4, 2003, the remarriage of a surviving spouse after age 55 shall not bar the furnishing of benefits relating to medical care for survivors and dependents under 38 U.S.C. 1781, subject to the limitation in paragraph (a)(9)(ii) of this section.

(ii) A surviving spouse who remarried after the age of 55, but before December 6, 2002, may be eligible for benefits relating to medical care for survivors and dependents under 38 U.S.C. 1781 pursuant to paragraph (a)(9)(i) only if the application for such benefits was received by VA before December 16, 2004.

(Authority: 38 U.S.C. 103).

(10) *Benefits for a surviving spouse who remarries after age 57.* (i) On or after January 1, 2004, the remarriage of a surviving spouse after the age of 57 shall not bar the furnishing of benefits relating to dependency and indemnity compensation under 38 U.S.C. 1311, medical care for survivors and dependents under 38 U.S.C. 1781, educational assistance under 38 U.S.C. chapter 35, or housing loans under 38 U.S.C. chapter 37, subject to the limitation in paragraph (a)(10)(ii) of this section.

(ii) A surviving spouse who remarried after the age of 57, but before December 16, 2003, may be eligible for dependency and indemnity compensation under 38 U.S.C. 1311, medical care for survivors and dependents under 38 U.S.C. 1781, educational assistance under 38 U.S.C. chapter 35, or housing loans under 38 U.S.C. chapter 37 pursuant to paragraph (a)(10)(i) only if the application for such benefits was received by VA before December 16, 2004.

(Authority: 38 U.S.C. 103).

(b) *Child.* (1) Marriage of a child shall not bar the furnishing of benefits to or on account of such child, if the marriage:

(i) Was void, or

(ii) Has been annulled by a court having basic authority to render annulment decrees, unless it is determined by the Department of Veterans Affairs that the annulment was obtained through fraud by either party or by collusion.

(2) On or after January 1, 1975, marriage of a child terminated prior to November 1, 1990, shall not bar the furnishing of benefits to or for such child provided that the marriage:

(i) Has been terminated by death, or

(ii) Has been dissolved by a court with basic authority to render divorce decrees unless the Department of Veterans Affairs determines that the divorce was secured through fraud by either party or by collusion.

(Authority: 38 U.S.C. 103; 105 Stat. 424, 106 Stat. 4322)

CROSS REFERENCES: Evidence. See §§ 3.206 and 3.207. Termination of marital relationship or conduct. See § 3.215.

[58 FR 32444, June 10, 1993, as amended at 60 FR 52863, Oct. 11, 1995; 64 FR 30245, June 7, 1999; 65 FR 43700, July 14, 2000; 71 FR 29084, May 19, 2006]

§ 3.56 [Reserved]

§ 3.57 Child.

(a) *General.* (1) Except as provided in paragraphs (a)(2) through (4) of this section, the term *child* of the veteran means an unmarried person who is a legitimate child, a child legally adopted before the age of 18 years, a stepchild who acquired that status before the age of 18 years and who is a member of the veteran's household or was a member of the veteran's household at the time of the veteran's death, or an illegitimate child; and

(i) Who is under the age of 18 years; or

(ii) Who, before reaching the age of 18 years, became permanently incapable of self-support; or

(iii) Who, after reaching the age of 18 years and until completion of education or training (but not after reaching the age of 23 years) is pursuing a course of instruction at an educational institution approved by the Department of Veterans Affairs. For the purposes of this section and § 3.667, the term ''educational institution'' means a permanent organization that offers courses of instruction to a group of students who meet its enrollment criteria, including schools, colleges, academies, seminaries, technical institutes, and universities. The term also includes home schools that operate in compliance with the compulsory attendance laws of the States in which they are located, whether treated as private schools or home schools under State law. The term ''home schools'' is limited to courses of instruction for grades kindergarten through 12.

(Authority: 38 U.S.C. 101(4)(A), 104(a))

(2) For the purposes of determining entitlement of benefits based on a child's school attendance, the term *child* of the veteran also includes the following unmarried persons:

(i) A person who was adopted by the veteran between the ages of 18 and 23 years.

(ii) A person who became a stepchild of the veteran between the ages of 18 and 23 years and who is a member of the veteran's household or was a member of the veteran's household at the time of the veteran's death.

(3) Subject to the provisions of paragraphs (c) and (e) of this section, the term *child* also includes a person who became permanently incapable of self-support before reaching the age of 18 years, who was a member of the veteran's household at the time he or she became 18 years of age, and who was adopted by the veteran, regardless of the age of such person at the time of adoption.

(Authority: 38 U.S.C. 101(4)(A))

(4) For purposes of any benefits provided under 38 U.S.C. 1115, Additional compensation for dependents, the term child does not include a child of a veteran who is adopted out of the family of the veteran. This limitation does not apply to any benefit administered by the Secretary that is payable directly to a child in the child's own right, such as dependency and indemnity compensation under 38 CFR 3.5.

(Authority: 38 U.S.C. 101(4), 501, 1115).

(b) *Stepchild.* The term means a legitimate or an illegitimate child of the veteran's spouse. A child of a surviving spouse whose marriage to the veteran is deemed valid under the provisions of § 3.52, and who otherwise meets the requirements of this section is included.

(c) *Adopted child.* Except as provided in paragraph (e) of this section, the term means a child adopted pursuant to a final decree of adoption, a child adopted pursuant to an unrescinded interlocutory decree of adoption while remaining in the custody of the adopting parent (or parents) during the interlocutory period, and a child who has been placed for adoption under an agreement entered into by the adopting parent (or parents) with any agency authorized under law to so act, unless and until such agreement is terminated, while the child remains in the custody of the adopting parent (or parents) during the period of placement

for adoption under such agreement. The term includes, as of the date of death of a veteran, such a child who:

(1) Was living in the veteran's household at the time of the veteran's death, and

(2) Was adopted by the veteran's spouse under a decree issued within 2 years after August 25, 1959, or the veteran's death whichever is later, and

(3) Was not receiving from an individual other than the veteran or the veteran's spouse, or from a welfare organization which furnishes services or assistance for children, recurring contributions of sufficient size to constitute the major portion of the child's support.

(Authority: 38 U.S.C. 101(4))

(d) Definition of *child custody*. The provisions of this paragraph are for the purpose of determining entitlement to improved pension under §§ 3.23 and 3.24.

(1) Custody of a child shall be considered to rest with a veteran, surviving spouse of a veteran or person legally responsible for the child's support if that person has the legal right to exercise parental control and responsibility for the welfare and care of the child. A child of the veteran residing with the veteran, surviving spouse of the veteran who is the child's natural or adoptive parent, or person legally responsible for the child's support shall be presumed to be in the custody of that individual. Where the veteran, surviving spouse, or person legally responsible for the child's support has not been divested of legal custody, but the child is not residing with that individual, the child shall be considered in the custody of the individual for purposes of Department of Veterans Affairs benefits.

(2) The term *person legally responsible for the child's support* means a person who is under a legally imposed obligation (e.g., by statute or court order) to provide for the child's support, as well as a natural or adoptive parent who has not been divested of legal custody. If the child's natural or adoptive parent has remarried, the stepparent may also be considered a person legally responsible for the child's support. A child shall be considered in the joint custody of his or her stepparent and natural or adoptive parent so long as the natural or adoptive parent and the stepparent are not estranged and residing apart, and the natural or adoptive parent has not been divested of legal custody. When a child is in such joint custody the combined income of the natural or adoptive parent and the stepparent shall be included as income of the person legally responsible for support under § 3.24(c).

(3) A person having custody of a child prior to the time the child attains age 18 shall be considered to retain custody of the child for periods on and after the child's 18th birthday, unless the person is divested of legal custody. This applies without regard to when a child reaches the age of majority under applicable State law. This also applies without regard to whether the child was entitled to pension prior to age 18, or whether increased pension was payable to a veteran or surviving spouse on behalf of the child prior to the child's 18th birthday. If the child's custodian dies after the child has attained age 18, the child shall be considered to be in custody of a successor custodian provided the successor custodian has the right to exercise parental control and responsibility for the welfare and care of the child.

(Authority: 38 U.S.C. 501, 1521(c), 1541(c))

(e) *Child adopted under foreign law*—(1) *General*. The provisions of this paragraph are applicable to a person adopted under the laws of any jurisdiction other than a State. The term *State* is defined in 38 U.S.C. 101(20) and also includes the Commonwealth of the Northern Mariana Islands. The term *veteran* includes, for the purposes of this paragraph, a Commonwealth Army veteran or new Philippine Scout as defined in 38 U.S.C. 3566.

(2) *Adopted child of living veteran*. A person residing outside any of the States shall not be considered to be a legally adopted child of a veteran during the lifetime of the veteran unless all of the following conditions are met.

(i) The person was less than 18 years of age at the time of adoption.

(ii) The person is receiving one-half or more of the person's support from the veteran.

(iii) The person is not in the custody of the person's natural parent unless the natural parent is the veteran's spouse.

(iv) The person is residing with the veteran (or in the case of divorce following adoption, with the divorced spouse who is also a natural or adoptive parent) except for periods during which the person is residing apart from the veteran for purposes of full-time attendance at an educational institution or during which the person or the veteran is confined in a hospital, nursing home, other health-care facility, or other institution.

(3) *Adopted child of deceased veteran*. A person shall not be considered to have been a legally adopted child of a veteran as of the date of the veteran's death and thereafter unless one of the following conditions is met.

(i) The veteran was entitled to and was receiving for the person a dependent's allowance or similar monetary benefit payable under title 38, United States Code at any time within the 1-year period immediately preceding the veteran's death; or

(ii) The person met the requirements of paragraph (e)(2) of this section for a period of at least 1 year prior to the veteran's death.

(4) *Verification*. In the case of an adopted child of a living veteran, the requirements of paragraphs (e)(2)(ii), (iii) and (iv) of this section are for prospective application. That is, in addition to meeting all of the requirements of paragraph (e)(2) of this section at the time of initial adjudication, benefits are not payable thereafter for or to a child adopted under the laws of any jurisdiction other than a State unless the requirements of paragraphs (e)(2)(ii), (iii) and (iv) of this section continue to be met. Consequently, whenever Department of Veterans Affairs benefits are payable to or for a child adopted under the laws of any jurisdiction other than a State, and the veteran who adopted the child is living, the beneficiary shall submit, upon Department of Veterans Affairs request, a report, or other evidence, to determine if the requirements of paragraph (e)(2)(ii), (iii), and (iv) of this section were met for any period for which payment was made for or to the child and whether such requirements will continue to be met for future entitlement periods. Failure to submit the requested report or evidence within a reasonable time from date of request may result in termination of benefits payable for or to the child.

(Authority: 38 U.S.C. 101(4), 501)

CROSS REFERENCES: Improved pension rates. See §3.23. Improved pension rates; surviving children. See §3.24. Child adopted out of family. See §3.58. Child's relationship. See §3.210. Helplessness. See §3.403(a)(1). Helplessness. See §3.503(a)(3). Veteran's benefits not apportionable. See §3.458. School attendance. See §3.667. Helpless children—Spanish-American and prior wars. See §3.950.

[44 FR 45935, Aug. 6, 1979 and 45 FR 1878, Jan. 9, 1980, as amended at 45 FR 25391, Apr. 15, 1980; 49 FR 47003, Nov. 30, 1984; 65 FR 12116, Mar. 8, 2000; 72 FR 6959, Feb. 14, 2007; 80 FR 48451, Aug. 13, 2015]

§3.58 Child adopted out of family.

(a) Except as provided in paragraph (b) of this section, a child of a veteran adopted out of the family of the veteran either prior or subsequent to the veteran's death is nevertheless a *child* within the meaning of that term as defined by §3.57 and is eligible for benefits payable under all laws administered by the Department of Veterans Affairs.

(b) A child of a veteran adopted out of the family of the veteran is not a child within the meaning of §3.57 for purposes of any benefits provided under 38 U.S.C. 1115, Additional compensation for dependents.

(Authority: 38 U.S.C. 101(4)(A), 1115).

CROSS REFERENCES: Child. See §3.57. Veteran's benefits not apportionable. See §3.458.

[80 FR 48451, Aug. 13, 2015]

§3.59 Parent.

(a) The term *parent* means a natural mother or father (including the mother of an illegitimate child or the father of an illegitimate child if the usual family relationship existed), mother or father through adoption, or a person who for a period of not less than 1 year stood in the relationship of a parent to a veteran at any time before his or her entry into active service.

(b) Foster relationship must have begun prior to the veteran's 21st birthday. Not more than one father and one mother, as defined, will be recognized in any case. If two persons stood in the relationship of father or mother for 1 year or more, the person who last stood in such relationship before the veteran's last entry into active service will be recognized as the *parent*.

(Authority: 38 U.S.C. 101(5))

[26 FR 1568, Feb. 24, 1961, as amended at 44 FR 45935, Aug. 6, 1979]

§ 3.60 Definition of "living with".

For the purposes of determining entitlement to pension under 38 U.S.C. 1521, a person shall be considered as living with his or her spouse even though they reside apart unless they are estranged.

(Authority: 38 U.S.C. 1521(h)(2))

[44 FR 45935, Aug. 6, 1979]

ADMINISTRATIVE

§ 3.100 Delegations of authority.

(a) Authority is delegated to the Under Secretary for Benefits and to supervisory or adjudicative personnel within the jurisdiction of the Veterans Benefits Administration designated by the Under Secretary to make findings and decisions under the applicable laws, regulations, precedents, and instructions, as to entitlement of claimants to benefits under all laws administered by the Department of Veterans Affairs governing the payment of monetary benefits to veterans and their dependents, within the jurisdiction of the Compensation Service or the Pension and Fiduciary Service.

(b) Authority is delegated to the Director, Compensation Service, and the Director, Pension and Fiduciary Service, and to personnel of each service designated by its Director to determine whether a claimant or payee has forfeited the right to gratuitious benefits or to remit a prior forfeiture pursuant to the provisions of 38 U.S.C. 6103 or 6104. See § 3.905.

(Authority: 38 U.S.C. 512(a))

[29 FR 7547, June 12, 1964, as amended at 31 FR 14455, Nov. 10, 1966; 37 FR 10442, May 23, 1972; 53 FR 3207, Feb. 4, 1988; 60 FR 18355, Apr. 11, 1995; 61 FR 20727, May 8, 1996; 78 FR 2100, Jan. 13, 2014]

§ 3.102 Reasonable doubt.

It is the defined and consistently applied policy of the Department of Veterans Affairs to administer the law under a broad interpretation, consistent, however, with the facts shown in every case. When, after careful consideration of all procurable and assembled data, a reasonable doubt arises regarding service origin, the degree of disability, or any other point, such doubt will be resolved in favor of the claimant. By reasonable doubt is meant one which exists because of an approximate balance of positive and negative evidence which does not satisfactorily prove or disprove the claim. It is a substantial doubt and one within the range of probability as distinguished from pure speculation or remote possibility. It is not a means of reconciling actual conflict or a contradiction in the evidence. Mere suspicion or doubt as to the truth of any statements submitted, as distinguished from impeachment or contradiction by evidence or known facts, is not justifiable basis for denying the application of the reasonable doubt doctrine if the entire, complete record otherwise warrants invoking this doctrine. The reasonable doubt doctrine is also applicable even in the absence of official records, particularly if the basic incident allegedly arose under combat, or similarly strenuous conditions, and is consistent with the probable results of such known hardships.

(Authority: 38 U.S.C. 501)

[50 FR 34458, Aug. 26, 1985, as amended at 66 FR 45630, Aug. 29, 2001]

§ 3.103 Procedural due process and other rights.

(a) *Statement of policy*. Every claimant has the right to written notice of the decision made on his or her claim, the right to a hearing, and the right of representation. Proceedings before VA

are ex parte in nature, and it is the obligation of VA to assist a claimant in developing the facts pertinent to the claim and to render a decision which grants every benefit that can be supported in law while protecting the interests of the Government. The provisions of this section apply to all claims for benefits and relief, and decisions thereon, within the purview of this part 3.

(b) *The right to notice*—

(1) *General*. Claimants and their representatives are entitled to notice of any decision made by VA affecting the payment of benefits or the granting of relief. Such notice will clearly set forth the elements described under paragraph (f) of this section, the right to a hearing on any issue involved in the claim as provided in paragraph (d) of this section, the right of representation, and the right, as well as the necessary procedures and time limits to initiate a higher-level review, supplemental claim, or appeal to the Board of Veterans' Appeals.

(2) *Advance notice and opportunity for hearing*. Except as otherwise provided in paragraph (b)(3) of this section, no award of compensation, pension or dependency and indemnity compensation shall be terminated, reduced or otherwise adversely affected unless the beneficiary has been notified of such adverse action and has been provided a period of 60 days in which to submit evidence for the purpose of showing that the adverse action should not be taken.

(3) *Exceptions*. In lieu of advance notice and opportunity for a hearing, VA will send a written notice to the beneficiary or his or her fiduciary at the same time it takes an adverse action under the following circumstances:

(i) An adverse action based solely on factual and unambiguous information or statements as to income, net worth, or dependency or marital status that the beneficiary or his or her fiduciary provided to VA in writing or orally (under the procedures set forth in §3.217(b)), with knowledge or notice that such information would be used to calculate benefit amounts.

(ii) An adverse action based upon the beneficiary's or fiduciary's failure to return a required eligibility verification report.

(iii) Evidence reasonably indicates that a beneficiary is deceased. However, in the event that VA has received a death certificate, a terminal hospital report verifying the death of a beneficiary or a claim for VA burial benefits, no notice of termination (contemporaneous or otherwise) will be required.

(iv) An adverse action based upon a written and signed statement provided by the beneficiary to VA renouncing VA benefits (see §3.106 on renouncement).

(v) An adverse action based upon a written statement provided to VA by a veteran indicating that he or she has returned to active service, the nature of that service, and the date of reentry into service, with the knowledge or notice that receipt of active service pay precludes concurrent receipt of VA compensation or pension (see §3.654 regarding active service pay).

(vi) An adverse action based upon a garnishment order issued under 42 U.S.C. 659(a).

(Authority: 38 U.S.C. 501(a))

(4) *Restoration of benefits*. VA will restore retroactively benefits that were reduced, terminated, or otherwise adversely affected based on oral information or statements if within 30 days of the date on which VA issues the notification of adverse action the beneficiary or his or her fiduciary asserts that the adverse action was based upon information or statements that were inaccurate or upon information that was not provided by the beneficiary or his or her fiduciary. This will not preclude VA from taking subsequent action that adversely affects benefits.

(c) *Submission of evidence*—(1) *General rule*. VA will include in the record, any evidence whether documentary, testimonial, or in other form, submitted by the claimant in support of a pending claim and any issue, contention, or argument a claimant may offer with respect to a claim, except as prescribed in paragraph (c)(2) of this section and §3.2601(f).

(2) *Treatment of evidence received after notice of a decision*. The evidentiary record for a claim before the agency of

original jurisdiction closes when VA issues notice of a decision on the claim. The agency of original jurisdiction will not consider, or take any other action on evidence that is submitted by a claimant, associated with the claims file, or constructively received by VA as described in paragraph (c)(2)(iii) of this section, after notice of decision on a claim, and such evidence will not be considered part of the record at the time of any decision by the agency of original jurisdiction, except as described in § 3.156(c) and under the following circumstances:

(i) *Receipt of a complete claim.* The agency of original jurisdiction subsequently receives a complete application for a supplemental claim or initial claim; or

(ii) *Board and higher-level review returns.* A claim is pending readjudication after identification of a duty to assist error (which includes an error resulting from constructive receipt of evidence prior to the notice of decision), during a higher-level review or appeal to the Board of Veterans' Appeals. Those events reopen the record and any evidence previously submitted to the agency of original jurisdiction or associated with the claims file while the record was closed will become part of the evidentiary record to be considered upon readjudication.

(iii) *Constructive receipt of VA treatment records.* Records within the actual custody of the Veterans Health Administration are deemed constructively received by the Veterans Benefits Administration at the time when the Veterans Benefits Administration had knowledge of the existence of said records through information furnished by the claimant sufficient to locate those records (see 38 U.S.C. 5103A(c)).

(d) *The right to a hearing.* (1) Upon request, a claimant is entitled to a hearing on any issue involved in a claim within the purview of part 3 of this chapter before VA issues notice of a decision on an initial or supplemental claim. A hearing is not available in connection with a request for higher-level review under § 3.2601. VA will provide the place of hearing in the VA field office having original jurisdiction over the claim, or at the VA office nearest the claimant's home having adjudicative functions, or video-conference capabilities, or, subject to available resources and solely at the option of VA, at any other VA facility or federal building at which suitable hearing facilities are available. VA will provide one or more employees who have original determinative authority of such issues to conduct the hearing and be responsible for establishment and preservation of the hearing record. Upon request, a claimant is entitled to a hearing in connection with proposed adverse actions before one or more VA employees having original determinative authority who did not participate in the proposed action. All expenses incurred by the claimant in connection with the hearing are the responsibility of the claimant.

(2) The purpose of a hearing is to permit the claimant to introduce into the record, in person, any available evidence which he or she considers relevant and any arguments or contentions with respect to the facts and applicable law which he or she may consider pertinent. All testimony will be under oath or affirmation. The claimant is entitled to produce witnesses, but the claimant and witnesses must be present. The agency of original jurisdiction will not normally schedule a hearing for the sole purpose of receiving argument from a representative. It is the responsibility of the VA employees conducting the hearings to explain fully the issues and suggest the submission of evidence which the claimant may have overlooked and which would be of advantage to the claimant's position. To assure clarity and completeness of the hearing record, questions which are directed to the claimant and to witnesses are to be framed to explore fully the basis for claimed entitlement rather than with an intent to refute evidence or to discredit testimony.

(e) *The right to representation.* Subject to the provisions of §§ 14.626 through 14.637 of this title, claimants are entitled to representation of their choice at every stage in the prosecution of a claim.

(f) *Notification of decisions.* The claimant or beneficiary and his or her representative will be notified in writing of decisions affecting the payment of

benefits or granting of relief. Written notification must include in the notice letter or enclosures or a combination thereof, all of the following elements:

(1) Identification of the issues adjudicated;

(2) A summary of the evidence considered;

(3) A summary of the laws and regulations applicable to the claim;

(4) A listing of any findings made by the adjudicator that are favorable to the claimant under § 3.104(c);

(5) For denied claims, identification of the element(s) required to grant the claim(s) that were not met;

(6) If applicable, identification of the criteria required to grant service connection or the next higher-level of compensation;

(7) An explanation of how to obtain or access evidence used in making the decision; and

(8) A summary of the applicable review options under § 3.2500 available for the claimant to seek further review of the decision.

(Authority:38 U.S.C. 501, 1115, 1506, 5104)

[55 FR 13527, Apr. 11, 1990; 55 FR 17530, Apr. 25, 1990, as amended at 55 FR 20148, May 15, 1990; 55 FR 25308, June 21, 1990; 57 FR 56993, Dec. 2, 1992; 58 FR 16360, Mar. 26, 1993; 58 FR 59366, Nov. 9, 1993; 59 FR 6218, Feb. 10, 1994; 59 FR 6901, Feb. 14, 1994; 66 FR 56613, Nov. 9, 2001; 76 FR 52574, Aug. 23, 2011; 77 FR 23129, Apr. 18, 2012; 84 FR 166, Jan. 18, 2019]

§ 3.104 Binding nature of decisions.

(a) *Binding decisions.* A decision of a VA rating agency is binding on all VA field offices as to conclusions based on the evidence on file at the time VA issues written notification in accordance with 38 U.S.C. 5104. A binding agency decision is not subject to revision except by the Board of Veterans' Appeals, by Federal court order, or as provided in §§ 3.105, 3.2500, and 3.2600.

(b) *Binding administrative determinations.* Current determinations of line of duty, character of discharge, relationship, dependency, domestic relations questions, homicide, and findings of fact of death or presumptions of death made in accordance with existing instructions, and by application of the same criteria and based on the same facts, by either an Adjudication activity or an Insurance activity are binding one upon the other in the absence of clear and unmistakable error.

(c) *Favorable findings.* Any finding favorable to the claimant made by either a VA adjudicator, as described in § 3.103(f)(4), or by the Board of Veterans' Appeals, as described in § 20.801(a) of this chapter, is binding on all subsequent agency of original jurisdiction and Board of Veterans' Appeals adjudicators, unless rebutted by evidence that identifies a clear and unmistakable error in the favorable finding. For purposes of this section, a finding means a conclusion either on a question of fact or on an application of law to facts made by an adjudicator concerning the issue(s) under review.

[29 FR 1462, Jan. 29, 1964, as amended at 29 FR 7547, June 12, 1964; 56 FR 65846, Dec. 19, 1991; 66 FR 21874, May 2, 2001; 84 FR 167, Jan. 18, 2019]

§ 3.105 Revision of decisions.

The provisions of this section apply except where an award was based on an act of commission or omission by the payee, or with his or her knowledge (§ 3.500(b)); there is a change in law or a Department of Veterans Affairs issue, or a change in interpretation of law or a Department of Veterans Affairs issue (§ 3.114); or the evidence establishes that service connection was clearly illegal. The provisions with respect to the date of discontinuance of benefits are applicable to running awards. Where the award has been suspended, and it is determined that no additional payments are in order, the award will be discontinued effective date of last payment.

(a)(1) *Error in final decisions.* Decisions are final when the underlying claim is finally adjudicated as provided in § 3.160(d). Final decisions will be accepted by VA as correct with respect to the evidentiary record and the law that existed at the time of the decision, in the absence of clear and unmistakable error. At any time after a decision is final, the claimant may request, or VA may initiate, review of the decision to determine if there was a clear and unmistakable error in the decision. Where evidence establishes such error, the prior decision will be reversed or amended.

(i) *Definition of clear and unmistakable error*. A clear and unmistakable error is a very specific and rare kind of error. It is the kind of error, of fact or of law, that when called to the attention of later reviewers compels the conclusion, to which reasonable minds could not differ, that the result would have been manifestly different but for the error. If it is not absolutely clear that a different result would have ensued, the error complained of cannot be clear and unmistakable. Generally, either the correct facts, as they were known at the time, were not before VA, or the statutory and regulatory provisions extant at the time were incorrectly applied.

(ii) *Effective date of reversed or revised decisions*. For the purpose of authorizing benefits, the rating or other adjudicative decision which constitutes a reversal or revision of a prior decision on the grounds of clear and unmistakable error has the same effect as if the corrected decision had been made on the date of the reversed decision. Except as provided in paragraphs (d) and (e) of this section, where an award is reduced or discontinued because of administrative error or error in judgment, the provisions of § 3.500(b)(2) will apply.

(iii) *Record to be reviewed*. Review for clear and unmistakable error in a prior final decision of an agency of original jurisdiction must be based on the evidentiary record and the law that existed when that decision was made. The duty to assist in § 3.159 does not apply to requests for revision based on clear and unmistakable error.

(iv) *Change in interpretation*. Clear and unmistakable error does not include the otherwise correct application of a statute or regulation where, subsequent to the decision being challenged, there has been a change in the interpretation of the statute or regulation.

(v) *Limitation on Applicability*. Decisions of an agency of original jurisdiction on issues that have been decided on appeal by the Board or a court of competent jurisdiction are not subject to revision under this subsection.

(vi) *Duty to assist not applicable*. For examples of situations that are not clear and unmistakable error see 38 CFR 20.1403(d).

(vii) *Filing Requirements*—(A) *General*. A request for revision of a decision based on clear and unmistakable error must be in writing, and must be signed by the requesting party or that party's authorized representative. The request must include the name of the claimant; the name of the requesting party if other than the claimant; the applicable Department of Veterans Affairs file number; and the date of the decision to which the request relates. If the applicable decision involved more than one issue, the request must identify the specific issue, or issues, to which the request pertains.

(B) *Specific allegations required*. The request must set forth clearly and specifically the alleged clear and unmistakable error, or errors, of fact or law in the prior decision, the legal or factual basis for such allegations, and why the result would have been manifestly different but for the alleged error. Nonspecific allegations of failure to follow regulations or failure to give due process, or any other general, non-specific allegations of error, are insufficient to satisfy the requirement of the previous sentence.

(2) *Error in binding decisions prior to final adjudication*. Prior to the time that a claim is finally adjudicated, previous decisions which are binding will be accepted as correct by the agency of original jurisdiction, with respect to the evidentiary record and law existing at the time of the decision, unless the decision is clearly erroneous, after considering whether any favorable findings may be reversed as provided in § 3.104(c).

(b) *Difference of opinion*. Whenever an adjudicative agency is of the opinion that a revision or an amendment of a previous decision is warranted on the basis of the evidentiary record and law that existed at the time of the decision, a difference of opinion being involved rather than a clear and unmistakable error, the proposed revision will be recommended to Central Office. However, a decision may be revised under § 3.2600 or § 3.2601 without being recommended to Central Office.

(c) *Character of discharge*. A determination as to character of discharge or line of duty which would result in discontinued entitlement is subject to

the provisions of paragraph (d) of this section.

(d) *Severance of service connection.* Subject to the limitations contained in §§3.114 and 3.957, service connection will be severed only where evidence establishes that it is clearly and unmistakably erroneous (the burden of proof being upon the Government). (Where service connection is severed because of a change in or interpretation of a law or Department of Veterans Affairs issue, the provisions of §3.114 are for application.) A change in diagnosis may be accepted as a basis for severance action if the examining physician or physicians or other proper medical authority certifies that, in the light of all accumulated evidence, the diagnosis on which service connection was predicated is clearly erroneous. This certification must be accompanied by a summary of the facts, findings, and reasons supporting the conclusion. When severance of service connection is considered warranted, a rating proposing severance will be prepared setting forth all material facts and reasons. The claimant will be notified at his or her latest address of record of the contemplated action and furnished detailed reasons therefor and will be given 60 days for the presentation of additional evidence to show that service connection should be maintained. Unless otherwise provided in paragraph (i) of this section, if additional evidence is not received within that period, final rating action will be taken and the award will be reduced or discontinued, if in order, effective the last day of the month in which a 60-day period from the date of notice to the beneficiary of the final rating action expires.

(Authority: 38 U.S.C. 5112(b)(6))

(e) *Reduction in evaluation—compensation.* Where the reduction in evaluation of a service-connected disability or employability status is considered warranted and the lower evaluation would result in a reduction or discontinuance of compensation payments currently being made, a rating proposing the reduction or discontinuance will be prepared setting forth all material facts and reasons. The beneficiary will be notified at his or her latest address of record of the contemplated action and furnished detailed reasons therefor, and will be given 60 days for the presentation of additional evidence to show that compensation payments should be continued at their present level. Unless otherwise provided in paragraph (i) of this section, if additional evidence is not received within that period, final rating action will be taken and the award will be reduced or discontinued effective the last day of the month in which a 60-day period from the date of notice to the beneficiary of the final rating action expires.

(Authority: 38 U.S.C. 5112(b)(6))

(f) *Reduction in evaluation—pension.* Where a change in disability or employability warrants a reduction or discontinuance of pension payments currently being made, a rating proposing the reduction or discontinuance will be prepared setting forth all material facts and reasons. The beneficiary will be notified at his or her latest address of record of the contemplated action and furnished detailed reasons therefor, and will be given 60 days for the presentation of additional evidence to show that pension benefits should be continued at their present level. Unless otherwise provided in paragraph (i) of this section, if additional evidence is not received within that period, final rating action will be taken and the award will be reduced or discontinued effective the last day of the month in which the final rating action is approved.

(Authority: 38 U.S.C. 5112(b)(5))

(g) *Reduction in evaluation—monetary allowance under 38 U.S.C. chapter 18 for certain individuals who are children of Vietnam veterans or children of veterans with covered service in Korea.* Where a reduction or discontinuance of a monetary allowance currently being paid under 38 U.S.C. chapter 18 is considered warranted, VA will notify the beneficiary at his or her latest address of record of the proposed reduction, furnish detailed reasons therefor, and allow the beneficiary 60 days to present additional evidence to show that the monetary allowance should be continued at the present level. Unless otherwise provided in paragraph (i) of this

section, if VA does not receive additional evidence within that period, it will take final rating action and reduce the award effective the last day of the month following 60 days from the date of notice to the beneficiary of the proposed reduction.

(Authority: 38 U.S.C. 1805, 1815, 1821, 1832, 5112(b)(6))

(h) *Other reductions/discontinuances.* Except as otherwise specified at § 3.103(b)(3) of this part, where a reduction or discontinuance of benefits is warranted by reason of information received concerning income, net worth, dependency, or marital or other status, a proposal for the reduction or discontinuance will be prepared setting forth all material facts and reasons. The beneficiary will be notified at his or her latest address of record of the contemplated action and furnished detailed reasons therefor, and will be given 60 days for the presentation of additional evidence to show that the benefits should be continued at their present level. Unless otherwise provided in paragraph (i) of this section, if additional evidence is not received within that period, final adverse action will be taken and the award will be reduced or discontinued effective as specified under the provisions of §§ 3.500 through 3.503 of this part.

(Authority: 38 U.S.C. 5112)

(i) *Predetermination hearings.* (1) In the advance written notice concerning proposed actions under paragraphs (d) through (h) of this section, the beneficiary will be informed that he or she will have an opportunity for a predetermination hearing, provided that a request for such a hearing is received by VA within 30 days from the date of the notice. If a timely request is received, VA will notify the beneficiary in writing of the time and place of the hearing at least 10 days in advance of the scheduled hearing date. The 10 day advance notice may be waived by agreement between VA and the beneficiary or representative. The hearing will be conducted by VA personnel who did not participate in the proposed adverse action and who will bear the decision-making responsibility. If a predetermination hearing is timely requested, benefit payments shall be continued at the previously established level pending a final determination concerning the proposed action.

(2) Following the predetermination procedures specified in this paragraph and paragraph (d), (e), (f), (g) or (h) of this section, whichever is applicable, final action will be taken. If a predetermination hearing was not requested or if the beneficiary failed without good cause to report for a scheduled predetermination hearing, the final action will be based solely upon the evidence of record. Examples of good cause include, but are not limited to, the illness or hospitalization of the claimant or beneficiary, death of an immediate family member, etc. If a predetermination hearing was conducted, the final action will be based on evidence and testimony adduced at the hearing as well as the other evidence of record including any additional evidence obtained following the hearing pursuant to necessary development. Whether or not a predetermination hearing was conducted, a written notice of the final action shall be issued to the beneficiary and his or her representative, setting forth the reasons therefor and the evidence upon which it is based. Where a reduction or discontinuance of benefits is found warranted following consideration of any additional evidence submitted, the effective date of such reduction or discontinuance shall be as follows:

(i) Where reduction or discontinuance was proposed under the provisions of paragraph (d) or (e) of this section, the effective date of final action shall be the last day of the month in which a 60-day period from the date of notice to the beneficiary of the final action expires.

(ii) Where reduction or discontinuance was proposed under the provisions of paragraphs (f) and (g) of this section, the effective date of final action shall be the last day of the month in which such action is approved.

(iii) Where reduction or discontinuance was proposed under the provisions of paragraph (h) of this section, the effective date of final action shall be as specified under the provisions of §§ 3.500 through 3.503 of this part.

(j) *Supplemental claims and higher-level review*. VA may revise an earlier decision denying benefits, if warranted, upon resolution of a supplemental claim under §3.160(c) or higher-level review under §3.2601.

(Authority: 38 U.S.C. 5112)

CROSS REFERENCES: Effective dates. See §3.400. Reductions and discontinuances. See §3.500. Protection; service connection. See §3.957.

[26 FR 1569, Feb. 24, 1961, as amended at 27 FR 11886, Dec. 1, 1962; 39 FR 17222, May 14, 1974; 55 FR 13528, Apr. 11, 1990; 56 FR 65846, Dec. 19, 1991; 57 FR 56993, Dec. 2, 1992; 62 FR 51278, Sept. 30, 1997; 66 FR 21874, May 2, 2001; 67 FR 49586, July 31, 2002; 76 FR 4247, Jan. 25, 2011; 84 FR 167, Jan. 18, 2019]

§3.106 Renouncement.

(a) Any person entitled to pension, compensation, or dependency and indemnity compensation under any of the laws administered by the Department of Veterans Affairs may renounce his or her right to that benefit but may not renounce less than all of the component items which together comprise the total amount of the benefit to which the person is entitled nor any fixed monetary amounts less than the full amount of entitlement. The renouncement will be in writing over the person's signature. Upon receipt of such renouncement in the Department of Veterans Affairs, payment of such benefits and the right thereto will be terminated, and such person will be denied any and all rights thereto from such filing.

(Authority: 38 U.S.C. 5306(a))

(b) The renouncement will not preclude the person from filing a new application for pension, compensation, or dependency and indemnity compensation at any future date. Such new application will be treated as an original application, and no payments will be made thereon for any period before the date such new application is received in the Department of Veterans Affairs.

(Authority: 38 U.S.C. 5306(b))

(c) Notwithstanding the provisions of paragraph (b) of this section, if a new application for pension or parents' dependency and indemnity compensation is filed within one year after the date that the Department of Veterans Affairs receives a renouncement of that benefit, such application shall not be treated as an original application and benefits will be payable as if the renouncement had not occurred.

(Authority: 38 U.S.C. 5306(c))

(d) The renouncement of dependency and indemnity compensation by one beneficiary will not serve to increase the rate payable to any other beneficiary in the same class.

(e) The renouncement of dependency and indemnity compensation by a surviving spouse will not serve to vest title to this benefit in children under the age of 18 years or to increase the rate payable to a child or children over the age of 18 years.

[26 FR 1569, Feb. 24, 1961, as amended at 37 FR 5384, Mar. 15, 1972; 39 FR 17222, May 14, 1974; 60 FR 18355, Apr. 11, 1995; 62 FR 5529, Feb. 6, 1997]

§3.107 Awards where not all dependents apply.

Except as provided in §3.251(a)(4), in any case where claim has not been filed by or on behalf of all dependents who may be entitled, the awards (original or amended) for those dependents who have filed claim will be made for all periods at the rates and in the same manner as though there were no other dependents. However, if the file reflects the existence of other dependents who have not filed claim and there is potential entitlement to benefits for a period prior to the date of filing claim, the award to a person who has filed claim will be made at the rate which would be payable if all dependents were receiving benefits. If at the expiration of the period allowed, claims have not been filed for such dependents, the full rate will be authorized for the first payee.

[29 FR 9564, July 15, 1964]

§3.108 State Department as agent of Department of Veterans Affairs.

Diplomatic and consular officers of the Department of State are authorized to act as agents of the Department of Veterans Affairs and therefore a complete claim as set forth in §3.160(a) or

an intent to file a claim as set forth in § 3.155(b) or evidence submitted in support of a claim filed in a foreign country will be considered as filed in the Department of Veterans Affairs as of the date of receipt by the State Department representative.

CROSS REFERENCE: Evidence from foreign countries. See § 3.202.

[26 FR 1569, Feb. 24, 1961, as amended at 79 FR 57695, Sept. 25, 2014]

§ 3.109 Time limit.

(a) *Notice of time limit for filing evidence.* (1) If a claimant's application is incomplete, the claimant will be notified of the evidence necessary to complete the application. If the evidence is not received within 1 year from the date of such notification, pension, compensation, or dependency and indemnity compensation may not be paid by reason of that application (38 U.S.C. 5103(a)). Information concerning the whereabouts of a person who has filed claim is not considered evidence.

(2) The provisions of this paragraph are applicable to original initial applications, to applications for increased benefits by reason of increased disability, age, or the existence of a dependent, and to applications for reopening or resumption of payments. If substantiating evidence is required with respect to the veracity of a witness or the authenticity of documentary evidence timely filed, there will be allowed for the submission of such evidence 1 year from the date of the request therefor. However, any evidence to enlarge the proofs and evidence originally submitted is not so included.

(b) *Extension of time limit.* Time limits within which claimants or beneficiaries are required to act to perfect a claim or challenge an adverse VA decision may be extended for good cause shown. Where an extension is requested after expiration of a time limit, the action required of the claimant or beneficiary must be taken concurrent with or prior to the filing of a request for extension of the time limit, and good cause must be shown as to why the required action could not have been taken during the original time period and could not have been taken sooner than it was. Denials of time limit extensions are separately appealable issues.

(Authority: 38 U.S.C. 501)

[26 FR 1569, Feb. 24, 1961, as amended at 26 FR 2231, Mar. 16, 1961; 29 FR 1462, Jan. 29, 1964; 30 FR 133, Jan. 7, 1965; 55 FR 13529, Apr. 11, 1990; 79 FR 57695, Sept. 25, 2014]

§ 3.110 Computation of time limit.

(a) In computing the time limit for any action required of a claimant or beneficiary, including the filing of claims or evidence requested by VA, the first day of the specified period will be excluded and the last day included. This rule is applicable in cases in which the time limit expires on a workday. Where the time limit would expire on a Saturday, Sunday, or holiday, the next succeeding workday will be included in the computation.

(b) *The first day of the specified period* referred to in paragraph (a) of this section shall be the date of mailing of notification to the claimant or beneficiary of the action required and the time limit therefor. The date of the letter of notification shall be considered the date of mailing for purposes of computing time limits. As to appeals, see §§ 19.52, 20.203, and 20.110 of this chapter.

(Authority: 38 U.S.C. 501)

[55 FR 13529, Apr. 11, 1990, as amended at 58 FR 32443, June 10, 1993; 84 FR 168, Jan. 18, 2019]

§ 3.111 [Reserved]

§ 3.112 Fractions of one cent.

In all cases where the amount to be paid under any award involves a fraction of a cent, the fractional part will be excluded.

[26 FR 1570, Feb. 24, 1961]

§ 3.114 Change of law or Department of Veterans Affairs issue.

(a) *Effective date of award.* Where pension, compensation, dependency and indemnity compensation, or a monetary allowance under 38 U.S.C. chapter 18 for an individual who is a child of a Vietnam veteran or child of a veteran

with covered service in Korea is awarded or increased pursuant to a liberalizing law, or a liberalizing VA issue approved by the Secretary or by the Secretary's direction, the effective date of such award or increase shall be fixed in accordance with the facts found, but shall not be earlier than the effective date of the act or administrative issue. Where pension, compensation, dependency and indemnity compensation, or a monetary allowance under 38 U.S.C. chapter 18 for an individual who is a child of a Vietnam veteran or child of a veteran with covered service in Korea is awarded or increased pursuant to a liberalizing law or VA issue which became effective on or after the date of its enactment or issuance, in order for a claimant to be eligible for a retroactive payment under the provisions of this paragraph the evidence must show that the claimant met all eligibility criteria for the liberalized benefit on the effective date of the liberalizing law or VA issue and that such eligibility existed continuously from that date to the date of claim or administrative determination of entitlement. The provisions of this paragraph are applicable to original and supplemental claims as well as claims for increase.

(1) If a claim is reviewed on the initiative of VA within 1 year from the effective date of the law or VA issue, or at the request of a claimant received within 1 year from that date, benefits may be authorized from the effective date of the law or VA issue.

(2) If a claim is reviewed on the initiative of VA more than 1 year after the effective date of the law or VA issue, benefits may be authorized for a period of 1 year prior to the date of administrative determination of entitlement.

(3) If a claim is reviewed at the request of the claimant more than 1 year after the effective date of the law or VA issue, benefits may be authorized for a period of 1 year prior to the date of receipt of such request.

(Authority: 38 U.S.C. 1805, 1815, 1821, 1832, 5110(g))

(b) *Discontinuance of benefits.* Where the reduction or discontinuance of an award is in order because of a change in law or a Department of Veterans Affairs issue, or because of a change in interpretation of a law or Department of Veterans Affairs issue, the payee will be notified at his or her latest address of record of the contemplated action and furnished detailed reasons therefor, and will be given 60 days for the presentation of additional evidence. If additional evidence is not received within that period, the award will be reduced or discontinued effective the last day of the month in which the 60–day period expired.

(Authority: 38 U.S.C. 5112(b)(6))

[27 FR 11886, Dec. 1, 1962, as amended at 55 FR 13529, Apr. 11, 1990; 62 FR 17706, Apr. 11, 1997; 65 FR 35282, June 2, 2000; 67 FR 49586, July 31, 2002; 76 FR 4247, Jan. 25, 2011; 84 FR 168, Jan. 18, 2019; 84 FR 4336, Feb. 15, 2019]

§ 3.115 Access to financial records.

(a) The Secretary of Veterans Affairs may request from a financial institution the names and addresses of its customers. Each such request, however, shall include a certification that the information is necessary for the proper administration of benefits programs under the laws administered by the Secretary, and cannot be obtained by a reasonable search of records and information of the Department of Veterans Affairs.

(b) Information received pursuant to a request referred to in paragraph (a) of this section shall not be used for any purpose other than the administration of benefits programs under the laws administered by the Secretary if the disclosure of that information would otherwise be prohibited by any provision of the Right to Financial Privacy Act of 1978 (12 U.S.C. 3401 through 3422).

(Authority: 38 U.S.C. 5319)

[58 FR 32445, June 10, 1993]

CLAIMS

§ 3.150 Forms to be furnished.

(a) Upon request made in person or in writing by any person applying for benefits under the laws administered by the Department of Veterans Affairs, the appropriate application form will be furnished.

(Authority: 38 U.S.C. 5102)

(b) Upon receipt of notice of death of a veteran, the appropriate application form will be forwarded for execution by or on behalf of any dependent who has apparent entitlement to pension, compensation, or dependency and indemnity compensation. If it is not indicated that any person would be entitled to such benefits, but there is payable an accrued benefit not paid during the veteran's lifetime, the appropriate application form will be forwarded to the preferred dependent. Notice of the time limit will be included in letters forwarding applications for benefits.

CROSS REFERENCE: Extension of time limit. *See* § 3.109(b).

[26 FR 1570, Feb. 14, 1961, as amended at 30 FR 133, Jan. 7, 1965; 79 FR 57695, Sept. 25, 2014]

§ 3.151 Claims for disability benefits.

(a) *General.* A specific claim in the form prescribed by the Secretary must be filed in order for benefits to be paid to any individual under the laws administered by VA. (38 U.S.C. 5101(a)). A claim by a veteran for compensation may be considered to be a claim for pension; and a claim by a veteran for pension may be considered to be a claim for compensation. The greater benefit will be awarded, unless the claimant specifically elects the lesser benefit. (See scope of claim, § 3.155(d)(2); complete claim, § 3.160(a); supplemental claims, § 3.2501(b)).

(b) *Retroactive disability pension claims.* Where disability pension entitlement is established based on a claim received by VA on or after October 1, 1984, the pension award may not be effective prior to the date of receipt of the pension claim unless the veteran specifically claims entitlement to retroactive benefits. The claim for retroactivity may be filed separately or included in the claim for disability pension, but it must be received by VA within one year from the date on which the veteran became permanently and totally disabled. Additional requirements for entitlement to a retroactive pension award are contained in § 3.400(b) of this part.

(c) *Issues within a claim.* (1) To the extent that a complete claim application encompasses a request for more than one determination of entitlement, each specific entitlement will be adjudicated and is considered a separate issue for purposes of the review options prescribed in § 3.2500. A single decision by an agency of original jurisdiction may adjudicate multiple issues in this respect, whether expressly claimed or determined by VA to be reasonably within the scope of the application as prescribed in § 3.155(d)(2). VA will issue a decision that addresses each such identified issue within a claim. Upon receipt of notice of a decision, a claimant may elect any of the applicable review options prescribed in § 3.2500 for each issue adjudicated.

(2) With respect to service-connected disability compensation, an issue for purposes of paragraph (c)(1) of this section is defined as entitlement to compensation for a particular disability. For example, if a decision adjudicates service-connected disability compensation for both a knee condition and an ankle condition, compensation for each condition is a separate entitlement or issue for which a different review option may be elected. However, different review options may not be selected for specific components of the knee disability claim, such as ancillary benefits, whether a knee injury occurred in service, or whether a current knee condition resulted from a service-connected injury or condition.

(d) *Evidentiary record.* The evidentiary record before the agency of original jurisdiction for an initial or supplemental claim includes all evidence received by VA before VA issues notice of a decision on the claim. Once the agency of original jurisdiction issues notice of a decision on a claim, the evidentiary record closes as described in § 3.103(c)(2) and VA no longer has a duty to assist in gathering evidence under § 3.159. (See § 3.155(b), submission of evidence).

(Authority: 38 U.S.C 5110(b)(3))

CROSS REFERENCE: Intent to file a claim. See § 3.155(b).

[50 FR 25981, June 24, 1985, as amended at 79 FR 57695, Sept. 25, 2014; 84 FR 168, Jan. 18, 2019]

§ 3.152 Claims for death benefits.

(a) A specific claim in the form prescribed by the Secretary (or jointly

with the Commissioner of Social Security, as prescribed by §3.153) must be filed in order for death benefits to be paid to any individual under the laws administered by VA. (See §3.400(c) concerning effective dates of awards.)

(Authority: 38 U.S.C. 5101(a))

(b)(1) A claim by a surviving spouse or child for compensation or dependency and indemnity compensation will also be considered to be a claim for death pension and accrued benefits, and a claim by a surviving spouse or child for death pension will be considered to be a claim for death compensation or dependency and indemnity compensation and accrued benefits.

(Authority: 38 U.S.C. 5101(b)(1))

(2) A claim by a parent for compensation or dependency and indemnity compensation will also be considered to be a claim for accrued benefits.

(Authority: 38 U.S.C. 5101(b)(2))

(c)(1) Where a child's entitlement to dependency and indemnity compensation arises by reason of termination of a surviving spouse's right to dependency and indemnity compensation or by reason of attaining the age of 18 years, a claim will be required. (38 U.S.C. 5110(e).) (See paragraph (c)(4) of this section.) Where the award to the surviving spouse is terminated by reason of her or his death, a claim for the child will be considered a claim for any accrued benefits which may be payable.

(2) A claim filed by a surviving spouse who does not have entitlement will be accepted as a claim for a child or children in her or his custody named in the claim.

(3) Where a claim of a surviving spouse is disallowed for any reason whatsoever and where evidence requested in order to determine entitlement from a child or children named in the surviving spouse's claim is submitted within 1 year from the date of request, requested either before or after disallowance of the surviving spouse's claim, an award for the child or children will be made as though the disallowed claim had been filed solely on their behalf. Otherwise, payments may not be made for the child or children for any period prior to the date of receipt of a new claim.

(4) Where payments of pension, compensation or dependency and indemnity compensation to a surviving spouse have been discontinued because of remarriage or death, or a child becomes eligible for dependency and indemnity compensation by reason of attaining the age of 18 years, and any necessary evidence is submitted within 1 year from date of request, an award for the child or children named in the surviving spouse's claim will be made on the basis of the surviving spouse's claim having been converted to a claim on behalf of the child. Otherwise, payments may not be made for any period prior to the date of receipt of a new claim.

(Authority: 38 U.S.C 501)

CROSS REFERENCES: State Department as agent of Department of Veterans Affairs. See §3.108. Change in status of dependents. See §3.651.

[50 FR 25981, June 24, 1985, as amended at 71 FR 44918, Aug. 8, 2006]

§3.153 Claims filed with Social Security.

An application on a form jointly prescribed by the Secretary and the Commissioner of Social Security filed with the Social Security Administration on or after January 1, 1957, will be considered a claim for death benefits, and to have been received in the Department of Veterans Affairs as of the date of receipt in Social Security Administration. The receipt of such an application (or copy thereof) by the Department of Veterans Affairs will not preclude a request for any necessary evidence.

(Authority: 38 U.S.C. 5105)

[26 FR 1570, Feb. 24, 1961, as amended at 71 FR 44918, Aug. 8, 2006]

§3.154 Injury due to hospital treatment, etc.

Claimants must file a complete claim on the appropriate application form prescribed by the Secretary when applying for benefits under 38 U.S.C. 1151 and 38 CFR 3.361. See §§3.151, 3.160(a), and 3.400(i) concerning effective dates

of awards; see § 3.155(b) regarding intent to file the appropriate application form.

(Authority: 38 U.S.C. 501 and 1151.)

CROSS REFERENCE: Effective Dates. See § 3.400(i). Disability or death due to hospitalization, etc. See §§ 3.358, 3.361 and 3.800.

[79 FR 57695, Sept. 25, 2014]

§ 3.155 How to file a claim.

The following paragraphs describe the manner and methods in which a claim can be initiated and filed. The provisions of this section are applicable to all claims governed by part 3, with the exception that paragraph (b) of this section, regarding intent to file a claim, does not apply to supplemental claims.

(a) *Request for an application for benefits.* A claimant, his or her duly authorized representative, a Member of Congress, or some person acting as next friend of a claimant who is not of full age or capacity, who indicates a desire to file for benefits under the laws administered by VA, by a communication or action, to include an electronic mail that is transmitted through VA's electronic portal or otherwise, that does not meet the standards of a complete claim is considered a request for an application form for benefits under § 3.150(a). Upon receipt of such a communication or action, the Secretary shall notify the claimant and the claimant's representative, if any, of the information necessary to complete the application form or form prescribed by the Secretary.

(b) *Intent to file a claim.* A claimant, his or her duly authorized representative, a Member of Congress, or some person acting as next friend of claimant who is not of full age or capacity may indicate a claimant's desire to file a claim for benefits by submitting an intent to file a claim to VA. An intent to file a claim must provide sufficient identifiable or biographical information to identify the claimant. Upon receipt of the intent to file a claim, VA will furnish the claimant with the appropriate application form prescribed by the Secretary. If VA receives a complete application form prescribed by the Secretary, as defined in paragraph (a) of § 3.160, appropriate to the benefit sought within 1 year of receipt of the intent to file a claim, VA will consider the complete claim filed as of the date the intent to file a claim was received.

(1) An intent to file a claim can be submitted in one of the following three ways:

(i) Saved electronic application. When an application otherwise meeting the requirements of this paragraph (b) is electronically initiated and saved in a claims-submission tool within a VA web-based electronic claims application system prior to filing of a complete claim, VA will consider that application to be an intent to file a claim.

(ii) Written intent on prescribed intent to file a claim form. The submission to an agency of original jurisdiction of a signed and dated intent to file a claim, on the form prescribed by the Secretary for that purpose, will be accepted as an intent to file a claim.

(iii) Oral intent communicated to designated VA personnel and recorded in writing. An oral statement of intent to file a claim will be accepted if it is directed to a VA employee designated to receive such a communication, the VA employee receiving this information follows the provisions set forth in § 3.217(b), and the VA employee documents the date VA received the claimant's intent to file a claim in the claimant's records.

(2) An intent to file a claim must identify the general benefit (e.g., compensation, pension), but need not identify the specific benefit claimed or any medical condition(s) on which the claim is based. To the extent a claimant provides this or other extraneous information on the designated form referenced in paragraph (b)(1)(ii) of this section that the form does not solicit, the provision of such information is of no effect other than that it is added to the file for appropriate consideration as evidence in support of a complete claim if filed. In particular, if a claimant identifies specific medical condition(s) on which the claim is based in an intent to file a claim, this extraneous information does not convert the intent to file a claim into a complete claim or a substantially complete application. Extraneous information provided in an oral communication under

paragraph (b)(1)(iii) of this section is of no effect and generally will not be recorded in the record of the claimant's intent to file.

(3) Upon receipt of an intent to file a claim, the Secretary shall notify the claimant and the claimant's representative, if any, of the information necessary to complete the appropriate application form prescribed by the Secretary.

(4) If an intent to file a claim is not submitted in the form required by paragraph (b)(1) of this section or a complete claim is not filed within 1 year of the receipt of the intent to file a claim, VA will not take further action unless a new claim or a new intent to file a claim is received.

(5) An intent to file a claim received from a service organization, an attorney, or agent indicating a represented claimant's intent to file a claim may not be accepted if a power of attorney was not executed at the time the communication was written. VA will only accept an oral intent to file from a service organization, an attorney, or agent if a power of attorney is of record at the time the oral communication is received by the designated VA employee.

(6) VA will not recognize more than one intent to file concurrently for the same benefit (e.g., compensation, pension). If an intent to file has not been followed by a complete claim, a subsequent intent to file regarding the same benefit received within 1 year of the prior intent to file will have no effect. If, however, VA receives an intent to file followed by a complete claim and later another intent to file for the same benefit is submitted within 1 year of the previous intent to file, VA will recognize the subsequent intent to file to establish an effective date for any award granted for the next complete claim, provided it is received within 1 year of the subsequent intent to file.

(c) *Incomplete application form.* Upon receipt of a communication indicating a belief in entitlement to benefits that is submitted on a paper application form prescribed by the Secretary that is not complete as defined in §3.160(a) of this section, the Secretary shall notify the claimant and the claimant's representative, if any, of the information necessary to complete the application form prescribed by the Secretary. If a complete claim is submitted within 1 year of receipt of such incomplete application form prescribed by the Secretary, VA will consider it as filed as of the date VA received the incomplete application form prescribed by the Secretary that did not meet the standards of a complete claim. See §3.160(a) for Complete Claim.

(d) *Claims.*

(1) *Requirement for complete claim and date of claim.* A complete claim is required for all types of claims, and will generally be considered filed as of the date it was received by VA for an evaluation or award of benefits under the laws administered by the Department of Veterans Affairs.

(i) *Supplemental claims.* Upon receipt of a communication indicating a belief in entitlement to benefits that is submitted in wiritng or electronically on a supplemental claim form prescribed by the Secretary that is not complete as defined in §3.160(a) of this section, the Secretary shall notify the claimant and the claimant's representative, if any, of the information necessary to complete the application form prescribed by the Secretary. If VA receives a complete claim within 60 days of notice by VA that an incomplete claim was filed, it will be considered filed as of the date of receipt of the incomplete claim (see §3.2501).

(ii) *For other types of claims.* If VA receives a complete claim within 1 year of the filing of an intent to file a claim that meets the requirements of paragraph (b) of this section, it will be considered filed as of the date of receipt of the intent to file a claim. Only one complete claim for a benefit (*e.g.*, compensation, pension) may be associated with each intent to file a claim for that benefit, though multiple issues may be contained within a complete claim. In the event multiple complete claims for a benefit are filed within 1 year of an intent to file a claim for that benefit, only the first claim filed will be associated with the intent to file a claim. In the event that VA receives both an intent to file a claim and an incomplete application form before the complete claim as defined in §3.160(a) is filed, the complete claim will be considered filed

as of the date of receipt of whichever was filed first provided it is perfected within the necessary timeframe, but in no event, will the complete claim be considered filed more than one year prior to the date of receipt of the complete claim.

(2) *Scope of claim.* Once VA receives a complete claim, VA will adjudicate as part of the claim entitlement to any ancillary benefits that arise as a result of the adjudication decision (e.g., entitlement to 38 U.S.C. Chapter 35 Dependents' Educational Assistance benefits, entitlement to special monthly compensation under 38 CFR 3.350, entitlement to adaptive automobile allowance, etc.). The claimant may, but need not, assert entitlement to ancillary benefits at the time the complete claim is filed. VA will also consider all lay and medical evidence of record in order to adjudicate entitlement to benefits for the claimed condition as well as entitlement to any additional benefits for complications of the claimed condition, including those identified by the rating criteria for that condition in 38 CFR Part 4, VA Schedule for Rating Disabilities. VA's decision on an issue within a claim implies that VA has determined that evidence of record does not support entitlement for any other issues that are reasonably within the scope of the issues addressed in that decision. VA's decision that addresses all outstanding issues enumerated in the complete claim implies that VA has determined evidence of record does not support entitlement for any other issues that are reasonably within the scope of the issues enumerated in the complete claim.

Cross Reference: Complete claim. See § 3.160(a). Effective dates. See § 3.400.

[79 FR 57695, Sept. 25, 2014, as amended at 84 FR 168, Jan. 18, 2019]

§ 3.156 New evidence.

New evidence is evidence not previously part of the actual record before agency adjudicators.

(a) *New and material evidence.* For claims to reopen decided prior to the effective date provided in § 19.2(a), the following standards apply. A claimant may reopen a finally adjudicated legacy claim by submitting new and material evidence. New evidence is evidence not previously part of the actual record before agency adjudicators. Material evidence means existing evidence that, by itself or when considered with previous evidence of record, relates to an unestablished fact necessary to substantiate the claim. New and material evidence can be neither cumulative nor redundant of the evidence of record at the time of the last prior final denial of the claim sought to be reopened, and must raise a reasonable possibility of substantiating the claim.

(Authority: 38 U.S.C. 501, 5103A(f), 5108)

(b) *Pending legacy claims not under the modernized review system.* New and material evidence received prior to the expiration of the appeal period, or prior to the appellate decision if a timely appeal has been filed (including evidence received prior to an appellate decision and referred to the agency of original jurisdiction by the Board of Veterans Appeals without consideration in that decision in accordance with the provisions of § 20.1304(b)(1) of this chapter), will be considered as having been filed in connection with the claim which was pending at the beginning of the appeal period.

(Authority: 38 U.S.C. 501)

(c) *Service department records.* (1) Notwithstanding any other section in this part, at any time after VA issues a decision on a claim, if VA receives or associates with the claims file relevant official service department records that existed and had not been associated with the claims file when VA first decided the claim, VA will reconsider the claim, notwithstanding paragraph (a) of this section. Such records include, but are not limited to:

(i) Service records that are related to a claimed in-service event, injury, or disease, regardless of whether such records mention the veteran by name, as long as the other requirements of paragraph (c) of this section are met;

(ii) Additional service records forwarded by the Department of Defense or the service department to VA any time after VA's original request for service records; and

(iii) Declassified records that could not have been obtained because the

records were classified when VA decided the claim.

(2) Paragraph (c)(1) of this section does not apply to records that VA could not have obtained when it decided the claim because the records did not exist when VA decided the claim, or because the claimant failed to provide sufficient information for VA to identify and obtain the records from the respective service department, the Joint Services Records Research Center, or from any other official source.

(3) An award made based all or in part on the records identified by paragraph (c)(1) of this section is effective on the date entitlement arose or the date VA received the previously decided claim, whichever is later, or such other date as may be authorized by the provisions of this part applicable to the previously decided claim.

(4) A retroactive evaluation of disability resulting from disease or injury subsequently service connected on the basis of the new evidence from the service department must be supported adequately by medical evidence. Where such records clearly support the assignment of a specific rating over a part or the entire period of time involved, a retroactive evaluation will be assigned accordingly, except as it may be affected by the filing date of the original claim.

(Authority: 38 U.S.C. 501(a))

(d) *New and relevant evidence.* On or after the effective date provided in §19.2(a), a claimant may file a supplemental claim as prescribed in §3.2501. If new and relevant evidence, as defined in §3.2501(a)(1), is presented or secured with respect to the supplemental claim, the agency of original jurisdiction will readjudicate the claim taking into consideration all of the evidence of record.

CROSS REFERENCES: Effective dates—general. See §3.400. Correction of military records. See §3.400(g).

[27 FR 11887, Dec. 1, 1962, as amended at 55 FR 20148, May 15, 1990; 55 FR 52275, Dec. 21, 1990; 58 FR 32443, June 10, 1993; 66 FR 45630, Aug. 29, 2001; 71 FR 52457, Sept. 6, 2006; 84 FR 169, Jan. 18, 2019; 84 FR 4336, Feb. 15, 2019]

§3.158 Abandoned claims.

(a) *General.* Except as provided in §3.652, where evidence requested in connection with an initial claim or supplemental claim or for the purpose of determining continued entitlement is not furnished within 1 year after the date of request, the claim will be considered abandoned. After the expiration of 1 year, further action will not be taken unless a new claim is received. Should the right to benefits be finally established, pension, compensation, dependency and indemnity compensation, or monetary allowance under the provisions of 38 U.S.C. chapter 18 based on such evidence shall commence not earlier than the date of filing the new claim.

(Authority: 38 U.S.C. 501)

(b) *Department of Veterans Affairs examinations.* Where the veteran fails without adequate reason to respond to an order to report for Department of Veterans Affairs examination within 1 year from the date of request and payments have been discontinued, the claim for such benefits will be considered abandoned.

(c) *Disappearance.* Where payments of pension, compensation, dependency and indemnity compensation, or monetary allowance under the provisions of 38 U.S.C. chapter 18 have not been made or have been discontinued because a payee's present whereabouts is unknown, payments will be resumed effective the day following the date of last payment if entitlement is otherwise established, upon receipt of a valid current address.

CROSS REFERENCES: Periodic certification of continued eligibility. See §3.652. Failure to report for VA examination. See §3.655. Disappearance of veteran. See §3.656.

[27 FR 11887, Dec. 1, 1962, as amended at 28 FR 13362, Dec. 10, 1963; 52 FR 43063, Nov. 9, 1987; 62 FR 51278, Sept. 30, 1997; 67 FR 49586, July 31, 2002; 84 FR 169, Jan. 18, 2019]

§3.159 Department of Veterans Affairs assistance in developing claims.

(a) *Definitions.* For purposes of this section, the following definitions apply:

(1) *Competent medical evidence* means evidence provided by a person who is

qualified through education, training, or experience to offer medical diagnoses, statements, or opinions. Competent medical evidence may also mean statements conveying sound medical principles found in medical treatises. It would also include statements contained in authoritative writings such as medical and scientific articles and research reports or analyses.

(2) *Competent lay evidence* means any evidence not requiring that the proponent have specialized education, training, or experience. Lay evidence is competent if it is provided by a person who has knowledge of facts or circumstances and conveys matters that can be observed and described by a lay person.

(3) *Substantially complete application* means an application containing:

(i) The claimant's name;

(ii) His or her relationship to the veteran, if applicable;

(iii) Sufficient service information for VA to verify the claimed service, if applicable;

(iv) The benefit sought and any medical condition(s) on which it is based;

(v) The claimant's signature; and

(vi) In claims for nonservice-connected disability or death pension and parents' dependency and indemnity compensation, a statement of income;

(vii) In supplemental claims, identification or inclusion of potentially new evidence (see § 3.2501);

(viii) For higher-level reviews, identification of the date of the decision for which review is sought.

(4) For purposes of paragraph (c)(4)(i) of this section, *event* means one or more incidents associated with places, types, and circumstances of service giving rise to disability.

(5) *Information* means non-evidentiary facts, such as the claimant's Social Security number or address; the name and military unit of a person who served with the veteran; or the name and address of a medical care provider who may have evidence pertinent to the claim.

(b) *VA's duty to notify claimants of necessary information or evidence.* (1) Except as provided in paragraph (3) of this section, when VA receives a complete or substantially complete initial or supplemental claim, VA will notify the claimant of any information and medical or lay evidence that is necessary to substantiate the claim (hereafter in this paragraph referred to as the ''notice'') In the notice, VA will inform the claimant which information and evidence, if any, that the claimant is to provide to VA and which information and evidence, if any, that VA will attempt to obtain on behalf of the claimant. The information and evidence that the claimant is informed that the claimant is to provide must be provided within one year of the date of the notice. If the claimant has not responded to the notice within 30 days, VA may decide the claim prior to the expiration of the one-year period based on all the information and evidence contained in the file, including information and evidence it has obtained on behalf of the claimant and any VA medical examinations or medical opinions. If VA does so, however, and the claimant subsequently provides the information and evidence within one year of the date of the notice in accordance with the requirements of paragraph (b)(4) of this section, VA must readjudicate the claim.

(Authority: 38 U.S.C. 5103)

(2) If VA receives an incomplete application for benefits, it will notify the claimant of the information necessary to complete the application and will defer assistance until the claimant submits this information.

(Authority: 38 U.S.C. 5102(b), 5103A(3))

(3) No duty to provide the notice described in paragraph (b)(1) of this section arises:

(i) Upon receipt of a supplemental claim under § 3.2501 within one year of the date VA issues notice of a prior decision;

(ii) Upon receipt of a request for higher-level review under § 3.2601;

(iii) Upon receipt of a Notice of Disagreement under § 20.202 of this chapter; or

(iv) When, as a matter of law, entitlement to the benefit claimed cannot be established.

(Authority: 38 U.S.C. 5103(a), 5103A(a)(2))

(4) After VA has issued a notice of decision, submission of information and evidence substantiating a claim must be accomplished through the proper filing of a review option in accordance with §3.2500 on a form prescribed by the Secretary. New and relevant evidence may be submitted in connection with either the filing of a supplemental claim under §3.2501 or the filing of a Notice of Disagreement with the Board under 38 CFR 20.202, on forms prescribed by the Secretary, and election of a Board docket that permits the filing of new evidence (see 38 CFR 20.302 and 20.303).

(c) *VA's duty to assist claimants in obtaining evidence.* VA has a duty to assist claimants in obtaining evidence to substantiate all substantially complete initial and supplemental claims, and when a claim is returned for readjudication by a higher-level adjudicator or the Board after identification of a duty to assist error on the part of the agency of original jurisdiction, until the time VA issues notice of a decision on a claim or returned claim. VA will make reasonable efforts to help a claimant obtain evidence necessary to substantiate the claim. VA will not pay any fees charged by a custodian to provide records requested. When a claim is returned for readjudication by a higher-level adjudicator or the Board after identification of a duty to assist error, the agency of original jurisdiction has a duty to correct any other duty to assist errors not identified by the higher-level adjudicator or the Board.

(1) *Obtaining records not in the custody of a Federal department or agency.* VA will make reasonable efforts to obtain relevant records not in the custody of a Federal department or agency, to include records from State or local governments, private medical care providers, current or former employers, and other non-Federal governmental sources. Such reasonable efforts will generally consist of an initial request for the records and, if the records are not received, at least one follow-up request. A follow-up request is not required if a response to the initial request indicates that the records sought do not exist or that a follow-up request for the records would be futile. If VA receives information showing that subsequent requests to this or another custodian could result in obtaining the records sought, then reasonable efforts will include an initial request and, if the records are not received, at least one follow-up request to the new source or an additional request to the original source.

(i) The claimant must cooperate fully with VA's reasonable efforts to obtain relevant records from non-Federal agency or department custodians. The claimant must provide enough information to identify and locate the existing records, including the person, company, agency, or other custodian holding the records; the approximate time frame covered by the records; and, in the case of medical treatment records, the condition for which treatment was provided.

(ii) If necessary, the claimant must authorize the release of existing records in a form acceptable to the person, company, agency, or other custodian holding the records.

(Authority: 38 U.S.C. 5103A(b))

(2) *Obtaining records in the custody of a Federal department or agency.* VA will make as many requests as are necessary to obtain relevant records from a Federal department or agency. These records include but are not limited to military records, including service medical records; medical and other records from VA medical facilities; records from non-VA facilities providing examination or treatment at VA expense; and records from other Federal agencies, such as the Social Security Administration. VA will end its efforts to obtain records from a Federal department or agency only if VA concludes that the records sought do not exist or that further efforts to obtain those records would be futile. Cases in which VA may conclude that no further efforts are required include those in which the Federal department or agency advises VA that the requested records do not exist or the custodian does not have them.

(i) The claimant must cooperate fully with VA's reasonable efforts to obtain relevant records from Federal agency or department custodians. If requested by VA, the claimant must provide

enough information to identify and locate the existing records, including the custodian or agency holding the records; the approximate time frame covered by the records; and, in the case of medical treatment records, the condition for which treatment was provided. In the case of records requested to corroborate a claimed stressful event in service, the claimant must provide information sufficient for the records custodian to conduct a search of the corroborative records.

(ii) If necessary, the claimant must authorize the release of existing records in a form acceptable to the custodian or agency holding the records.

(Authority: 38 U.S.C. 5103A(b))

(3) *Obtaining records in compensation claims.* In a claim for disability compensation, VA will make efforts to obtain the claimant's service medical records, if relevant to the claim; other relevant records pertaining to the claimant's active military, naval or air service that are held or maintained by a governmental entity; VA medical records or records of examination or treatment at non-VA facilities authorized by VA; and any other relevant records held by any Federal department or agency. The claimant must provide enough information to identify and locate the existing records including the custodian or agency holding the records; the approximate time frame covered by the records; and, in the case of medical treatment records, the condition for which treatment was provided.

(Authority: 38 U.S.C. 5103A(c))

(4) *Providing medical examinations or obtaining medical opinions.* (i) In a claim for disability compensation, VA will provide a medical examination or obtain a medical opinion based upon a review of the evidence of record if VA determines it is necessary to decide the claim. A medical examination or medical opinion is necessary if the information and evidence of record does not contain sufficient competent medical evidence to decide the claim, but:

(A) Contains competent lay or medical evidence of a current diagnosed disability or persistent or recurrent symptoms of disability;

(B) Establishes that the veteran suffered an event, injury or disease in service, or has a disease or symptoms of a disease listed in § 3.309, § 3.313, § 3.316, and § 3.317 manifesting during an applicable presumptive period provided the claimant has the required service or triggering event to qualify for that presumption; and

(C) Indicates that the claimed disability or symptoms may be associated with the established event, injury, or disease in service or with another service-connected disability.

(ii) Paragraph (4)(i)(C) could be satisfied by competent evidence showing post-service treatment for a condition, or other possible association with military service.

(iii) For requests to reopen a finally adjudicated claim received prior to the effective date provided in § 19.2(a) of this chapter, this paragraph (c)(4) applies only if new and material evidence is presented or secured as prescribed in § 3.156.

(iv) This paragraph (c)(4) applies to a supplemental claim only if new and relevant evidence under § 3.2501 is presented or secured.

(Authority: 38 U.S.C. 5103A(d))

(d) *Circumstances where VA will refrain from or discontinue providing assistance.* VA will refrain from providing assistance in obtaining evidence for an initial or supplemental claim if the substantially complete application for benefits indicates that there is no reasonable possibility that any assistance VA would provide to the claimant would substantiate the claim. VA will discontinue providing assistance in obtaining evidence for a claim if the evidence obtained indicates that there is no reasonable possibility that further assistance would substantiate the claim. Circumstances in which VA will refrain from or discontinue providing assistance in obtaining evidence include, but are not limited to:

(1) The claimant's ineligibility for the benefit sought because of lack of qualifying service, lack of veteran status, or other lack of legal eligibility;

(2) Claims that are inherently incredible or clearly lack merit; and

(3) An application requesting a benefit to which the claimant is not entitled as a matter of law.

(Authority: 38 U.S.C. 5103A(a)(2))

(e) *Duty to notify claimant of inability to obtain records.* (1) If VA makes reasonable efforts to obtain relevant non-Federal records but is unable to obtain them, or after continued efforts to obtain Federal records concludes that it is reasonably certain they do not exist or further efforts to obtain them would be futile, VA will provide the claimant with oral or written notice of that fact. VA will make a record of any oral notice conveyed to the claimant. For non-Federal records requests, VA may provide the notice at the same time it makes its final attempt to obtain the relevant records. In either case, the notice must contain the following information:

(i) The identity of the records VA was unable to obtain;

(ii) An explanation of the efforts VA made to obtain the records;

(iii) A description of any further action VA will take regarding the claim, including, but not limited to, notice that VA will decide the claim based on the evidence of record unless the claimant submits the records VA was unable to obtain; and

(iv) A notice that the claimant is ultimately responsible for providing the evidence.

(2) If VA becomes aware of the existence of relevant records before deciding the claim, VA will notify the claimant of the records and request that the claimant provide a release for the records. If the claimant does not provide any necessary release of the relevant records that VA is unable to obtain, VA will request that the claimant obtain the records and provide them to VA.

(Authority: 38 U.S.C. 5103A(b)(2))

(f) For the purpose of the notice requirements in paragraphs (b) and (e) of this section, notice to the claimant means notice to the claimant or his or her fiduciary, if any, as well as to his or her representative, if any.

(Authority: 38 U.S.C. 5102(b), 5103(a))

(g) The authority recognized in subsection (g) of 38 U.S.C. 5103A is reserved to the sole discretion of the Secretary and will be implemented, when deemed appropriate by the Secretary, through the promulgation of regulations.

(Authority: 38 U.S.C. 5103A(g))

[66 FR 45630, Aug. 29, 2001, as amended at 73 FR 23356, Apr. 30, 2008; 84 FR 169, Jan. 18, 2019]

§3.160 Status of claims.

(a) *Complete claim.* A submission of an application form prescribed by the Secretary, whether paper or electronic, that meets the following requirements:

(1) A complete claim must provide the name of the claimant; the relationship to the veteran, if applicable; and sufficient information for VA to verify the claimed service, if applicable.

(2) A complete claim must be signed by the claimant or a person legally authorized to sign for the claimant.

(3) A complete claim must identify the benefit sought.

(4) A description of any symptom(s) or medical condition(s) on which the benefit is based must be provided to the extent the form prescribed by the Secretary so requires.

(5) For nonservice-connected disability or death pension and parents' dependency and indemnity compensation claims, a statement of income must be provided to the extent the form prescribed by the Secretary so requires; and

(6) For supplemental claims, potentially new evidence must be identified or included.

(b) *Original claim.* The initial complete claim for one or more benefits on an application form prescribed by the Secretary.

(c) *Pending claim.* A claim which has not been finally adjudicated.

(d) *Finally adjudicated claim.* A claim that is adjudicated by the Department of Veterans Affairs as either allowed or disallowed is considered finally adjudicated when:

(1) For legacy claims not subject to the modernized review system, whichever of the following occurs first:

(i) The expiration of the period in which to file a Notice of Disagreement, pursuant to the provisions of §19.52(a)

or § 20.502(a) of this chapter, as applicable; or

(ii) Disposition on appellate review.

(2) For claims under the modernized review system, the expiration of the period in which to file a review option available under § 3.2500 or disposition on judicial review where no such review option is available.

(e) *Reopened claims prior to effective date of modernized review system.* An application for a benefit received prior to the effective date provided in § 19.2(a) of this chapter, after final disallowance of an earlier claim that is subject to readjudication on the merits based on receipt of new and material evidence related to the finally adjudicated claim, or any claim based on additional evidence or a request for a personal hearing submitted more than 90 days following notification to the appellant of the certification of an appeal and transfer of applicable records to the Board of Veterans' Appeals which was not considered by the Board in its decision and was referred to the agency of original jurisdiction for consideration as provided in § 20.1304(b)(1) of this chapter. As of the effective date provided in § 19.2(a) of this chapter, claimants may no longer file to reopen a claim, but may file a supplemental claim as prescribed in § 3.2501 to apply for a previously disallowed benefit. A request to reopen a finally decided claim that has not been adjudicated as of the effective date will be processed as a supplemental claim subject to the modernized review system.

(Authority: 38 U.S.C. 501)

[27 FR 11887, Dec. 1, 1962, as amended at 31 FR 12056, Sept. 15, 1966; 55 FR 20148, May 15, 1990; 58 FR 32445, June 10, 1993; 79 FR 57696, Sept. 25, 2014; 84 FR 170, Jan. 18, 2019]

§ 3.161 [Reserved]

EVIDENCE REQUIREMENTS

§ 3.200 Testimony certified or under oath.

(a) All oral testimony presented by claimants and witnesses on their behalf before any rating or authorization body will be under oath or affirmation. (See § 3.103(c).)

(b) All written testimony submitted by the claimant or in his or her behalf for the purpose of establishing a claim for service connection will be certified or under oath or affirmation. This includes records, examination reports, and transcripts material to the issue received by the Department of Veterans Affairs at the instance of the claimant or in his or her behalf or requested by the Department of Veterans Affairs from State, county, municipal, recognized private institutions, and contract hospitals.

[40 FR 36329, Aug. 20, 1975]

§ 3.201 Exchange of evidence; Social Security and Department of Veterans Affairs.

(a) A claimant for dependency and indemnity compensation may elect to furnish to the Department of Veterans Affairs in support of that claim copies of evidence which was previously furnished to the Social Security Administration or to have the Department of Veterans Affairs obtain such evidence from the Social Security Administration. For the purpose of determining the earliest effective date for payment of dependency and indemnity compensation, such evidence will be deemed to have been received by the Department of Veterans Affairs on the date it was received by the Social Security Administration.

(b) A copy or certification of evidence filed in the Department of Veterans Affairs in support of a claim for dependency and indemnity compensation will be furnished the Social Security Administration upon request from the agency.

(Authority: 38 U.S.C. 501(a) and 5105)

CROSS REFERENCE: Claims filed with Social Security. See § 3.153.

[26 FR 1571, Feb. 24, 1961, as amended at 58 FR 25562, Apr. 27, 1993]

§ 3.202 Evidence from foreign countries.

(a) Except as provided in paragraph (b) of this section, where an affidavit or other document is required to be executed under oath before an official in a foreign country, the signature of that official must be authenticated by a United States Consular Officer in that

jurisdiction or by the State Department. Where the United States has no consular representative in a foreign country, such authentication may be made as follows:

(1) By a consular agent of a friendly government whereupon the signature and seal of the official of the friendly government may be authenticated by the State Department; or

(2) By the nearest American consul who will attach a certificate showing the result of the investigation concerning its authenticity.

(b) Authentication will not be required: (1) On documents approved by the Deputy Minister of Veterans Affairs, Department of Veterans Affairs, Ottawa, Canada: or

(2) When it is indicated that the attesting officer is authorized to administer oaths for general purposes and the document bears his or her signature and seal; or

(3) When the document is executed before a Department of Veterans Affairs employee authorized to administer oaths; or

(4) When a copy of a public or church record from any foreign country purports to establish birth, adoption, marriage, annulment, divorce, or death, provided it bears the signature and seal of the custodian of such record and there is no conflicting evidence in the file which would serve to create doubt as to the correctness of the record; or

(5) When a copy of the public or church record from one of the countries comprising the United Kingdom, namely: England, Scotland, Wales, or Northern Ireland, purports to establish birth, marriage, or death, provided it bears the signature or seal or stamp of the custodian of such record and there is no evidence which would serve to create doubt as to the correctness of the records; or

(6) When affidavits prepared in the Republic of the Philippines are certified by a Department of Veterans Affairs representative located in the Philippines having authority to administer oaths.

(c) Photocopies of original documents meeting the requirements of this section will be accepted if they satisfy the requirements of § 3.204 of this part.

(Authority: 38 U.S.C. 501)

CROSS REFERENCE: State Department as agent of Department of Veterans Affairs. See § 3.108.

[26 FR 1571, Feb. 24, 1961, as amended at 40 FR 36329, Aug. 20, 1975; 52 FR 19348, May 22, 1987; 59 FR 46338, Sept. 8, 1994]

§ 3.203 Service records as evidence of service and character of discharge.

(a) *Evidence submitted by a claimant.* For the purpose of establishing entitlement to pension, compensation, dependency and indemnity compensation or burial benefits the Department of Veterans Affairs may accept evidence of service submitted by a claimant (or sent directly to the Department of Veterans Affairs by the service department), such as a DD Form 214, Certificate of Release or Discharge from Active Duty, or original Certificate of Discharge, without verification from the appropriate service department if the evidence meets the following conditions:

(1) The evidence is a document issued by the service department. A copy of an original document is acceptable if the copy was issued by the service department or if the copy was issued by a public custodian of records who certifies that it is a true and exact copy of the document in the custodian's custody or, if the copy was submitted by an accredited agent, attorney or service organization representative who has successfully completed VA-prescribed training on military records, and who certifies that it is a true and exact copy of either an original document or of a copy issued by the service department or a public custodian of records; and

(2) The document contains needed information as to length, time and character of service; and

(3) In the opinion of the Department of Veterans Affairs the document is genuine and the information contained in it is accurate.

(b) *Additional requirements for pension claimants.* In addition to meeting the requirements of paragraph (a) of this section, a document submitted to establish a creditable period of wartime service for pension entitlement may be

accepted without verification if the document (or other evidence of record) shows:

(1) Service of 4 months or more; or

(2) Discharge for disability incurred in line of duty; or

(3) Ninety days creditable service based on records from the service department such as hospitalization for 90 days for a line of duty disability.

(c) *Verification from the service department.* When the claimant does not submit evidence of service or the evidence submitted does not meet the requirements of paragraph (a) of this section (and paragraph (b) of this section in pension claims), the Department of Veterans Affairs shall request verification of service from the service department. However, payment of non-service-connected burial benefits may be authorized, if otherwise in order, based upon evidence of service which VA relied upon to authorize payment of compensation or pension during the veteran's lifetime, provided that there is no evidence which would serve to create doubt as to the correctness of that service evidence. If it appears that a length of service requirement may not be met (e.g., the 90 days wartime service requirement to receive pension under 38 U.S.C. 1521(j)), the Department of Veterans Affairs shall request a complete statement of service to determine if there are any periods of active service that are required to be excluded under § 3.15.

[45 FR 72654, Nov. 3, 1980, as amended at 46 FR 51246, Oct. 19, 1981; 58 FR 37857, July 14, 1993; 58 FR 42623, Aug. 10, 1993; 66 FR 19858, Apr. 18, 2001]

§ 3.204 Evidence of dependents and age.

(a)(1) Except as provided in paragraph (a)(2) of this section, VA will accept, for the purpose of determining entitlement to benefits under laws administered by VA, the statement of a claimant as proof of marriage, dissolution of a marriage, birth of a child, or death of a dependent, provided that the statement contains: the date (month and year) and place of the event; the full name and relationship of the other person to the claimant; and, where the claimant's dependent child does not reside with the claimant, the name and address of the person who has custody of the child. In addition, a claimant must provide the social security number of any dependent on whose behalf he or she is seeking benefits (see § 3.216).

(2) VA shall require the types of evidence indicated in §§ 3.205 through 3.211 where: the claimant does not reside within a state; the claimant's statement on its face raises a question of its validity; the claimant's statement conflicts with other evidence of record; or, there is a reasonable indication, in the claimant's statement or otherwise, of fraud or misrepresentation of the relationship in question.

(Authority: 38 U.S.C. 5124)

(b) *Marriage or birth.* The classes of evidence to be furnished for the purpose of establishing marriage, dissolution of marriage, age, relationship, or death, if required under the provisions of paragraph (a)(2), are indicated in §§ 3.205 through 3.211 in the order of preference. Failure to furnish the higher class, however, does not preclude the acceptance of a lower class if the evidence furnished is sufficient to prove the point involved.

(c) *Acceptability of photocopies.* Photocopies of documents necessary to establish birth, death, marriage or relationship under the provisions of §§ 3.205 through 3.215 of this part are acceptable as evidence if the Department of Veterans Affairs is satisfied that the copies are genuine and free from alteration. Otherwise, VA may request a copy of the document certified over the signature and official seal of the person having custody of such record.

(Authority: 38 U.S.C. 501)

(The Office of Management and Budget has approved the information collection requirements in this section under control number 2900–0624)

[26 FR 1572, Feb. 24, 1961, as amended at 40 FR 53581, Nov. 19, 1975; 45 FR 72655, Nov. 3, 1980; 59 FR 46338, Sept. 8, 1994; 61 FR 56626, Nov. 4, 1996; 66 FR 56614, Nov. 9, 2001]

§ 3.205 Marriage.

(a) *Proof of marriage.* Marriage is established by one of the following types of evidence:

(1) Copy or abstract of the public record of marriage, or a copy of the church record of marriage, containing sufficient data to identify the parties, the date and place of marriage, and the number of prior marriages if shown on the official record.

(2) Official report from service department as to marriage which occurred while the veteran was in service.

(3) The affidavit of the clergyman or magistrate who officiated.

(4) The original certificate of marriage, if the Department of Veterans Affairs is satisfied that it is genuine and free from alteration.

(5) The affidavits or certified statements of two or more eyewitnesses to the ceremony.

(6) In jurisdictions where marriages other than by ceremony are recognized the affidavits or certified statements of one or both of the parties to the marriage, if living, setting forth all of the facts and circumstances concerning the alleged marriage, such as the agreement between the parties at the beginning of their cohabitation, the period of cohabitation, places and dates of residences, and whether children were born as the result of the relationship. This evidence should be supplemented by affidavits or certified statements from two or more persons who know as the result of personal observation the reputed relationship which existed between the parties to the alleged marriage including the periods of cohabitation, places of residences, whether the parties held themselves out as married, and whether they were generally accepted as such in the communities in which they lived.

(7) Any other secondary evidence which reasonably supports a belief by the Adjudicating activity that a valid marriage actually occurred.

(b) *Valid marriage.* In the absence of conflicting information, proof of marriage which meets the requirements of paragraph (a) of this section together with the claimant's certified statement concerning the date, place and circumstances of dissolution of any prior marriage may be accepted as establishing a valid marriage, provided that such facts, if they were to be corroborated by record evidence, would warrant acceptance of the marriage as valid. Where necessary to a determination because of conflicting information or protest by a party having an interest therein, proof of termination of a prior marriage will be shown by proof of death, or a certified copy or a certified abstract of final decree of divorce or annulment specifically reciting the effects of the decree.

(c) *Marriages deemed valid.* Where a surviving spouse has submitted proof of marriage in accordance with paragraph (a) of this section and also meets the requirements of § 3.52, the claimant's signed statement that he or she had no knowledge of an impediment to the marriage to the veteran will be accepted, in the absence of information to the contrary, as proof of that fact.

(Authority: 38 U.S.C. 501)

CROSS REFERENCES: Marriages deemed valid. See § 3.52. Definitions; marriage. See § 3.1(j). Evidence of dependents and age. See § 3.204.

[26 FR 1572, Feb. 24, 1961, as amended at 27 FR 6281, July 3, 1962; 36 FR 20946, Nov. 2, 1971; 40 FR 53581, Nov. 19, 1975; 45 FR 72655, Nov. 3, 1980; 47 FR 28096, June 29, 1982; 52 FR 19349, May 22, 1987; 58 FR 37857, July 14, 1993; 59 FR 46338, Sept. 8, 1994; 62 FR 5529, Feb. 6, 1997]

§ 3.206 Divorce.

The validity of a divorce decree regular on its face, will be questioned by the Department of Veterans Affairs only when such validity is put in issue by a party thereto or a person whose interest in a claim for Department of Veterans Affairs benefits would be affected thereby. In cases where recognition of the decree is thus brought into question:

(a) Where the issue is whether the veteran is single or married (dissolution of a subsisting marriage), there must be a bona fide domicile in addition to the standards of the granting jurisdiction respecting validity of divorce;

(b) Where the issue is the validity of marriage to a veteran following a divorce, the matter of recognition of the divorce by the Department of Veterans Affairs (including any question of bona fide domicile) will be determined according to the laws of the jurisdictions specified in § 3.1(j).

(c) Where a foreign divorce has been granted the residents of a State whose laws consider such decrees to be valid, it will thereafter be considered as valid under the laws of the jurisdictions specified in § 3.1(j) in the absence of a determination to the contrary by a court of last resort in those jurisdictions.

CROSS REFERENCE: Evidence of dependents and age. See § 3.204.

[27 FR 6281, July 3, 1962, as amended at 35 FR 16831, Oct. 31, 1970; 40 FR 53581, Nov. 19, 1975; 52 FR 19349, May 22, 1987]

§ 3.207 Void or annulled marriage.

Proof that a marriage was void or has been annulled should consist of:

(a) *Void*. A certified statement from the claimant setting forth the circumstances which rendered the marriage void, together with such other evidence as may be required for a determination.

(b) *Annulled*. A copy or abstract of the decree of annulment. A decree regular on its face will be accepted unless there is reason to question the basic authority of the court to render annulment decrees or there is evidence indicating that the annulment may have been obtained through fraud by either party or by collusion.

CROSS REFERENCES: Effective dates, void or annulled marriage. See § 3.400 (u) and (v). Evidence of dependents and age. See § 3.204.

[28 FR 2904, Mar. 3, 1963, as amended at 40 FR 53581, Nov. 19, 1975; 52 FR 19349, May 22, 1987; 59 FR 46338, Sept. 8, 1994]

§ 3.208 Claims based on attained age.

In claims for pension where the age of the veteran or surviving spouse is material, the statements of age will be accepted where they are in agreement with other statements in the record as to age. However, where there is a variance in such records, the youngest age will be accepted subject to the submission of evidence as outlined in § 3.209.

CROSS REFERENCE: Evidence of dependents and age. See § 3.204.

[40 FR 53581, Nov. 19, 1975, as amended at 52 FR 19349, May 22, 1987]

§ 3.209 Birth.

Age or relationship is established by one of the following types of evidence. If the evidence submitted for proof of age or relationship indicates a difference in the name of the person as shown by other records, the discrepancy is to be reconciled by an affidavit or certified statement identifying the person having the changed name as the person whose name appears in the evidence of age or relationship.

(a) A copy or abstract of the public record of birth. Such a record established more than 4 years after the birth will be accepted as proof of age or relationship if, it is not inconsistent with material of record with the Department of Veterans Affairs, or if it shows on its face that it is based upon evidence which would be acceptable under this section.

(b) A copy of the church record of baptism. Such a record of baptism performed more than 4 years after birth will not be accepted as proof of age or relationship unless it is consistent with material of record with the Department of Veterans Affairs, which will include at least one reference to age or relationship made at a time when such reference was not essential to establishing entitlement to the benefit claimed.

(c) Official report from the service department as to birth which occurred while the veteran was in service.

(d) Affidavit or a certified statement of the physician or midwife in attendance at birth.

(e) Copy of Bible or other family record certified to by a notary public or other officer with authority to administer oaths, who should state in what year the Bible or other book in which the record appears was printed, whether the record bears any erasures or other marks of alteration, and whether from the appearance of the writing he or she believes the entries to have been made at the time purported.

(f) Affidavits or certified statements of two or more persons, preferably disinterested, who will state their ages, showing the name, date, and place of birth of the person whose age or relationship is being established, and that to their own knowledge such person is

the child of such parents (naming the parents) and stating the source of their knowledge.

(g) Other evidence which is adequate to establish the facts in issue, including census records, original baptismal records, hospital records, insurance policies, school, employment, immigration, or naturalization records.

(Authority: 38 U.S.C. 501)

CROSS REFERENCE: Evidence of dependents and age. See §3.204.

[26 FR 1573, Feb. 24, 1961, as amended at 27 FR 1899, Feb. 28, 1962; 40 FR 53581, Nov. 19, 1975; 47 FR 28096, June 29, 1982; 52 FR 19349, May 22, 1987; 59 FR 46338, Sept. 8, 1994]

§3.210 Child's relationship.

(a) *Legitimate child.* Where it is necessary to determine the legitimacy of a child, evidence will be required to establish the legality of the marriage of the mother of the child to the veteran or to show that the child is otherwise legitimate by State laws together with evidence of birth as outlined in §3.209. Where the legitimacy of a child is not a factor, evidence to establish legitimacy will not be required: *Provided*, That, evidence is on file which meets the requirements of paragraph (b) of this section sufficient to warrant recognition of the relationship of the child without regard to legitimacy.

(b) *Illegitimate child.* As to the mother of an illegitimate child, proof of birth is all that is required. As to the father, the sufficiency of evidence will be determined in accordance with the facts in the individual case. Proof of such relationship will consist of:

(1) An acknowledgment in writing signed by him; or

(2) Evidence that he has been identified as the child's father by a judicial decree ordering him to contribute to the child's support or for other purposes; or

(3) Any other secondary evidence which reasonably supports a finding of relationship, as determined by an official authorized to approve such findings, such as:

(i) A copy of the public record of birth or church record of baptism, showing that the veteran was the informant and was named as parent of the child; or

(ii) Statements of persons who know that the veteran accepted the child as his; or

(iii) Information obtained from service department or public records, such as school or welfare agencies, which shows that with his knowledge the veteran was named as the father of the child.

(c) *Adopted child.* Except as provided in paragraph (c)(1) of this section evidence of relationship will include a copy of the decree of adoption or a copy of the adoptive placement agreement and such other evidence as may be necessary.

(1) In jurisdictions where petition must be made to the court for release of adoption documents or information, or where release of such documents or information is prohibited, the following may be accepted to establish the fact of adoption:

(i) As to a child adopted into the veteran's family, a copy of the child's revised birth certificate.

(ii) As to a child adopted out of the veteran's family, a statement over the signature of the judge or the clerk of the court setting forth the child's former name and the date of adoption, or a certified statement by the veteran, the veteran's surviving spouse, apportionee, or their fiduciaries setting forth the child's former name, date of birth, and the date and fact of adoption together with evidence indicating that the child's original public record of birth has been removed from such records. Where application is made for an apportionment under §3.458(d) on behalf of a child adopted out of the veteran's family, the evidence must be sufficient to establish the veteran as the natural parent of the child.

(2) As to a child adopted by the veteran's surviving spouse after the veteran's death, the statement of the adoptive parent or custodian of the child will be accepted in absence of information to the contrary, to show that the child was a member of the veteran's household at the date of the veteran's death and that recurring contributions were not being received for the child's maintenance sufficient to provide for the major portion of the child's support, from any person other than the veteran or surviving spouse or

from any public or private welfare organization which furnished services or assistance to children. (Pub. L. 86–195)

(d) *Stepchild*. Evidence of relationship of a stepchild will consist of proof of birth as outlined in § 3.209, evidence of the marriage of the veteran to the natural parent of the child, and evidence that the child is a member of the veteran's household or was a member of the veteran's household at the date of the veteran's death.

CROSS REFERENCE: Evidence of dependents and age. See § 3.204.

[26 FR 1573, Feb. 24, 1961, as amended at 27 FR 1899, Feb. 28, 1962; 28 FR 2959, Mar. 26, 1963; 38 FR 871, Jan. 5, 1973; 47 FR 28096, June 29, 1982; 52 FR 19349, May 22, 1987; 59 FR 46338, Sept. 8, 1994]

§ 3.211 Death.

Death should be established by one of the following types of evidence:

(a)(1) A copy of the public record of the State or community where death occurred.

(2) A copy of a coroner's report of death or a verdict of a coroner's jury of the State or community where death occurred, provided such report or verdict properly identified the deceased.

(b) Where death occurs in a hospital or institution under the control of the United States Government:

(1) A death certificate signed by a medical officer; or

(2) A clinical summary or other report showing fact and date of death signed by a medical officer.

(c) An official report of death of a member of a uniformed service from the Secretary of the department concerned where death occurs while deceased was on the retired list, in an inactive duty status, or in the active service.

(d) Where death occurs abroad:

(1) A United States consular report of death bearing the signature and seal of the United States consul; or

(2) A copy of the public record of death authenticated (see § 3.202(b)(4) for exception) by the United States consul or other agency of the State Department; or

(3) An official report of death from the head of the department concerned, where the deceased person was, at the time of death, a civilian employee of such department.

(e) If the foregoing evidence cannot be furnished, the reason must be stated. The fact of death may then be established by the affidavits of persons who have personal knowledge of the fact of death, have viewed the body of the deceased, know it to be the body of the person whose death is being established, setting forth all the facts and circumstances concerning the death, place, date, time, and cause thereof.

(f) If proof of death, as defined in paragraphs (a) through (e) of this section cannot be furnished, a finding of fact of death, where death is otherwise shown by competent evidence, may be made by an official authorized to approve such findings. Where it is indicated that the veteran died under circumstances which precluded recovery or identification of the body, the fact of death should be established by the best evidence, which from the nature of the case must be supposed to exist.

(g) In the absence of evidence to the contrary, a finding of fact of death made by another Federal agency will be accepted for the purposes of paragraph (f) of this section.

CROSS REFERENCE: Evidence of dependents and age. See § 3.204.

[26 FR 1573, Feb. 24, 1961, as amended at 27 FR 1899, Feb. 28, 1962; 52 FR 19349, May 22, 1987; 59 FR 46338, Sept. 8, 1994]

§ 3.212 Unexplained absence for 7 years.

(a) If satisfactory evidence is produced establishing the fact of the continued and unexplained absence of any individual from his or her home and family for a period of 7 years or more and that a diligent search disclosed no evidence of his or her existence after the date of disappearance, and if evidence as provided in § 3.211 cannot be furnished, the death of such individual as of the expiration of such period may be considered as sufficiently proved.

(b) No State law providing for presumption of death will be applicable to claims for benefits under laws administered by the Department of Veterans Affairs and the finding of death will be final and conclusive except where suit

is filed for insurance under 38 U.S.C. 1984.

(Authority: 38 U.S.C. 108)

(c) In the absence of evidence to the contrary, a finding of death made by another Federal agency will be accepted if the finding meets the requirements of paragraph (a) of this section.

CROSS REFERENCE: Evidence of dependents and age. See §3.204.

[26 FR 1573, Feb. 24, 1961, as amended at 27 FR 1899, Feb. 28, 1962; 52 FR 19349, May 22, 1987]

§3.213 Change of status affecting entitlement.

(a) *General.* For the purpose of establishing entitlement to a higher rate of pension, compensation, or dependency and indemnity compensation based on the existence of a dependent, VA will require evidence which satisfies the requirements of §3.204. For the purpose of reducing or discontinuing such benefits, a statement by a claimant or payee setting forth the month and year of change of status which would result in a reduction or discontinuance of benefits to that person will be accepted, in the absence of contradictory information. This includes:

(1) *Veteran.* A statement by the veteran setting forth the month and year of death of a spouse, child, or dependent parent.

(2) *Surviving spouse.* A statement by the surviving spouse or remarried surviving spouse setting forth the month and year of remarriage and any change of name. (An award for a child or children who are otherwise entitled may be made to commence the day following the date of discontinuance of any payments to the surviving spouse.)

(3) *Child.* A statement by the veteran or surviving spouse (where an additional allowance is being paid to the veteran or surviving spouse for a child), or fiduciary, setting forth the month and year of the child's death, marriage, or discontinuance of school attendance. A similar statement by a child who is receiving payments direct will be accepted to establish the child's marriage or the discontinuance of school attendance. Where appropriate, the month and year of discontinuance of school attendance will be required in addition to the month and year of death or marriage of a child.

(Authority: 38 U.S.C. 501)

(4) *Parent.* A statement by a parent setting forth the month and year:

(i) Of marriage or remarriage;

(ii) When two parents or a parent and spouse ceased living together;

(iii) When two parents or a parent and spouse resumed living together following a period of separation;

(iv) Of divorce or death of a spouse.

(b) *Date not reported.* If the month and year of the event is not reported, the award will be reduced or discontinued, whichever is appropriate, effective date of last payment. The payee will be requested to furnish within 60 days from the date of request a statement setting forth the date of the event. Where payments are continued at a reduced rate, the award will be discontinued effective date of last payment if the required statement is not received within the 60-day period. Payments on a discontinued award may be resumed, if otherwise in order, from the date of discontinuance if the necessary information is received within 1 year from the date of request; otherwise from the date of receipt of a new claim.

(c) *Contradictory information.* Where there is reason to believe that the event reported may have occurred at an earlier date, formal proof will be required.

CROSS REFERENCES: Abandoned claims. See §3.158. Change in status of dependents. See §3.651. Material change in income, net worth or change in status. See §3.660. Evidence of dependents and age. See §3.204.

[26 FR 1574, Feb. 24, 1961, as amended at 27 FR 1899, Feb. 28, 1962; 27 FR 11888, Dec. 1, 1962; 52 FR 19349, May 22, 1987; 61 FR 56626, Nov. 4, 1996]

§3.214 Court decisions; unremarried surviving spouses.

Effective July 15, 1958, a decision rendered by a Federal court in an action to which the United States was a party holding that a surviving spouse of a veteran has not remarried will be followed in determining eligibility for

pension, compensation or dependency and indemnity compensation.

CROSS REFERENCES: Abandoned claims. See § 3.158. Change in status of dependents. See § 3.651. Dependency, income and estate. See § 3.660. Evidence of dependents and age. See § 3.204.

[31 FR 2782, Feb. 16, 1966, as amended at 52 FR 19349, May 22, 1987]

§ 3.215 Termination of marital relationship or conduct.

On or after January 1, 1971, benefits may be resumed to an unmarried surviving spouse upon filing of an application and submission of satisfactory evidence that the surviving spouse has ceased living with another person and holding himself or herself out openly to the public as that person's spouse or that the surviving spouse has terminated a relationship or conduct which had created an inference or presumption of remarriage or related to open or notorious adulterous cohabitation or similar conduct, if the relationship terminated prior to November 1, 1990. Such evidence may consist of, but is not limited to, the surviving spouse's certified statement of the fact.

[57 FR 10426, Mar. 26, 1992, as amended at 58 FR 32445, June 10, 1993]

§ 3.216 Mandatory disclosure of social security numbers.

Any person who applies for or receives any compensation or pension benefit as defined in §§ 3.3, 3.4, or 3.5 of this part, or a monetary allowance under 38 U.S.C. chapter 18, shall, as a condition for receipt or continued receipt of benefits, furnish the Department of Veterans Affairs upon request with his or her social security number and the social security number of any dependent or beneficiary on whose behalf, or based upon whom, benefits are sought or received. However, no one shall be required to furnish a social security number for any person to whom none has been assigned. Benefits will be terminated if a beneficiary fails to furnish the Department of Veterans Affairs with his or her social security number or the social security number of any dependent or beneficiary on whose behalf, or based upon whom, benefits are sought or received, within 60 days from the date the beneficiary is requested to furnish the social security number.

(Authority: 38 U.S.C. 1832, 5101(c))

(Approved by the Office of Management and Budget under control number 2900–0522)

[57 FR 8268, Mar. 9, 1992, as amended at 57 FR 27935, June 23, 1992; 65 FR 35282, June 2, 2000; 67 FR 49586, July 31, 2002; 76 FR 4248, Jan. 25, 2011]

§ 3.217 Submission of statements or information affecting entitlement to benefits.

(a) For purposes of this part, unless specifically provided otherwise, the submission of information or a statement that affects entitlement to benefits by e-mail, facsimile, or other written electronic means, will satisfy a requirement or authorization that the statement or information be submitted in writing.

NOTE TO PARAGRAPH (a): Section 3.217(a) merely concerns the submission of information or a statement in writing. Other requirements specified in this part, such as a requirement to use a specific form, to provide specific information, to provide a signature, or to provide a certified statement, must still be met.

(b) For purposes of this part, unless specifically provided otherwise, VA may take action affecting entitlement to benefits based on oral or written information or statements provided to VA by a beneficiary or his or her fiduciary. However, VA may not take action based on oral information or statements unless the VA employee receiving the information meets the following conditions:

(1) During the conversation in which the information or statement is provided, the VA employee:

(i) Identifies himself or herself as a VA employee who is authorized to receive the information or statement (these are VA employees authorized to take actions under §§ 2.3 or 3.100 of this chapter);

(ii) Verifies the identity of the provider as either the beneficiary or his or her fiduciary by obtaining specific information about the beneficiary that can be verified from the beneficiary's VA records, such as Social Security number, date of birth, branch of military service, dates of military service, or other information; and

(iii) Informs the provider that the information or statement will be used for the purpose of calculating benefit amounts; and

(2) During or following the conversation in which the information or statement is provided, the VA employee documents in the beneficiary's VA records the specific information or statement provided, the date such information or statement was provided, the identity of the provider, the steps taken to verify the identity of the provider as being either the beneficiary or his or her fiduciary, and that he or she informed the provider that the information would be used for the purpose of calculating benefit amounts.

AUTHORITY: 38 U.S.C. 501, 1115, 1506, 5104.

[66 FR 56614, Nov. 9, 2001]

DEPENDENCY, INCOME AND ESTATE

REGULATIONS APPLICABLE TO PROGRAMS IN EFFECT PRIOR TO JANUARY 1, 1979

§ 3.250 Dependency of parents; compensation.

(a) *Income*—(1) *Conclusive dependency*. Dependency of a parent (other than one who is residing in a foreign country) will be held to exist where the monthy income does not exceed:

(i) $400 for a mother or father not living together;

(ii) $660 for a mother and father, or remarried parent and spouse, living together;

(iii) $185 for each additional ''member of the family'' as defined in paragraph (b)(2).

(Authority: 38 U.S.C. 102(a))

(2) *Excess income*. Where the income exceeds the monthly amounts stated in paragraph (a)(1) of this section dependency will be determined on the facts in the individual case under the principles outlined in paragraph (b) of this section. In such cases, dependency will not be held to exist if it is reasonable that some part of the corpus of the claimant's estate be consumed for his or her maintenance.

(3) *Foreign residents*. There is no conclusive presumption of dependency. Dependency will be determined on the facts in the individual case under the principles outlined in this section.

(b) *Basic rule*. Dependency will be held to exist if the father or mother of the veteran does not have an income sufficient to provide reasonable maintenance for such father or mother and members of his or her family under legal age and for dependent adult members of the family if the dependency of such adult member results from mental or physical incapacity.

(1) ''Reasonable Maintenance'' includes not only housing, food, clothing, and medical care sufficient to sustain life, but such items beyond the bare necessities as well as other requirements reasonably necessary to provide those conveniences and comforts of living suitable to and consistent with the parents' reasonable mode of life.

(2) ''Member of the family'' means a person (other than spouse) including a relative in the ascending as well as descending class, whom the father or mother is under moral or legal obligation to support. In determining whether other members of the family under legal age are factors in necessary expenses of the mother or father, consideration will be given to any income from business or property (including trusts) actually available, directly or indirectly, to the mother or father for the support of the minor but not to the corpus of the estate or the income of the minor which is not so available.

(c) *Inception of dependency*. The fact that the veteran has made habitual contributions to the father or mother, or both, is not conclusive evidence that dependency existed but will be considered in connection with all other evidence. In death claims, it is not material whether dependency arose prior or subsequent to the veteran's death. (See § 3.1000(d)(3) as to accrued.)

(Authority: 38 U.S.C. 102(a))

(d) *Remarriage*. Dependency will not be denied solely because of remarriage (38 U.S.C. 102(b)(1)). Compensation may be continued if the parent submits evidence to show that dependency exists, considering the combined income and expenses of the parent and spouse.

[28 FR 29, Jan. 1, 1963, as amended at 40 FR 16065, Apr. 9, 1975; 49 FR 47004, Nov. 30, 1984; 61 FR 20727, May 8, 1996]

§ 3.251 Income of parents; dependency and indemnity compensation.

(a) *Annual income limitations and rates.* (1) Dependency and indemnity compensation is not payable to a parent or parents whose annual income exceeds the limitations set forth in 38 U.S.C. 1315 (b), (c), or (d).

(2) Where there is only one parent, and the parent has remarried and is living with his or her spouse, dependency and indemnity compensation will be paid under either the formula in 38 U.S.C. 1315(b)(1) or the formula in 38 U.S.C. 1315(d), whichever will provide the greater monthly rate of dependency and indemnity compensation. The total combined annual income of the parent and spouse will be counted.

(Authority: 38 U.S.C. 1315)

(3) Where the claim is based on service in the Commonwealth Army of the Philippines, or as a guerrilla or as a Philippine Scout under section 14, Pub. L. 190, 79th Congress, the income limitation will be at a rate of $0.50 for each dollar. See § 3.100(b).

(Authority: 38 U.S.C. 107)

(4) If the remarriage of a parent has been terminated, or the parent is separated from his or her spouse, the rate of dependency and indemnity compensation for the parent will be that which would be payable if there were one parent alone or two parents not living together, whichever is applicable.

(5) Where there are two parents living and only one parent has filed claim, the rate of dependency and indemnity compensation will be that which would be payable if both parents had filed claim.

(b) *Basic rule.* Payments of any kind or from any source will be counted as income unless specifically excluded. Income will be counted for the calendar year in which it is received and total income for the full calendar year will be considered except as provided in § 3.260.

[28 FR 29, Jan. 1, 1963, as amended at 31 FR 14455, Nov. 10, 1966; 40 FR 16065, Apr. 9, 1975; 41 FR 15411, Apr. 13, 1976; 60 FR 18355, Apr. 11, 1995]

§ 3.252 Annual income; pension; Mexican border period and later war periods.

(a) *Annual income limitations; old-law pension.* Where the right to old-law pension is payable under section 306(b) of Pub. L. 95–588 (92 Stat. 2497), pension is not payable if the pensioner's annual income exceeds the income limitations prescribed by § 3.26(c).

(b) *Annual income and net worth limitations; Pub. L. 86–211.* Pension is not payable to a veteran, surviving spouse or child whose annual income exceeds the limitations set forth in 38 U.S.C. 1521, 1541 or 1542; or to a veteran, surviving spouse or child if it is reasonable that some part of the claimant's estate be consumed for his or her maintenance. Where a veteran and spouse are living together, the separate income of the spouse will be considered as the veteran's income as provided in § 3.262(b).

(Authority: 38 U.S.C. 1543)

(c) *Basic rule.* Payments of any kind or from any source will be counted as income unless specifically excluded. Income will be counted for the calendar year in which it is received and total income for the full calendar year will be considered except as provided in § 3.260.

(d) *Veteran with a spouse.* For the purpose of determining eligibility under paragraph (b) of this section the pension rates provided by 38 U.S.C. 1521(c) may be authorized for a married veteran if he or she is living with or, if estranged, is reasonably contributing to the support of his or her spouse. The determination of ''reasonable'' contribution will be based on all the circumstances in the case, considering the income and estate of the veteran and the separate income and estate of the spouse. Apportionment of the veteran's pension under § 3.451 meets the requirement of reasonable contribution.

(e) *Surviving spouse with a child*—(1) *Child.* The term ''child'' means a child as defined in § 3.57. Where a veteran's child is born after the veteran dies, the surviving spouse will not be considered a surviving spouse with a child prior to the child's date of birth.

(2) *Veteran's child not in surviving spouse's custody.* Where the veteran was

survived by a surviving spouse and by a child, the income increments for a surviving spouse and child apply even though the child is not the child of the surviving spouse and not in his or her custody.

(3) *Income of child.* The separate income received by a child or children, regardless of custody, will not be considered in computing the surviving spouse's income. Where the separate income of the child is turned over to the surviving spouse, only so much of the money as is left after deducting any expenses for maintenance of the child will be considered the surviving spouse's income.

(4) *Alternative rate.* Whenever the monthly pension rate payable to the surviving spouse under the formula in 38 U.S.C. 1541(c) is less than the rate payable for one child under section 1542 if the surviving spouse were not entitled, the surviving spouse will be paid the child's rate.

(f) *Income over maximum; reduced aid and attendance allowance.* Beginning January 1, 1977, veterans in need of regular aid and attendance who are not receiving pension because their income exceeds the applicable statutory limitation may be eligible for a reduced aid and attendance allowance. The amount payable is the regular aid and attendance allowance authorized by 38 U.S.C. 1521(d)(1) reduced by 16.6 percent for each $100, or portion thereof, by which the veteran's annual income exceeds the applicable maximum income limitation. The reduced aid and attendance allowance is payable when:

(1) A veteran in need of regular aid and attendance is denied pension under 38 U.S.C. 1521 solely because the veteran's annual income exceeds the applicable maximum income limitation in 38 U.S.C. 1521 (b)(3) and (c)(3); or

(2) Pension payable under 38 U.S.C. 1521 to a veteran in need of regular aid and attendance is discontinued solely because the veteran's annual income exceeds the applicable maximum income limitation in 38 U.S.C. 1521 (b)(3) or (c)(3); and

(3) The veteran's annual income exceeds the applicable maximum income limitation in 38 U.S.C. 1521 (b)(3) or (c)(3) by an amount not greater than the amount specified in 38 U.S.C. 1521 (d)(2).

CROSS REFERENCES: Basic pension determinations. See § 3.314. Determination of permanent need for regular aid and attendance and ''permanently bedridden''. See § 3.352.

[28 FR 30, Jan. 1, 1963, as amended at 40 FR 16065, Apr. 9, 1975; 41 FR 15411, Apr. 13, 1976; 41 FR 56803, Dec. 30, 1976; 44 FR 45935, Aug. 6, 1979; 61 FR 20727, May 8, 1996; 62 FR 5529, Feb. 6, 1997]

§§ 3.253–3.255 [Reserved]

§ 3.256 Eligibility reporting requirements.

(a) *Obligation to report changes in factors affecting entitlement.* Any individual who has applied for or receives pension or parents' dependency and indemnity compensation must promptly notify the Secretary of any change affecting entitlement in any of the following:

(1) Income;

(2) Net worth or corpus of estate;

(3) Marital status;

(4) Nursing home patient status;

(5) School enrollment status of a child 18 years of age or older; or

(6) Any other factor that affects entitlement to benefits under the provisions of this part.

(b) *Eligibility verification reports.* (1) For purposes of this section the term eligibility verification report means a form prescribed by the Secretary that is used to request income, net worth (if applicable), dependency status, and any other information necessary to determine or verify entitlement to pension or parents' dependency and indemnity compensation.

(2) VA will not require old law or section 306 pensioners to submit eligibility verification reports unless the Secretary determines that doing so is necessary to preserve program integrity.

(3) Except for a parent who has attained 72 years of age and has been paid dependency and indemnity compensation during two consecutive calendar years, the Secretary shall require an eligibility verification report from individuals receiving parents' dependency and indemnity compensation under the following circumstances:

(i) If the Social Security Administration has not verified the beneficiary's

Social Security number and, if the beneficiary is married, his or her spouse's Social Security number.

(ii) If there is reason to believe that the beneficiary or, if the spouse's income could affect entitlement, his or her spouse may have received income other than Social Security during the current or previous calendar year; or

(iii) If the Secretary determines that an eligibility verification report is necessary to preserve program integrity.

(4) An individual who applies for or receives pension or parents' dependency and indemnity compensation as defined in §§ 3.3 or 3.5 of this part shall, as a condition of receipt or continued receipt of benefits, furnish the Department of Veterans Affairs an eligibility verification report upon request.

(c) If VA requests that a claimant or beneficiary submit an eligibility verification report but he or she fails to do so within 60 days of the date of the VA request, the Secretary shall suspend the award or disallow the claim.

(Authority: Sec. 306(a)(2) and (b)(3), Pub. L. 95–588, 92 Stat. 2508–2509; 38 U.S.C. 1315(e))

(The Office of Management and Budget has approved the information collection requirements in this section under control numbers 2900–0101 and 2900–0624)

[63 FR 53595, Oct. 6, 1998, as amended at 66 FR 56614, Nov. 9, 2001; 73 FR 40466, July 15, 2008]

§ 3.257 Children; no surviving spouse entitled.

Where pension is not payable to a surviving spouse because his or her annual income exceeds the statutory limitation or because of his or her net worth, payments will be made to or for the child or children as if there were no surviving spouse.

[62 FR 5529, Feb. 6, 1997]

§§ 3.258–3.259 [Reserved]

§ 3.260 Computation of income.

For entitlement to pension or dependency and indemnity compensation, income will be counted for the calendar year in which it is received.

(a) *Installments.* Income will be determined by the total amount received or anticipated during the calendar year.

(b) *Deferred determinations.* Where there is doubt as to the amount of the anticipated income, pension or dependency and indemnity compensation will be allowed at the lowest appropriate rate or will be withheld, as may be in order, until the end of the calendar year when the total income received during the year may be determined.

(c) *Proportionate income limitations; excess income.* A proportionate income limitation will be established under the conditions set forth in paragraph (d) of this section except where application of a proportionate income limitation would result in payment of a lower rate than would be payable on the basis of income for the full calendar year.

(d) *Proportionate income limitations; computation.* Income limitations will be computed proportionately for the purpose of determining initial entitlement, or for resuming payments on an award which was discontinued for a reason other than excess income or a change in marital or dependency status. A proportionate income limitation will be established for the period from the date of entitlement to the end of that calendar year. The total amount of income received by the claimant during that period will govern the payment of benefits. Income received prior to the date of entitlement will be disregarded.

(e) *Proportionate income limitations; spouse.* In determining whether proportionate computation is applicable to a claim under Pub. L. 86–211 (73 Stat. 432), the total income for the calendar year of entitlement of both veteran and that of the spouse available for use of the veteran will be considered. If a proportionate income limitation is then applicable, it will be applied to both the veteran's and the spouse's income. The spouse's income will not be included, however, where his or her total income for the calendar year does not exceed $1,200.

(f) *Rate changes.* In years after that for which entitlement to pension or dependency and indemnity compensation has been established or reestablished as provided in paragraph (d) of this section, total income for the calendar year will govern the payment of benefits. Where there is a change in the

conditions of entitlement because of a change in marital or dependency status, entitlement for each period will be determined separately. For the period when the claimant was married or had a dependent, the rate payable will be determined under the annual income limitation or increment applicable to a claimant who is married or has a dependent. For the period when the claimant was unmarried or without a dependent, the rate payable will be determined under the annual income limitation or increment applicable to a claimant who is not married or has no dependent. Since these determinations will be based on total income for the calendar year, it is not material whether such income was received before or after the change of status.

(g) *Fractions of dollars.* In computing a claimant's annual income a fraction of a dollar will be disregarded for the purpose of determining entitlement to monthly payments of pension and dependency and indemnity compensation.

(Authority: 38 U.S.C. 1315(g)(2); 1503(b))

[28 FR 30, Jan. 1, 1963, as amended at 29 FR 2944, Mar. 4, 1964; 37 FR 6677, Apr. 1, 1972; 40 FR 16066, Apr. 9, 1975]

§ 3.261 Character of income; exclusions and estates.

The following factors will be considered in determining whether a claimant meets the requirements of §§ 3.250, 3.251 and 3.252 with reference to dependency, income limitations and corpus of estate:

(a) *Income.*

Income	Dependency (parents)	Dependency and indemnity compensation (parents)	Pension; old-law (veterans, surviving spouses and children)	Pension; section 306 (veterans, surviving spouses and children)	See—
(1) Total income from employment, business, investments, or rents.	Included	Included	Included	Included	§ 3.262(a).
(2) Income of spouse	do	do	Excluded	do	§ 3.262(b).
(3) Earnings of members of family under legal age.	do	Excluded	do	Excluded	§ 3.250(b)(2). § 3.252(e)(3).
(4) Earned income of child-claimant			Included	do.	
(5) Gifts, including contributions from adult members of family:					
Property	do	Included	do	do	§ 3.262(k).
Money	do	do	do	Included.	
(6) Value of maintenance by relative, friend, or organization.	Excluded	Excluded	Excluded	Excluded	§ 3.262(c).
(7) Rental value of property owned by and resided in by claimant.	do	do	do	do.	
(8) Charitable donations	do	do	Included	do	§ 3.262(d).
(9) Family allowance authorized by service personnel.	Included	Included	do	Included.	
(10) Reasonable value of allowances to person in service in addition to base pay.	do	do	do	Included except as earned income of child-claimant.	
(11) Mustering-out pay	Excluded	do	Excluded	do.	
(12) Six-months' death gratuity	do	Excluded	do	Excluded.	
(13) Bonus or similar cash gratuity paid by any State based on service in Armed Forces of United States.	Excluded	Excluded	Excluded	Excluded.	
(14) Retired Serviceman's Family Protection Plan; Survivor Benefit Plan (10 U.S.C. ch. 73):					
Retired Serviceman's Family Protection Plan (Subch. I):					
Annuities	do	do	do	do.	
Refund (10 U.S.C. 1446)	Included	Included	Included	Included.	
Survivor Benefit Plan (Subch. II) (Pub. L. 92–425; 86 Stat. 706).	do	do	do	do	§ 3.262(e).
Annuity under § 653, Pub. L. 100–456	Included	Included	Excluded	Excluded	§ 3.262(r)
(15) Retirement pay received direct from service department.	Included	Included	Included	Included	§ 3.262(e).
	do	do	do	do	§ 3.262(h).
(16) Retirement benefits; general	do	do	do	do	§ 3.262(e).

Income	Dependency (parents)	Dependency and indemnity compensation (parents)	Pension; old-law (veterans, surviving spouses and children)	Pension; section 306 (veterans, surviving spouses and children)	See—
(17) Social security benefits:					
Old age and survivors', and disability insurance.	Included	Included	Included	Included	§ 3.262(f).
Charitable programs	Excluded	Excluded	do	Excluded.	
Lump-sum death payments	Included	do	do	do.	
Supplemental security income	Excluded	Excluded	do	do.	
(18) Railroad Retirement benefits	do	Included	Disability pension—Excluded Death pension—Included.	Included	§ 3.262(g).
(19) Retirement pay waived under Federal statute.	Excluded	Excluded	Excluded	do	§ 3.262(h).
(20) Department of Veterans Affairs payments:					
Pension	Excluded	Excluded	Excluded	Excluded.	
Compensation and dependency and indemnity compensation.	do	do	do	do.	
World War I adjusted compensation	do	Included	do	Included.	
U.S. Government life insurance or national service life insurance for disability or death, maturity of endowment policies, and dividends, including special and termination dividends.	Excluded	Excluded	Excluded	Excluded.	
Servicemembers' group life insurance	do	do	do	do.	
Veterans' group life insurance	do	do	do	do.	
Servicemembers' indemnity	do	do	do	do.	
Subsistence allowance (38 U.S.C. ch. 31)	Included	Included	Included	Included.	
Veterans educational assistance in excess of amounts expended for training (38 U.S.C. ch. 34).	do	do	do	do.	
Educational assistance (38 U.S.C. ch. 35)			Excluded	Excluded.	
Special allowance under 38 U.S.C. 1312(a).	Excluded	Included	do	Included.	
Statutory burial allowance	do	Excluded	do	Excluded.	
Accrued	do	Included, except accrued as reimbursement.	do	Included, except accrued as reimbursement.	
(21) Compensation (civilian) for injury or death.	Included	Included	Included	Included	§ 3.262(i).
(22) Contributions by a public or private employer to a:					
Public or private health or hospitalization plan for an active or retired employee.	Excluded	Excluded	Excluded	Excluded.	
Retired employee as reimbursement for premiums for supplementary medical insurance benefits under the Social Security Program (Pub. L. 91–588; 84 Stat. 1580).	Included	Included	Excluded	Excluded.	
(23) Overtime pay; Government employees	Included	Included	Disability pension—Excluded. Death pension—Included.	Included.	
(24) Commercial life insurance; disability, accident, or health insurance, less payments of medical or hospital expenses resulting from the accident or disease for which payments are made.	Included (as received).	Included (as received).	Included (special provision).	Included (as received).	§ 3.262(j).
(25) Commercial annuities or endowments	do	Included (special provision).	do	Included (special provision).	§ 3.262(j).
(26) Dividends from commercial insurance	Excluded	Excluded	Excluded	Excluded.	
(27) Insurance under Merchant Marine Act of 1936, as amended.	Included	Included	Included	Included.	

Income	Dependency (parents)	Dependency and indemnity compensation (parents)	Pension; old-law (veterans, surviving spouses and children)	Pension; section 306 (veterans, surviving spouses and children)	See—
(28) Reimbursement for casualty loss (Pub. L. 100–687).	Included	Excluded	Included	Included	§3.262(t)
Other fire Insurance	Excluded	Excluded	Excluded	Excluded	§3.262(t)
(29) Bequests, devises and inheritances:					
Property	Included	Excluded	Included	do	§3.262(k).
Money	do	Included	do	Included.	
Joint bank accounts	do	do	do	Excluded	§3.262(k)(1).
(30) Profit from sale of property	Excluded	Excluded	Excluded	Excluded	§3.262(k).
(31) Jury duty or obligatory civic duties	do	do	do	do.	
(32) Relocation payments (Pub. L. 90–448; Pub. L. 90–495).	do	do	do	do	§3.262(c).
(33) The following programs administered by the ACTION Agency:					
Foster Grandparent Program and Older Americans Community Service Programs payments (Pub. L. 93–29; 87 Stat. 55).	do	do	do	do	§3.262(q)(1).
Volunteers in Service to America (VISTA), University Year for ACTION (UYA), Program for Local Services (PLS), ACTION Cooperative Volunteers (ACV), Foster Grandparent Program (FGP), and Older American Community Service Programs, Retired Senior Volunteer Program (RSVP), Senior Companion Program (Pub. L. 93–113; 87 Stat. 394).	do	do	do	do	§3.262(q)(2).
(34) The Service Corps of Retired Executives (SCORE) and Active Corps of Executives (ACE) administered by the Small Business Administration. (Pub. L. 93–113; 87 Stat. 394).	do	do	do	do	§3.262(q)(2).
(35) Income received under Section 6 of the Radiation Exposure Compensation Act (Pub. L. 101–426).	Excluded	Excluded	Included	Included	§3.262(t)
(36) Income received from income tax returns	Excluded	Excluded	Excluded	Excluded	§3.262(u)
(37) Other amounts excluded from income by statute.	Excluded	Excluded	Excluded	Excluded	§3.262(v) §3.279

[1] The compensation received through a crime victim compensation program will be excluded from income computations unless the total amount of assistance received from all federally funded programs is sufficient to fully compensate the claimant for losses suffered as a result of the crime.

(b) *Deduction of amounts paid by claimant.*

Deduction	Dependency (parents)	Dependency and indemnity compensation	Pension; old-law (veterans, surviving spouses, and children)	Pension; section 306 (veterans, surviving spouses, and children)	See
(1) Unusual medical expenses	Not authorized	Authorized	Not authorized	Authorized	§§3.262(b)(1) and (1).
(2) Veteran: just debts, expenses of last illness and burial.	Not authorized	Authorized, except debts.	Not authorized	Authorized	§§3.262(m) and (o).
(3) Veteran's spouse or child: expenses of last illness and burial.	Not authorized	Not authorized	Not authorized	Authorized	§3.262(n).
(4) Parent's spouse: just debts; expenses of last illness and burial.	Not authorized	Authorized			§3.262(o).
(5) Prepayment on real property mortgages after death of spouse (Pub. L. 91–588).	Not authorized	Not authorized	Not authorized	Authorized	§§3.262(k)(6).

(c) *Corpus of estate.*

	Dependency (parents)	Dependency and indemnity compensation	Pension; old-law (veterans, widows, and children)	Pension; section 306 (veterans, surviving spouses, and children)	See
	Considered conditionally	Not considered.	Not considered.	Considered ...	§ 3.263.

[28 FR 31, Jan. 1, 1963, as amended at 29 FR 15205, Nov. 11, 1964; 31 FR 15632, Dec. 13, 1966; 33 FR 15286, Oct. 15, 1968; 36 FR 8446, May 6, 1971; 37 FR 6677, Apr. 1, 1972; 37 FR 7092, Apr. 8, 1972; 37 FR 21436, Oct. 11, 1972; 38 FR 872, Jan. 5, 1973; 38 FR 26804, Sept. 26, 1973; 38 FR 28826, Oct. 17, 1973; 40 FR 13305, Mar. 26, 1975; 40 FR 57459, Dec. 10, 1975; 41 FR 17386, Apr. 26, 1976; 42 FR 43834, Aug. 31, 1977; 57 FR 59298, Dec. 15, 1992; 58 FR 12174, Mar. 3, 1993; 58 FR 31909, June 7, 1993; 58 FR 33766, June 21, 1993; 59 FR 37696, July 25, 1994; 60 FR 2522, Jan. 10, 1995; 60 FR 18355, Apr. 11, 1995; 62 FR 51278, Sept. 30, 1997; 67 FR 49586, July 31, 2002; 68 FR 60852, Oct. 24, 2003; 70 FR 15591, Mar. 28, 2005; 76 FR 4248, Jan. 25, 2011; 83 FR 47268, Sept 18, 2018]

§ 3.262 Evaluation of income.

(a) *Total income.* All income from sources such as wages, salaries, earnings, bonuses from employers, income from a business or profession or from investments or rents as well as the fair value of personal services, goods or room and board received in lieu thereof will be included.

(1) Salary is not determined by ''takehome'' pay, but includes deductions made under a retirement act or plan and amounts withheld by virtue of income tax laws.

(2) The gross income from a business or profession may be reduced by the necessary operating expenses, such as cost of goods sold, or expenditures for rent, taxes, and upkeep. Depreciation is not a deductible expense. The cost of repairs or replacement may be deducted. The value of an increase in stock inventory of a business is not considered income.

(3) A loss sustained in operating a business, profession, or farm or from investments may not be deducted from income derived from any other source.

(b) *Income of spouse.* Income of the spouse will be determined under the rules applicable to income of the claimant.

(1) *Parents.* Where the mother and father, or remarried parent and spouse are living together, the total combined income will be considered in determining dependency, or in determining the rate of dependency and indemnity compensation payable to the parent. This rule is equally applicable where both parents have remarried and each is living with his or her spouse. If the remarriage of a parent has been terminated, or the parent is separated from his or her spouse, income of the spouse will be excluded.

(2) *Veterans.* The separate income of the spouse of a disabled veteran who is entitled to pension under laws in effect on June 30, 1960, will not be considered. Where pension is payable under section 306(a) of Pub. L. 95–588, to a veteran who is living with a spouse there will be included as income of the veteran all income of the spouse in excess of whichever is the greater, the amount of the spouse income exclusion specified in section 306(a)(2)(B) of Pub. L. 95–588 as increased from time to time under section 306 (a)(3) of Pub. L. 95–588 or the total earned income of the spouse, which is reasonably available to or for the veteran, unless hardship to the veteran would result. Each time there is an increase in the spouse income exclusion pursuant to section 306(a)(3) of Pub. L. 95–588, the actual amount of the exclusion will be published in the ''Notices'' section of the FEDERAL REGISTER. The presumption that inclusion of such income is available to the veteran and would not work a hardship on him or her may be rebutted by evidence of unavailability or of expenses beyond the usual family requirements.

(Authority: 38 U.S.C. 1521(f); sec. 306(a)(2)(B) of Pub. L. 95–588)

(c) *Maintenance.* The value of maintenance furnished by a relative, friend, or

a charitable organization (civic or governmental) will not be considered income. Where the claimant is maintained in a rest home or other community institution or facility, public or private, because of impaired health or advanced age, money paid to the home or to the claimant to cover the cost of maintenance will not be considered income, regardless of whether it is furnished by a relative, friend or charitable organization. The expense of maintenance is not deductible if it is paid from the claimant's income, except as provided in paragraph (l) of this section in claims for dependency and indemnity compensation.

(d) *Charitable donations.* Charitable donations from public or private relief or welfare organizations will not be considered income except in claims for pension under laws in effect on June 30, 1960. In the latter cases, additional charitable allowances received by a claimant for members of his or her family may not be divided per capita in determining the amount of the claimant's income.

(e) *Retirement benefits; general.* Retirement benefits, including an annuity or endowment, paid under a Federal, State, municipal, or private business or industrial plan are considered income as limited by this paragraph. Where the payments received consist of part principal and part interest, interest will not be counted separately.

(1) *Protected pension.* Except as provided in this paragraph (e)(1), effective January 1, 1965, in determining income for pension purposes under laws in effect on June 30, 1960, 10 percent of the retirement payments received by a veteran, surviving spouse, or child will be excluded. The remaining 90 percent will be considered income as received. Where the retirement benefit is based on the claimant's own employment, payments will not be considered income until the amount of the claimant's personal contribution (as distinguished from amounts contributed by the employer) has been received. Thereafter the 10 percent exclusion will apply.

(2) *Pension; Pub. L. 86–211.* Except as provided in this subparagraph, effective January 1, 1965, in determining income for pension purposes, under Pub. L. 86–211 (73 Stat. 432), 10 percent of the retirement payments received by a veteran, the veteran's spouse, surviving spouse, or child will be excluded. The remaining 90 percent will be considered income as received. Where a person was receiving or entitled to receive pension and retirement benefits based on his or her own employment on December 31, 1964, the retirement payments will not be considered income until the amount of the claimant personal contribution (as distinguished from amounts contributed by the employer) has been received. Thereafter the 10 percent exclusion will apply.

(3) *Compensation.* In determining dependency of a parent for compensation purposes, all payments will be considered income as received.

(4) *Dependency and indemnity compensation.* Except as provided in this subparagraph, effective January 1, 1967, in determining income for dependency and indemnity compensation purposes, 10 percent of the retirement payments received by a deceased veteran's parent or by the parent's spouse will be excluded. The remaining 90 percent will be considered income as received. Where a parent was receiving or entitled to receive dependency and indemnity compensation and retirement benefits based on his or her own employment on December 31, 1966, the retirement payments will not be considered income until the amount of the claimant's personal contribution (as distinguished from amounts contributed by the employer) has been received. Thereafter the 10 percent exclusion will apply.

(Authority: 38 U.S.C. 1315(g), 1503(a)(6))

(f) *Social security benefits.* Old age and survivor's insurance and disability insurance under title II of the Social Security Act will be considered income as a retirement benefit under the rules contained in paragraph (e) of this section. Benefits received under noncontributory programs, such as old age assistance, aid to dependent children, and supplemental security income are subject to the rules contained in paragraph (d) of this section applicable to charitable donations. The lumpsum death payment under title II of the Social Security Act will be considered as

income except in claims for dependency and indemnity compensation and for pension under Pub. L. 86–211 (73 Stat. 432).

(g) *Railroad retirement benefits*—(1) *Parents, surviving spouses and children.* Retirement benefits received from the Railroad Retirement Board will be considered as income under the rules contained in paragraph (e) of this section. (See paragraph (h) of this section as to waivers.)

(2) *Veterans.* Effective July 1, 1959, retirement benefits received from the Railroad Retirement Board were excluded from consideration as income in determining eligibility for disability pension. (45 U.S.C. 228s–1) This exclusion continues to be applicable to claims under laws in effect on June 30, 1960. For purposes of section 306 pension, such retirement benefits will be considered as income under the rules contained in paragraph (e) of this section.

(h) *Retirement benefits waived.* Except as provided in this paragraph, retirement benefits (pension or retirement payments) which have been waived will be included as income. For the purpose of determining dependency of a parent, or eligibility of a parent for dependency and indemnity compensation or eligibility of a veteran, surviving spouse, or child for pension under laws in effect on June 30, 1960, retirement benefits from the following sources which have been waived pursuant to Federal statute will not be considered as income:

(1) Civil Service Retirement and Disability Fund;

(2) Railroad Retirement Board (see paragraph (g)(2) of this section);

(3) District of Columbia, firemen, policemen, or public school teachers;

(4) Former lighthouse service.

(i) *Compensation (civilian) for injury or death.* (1) Compensation paid by the Bureau of Employees' Compensation, Department of Labor (of the United States), or by Social Security Administration, or by Railroad Retirement Board, or pursuant to any workmen's compensation or employer's liability statute, or damages collected because of personal injury or death, less medical, legal, or other expenses incident to the injury or death, or the collection or recovery of such moneys will be considered income as received, except as provided in paragraph (i)(2) of this section. The criteria of paragraph (i)(1) of this section are for application as to all medical expenditures after such award or settlement.

(Authority: Pub. L. 92–198, 85 Stat. 663)

(2) For pension, effective October 7, 1966, and for dependency and indemnity compensation effective January 1, 1967, if payments based on permanent and total disability or death are received from the Bureau of Employees' Compensation, Social Security Administration or Railroad Retirement Board, or pursuant to any workmen's compensation or employer's liability statute, there will be excluded 10 percent of the payments received after deduction of medical, legal, and other expenses as authorized by paragraph (i)(1) of this section. The 10 percent exclusion does not apply to damages collected incident to a tort suit under other than an employer's liability law of the United States or a political subdivision of the United States, or to determinations of dependency for compensation purposes.

(j) *Commercial insurance*—(1) *Annuity or endowment insurance.* For pension, effective January 1, 1965, or for dependency and indemnity compensation, effective January 1, 1967, the provisions of paragraph (e) of this section apply. In such cases, 10 percent of the payments received will be excluded. In dependency and indemnity compensation claims, where the parent is receiving or entitled to receive dependency and indemnity compensation on December 31, 1966, and is also receiving or entitled to receive annuity payments on that date, or endowment insurance matures on or before that date, no part of the payments received will be considered income until the full amount of the consideration has been received, after which 10 percent of the amount received will be excluded. For compensation, the full amount of each payment is considered income as received.

(2) *Life insurance; general.* In determining dependency, or eligibility for dependency and indemnity compensation, or for section 306 pension the full

amount of payments is considered income as received. For section 306 pension, effective October 7, 1966, and for dependency and indemnity compensation, effective January 1, 1967, 10 percent of the payments received will be excluded.

(3) *Life insurance; old-law pension.* For pension under laws in effect on June 30, 1960, 10 percent of the payments received will be excluded. Where it is considered that life insurance was received in a lump sum in the calendar year in which the veteran died and payments are actually received in succeeding years, no part of the payments received in succeeding years will be considered income until an amount equal to the lump-sum face value of the policy has been received, after which 10 percent of the payments received will be excluded. The 10 percent exclusion is authorized effective October 7, 1966.

(4) *Disability, accident or health insurance.* For pension, effective October 7, 1966, and for dependency and indemnity compensation, effective January 1, 1967, there will be excluded 10 percent of the payments received for disability after deduction of medical, legal, or other expenses incident to the disability. For compensation, after deduction of such expenses, the full amount of payments is considered income as received.

(k) *Property*—(1) *Ownership.* The terms of the recorded deed or other evidence of title will constitute evidence of ownership of real or personal property. This includes property acquired through purchase, bequest or inheritance except that, effective January 1, 1971, amounts in joint accounts in banks and similar institutions acquired by reason of the death of another joint owner shall not be considered income of a survivor for section 306 pension purposes. With the foregoing exception, if property is owned jointly each person will be considered as owning a proportionate share. The claimant's share of property held in partnership will be determined on the facts found. In the absence of evidence to the contrary, the claimant's statement as to the terms of ownership will be accepted.

(Authority: Sec. 306, Pub. L. 95–588; 92 Stat. 2508)

(2) *Income-producing property.* Income received from real or personal property owned by the claimant will be counted. The claimant's share will be determined in proportion to his right according to the rules of ownership.

(3) *Sale of property.* Except as provided in paragraphs (k)(4) and (5) of this section, net profit from the sale of real or personal property will be counted. In determining net profit from the sale of property owned prior to the date of entitlement, the value at the date of entitlement will be considered in relation to the selling price. Where payments are received in installments, payments will not be considered income until the claimant has received amounts equal to the value of the property at the date of entitlement. Principal and interest will not be counted separately.

(4) *Homes.* Net profit from the sale of the claimant's residence which is received during the calendar year of sale will not be considered as income under the following conditions:

(i) To the extent that it is applied within the calendar year of the sale, or the succeeding calendar year, to the purchase price of another residence as his principal dwelling;

(ii) Such application of the net profit is reported within 1 year following the date so applied, and

(iii) The net profit is so applied after January 10, 1962, to a purchase made after said date.

This exclusion will not apply where the net profit is applied to the price of a home purchased earlier than the calendar year preceding the calendar year of sale of the old residence.

(5) *Sale of property; section 306 pension and dependency and indemnity compensation.* For pension under section 306 pension and for dependency and indemnity compensation, profit from the sale of real or personal property other than in the course of a business will not be considered income. This applies to property acquired either before or after the date of entitlement. Any amounts received in excess of the sales price will be counted as income. Where payments are received in installments, principal and interest will not be counted separately. For pension, this provision is effective January 1, 1965;

for dependency and indemnity compensation, January 1, 1967.

(Authority: 38 U.S.C. 1503(a)(10); 38 U.S.C. 1315(g))

(6) *Payments on mortgages on real property; section 306 pension.* Effective January 1, 1971, for the purposes of section 306 pension, an amount equaling any prepayments made by a veteran or surviving spouse on a mortgage or similar type security instrument in existence at the death of veteran or spouse on real property which prior to the death was the principal residence of the veteran and spouse will be excluded from consideration as income if such payment was made after the death and prior to the close of the year succeeding the year of death.

(Authority: 38 U.S.C. 1503(a)(14))

(l) *Unusual medical expenses.* Within the provisions of paragraphs (l)(1) through (4) of this section there will be excluded from the amount of the claimant's annual income any unreimbursed amounts which have been paid within the calendar year for unusual medical expenses regardless of the year the indebtedness was incurred. The term *unusual* means *excessive.* It does not describe the nature of a medical condition but rather the amount expended for medical treatment in relationship to the claimant's resources available for sustaining a reasonable mode of life. Unreimbursed expenditures which exceed 5 percent of the claimant's reported annual income will be considered unusual. Health, accident, sickness and hospitalization insurance premiums will be included as medical expenses in determining whether the claimant's unreimbursed medical expenses meet the criterion for *unusual.* A claimant's statement as to amounts expended for medical expenses ordinarily will be accepted unless the circumstances create doubt as to its credibility. An estimate based on a clear and reasonable expectation that unusual medical expenditure will be realized may be accepted for the purpose of authorizing prospective payments of benefits subject to necessary adjustment in the award upon receipt of an amended estimate or after the end of the calendar year upon receipt of an income questionnaire. For the definition of what constitutes a medical expense, see § 3.278, Deductible medical expenses.

(1) *Veterans.* For the purpose of section 306 pension, there will be excluded unreimbursed amounts paid by the veteran for unusual medical expenses of self, spouse, and other relatives of the veteran in the ascending as well as descending class who are members or constructive members of the veteran's household and whom the veteran has a moral or legal obligation to support.

(2) *Surviving spouses.* For the purpose of section 306 pension, there will be excluded unreimbursed amounts paid by the surviving spouse for the unusual medical expenses of self, the veteran's children, and other relatives of the surviving spouse in the ascending as well as descending class who are members or constructive members of the surviving spouse's household and whom the surviving spouse has a moral or legal obligation to support.

(3) *Children.* For the purpose of section 306 pension, there will be excluded unreimbursed amounts paid by a child for the unusual medical expenses of self, parent, and brothers and sisters of the child.

(4) *Parents.* For dependency and indemnity compensation purposes there will be excluded unreimbursed amounts paid by the parent for the unusual medical expenses of self, spouse, and other relatives of the parent in the ascending as well as descending class who are members or constructive members of the parent's household and whom the parent has a moral or legal obligation to support. If the combined annual income of the parent and the parent's spouse is the basis for dependency and indemnity compensation, the exclusion is applicable to the combined annual income and extends to the unusual unreimbursed medical expenses of the spouse's relatives in the ascending as well as descending class who are members or constructive members of the household and whom the parent's spouse has a moral or legal obligation to support.

(Authority: 38 U.S.C. 1315(f)(3); Sec. 306, Pub. L. 95–588; 92 Stat. 2508)

(m) *Veteran's final expenses; pension.* In claims for pension under section 306, there will be excluded, as provided in paragraph (p) of this section:

(1) From the income of a surviving spouse, amounts equal to amounts paid for the expenses of the veteran's last illness;

(2) From the income of a surviving spouse, or of a child of a deceased veteran where there is no surviving spouse, amounts equal to amounts paid by the surviving spouse or child for the veteran's just debts, for the expenses of the veteran's last illness, and burial to the extent such expenses are not reimbursed by the Department of Veterans Affairs. The term ''just debts'' does not include any debt that is secured by real or personal property.

(Authority: Sec. 306, Pub. L. 95–588; 92 Stat. 2508)

(n) *Final expenses of veteran's spouse or child; pension.* In claims for pension under section 306, there will be excluded, as provided in paragraph (p) of this section:

(1) From the income of a veteran, amounts equal to amounts paid by the veteran for the last illness and burial of the veteran's deceased spouse or child; and

(2) From the income of a spouse or surviving spouse, amounts equal to amounts paid by her as spouse or surviving spouse of the deceased veteran for the last illness and burial of a child of such veteran.

(Authority: Sec. 306, Pub. L. 95–588; 92 Stat. 2508)

(o) *Final expenses of veteran or parent's spouse; dependency and indemnity compensation.* In claims for dependency and indemnity compensation there will be excluded from the income of a parent, as provided in paragraph (p) of this section, amounts equal to amounts paid by the parent for:

(1) The expenses of the veteran's last illness and burial to the extent that such expenses are not reimbursed under 38 U.S.C. ch. 23.

(2) The parent's deceased spouse's just debts, the expenses of the spouse's last illness to the extent such expenses are not reimbursed under 38 U.S.C. ch. 51 and the expenses of the spouse's burial to the extent that such expenses are not reimbursed under 38 U.S.C. ch. 23 or 51. The term ''just debts'' does not include any debt that is secured by real or personal property.

(Authority: 38 U.S.C. 1315(f))

(p) *Final expenses; year of exclusion.* For the purpose of paragraphs (m), (n) and (o) of this section, in the absence of contradictory information, the claimant's statement will be accepted as to the nature, amount and date of payment, and identity of the creditor. Except as provided in this paragraph, payments will be deducted from annual income for the year in which such payments are made. Payments made by a veteran, the spouse or surviving spouse of a veteran, child or, in dependency and indemnity compensation claims, by a parent during the calendar year following the year in which the veteran, spouse or child died may be deducted from the claimant's income for the year of last illness or burial if this deduction is advantageous to the claimant.

(q) *Volunteer programs*—(1) *Payments under Foster Grandparent Program and Older Americans Community Service Programs.* Effective May 3, 1973, compensation received under the Foster Grandparent Program and the Older Americans Community Service Programs will be excluded from income in claims for compensation, pension and dependency and indemnity compensation.

(Authority: Pub. L. 93–29; 87 Stat. 55)

(2) *Payments under domestic volunteer service act programs.* Effective October 1, 1973, compensation or reimbursement received under a Domestic Volunteer Service Act Program (including Volunteers in Service to America (VISTA), University Year for ACTION (UYA), Program for Local Services (PLS), ACTION Cooperative Volunteers (ACV), Foster Grandparent Program (FGP) and Older American Community Service Program, Retired Senior Volunteer Program (RSVP), Senior Companion Program, Service Corps of Retired Executives (SCORE) and Active Corps of Executives (ACE), will be excluded

from income in claims for compensation, pension and dependency and indemnity compensation.

(Authority: Pub. L. 93–113; 87 Stat. 394)

(r) *Survivor benefit annuity*. For the purposes of old law pension and section 306 pension, there shall be excluded from computation of income annuity paid by the Department of Defense under the authority of section 653, Public Law 100–456 to qualified surviving spouses of veterans who died prior to November 1, 1953. (September 29, 1988)

(Authority: Sec. 653, Pub. L. 100–456; 102 Stat. 1991)

(s) *Reimbursement for casualty loss*. The following sources of reimbursements for casualty loss will not be considered as income in determining entitlement to benefits under the programs specified. Amounts to be excluded from computation in parens' dependency and indemnity compensation claims are limited to amounts of reimbursement which do not exceed the greater of the fair market value or the reasonable replacement cost of the property involved at the time immediately preceding the loss.

(1) Reimbursement for casualty loss of any kind in determining entitlement to parents' dependency and indemnity compensation benefits. For purposes of paragraph (t) of this section, the term ''casualty loss'' means the complete or partial destruction of property resulting from an identifiable event of a sudden, unexpected or unusual nature.

(2) Proceeds from fire insurance in determining dependency of a parent for compensation purposes or in determining entitlement to old-law and section 306 pension benefits.

(Authority: 38 U.S.C. 1315(f))

(t) *Radiation Exposure Compensation Act*. For the purposes of parents' dependency and indemnity compensation and dependency of parents under § 3.250, there shall be excluded from income computation payments under Section 6 of the Radiation Exposure Compensation Act of 1990.

(Authority: 42 U.S.C. 2210 note)

(u) *Income tax returns*. VA will exclude from income payments from income tax returns. See § 3.279(d)(1).

(Authority: 26 U.S.C. 6409)

(v) *Statutory exclusions*. Other amounts excluded from income by statute. See § 3.279. VA will exclude from income any amount designated by statute as not countable as income, regardless of whether or not it is listed in this section or in § 3.279.

(Authority: 42 U.S.C. 1395w–141(g)(6))

[28 FR 32, Jan. 1, 1963]

EDITORIAL NOTE: For FEDERAL REGISTER citations affecting § 3.262, see the List of CFR Sections Affected, which appears in the Finding Aids section of the printed volume and at *www.fdsys.gov*.

§ 3.263 Corpus of estate; net worth.

(a) *General*. The following rules are for application in determining the corpus of estate of a parent where dependency is a factor under § 3.250, and the net worth of a veteran, surviving spouse, or child where pension is subject to Pub. L. 86–211 (73 Stat. 432) under § 3.252(b). Only the estate of the parent, in claims based on dependency, or the estate of the veteran, surviving spouse, or child-claimant in claims for pension, will be considered. In the absence of contradictory information, the claimant's statement as to ownership and estimate of value will be accepted.

(b) *Definition*. *Corpus of estate* and *net worth* mean the market value, less mortgages or other encumbrances, of all real and personal property owned by the claimant except the claimant's dwelling (single-family unit) including a reasonable lot area, and personal effects suitable to and consistent with the claimant's reasonable mode of life.

(c) *Ownership*. See § 3.262(k).

(d) *Evaluation*. In determining whether some part of the claimant's estate should be consumed for his or her maintenance, consideration will be given to the amount of the claimant's income, together with the following factors: whether the property can be readily converted into cash at no substantial sacrifice; ability to dispose of property as limited by community property laws; life expectancy; number

of dependents who meet the requirements of §3.250(b)(2); potential rate of depletion, including unusual medical expenses under the principles outlined in §3.262(l) for the claimant and his or her dependents.

(e) VA will exclude from the corpus of estate or net worth any amount designated by statute as not countable as a resource. See §3.279.

(Authority: 42 U.S.C. 1395w–141(g)(6))

[28 FR 33, Jan. 1, 1963, as amended at 39 FR 28527, Aug. 8, 1974; 44 FR 45936, Aug. 6, 1979; 57 FR 59299, Dec. 15, 1992; 58 FR 33767, June 21, 1993; 62 FR 51279, Sept. 30, 1997; 67 FR 49587, July 31, 2002; 68 FR 60852, Oct. 24, 2003; 70 FR 15591, Mar. 28, 2005; 76 FR 4248, Jan. 25, 2011; 83 FR 47269, Sept. 18, 2018]

§3.270 Applicability of various dependency, income and estate regulations.

(a) *Sections 3.250 through 3.263 and 3.278 through 3.279.* These sections are applicable to dependency, income and estate determinations needed to determine entitlement or continued entitlement for the following programs:

(1) Parents' death compensation.

(2) Old-law pension.

(3) Section 306 pension.

(4) Parents' dependency and indemnity compensation.

NOTE: Citations to title 38 U.S.C. in §§3.250 through 3.263 and 3.278 through 3.279 referring to section 306 or old-law pension generally refer to provisions of law in effect on December 31, 1978.

(b) *Sections 3.271 through 3.279.* These sections apply to income and estate determinations of entitlement to the improved disability and death pension program which became effective January 1, 1979.

[44 FR 45936, Aug. 6, 1979, as amended at 83 FR 47269, Sept. 18, 2018]

REGULATIONS APPLICABLE TO THE IMPROVED PENSION PROGRAM WHICH BECAME EFFECTIVE JANUARY 1, 1979

SOURCE: 44 FR 45936, Aug. 6, 1979, unless otherwise noted.

§3.271 Computation of income.

(a) *General.* Payments of any kind from any source shall be counted as income during the 12-month annualization period in which received unless specifically excluded under §3.272.

(Authority: 38 U.S.C. 501)

(1) *Recurring income.* Recurring income means income which is received or anticipated in equal amounts and at regular intervals (e.g., weekly, monthly, quarterly, etc.), and which will continue throughout an entire 12-month annualization period. The amount of recurring income for pension purposes will be the amount received or anticipated during a 12-month annualization period. Recurring income which terminates prior to being counted for at least one full 12-month annualization period will be treated as nonrecurring income for computation purposes.

(2) *Irregular income.* Irregular income means income which is received or anticipated during a 12-month annualization period, but which is received in unequal amounts or at irregular intervals. The amount of irregular income for pension purposes will be the amount received or anticipated during a 12-month annualization period following initial receipt of such income.

(3) *Nonrecurring income.* Nonrecurring income means income received or anticipated on a one-time basis during a 12-month annualization period (e.g., an inheritance). Pension computations of income will include nonrecurring income for a full 12-month annualization period following receipt of the income.

(b) *Salary.* Salary means the gross amount of a person's earnings or wages before any deductions are made for such things as taxes, insurance, retirement plans, social security, etc.

(c) *Business, farm or professional income.* (1) This includes gross income from a business, farm or profession as reduced by the necessary operating expenses such as cost of goods sold, or expenditures for rent, taxes, and upkeep, or costs of repairs or replacements. The value of an increase in stock inventory of a business is not considered income.

(2) Depreciation is not a deductible expense.

(3) A loss sustained in operating a business, profession, farm, or from investments, may not be deducted from income derived from any other source.

(d) *Income from property.* Income from real or personal property is countable

as income of the property's owner. The terms of a recorded deed or other evidence of title shall constitute evidence of ownership. This includes property acquired through purchase, gift, devise, or descent. If property is owned jointly, income of the various owners shall be determined in proportion to shares of ownership of the property. The owner's shares of income held in partnership shall be determined on the basis of the facts found.

(e) *Installments.* Income shall be determined by the total amount received or anticipated during a 12-month annualization period.

(Authority: 38 U.S.C. 501)

(f) *Deferred determinations.* (1) When an individual is unable to predict with certainty the amount of countable annual income, the annual rate of improved pension shall be reduced by the greatest amount of anticipated countable income until the end of the 12-month annualization period, when total income received during that period will be determined and adjustments in pension payable made accordingly.

(Authority: 38 U.S.C. 501)

(2) When a claimed dependent is shown to have income which exceeds the additional amount of benefits payable based on the claimed dependency, but evidence requirements of § 3.204, § 3.205, § 3.209, or § 3.210 have not been met, the maximum annual rate of improved pension shall be determined without consideration of the claimed dependency. This amount shall be reduced by an amount which includes the income of the unestablished dependent. Adjustments in computation of the maximum annual rate of improved pension shall occur following receipt of evidence necessary to establish the dependency.

(Authority: 38 U.S.C. 501(a))

(g) *Compensation (civilian) for injury or death.* Compensation paid by the United States Department of Labor, Office of Workers' Compensation Programs, Social Security Administration, or the Railroad Retirement Board, or pursuant to any worker's compensation or employer's liability statute, or damages collected because of personal injury or death, will be considered income as received. However, medical, legal or other expenses incident to the injury or death, or incident to the collection or recovery of the amount of the award or settlement, may be deducted. The criteria in § 3.272(g) apply as to all medical expenditures after the award or settlement.

(Authority: 38 U.S.C. 501)

(h) *Fractions of dollars.* Fractions of dollars will be disregarded in computing annual income.

(i) *Waiver of receipt of income.* Potential income that is not excludable under § 3.272 or § 3.279 but is waived by an individual is included as countable income of the individual. However, if an individual withdraws a claim for Social Security benefits, after a finding of entitlement to those benefits, in order to maintain eligibility for unreduced Social Security benefits upon reaching a particular age, VA will not regard this potential income as having been waived and will therefore not count it.

(Authority: 38 U.S.C. 1503(a))

[44 FR 45936, Aug. 6, 1979, as amended at 53 FR 23235, June 21, 1988; 57 FR 59299, Dec. 15, 1992; 83 FR 47269, Sept. 18, 2018]

§ 3.272 Exclusions from income.

The following shall be excluded from countable income for the purpose of determining entitlement to improved pension. Unless otherwise provided, expenses deductible under this section are deductible only during the 12-month annualization period in which they were paid.

(Authority: 38 U.S.C. 501)

(a) *Welfare.* Donations from public or private relief, welfare, or charitable organizations.

(Authority: 38 U.S.C. 1503(a)(1))

(b) *Maintenance.* The value of maintenance furnished by a relative, friend, or

a charitable organization (civic or governmental) will not be considered income. Where the individual is maintained in a rest home or other community institution or facility, public or private, because of impaired health or advanced age, money paid to the home or the individual to cover the cost of maintenance will not be considered income, regardless of whether it is furnished by a relative, friend, or charitable organization. The expense of maintenance is not deductible if it is paid from the individual's income.

(Authority: 38 U.S.C. 501, 1503(a)(1))

(c) *Department of Veterans Affairs pension benefits.* Payments under chapter 15 of title 38, United States Code, including accrued pension benefits payable under 38 U.S.C. 5121.

(Authority: 38 U.S.C. 1503(a)(2))

(d) *Reimbursement for casualty loss.* Reimbursement of any kind for any casualty loss. The amount to be excluded is not to exceed the greater of the fair market value or the reasonable replacement cost of the property involved at the time immediately preceding the loss. For purposes of this paragraph, the term ''casualty loss'' means the complete or partial destruction of property resulting from an identifiable event of a sudden, unexpected or unusual nature.

(Authority: 38 U.S.C. 1503(a)(5))

(e) *Profit from sale of property.* Profit realized from the disposition of real or personal property other than in the course of business, except amounts received in excess of the sales price, for example, interest on deferred sales is included as income. In installment sales, any payments received until the sales price is recovered are not included as income, but any amounts received which exceed the sales price are included, regardless of whether they represent principal or interest.

(Authority: 38 U.S.C. 1503(a)(6))

(f) *Joint accounts.* Amounts in joint accounts in banks and similar institutions acquired by reason of death of the other joint owner.

(Authority: 38 U.S.C. 1503(a)(7))

(g) *Medical expenses.* Within the provisions of the following paragraphs, there will be excluded from the amount of an individual's annual income any unreimbursed amounts which have been paid within the 12-month annualization period for medical expenses regardless of when the indebtedness was incurred. An estimate based on a clear and reasonable expectation that unusual medical expenditure will be realized may be accepted for the purpose of authorizing prospective payments of benefits subject to necessary adjustment in the award upon receipt of an amended estimate, or after the end of the 12-month annualization period upon receipt of an eligibility verification report. For the definition of what constitutes a medical expense, see §3.278, Deductible medical expenses.

(Authority: 38 U.S.C. 501)

(1) *Veteran's income.* Unreimbursed medical expenses will be excluded when all of the following requirements are met:

(i) They were or will be paid by a veteran or spouse for medical expenses of the veteran, spouse, children, parents and other relatives for whom there is a moral or legal obligation of support;

(ii) They were or will be incurred on behalf of a person who is a member or a constructive member of the veteran's or spouse's household; and

(iii) They were or will be in excess of 5 percent of the applicable maximum annual pension rate or rates for the veteran (including increased pension for family members but excluding increased pension because of need for aid and attendance or being housebound) as in effect during the 12-month annualization period in which the medical expenses were paid.

(2) *Surviving spouse's income.* Unreimbursed medical expenses will be excluded when all of the following requirements are met:

(i) They were or will be paid by a surviving spouse for medical expenses of the spouse, veteran's children, parents

and other relatives for whom there is a moral or legal obligation of support;

(ii) They were or will be incurred on behalf of a person who is a member or a constructive member of the spouse's household; and

(iii) They were or will be in excess of 5 percent of the applicable maximum annual pension rate or rates for the spouse (including increased pension for family members but excluding increased pension because of need for aid and attendance or being housebound) as in effect during the 12-month annualization period in which the medical expenses were paid.

(Authority: 38 U.S.C. 501)

(3) *Children's income.* Unreimbursed amounts paid by a child for medical expenses of self, parent, brothers and sisters, to the extent that such amounts exceed 5 percent of the maximum annual pension rate or rates payable to the child during the 12-month annualization period in which the medical expenses were paid.

(Authority: 38 U.S.C. 501)

(h) *Expenses of last illnesses, burials, and just debts.* Expenses specified in paragraphs (h)(1) and (h)(2) of this section which are paid during the calendar year following that in which death occurred may be deducted from annual income for the 12-month annualization period in which they were paid or from annual income for any 12-month annualization period which begins during the calendar year of death, whichever is to the claimant's advantage. Otherwise, such expenses are deductible only for the 12-month annualization period in which they were paid.

(Authority: 38 U.S.C. 501)

(1) *Veteran's final expenses.* (i) Amounts paid by a spouse before a veteran's death for expenses of the veteran's last illness will be deducted from the income of the surviving spouse.

(Authority: 38 U.S.C. 1503(a)(3))

(ii) Amounts paid by a surviving spouse or child of a veteran for the veteran's just debts, expenses of last illness and burial (to the extent such burial expenses are not reimbursed under chapter 23 of title 38 U.S.C.) will be deducted from the income of the surviving spouse or child. The term ''just debts'' does not include any debt that is secured by real or personal property.

(Authority: 38 U.S.C. 1503(a)(3))

(2) *Spouse or child's final expenses.* (i) Amounts paid by a veteran for the expenses of the last illness and burial of the veteran's deceased spouse or child will be deducted from the veteran's income.

(ii) Amounts paid by a veteran's spouse or surviving spouse for expenses of the last illness and burial of the veteran's child will be deducted from the spouse's or surviving spouse's income.

(Authority: 38 U.S.C. 1503(a)(4))

(i) *Educational expenses.* Amounts equal to expenses paid by a veteran or surviving spouse pursuing a course of education or vocational rehabilitation or training, to include amounts paid for tuition, fees, books, and materials, and in the case of a veteran or surviving spouse in need of regular aid and attendance, unreimbursed amounts paid for unusual transportation expenses in connection with the pursuit of such course. Unusual transportation expenses are those exceeding the reasonable expenses which would have been incurred by a nondisabled person using an appropriate means of transportation (public transportation, if reasonably available).

(Authority: 38 U.S.C. 1503(a)(9))

(j) *Child's income.* In the case of a child, any current work income received during the year, to the extent that the total amount of such income does not exceed an amount equal to the sum of the following:

(1) The lowest amount of gross income for which a Federal income tax return must be filed, as specified in section 6012(a) of the Internal Revenue Code of 1954, by an individual who is not married (as determined under section 143 of such Code), and is not a surviving spouse (as defined in section 2(a) of such Code), and is not a head of

household (as defined in section 2(b) of such Code); and

(2) If the child is pursuing a course of postsecondary education or vocational rehabilitation or training, the amount paid by the child for those educational expenses including the amount paid for tuition, fees, books, and materials.

(Authority: 38 U.S.C. 1503(a)(10))

(k) *Veterans' benefits from States and municipalities.* VA will exclude from income payments from a State or municipality to a veteran of a monetary benefit that is paid as a veterans' benefit due to injury or disease. VA will exclude up to $5,000 of such benefit in any annualization period.

(Authority: 38 U.S.C. 1503(a)(11))

(l) *Distributions of funds under 38 U.S.C. 1718.* Distributions from the Department of Veterans Affairs Special Therapeutic and Rehabilitation Activities Fund as a result of participation in a therapeutic or rehabilitation activity under 38 U.S.C. 1718 and payments from participation in a program of rehabilitative services provided as part of the care furnished by a State home and which is approved by VA as conforming to standards for activities under 38 U.S.C. 1718 shall be considered donations from a public or private relief or welfare organization and shall not be countable as income for pension purposes.

(Authority: 38 U.S.C. 1718(f))

(m) *Hardship exclusion of child's available income.* When hardship is established under the provisions of §3.23(d)(6) of this part, there shall be excluded from the available income of any child or children an amount equal to the amount by which annual expenses necessary for reasonable family maintenance exceed the sum of countable annual income plus VA pension entitlement computed without consideration of this exclusion. The amount of this exclusion shall not exceed the available income of any child or children, and annual expenses necessary for reasonable family maintenance shall not include any expenses which were considered in determining the available income of the child or children or the countable annual income of the veteran or surviving spouse.

(Authority: 38 U.S.C. 1521(h), 1541(g))

(n) *Survivor benefit annuity.* Annuity paid by the Department of Defense under the authority of section 653, Public Law 100–456 to qualified surviving spouses of veterans who died prior to November 1, 1953. (September 29, 1988)

(Authority: Sec. 653, Pub. L. 100–456; 102 Stat. 1991)

(o) *Cash surrender value of life insurance.* That portion of proceeds from the cash surrender of a life insurance policy which represents a return of insurance premiums.

(Authority: 38 U.S.C. 501(a))

(p) *Radiation Exposure Compensation Act.* Any payment made under Section 6 of the Radiation Exposure Compensation Act of 1990.

(Authority: 42 U.S.C. 2210 note)

(q) *Life insurance proceeds.* Lump-sum proceeds of any life insurance policy on a veteran.

(Authority: 38 U.S.C. 1503(a)(12))

(r) *Income tax returns.* VA will exclude from income payments from income tax returns. See §3.279(e)(1).

(Authority: 26 U.S.C. 6409)

(s) *Reimbursements for loss.* VA will exclude from income payments described in 38 U.S.C. 1503(a)(5).

(Authority: 38 U.S.C. 1503(a)(5))

(t) *Statutory exclusions.* Other amounts excluded from income by statute. See §3.279. VA will exclude from income any amount designated by statute as not countable as income, regardless of whether or not it is listed in this section or in §3.279.

[44 FR 45936, Aug. 6, 1979]

EDITORIAL NOTE: For FEDERAL REGISTER citations affecting §3.272, see the List of CFR Sections Affected, which appears in the Finding Aids section of the printed volume and at *www.fdsys.gov.*

§ 3.273 Rate computation.

The commencement date of change in benefit payments based on rate computations under the provisions of this section will be determined under the provisions of § 3.31 or § 3.660.

(a) *Initial award.* For the purpose of determining initial entitlement, or for resuming payments on an award which was previously discontinued, the monthly rate of pension payable to a beneficiary shall be computed by reducing the beneficiary's applicable maximum pension rate by the beneficiary's countable income on the effective date of entitlement and dividing the remainder by 12. Effective June 1, 1983, the provisions of § 3.29(b) apply to this paragraph. Recomputation of rates due to changes in the maximum annual pension rate or rate of income following the initial date of entitlement are subject to the provisions of paragraph (b) of this section.

(b) *Running awards*—(1) *Change in maximum annual pension rate.* Whenever there is change in a beneficiary's applicable maximum annual pension rate, the monthly rate of pension payable shall be computed by reducing the new applicable maximum annual pension rate by the beneficiary's countable income on the effective date of the change in the applicable maximum annual pension rate, and dividing the remainder by 12. Effective June 1, 1983, the provisions of § 3.29(b) apply to this paragraph.

(2) *Change in amount of income.* Whenever there is a change in a beneficiary's amount of countable income the monthly rate of pension payable shall be computed by reducing the beneficiary's applicable maximum annual pension rate by the beneficiary's new amount of countable income on the effective date of the change in the amount of income, and dividing the remainder by 12. Effective June 1, 1983, the provisions of § 3.29(b) apply to this paragraph.

(c) *Nonrecurring income.* The amount of any nonrecurring countable income (e.g. an inheritance) received by a beneficiary shall be added to the beneficiary's annual rate of income for a 12-month annualization period commencing on the effective date on which the nonrecurring income is countable.

(Authority: 38 U.S.C. 501)

(d) *Recurring and irregular income.* The amount of recurring and irregular income anticipated or received by a beneficiary shall be added to determine the beneficiary's annual rate of income for a 12-month annualization period commencing at the beginning of the 12-month annualization, subject to the provisions of § 3.660(a)(2) of this chapter.

[44 FR 45936, Aug. 6, 1979, as amended at 48 FR 34472, July 29, 1983; 57 FR 59300, Dec. 15, 1992]

§ 3.274 Net worth and VA pension.

(a) *Net worth limit.* For purposes of entitlement to VA pension, the net worth limit effective October 18, 2018 is $123,600. This limit will be increased by the same percentage as the Social Security increase whenever there is a cost-of-living increase in benefit amounts payable under section 215(i) of title II of the Social Security Act (42 U.S.C. 415(i)). VA will publish the current limit on its website at *www.benefits.va.gov/pension/.*

(b) *When a claimant's or beneficiary's net worth exceeds the limit.* Except as provided in paragraph (h)(2) of this section, VA will deny or discontinue pension if a claimant's or beneficiary's net worth exceeds the net worth limit in paragraph (a) of this section.

(1) *Net worth.* Net worth means the sum of a claimant's or beneficiary's assets and annual income.

(2) *Asset calculation.* VA will calculate a claimant's or beneficiary's assets under this section and § 3.275.

(3) *Annual income calculation.* VA will calculate a claimant's or beneficiary's annual income under § 3.271, and will include the annual income of dependents as required by law. *See* §§ 3.23(d)(4), 3.23(d)(5), and 3.24 for more information on annual income included when VA calculates a claimant's or beneficiary's pension entitlement rate. In calculating annual income for this purpose, VA will subtract all applicable deductible expenses, to include appropriate prospective medical expenses under § 3.272(g).

(4) *Example of net worth calculation.* For purposes of this example, presume the net worth limit is $123,600. A claimant's assets total $117,000 and annual income is $9,000. Therefore, adding the claimant's annual income to assets produces net worth of $126,000. This amount exceeds the net worth limit.

(c) *Assets of other individuals included as claimant's or beneficiary's assets*—(1) *Claimant or beneficiary is a veteran.* A veteran's assets include the assets of the veteran as well as the assets of his or her spouse, if the veteran has a spouse.

(2) *Claimant or beneficiary is a surviving spouse.* A surviving spouse's assets include only the assets of the surviving spouse.

(3) *Claimant or beneficiary is a surviving child.* (i) If a surviving child has no custodian or is in the custody of an institution, the child's assets include only the assets of the child.

(ii) If a surviving child has a custodian other than an institution, the child's assets include the assets of the child as well as the assets of the custodian. If the child is in the joint custody of his or her natural or adoptive parent and a stepparent, the child's assets also include the assets of the stepparent. *See* §3.57(d) for more information on child custody for pension purposes.

(d) *How a child's net worth affects a veteran's or surviving spouse's pension entitlement.* VA will not consider a child to be a veteran's or surviving spouse's dependent child for pension purposes if the child's net worth exceeds the net worth limit in paragraph (a) of this section.

(1) *Dependent child and potential dependent child.* For the purposes of this section—

(i) ''Dependent child'' refers to a child for whom a veteran or a surviving spouse is entitled to an increased maximum annual pension rate.

(ii) ''Potential dependent child'' refers to a child who is excluded from a veteran's or surviving spouse's pension award solely or partly because of this paragraph (d). References in this section to ''dependent child'' include a potential dependent child.

(2) *Dependent child net worth.* A dependent child's net worth is the sum of his or her annual income and the value of his or her assets.

(3) *Dependent child asset calculation.* VA will calculate the value of a dependent child's assets under this section and §3.275. A dependent child's assets include the child's assets only.

(4) *Dependent child annual income calculation.* VA will calculate a dependent child's annual income under §3.271, and will include the annual income of the child as well as the annual income of the veteran or surviving spouse that would be included if VA were calculating a pension entitlement rate for the veteran or surviving spouse.

(e) *When VA calculates net worth.* VA calculates net worth only when:

(1) VA has received—

(i) An original pension claim;

(ii) A new pension claim after a period of non-entitlement;

(iii) A request to establish a new dependent; or

(iv) Information that a veteran's, surviving spouse's, or child's net worth has increased or decreased; and

(2) The claimant or beneficiary meets the other factors necessary for pension entitlement as provided in §3.3(a)(3) and (b)(4).

NOTE TO PARAGRAPH (e): If the evidence shows that net worth exceeds the net worth limit, VA may decide the pension claim before determining if the claimant meets other entitlement factors. VA will notify the claimant of the entitlement factors that have not been established.

(f) *How net worth decreases.* Net worth may decrease in three ways: Assets can decrease, annual income can decrease, or both assets and annual income can decrease.

(1) *How assets decrease.* A veteran, surviving spouse, or child, or someone acting on their behalf, may decrease assets by spending them on any item or service for which fair market value is received unless the item or items purchased are themselves part of net worth. *See* §3.276(a)(4) for the definition of ''fair market value.'' The expenses must be those of the veteran, surviving spouse, or child, or a relative of the veteran, surviving spouse, or child. The relative must be a member or constructive member of the veteran's, surviving spouse's, or child's household.

(2) *How annual income decreases. See* §§ 3.271 through 3.273.

(3) *Example 1.* For purposes of this example, presume the net worth limit is $123,600 and the maximum annual pension rate (MAPR) is $12,000. A claimant has assets of $115,000 and annual income of $9,000. Adding annual income to assets produces a net worth of $124,000, which exceeds the net worth limit. However, the claimant is a patient in a nursing home and pays annual unreimbursed nursing home fees of $29,000. Reasonably predictable unreimbursed medical expenses are deductible from annual income under § 3.272(g) to the extent that they exceed 5 percent of the applicable MAPR. VA subtracts the projected expenditures that exceed 5 percent of the applicable MAPR (here, $28,400) from annual income, which decreases annual income to zero. The claimant's net worth is now $115,000; therefore, net worth is within the limit to qualify for VA pension.

(4) *Example 2.* For purposes of this example, presume the net worth limit is $123,600 and the MAPR is $12,000. A claimant has assets of $123,000 and annual income of $9,500. Adding annual income to assets produces a net worth of $132,500, which exceeds the net worth limit. The claimant pays reasonably predictable annual unreimbursed medical expenses of $9,000. Unreimbursed medical expenses are deductible from annual income under § 3.272(g) to the extent that they exceed 5 percent of the applicable MAPR. VA subtracts the projected expenditures that exceed 5 percent of the applicable MAPR (here, $8,400) from annual income, which decreases annual income to $1,100. This decreases net worth to $124,100, which is still over the limit. VA must deny the claim for excessive net worth.

(g) *Effective dates of pension entitlement or increased entitlement after a denial, reduction, or discontinuance based on excessive net worth*—(1) *Scope of paragraph.* This paragraph (g) applies when VA has:

(i) Discontinued pension or denied pension entitlement for a veteran, surviving spouse, or surviving child based on the veteran's, surviving spouse's, or surviving child's excessive net worth; or

(ii) Reduced pension or denied increased pension entitlement for a veteran or surviving spouse based on a dependent child's excessive net worth.

(2) *Effective date of entitlement or increased entitlement.* The effective date of entitlement or increased entitlement is the day net worth ceases to exceed the limit. For this effective date to apply, the claimant or beneficiary must submit a certified statement that net worth has decreased and VA must receive the certified statement before the pension claim has become finally adjudicated under § 3.160. This means that VA must receive the certified statement within 1 year after its decision notice to the claimant concerning the denial, reduction, or discontinuance unless the claimant appeals VA's decision. Otherwise, the effective date is the date VA receives a new pension claim. In accordance with § 3.277(a), VA may require the claimant or beneficiary to submit additional evidence as the individual circumstances may require.

(h) *Reduction or discontinuance of beneficiary's pension entitlement based on excessive net worth*—(1) *Effective date of reduction or discontinuance.* When an increase in a beneficiary's or dependent child's net worth results in a pension reduction or discontinuance because net worth exceeds the limit, the effective date of reduction or discontinuance is the last day of the calendar year in which net worth exceeds the limit.

(2) *Net worth decreases before the effective date.* If net worth decreases to the limit or below the limit before the effective date provided in paragraph (h)(1) of this section, VA will not reduce or discontinue the pension award on the basis of excessive net worth.

(i) *Additional effective-date provisions for dependent children*—(1) *Establishing a dependent child on veteran's or surviving spouse's pension award results in increased pension entitlement.* When establishing a dependent child on a veteran's or surviving spouse's pension award results in increased pension entitlement for the veteran or surviving spouse, VA will apply the effective-date provisions in paragraphs (g) and (h) of this section.

(2) *Establishing a dependent child on veteran's or surviving spouse's pension award results in decreased pension entitlement.* (i) When a dependent child's non-excessive net worth results in decreased pension entitlement for the veteran or surviving spouse, the effective date of the decreased pension entitlement rate (*i.e.*, VA action to add the child to the award) is the end of the year that the child's net worth decreases.

(ii) When a dependent child's excessive net worth results in increased pension entitlement for the veteran or surviving spouse, the effective date of the increased pension entitlement rate (*i.e.*, VA action to remove the child from the award) is the date that VA receives a claim for an increased rate based on the child's net worth increase.

(Authority: 38 U.S.C. 1522, 1543, 5110, 5112)

[83 FR 47269, Sept 18, 2018]

§ 3.275 How VA determines the asset amount for pension net worth determinations.

(a) *Definitions pertaining to assets*—(1) *Assets.* The term *assets* means the fair market value of all property that an individual owns, including all real and personal property, unless excluded under paragraph (b) of this section, less the amount of mortgages or other encumbrances specific to the mortgaged or encumbered property. VA will consider the terms of the recorded deed or other evidence of title to be proof of ownership of a particular asset. *See also* § 3.276(a)(4), which defines ''fair market value.''

(2) *Claimant.* (i) Except as provided in paragraph (a)(2)(ii) of this section, for the purposes of this section and § 3.276, *claimant* means a pension beneficiary, a dependent spouse, or a dependent or potential dependent child as described in § 3.274(d), as well as a veteran, surviving spouse, or surviving child pension applicant.

(ii) For the purpose of paragraph (b)(1) of this section, *claimant* means a pension beneficiary or applicant who is a veteran, a surviving spouse, or a surviving child.

(3) *Residential lot area.* For purposes of this section, *residential lot area* means the lot on which a residence sits that does not exceed 2 acres (87,120 square feet), unless the additional acreage is not marketable.

(b) *Exclusions from assets.* Assets do not include the following:

(1) *Primary residence.* The value of a claimant's primary residence (single-family unit), including the residential lot area, in which the claimant has an ownership interest. VA recognizes one primary residence per claimant. If the residence is sold after pension entitlement is established, any net proceeds from the sale is an asset except to the extent the proceeds are used to purchase another residence within the same calendar year as the year in which the sale occurred.

(i) *Personal mortgage not deductible.* VA will not subtract from a claimant's assets the amount of any mortgages or encumbrances on a claimant's primary residence.

(ii) *Claimant not residing in primary residence.* Although rental income counts as annual income as provided in § 3.271(d), VA will not include a claimant's primary residence as an asset even if the claimant resides in any of the following as defined in § 3.278(b):

(A) A nursing home or medical foster home;

(B) A care facility other than a nursing home; or

(C) The home of a family member for health care or custodial care.

(2) *Personal effects.* Value of personal effects suitable to and consistent with a reasonable mode of life, such as appliances and family transportation vehicles.

(3) *Radiation Exposure Compensation Act payments.* Payments made under section 6 of the Radiation Exposure Compensation Act of 1990.

(Authority: 42 U.S.C. 2210 (note))

(4) *Ricky Ray Hemophilia Relief Fund payments.* Payments made under section 103(c) and excluded under section 103(h)(2) of the Ricky Ray Hemophilia Relief Fund Act of 1998.

(Authority: 42 U.S.C. 300c–22 (note))

(5) *Energy Employees Occupational Illness Compensation Program payments.*

Payments made under the Energy Employees Occupational Illness Compensation Program.

(Authority: 42 U.S.C. 7385e(2))

(6) *Payments to Aleuts.* Payments made to certain Aleuts under 50 U.S.C. App. 1989c–5.

(Authority: 50 U.S.C. App. 1989c–5(d)(2))

(7) *Statutory exclusions.* Other amounts excluded from assets by statute. See § 3.279. VA will exclude from assets any amount designated by statute as not countable as a resource, regardless of whether or not it is listed in this section or in § 3.279.

(Authority: 38 U.S.C. 1522, 1543)

[83 FR 47271, Sept. 18, 2018]

§ 3.276 Asset transfers and penalty periods.

(a) *Asset transfer definitions.* For purposes of this section—

(1) *Claimant* has the same meaning as defined in § 3.275(a)(2)(i).

(2) *Covered asset* means an asset that—

(i) Was part of a claimant's net worth;

(ii) Was transferred for less than fair market value; and

(iii) If not transferred, would have caused or partially caused the claimant's net worth to exceed the net worth limit under § 3.274(a).

(3) *Covered asset amount* means the monetary amount by which a claimant's net worth would have exceeded the limit due to the covered asset alone if the uncompensated value of the covered asset had been included in net worth.

(i) *Example 1.* For purposes of this example, presume the net worth limit under § 3.274(a) is $123,600. A claimant's assets total $115,900 and his annual income is zero. However, the claimant transferred $30,000 by giving it to a friend. If the claimant had not transferred the $30,000, his net worth would have been $145,900, which exceeds the net worth limit. The claimant's covered asset amount is $22,300, because this is the amount by which the claimant's net worth would have exceeded the limit due to the covered asset.

(ii) *Example 2.* For purposes of this example, presume the net worth limit under § 3.274(a) is $123,600. A claimant's annual income is zero and her total assets are $125,000, which exceeds the net worth limit. In addition, the claimant transferred $30,000 by giving $20,000 to her married son and giving $10,000 to a friend. The claimant's covered asset amount is $30,000 because this is the amount by which the claimant's net worth would have exceeded the limit due to the covered assets alone.

(4) *Fair market value* means the price at which an asset would change hands between a willing buyer and a willing seller, neither being under any compulsion to buy or to sell and both having reasonable knowledge of relevant facts. VA will use the best available information to determine fair market value, such as inspections, appraisals, public records, and the market value of similar property if applicable.

(5) *Transfer for less than fair market value* means—

(i) Selling, conveying, gifting, or exchanging an asset for an amount less than the fair market value of the asset; or

(ii) A voluntary asset transfer to, or purchase of, any financial instrument or investment that reduces net worth by transferring the asset to, or purchasing, the instrument or investment unless the claimant establishes that he or she has the ability to liquidate the entire balance of the asset for the claimant's own benefit. If the claimant establishes that the asset can be liquidated, the asset is included as net worth. Examples of such instruments or investments include—

(A) *Annuities. Annuity* means a financial instrument that provides income over a defined period of time for an initial payment of principal.

(B) *Trusts. Trust* means a legal instrument by which an individual (the grantor) transfers property to an individual or an entity (the trustee), who manages the property according to the terms of the trust, whether for the grantor's own benefit or for the benefit of another individual.

(6) *Uncompensated value* means the difference between the fair market value of an asset and the amount of compensation an individual receives

for it. In the case of a trust, annuity, or other financial instrument or investment described in paragraph (a)(5)(ii) of this section, *uncompensated value* means the amount of money or the monetary value of any other type of asset transferred to such a trust, annuity, or other financial instrument or investment.

(7) *Look-back period* means the 36-month period immediately preceding the date on which VA receives either an original pension claim or a new pension claim after a period of non-entitlement. This definition does not include any date before October 18, 2018.

(8) *Penalty period* means a period of non-entitlement, calculated under paragraph (e) of this section, due to transfer of a covered asset.

(b) *General statement of policy pertaining to pension and covered assets.* VA pension is a needs-based benefit and is not intended to preserve the estates of individuals who have the means to support themselves. Accordingly, a claimant may not create pension entitlement by transferring covered assets. VA will review the terms and conditions of asset transfers made during the 36-month look-back period to determine whether the transfer constituted transfer of a covered asset. However, VA will disregard asset transfers made before October 18, 2018. In accordance with §3.277(a), for any asset transfer, VA may require a claimant to provide evidence such as a Federal income tax return transcript, the terms of a gift, trust, or annuity, or the terms of a recorded deed or other evidence of title.

(c) *Exception for transfers as a result of fraud or unfair business practice.* An asset transferred as the result of fraud, misrepresentation, or unfair business practice related to the sale or marketing of financial products or services for purposes of establishing entitlement to VA pension will not be considered a covered asset. Evidence supporting this exception may include, but is not limited to, a complaint contemporaneously filed with State, local, or Federal authorities reporting the incident.

(d) *Exception for transfers to certain trusts.* VA will not consider as a covered asset an asset that a veteran, a veteran's spouse, or a veteran's surviving spouse transfers to a trust established on behalf of a child of the veteran if:

(1) VA rates or has rated the child incapable of self-support under §3.356; and

(2) There is no circumstance under which distributions from the trust can be used to benefit the veteran, the veteran's spouse, or the veteran's surviving spouse.

(e) *Penalty periods and calculations.* When a claimant transfers a covered asset during the look-back period, VA will assess a penalty period not to exceed 5 years. VA will calculate the length of the penalty period by dividing the total covered asset amount by the monthly penalty rate described in paragraph (e)(1) of this section and rounding the quotient down to the nearest whole number. The result is the number of months for which VA will not pay pension.

(1) *Monthly penalty rate.* The monthly penalty rate is the maximum annual pension rate (MAPR) under 38 U.S.C. 1521(d)(2) for a veteran in need of aid and attendance with one dependent that is in effect as of the date of the pension claim, divided by 12, and rounded down to the nearest whole dollar. The monthly penalty rate is located on VA's website at *www.benefits.va.gov/pension*.

(2) *Beginning date of penalty period.* When a claimant transfers a covered asset or assets during the look-back period, the penalty period begins on the first day of the month that follows the date of the transfer. If there was more than one transfer, the penalty period will begin on the first day of the month that follows the date of the last transfer.

(3) *Entitlement upon ending of penalty period.* VA will consider that the claimant, if otherwise qualified, is entitled to benefits effective the last day of the last month of the penalty period, with a payment date as of the first day of the following month in accordance with §3.31.

(4) *Example of penalty period calculation.* VA receives a pension claim in November 2018. The claimant's net worth is equal to the net worth limit.

However, the claimant transferred covered assets totaling $10,000 on August 20, 2018, and September 23, 2018. Therefore, the total covered asset amount is $10,000, and the penalty period begins on October 1, 2018. Assume the MAPR for a veteran in need of aid and attendance with one dependent in effect in November 2018 is $24,000. The monthly penalty rate is $2,000. The penalty period is $10,000/$2,000 per month = 5 months. The fifth month of the penalty period is February 2019. The claimant may be entitled to pension effective February 28, 2019, with a payment date of March 1, 2019, if other entitlement requirements are met.

(5) *Penalty period recalculations.* VA will not recalculate a penalty period under this section unless—

(i) The original calculation is shown to be erroneous; or

(ii) VA receives evidence showing that some or all covered assets were returned to the claimant before the date of claim or within 60 days after the date of VA's notice to the claimant of VA's decision concerning the penalty period. If covered assets are returned to the claimant, VA will recalculate or eliminate the penalty period. For this exception to apply, VA must receive the evidence not later than 90 days after the date of VA's notice to the claimant of VA's decision concerning the penalty period. Once covered assets are returned, a claimant may reduce net worth at the time of transfer under the provisions of § 3.274(f).

(Authority: 38 U.S.C. 1522, 1543, 1506(1))

(The Office of Management and Budget has approved the information collection requirement in this section under control numbers 2900–0002, and 2900–0004.)

[83 FR 47271, Sept. 18, 2018]

§ 3.277 Eligibility reporting requirements.

(a) *Evidence of entitlement.* As a condition of granting or continuing pension, the Department of Veterans Affairs may require from any person who is an applicant for or a recipient of pension such information, proofs, and evidence as is necessary to determine the annual income and the value of the corpus of the estate of such person, and of any spouse or child for whom the person is receiving or is to receive increased pension (such child is hereinafter in this section referred to as a *dependent child*), and, in the case of a child applying for or in receipt of pension in his or her own behalf (hereinafter in this section referred to as a *surviving child*), of any person with whom such child is residing who is legally responsible for such child's support.

(b) *Obligation to report changes in factors affecting entitlement.* Any individual who has applied for or receives pension must promptly notify the Secretary of any change affecting entitlement in any of the following:

(1) Income;

(2) Net worth or corpus of estate;

(3) Marital status;

(4) Nursing home patient status;

(5) School enrollment status of a child 18 years of age or older; or

(6) Any other factor that affects entitlement to benefits under the provisions of this Part.

(c) *Eligibility verification reports.* (1) For purposes of this section the term eligibility verification report means a form prescribed by the Secretary that is used to request income, net worth, dependency status, and any other information necessary to determine or verify entitlement to pension.

(2) The Secretary may require an eligibility verification report under the following circumstances:

(i) If the Social Security Administration has not verified the beneficiary's Social Security number and, if the beneficiary is married, his or her spouse's Social Security number;

(ii) If there is reason to believe that the beneficiary or his or her spouse may have received income other than Social Security during the current or previous calendar year; or

(iii) If the Secretary determines that an eligibility verification report is necessary to preserve program integrity.

(3) An individual who applies for or receives pension as defined in § 3.3 of this part shall, as a condition of receipt or continued receipt of benefits, furnish the Department of Veterans Affairs an eligibility verification report upon request.

(d) If VA requests that a claimant or beneficiary submit an eligibility verification report but he or she fails

to do so within 60 days of the date of the VA request, the Secretary shall suspend the award or disallow the claim.

(Authority: 38 U.S.C. 1506)

(The Office of Management and Budget has approved the information collection requirements in this section under control numbers 2900–0101 and 2900–0624)

[44 FR 45936, Aug. 6, 1979, as amended at 60 FR 51922, Oct. 4, 1995; 65 FR 16827, Mar. 30, 2000; 66 FR 56614, Nov. 9, 2001; 83 FR 47272, Sept. 18, 2018]

§ 3.278 Deductible medical expenses.

(a) *Scope*. This section identifies medical expenses that VA may deduct from countable income for purposes of three of its needs-based programs: Pension, section 306 pension, and parents' dependency and indemnity compensation (DIC). Payments for such medical expenses must be unreimbursed to be deductible from income.

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

(1) *Health care provider* means:

(i) An individual licensed by a State or country to provide health care in the State or country in which the individual provides the health care. The term includes, but is not limited to, a physician, physician assistant, psychologist, chiropractor, registered nurse, licensed vocational nurse, licensed practical nurse, and physical or occupational therapist; or

(ii) A nursing assistant or home health aide who is supervised by a licensed health care provider as defined in paragraph (b)(1)(i) of this section.

(2) *Activities of daily living (ADLs)* mean basic self-care activities and consist of bathing or showering, dressing, eating, toileting, transferring, and ambulating within the home or living area. *Transferring* means an individual's moving himself or herself from one position to another, such as getting in and out of bed.

(3) *Instrumental activities of daily living (IADLs)* mean independent living activities, such as shopping, food preparation, housekeeping, laundering, managing finances, handling medications, using the telephone, and transportation for non-medical purposes.

(4) *Custodial care* means regular:

(i) Assistance with two or more ADLs; or

(ii) Supervision because an individual with a physical, mental, developmental, or cognitive disorder requires care or assistance on a regular basis to protect the individual from hazards or dangers incident to his or her daily environment.

(5) *Nursing home* means a facility defined in § 3.1(z)(1) or (2). If the facility is not located in a State, the facility must be licensed in the country in which it is located.

(6) *Medical foster home* means a privately-owned residence, recognized and approved by VA under 38 CFR 17.73(d), that offers a non-institutional alternative to nursing home care for veterans who are unable to live alone safely due to chronic or terminal illness.

(7) *Care facility other than a nursing home* means a facility in which a disabled individual receives health care or custodial care under the provisions of paragraph (d) of this section. A facility must be licensed if facilities of that type are required to be licensed in the State or country in which the facility is located. A facility that is residential must be staffed 24 hours per day with care providers. The providers do not have to be licensed health care providers.

(8) *Needs A&A or is housebound* refers to a disabled individual who meets the criteria in § 3.351 for needing regular aid and attendance (A&A) or being housebound and is a:

(i) Veteran;

(ii) Surviving spouse;

(iii) Parent (for parents' DIC purposes); or

(iv) Spouse of a living veteran with a service-connected disability rated at least 30 percent disabling, who is receiving pension.

(c) *Medical expenses for VA purposes*. Generally, medical expenses for VA needs-based benefit purposes are payments for items or services that are medically necessary; that improve a disabled individual's functioning; or that prevent, slow, or ease an individual's functional decline. Medical expenses may include, but are not limited to, the payments specified in paragraphs (c)(1) through (7) of this section.

(1) *Care by a health care provider.* Payments to a health care provider for services performed within the scope of the provider's professional capacity are medical expenses. Cosmetic procedures that a health care provider performs to improve a congenital or accidental deformity or related to treatment for a diagnosed medical condition are medical expenses.

(2) *Medications, medical supplies, medical equipment, and medical food, vitamins, and supplements.* Payments for prescription and non-prescription medication procured lawfully under Federal law, as well as payments for medical supplies or medical equipment, are medical expenses. Medically necessary food, vitamins, and supplements as prescribed or directed by a health care provider authorized to write prescriptions are medical expenses.

(3) *Adaptive equipment.* Payments for adaptive devices or service animals, including veterinary care, used to assist a person with an ongoing disability are medical expenses. Medical expenses do not include non-prescription food, boarding, grooming, or other routine expenses of owning an animal.

(4) *Transportation expenses.* Payments for transportation for medical purposes, such as the cost of transportation to and from a health care provider's office by taxi, bus, or other form of public transportation are medical expenses. The cost of transportation for medical purposes by privately owned vehicle (POV), including mileage, parking, and tolls, is a medical expense. For transportation in a POV, VA limits the deductible mileage rate to the current POV mileage reimbursement rate specified by the United States General Services Administration (GSA). The current amount can be obtained from *www.gsa.gov* or on VA's website at *www.benefits.va.gov/pension/*. Amounts by which transportation expenses set forth in this paragraph (c)(4) exceed the amounts of other VA or non-VA reimbursements for the expense are medical expenses.

(i) *Example.* In February 2013, a veteran drives 60 miles round trip to a VA medical center and back. The veteran is reimbursed $24.90 from the Veterans Health Administration. The POV mileage reimbursement rate specified by GSA is $0.565 per mile, so the transportation expense is $0.565/mile * 60 miles = $33.90. For VA needs-based benefits purposes, the unreimbursed amount, here, the difference between $33.90 and $24.90, is a medical expense.

(ii) [Reserved]

(5) *Health insurance premiums.* Payments for health, medical, hospitalization, and long-term care insurance premiums are medical expenses. Premiums for Medicare Parts A, B, and D and for long-term care insurance are medical expenses.

(6) *Smoking cessation products.* Payments for items and services specifically related to smoking cessation are medical expenses.

(7) *Institutional forms of care and in-home care.* As provided in paragraph (d) of this section.

(d) *Institutional forms of care and in-home care.* This paragraph (d) applies with respect to claims for a medical expense deduction for institutional forms of care or in-home care received on or after October 18, 2018 that VA has not previously granted.

(1) *Hospitals, nursing homes, medical foster homes, and inpatient treatment centers.* Payments to hospitals, nursing homes, medical foster homes, and inpatient treatment centers (including inpatient treatment centers for drug or alcohol addiction), including the cost of meals and lodging charged by such facilities, are medical expenses.

(2) *In-home care.* Payments for assistance with ADLs and IADLs by an in-home attendant are medical expenses as long as the attendant provides the disabled individual with health care or custodial care. Payments must be commensurate with the number of hours that the provider attends to the disabled person. The attendant must be a health care provider unless—

(i) The disabled individual needs A&A or is housebound; or

(ii) A physician, physician assistant, certified nurse practitioner, or clinical nurse specialist states in writing that, due to a physical, mental, developmental, or cognitive disorder, the individual requires the health care or custodial care that the in-home attendant provides.

(3) *Care facilities other than nursing homes.* (i) Care in a facility may be provided by the facility, contracted by the facility, obtained from a third-party provider, or provided by family or friends.

(ii) Payments for health care provided by a health care provider are medical expenses.

(iii) The provider does not need to be a health care provider, and payments for assistance with ADLs and IADLs are medical expenses, if the disabled individual is receiving health care or custodial care in the facility and—

(A) The disabled individual needs A&A or is housebound; or

(B) A physician, physician assistant, certified nurse practitioner, or clinical nurse specialist states in writing that, due to a physical, mental, developmental, or cognitive disorder, the individual needs to be in a protected environment.

(iv) Payments for meals and lodging (and other facility expenses not directly related to health care or custodial care) are medical expenses if:

(A) The facility provides or contracts for health care or custodial care for the disabled individual; or

(B) A physician, physician assistant, certified nurse practitioner, or clinical nurse specialist states in writing that the individual must reside in the facility (or a similar facility) to separately contract with a third-party provider to receive health care or custodial care or to receive (paid or unpaid) health care or custodial care from family or friends.

(e) *Non-medical expenses for VA purposes.* Payments for items and services listed in paragraphs (e)(1) through (4) of this section are not medical expenses for VA needs-based benefit purposes. The list is not all-inclusive.

(1) *Maintenance of general health.* Payments for items or services that benefit or maintain general health, such as vacations and dance classes, are not medical expenses.

(2) *Cosmetic procedures.* Except as provided in paragraph (c)(1) of this section, cosmetic procedures are not medical expenses.

(3) *Meals and lodging.* Except as provided in paragraph (d) of this section, payments for meals and lodging are not medical expenses.

(4) *Assistance with IADLs.* Except as provided in paragraph (d) of this section, payments for assistance with IADLs are not medical expenses.

CROSS REFERENCES: For the rules governing how medical expenses are deducted, see §3.272(g) (regarding pension) and §3.262(l) (regarding section 306 pension and parents' DIC).

(Authority: 38 U.S.C. 501(a), 1315(f)(3), 1503(a)(8), 1506(1))

(The Office of Management and Budget has approved the information collection requirement in this section under control numbers 2900–0002, 2900–0004, and 2900–0161.)

[83 FR 47272, Sept. 18, 2018]

§3.279 Statutory exclusions from income or assets (net worth or corpus of the estate).

This section sets forth payments that Federal statutes exclude from income for the purpose of determining entitlement to any VA-administered benefit that is based on financial need. Some of the exclusions also apply to assets (pension), also known as net worth or the corpus of the estate (section 306 pension and parents as dependents for compensation). VA will exclude from income or assets any amount designated by statute as not countable as income or resources, regardless of whether or not it is listed in this section.

Program or payment	Income	Assets (corpus of the estate)	Authority
(a) COMPENSATION OR RESTITUTION PAYMENTS:			
(1) *Relocation payments.* Payments to individuals displaced as a direct result of programs or projects undertaken by a Federal agency or with Federal financial assistance under the Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970, as amended.	Excluded	Included	42 U.S.C. 4636.
(2) *Crime victim compensation.* Amounts received as compensation under the Victims of Crime Act of 1984 unless the total amount of assistance received from all federally funded programs is sufficient to fully compensate the claimant for losses suffered as a result of the crime.	Excluded	Excluded	42 U.S.C. 10602(c).
(3) *Restitution to individuals of Japanese ancestry.* Payments made as restitution under Public Law 100–383 to an individual of Japanese ancestry who was interned, evacuated, or relocated during the period of December 7, 1941, through June 30, 1946, pursuant to any law, Executive Order, Presidential proclamation, directive, or other official action respecting these individuals.	Excluded	Excluded	50 U.S.C. App. 1989b–4(f).
(4) *Victims of Nazi persecution.* Payments made to individuals because of their status as victims of Nazi persecution.	Excluded	Excluded	42 U.S.C. 1437a note.
(5) *Agent Orange settlement payments.* Payments made from the Agent Orange Settlement Fund or any other fund established pursuant to the settlement in the In Re Agent Orange product liability litigation, M.D.L. No. 381 (E.D.N.Y.).	Excluded	Excluded	Sec. 1, Public Law 101–201.
(6) *Chapter 18 benefits.* Allowances paid under 38 U.S.C. chapter 18 to a veteran's child with a birth defect.	Excluded	Excluded	38 U.S.C. 1833(c).

Program or payment	Income	Assets (corpus of the estate)	Authority
(7) *Flood mitigation activities.* Assistance provided under the National Flood Insurance Act of 1968, as amended.	Excluded	Excluded	42 U.S.C. 4031.
(b) PAYMENTS TO NATIVE AMERICANS:			
(1) *Indian Tribal Judgment Fund distributions.* All Indian Tribal Judgment Fund distributions excluded from income and assets while such funds are held in trust. First $2,000 per year of income received by individual Indians under the Indian Tribal Judgment Funds Use or Distribution Act in satisfaction of a judgment of the United States Court of Federal Claims excluded from income.	Excluded	Excluded	25 U.S.C. 1407.
(2) *Interests of individual Indians in trust or restricted lands.* Interests of individual Indians in trust or restricted lands excluded from assets. First $2,000 per year of income received by individual Indians that is derived from interests in trust or restricted lands excluded from income.	Excluded	Excluded	25 U.S.C. 1408.
(3) *Per Capita Distributions Act.* First $2,000 per year of per capita distributions to members of a tribe from funds held in trust by the Secretary of the Interior for an Indian tribe. All funds excluded from income and assets while funds are held in trust.	Excluded	Excluded	25 U.S.C. 117b, 25 U.S.C. 1407.
(4) *Submarginal land.* Income derived from certain submarginal land of the United States that is held in trust for certain Indian tribes.	Excluded	Excluded	25 U.S.C. 459e.
(5) *Old Age Assistance Claims Settlement Act.* Up to $2,000 per year of per capita distributions under the Old Age Assistance Claims Settlement Act.	Excluded	Excluded	25 U.S.C. 2307.

Program or payment	Income	Assets (corpus of the estate)	Authority
(6) *Alaska Native Claims Settlement Act.* Any of the following, if received from a Native Corporation, under the Alaska Native Claims Settlement Act: (i) Cash, including cash dividends on stocks and bonds, up to a maximum of $2,000 per year; (ii) Stock, including stock issued as a dividend or distribution; (iii) Bonds that are subject to the protection under 43 U.S.C. 1606(h) until voluntarily and expressly sold or pledged by the shareholder after the date of distribution; (iv) A partnership interest; (v) Land or an interest in land, including land received as a dividend or distribution on stock; (vi) An interest in a settlement trust.	Excluded	Excluded	43 U.S.C. 1626(c).
(7) *Maine Indian Claims Settlement Act.* Payments received under the Maine Indian Claims Settlement Act of 1980.	Excluded	Excluded	25 U.S.C. 1728.
(8) *Cobell Settlement.* Payments received under *Cobell* v. *Salazar,* Civil Action No. 96–1285 (TFH) (D.D.C.).	Excluded for one year.	Excluded for one year.	Sec. 101, Public Law 111–291.
(c) WORK–RELATED PAYMENTS:			
(1) *Workforce investment.* Allowances, earnings, and payments to individuals participating in programs under the Workforce Investment Act of 1998.	Excluded	Included	29 U.S.C. 3241(a)(2).

Program or payment	Income	Assets (corpus of the estate)	Authority
(2) *AmeriCorps participants.* Allowances, earnings, and payments to AmeriCorps participants under the National and Community Service Act of 1990.	Excluded	Included	42 U.S.C. 12637(d).
(3) *Volunteer work.* Compensation or reimbursement to volunteers involved in programs administered by the Corporation for National and Community Service, unless the payments are equal to or greater than the minimum wage. The minimum wage is either that under the Fair Labor Standards Act of 1938 (29 U.S.C. 201 *et seq.*) or that under the law of the State where the volunteers are serving, whichever is greater.	Excluded	Excluded	42 U.S.C. 5044(f).
(d) MISCELLANEOUS PAYMENTS:			
(1) *Income tax refunds.* Income tax refunds, including the Federal Earned Income Credit and advance payments with respect to a refundable credit.	Excluded	Excluded for one year.	26 U.S.C. 6409.
(2) *Food stamps.* Value of the allotment provided to an eligible household under the Food Stamp Program.	Excluded	Excluded	7 U.S.C. 2017(b).
(3) *Food for children.* Value of free or reduced-price for food under the Child Nutrition Act of 1966.	Excluded	Excluded	42 U.S.C. 1780(b).
(4) *Child care.* Value of any child care provided or arranged (or any amount received as payment for such care or reimbursement for costs incurred for such care) under the Child Care and Development Block Grant Act of 1990.	Excluded	Included	42 U.S.C. 9858q.
(5) *Services for housing recipients.* Value of services, but not wages, provided to a resident of an eligible housing project under a congregate services program under the Cranston-Gonzalez National Affordable Housing Act.	Excluded	Included	42 U.S.C. 8011(j)(2).

Program or payment	Income	Assets (corpus of the estate)	Authority
(6) *Home energy assistance.* The amount of any home energy assistance payments or allowances provided directly to, or indirectly for the benefit of, an eligible household under the Low-Income Home Energy Assistance Act of 1981.	Excluded	Excluded	42 U.S.C. 8624(f).
(7) *Programs for older Americans.* Payments, other than wages or salaries, received from programs funded under the Older Americans Act of 1965, 42 U.S.C. 3001.	Excluded	Included	42 U.S.C. 3020a(b).
(8) *Student financial aid.* Amounts of student financial assistance received under Title IV of the Higher Education Act of 1965, including Federal work-study programs, Bureau of Indian Affairs student assistance programs, or vocational training under the Carl D. Perkins Vocational and Technical Education Act of 1998.	Excluded	Excluded	20 U.S.C. 1087uu, 2414(a).
(9) *Retired Serviceman's Family Protection Plan annuities.* Annuities received under subchapter I of the Retired Serviceman's Family Protection Plan.	Excluded	Included	10 U.S.C. 1441.

(Authority: 38 U.S.C. 501(a))

[83 FR 47274, Sept. 18, 2018]

RATINGS AND EVALUATIONS; BASIC ENTITLEMENT CONSIDERATIONS

§ 3.300 Claims based on the effects of tobacco products.

(a) For claims received by VA after June 9, 1998, a disability or death will not be considered service-connected on the basis that it resulted from injury or disease attributable to the veteran's use of tobacco products during service. For the purpose of this section, the term ''tobacco products'' means cigars, cigarettes, smokeless tobacco, pipe tobacco, and roll-your-own tobacco.

(b) The provisions of paragraph (a) of this section do not prohibit service connection if:

(1) The disability or death resulted from a disease or injury that is otherwise shown to have been incurred or aggravated during service. For purposes of this section, ''otherwise shown'' means that the disability or death can be service-connected on some basis other than the veteran's use of tobacco products during service, or that the disability became manifest or death occurred during service; or

(2) The disability or death resulted from a disease or injury that appeared to the required degree of disability

within any applicable presumptive period under §§3.307, 3.309, 3.313, or 3.316; or

(3) Secondary service connection is established for ischemic heart disease or other cardiovascular disease under §3.310(b).

(c) For claims for secondary service connection received by VA after June 9, 1998, a disability that is proximately due to or the result of an injury or disease previously service-connected on the basis that it is attributable to the veteran's use of tobacco products during service will not be service-connected under §3.310(a).

(Authority: 38 U.S.C. 501(a), 1103, 1103 note)

[66 FR 18198, Apr. 6, 2001]

§3.301 Line of duty and misconduct.

(a) *Line of duty*. Direct service connection may be granted only when a disability or cause of death was incurred or aggravated in line of duty, and not the result of the veteran's own willful misconduct or, for claims filed after October 31, 1990, the result of his or her abuse of alcohol or drugs.

(Authority: 38 U.S.C. 105)

(b) *Willful misconduct*. Disability pension is not payable for any condition due to the veteran's own willful misconduct.

(Authority: 38 U.S.C. 1521)

(c) *Specific applications; willful misconduct*. For the purpose of determining entitlement to service-connected and nonservice-connected benefits the definitions in §§3.1 (m) and (n) of this part apply except as modified within paragraphs (c)(1) through (c)(3) of this section. The provisions of paragraphs (c)(2) and (c)(3) of this section are subject to the provisions of §3.302 of this part where applicable.

(Authority: 38 U.S.C. 501)

(1) *Venereal disease*. The residuals of venereal disease are not to be considered the result of willful misconduct. Consideration of service connection for residuals of venereal disease as having been incurred in service requires that the initial infection must have occurred during active service. Increase in service of manifestations of venereal disease will usually be held due to natural progress unless the facts of record indicate the increase in manifestations was precipitated by trauma or by the conditions of the veteran's service, in which event service connection may be established by aggravation. Medical principles pertaining to the incubation period and its relation to the course of the disease; *i.e.*, initial or acute manifestation, or period and course of secondary and late residuals manifested, will be considered when time of incurrence of venereal disease prior to or after entry into service is at issue. In the issue of service connection, whether the veteran complied with service regulations and directives for reporting the disease and undergoing treatment is immaterial after November 14, 1972, and the service department characterization of acquisition of the disease as *willful misconduct* or as *not in line of duty* will not govern.

(2) The simple drinking of alcoholic beverage is not of itself willful misconduct. The deliberate drinking of a known poisonous substance or under conditions which would raise a presumption to that effect will be considered willful misconduct. If, in the drinking of a beverage to enjoy its intoxicating effects, intoxication results proximately and immediately in disability or death, the disability or death will be considered the result of the person's willful misconduct. Organic diseases and disabilities which are a secondary result of the chronic use of alcohol as a beverage, whether out of compulsion or otherwise, will not be considered of willful misconduct origin. (See §§21.1043, 21.5041, and 21.7051 of this title regarding the disabling effects of chronic alcoholism for the purpose of extending delimiting periods under education or rehabilitation programs.)

(Authority: 38 U.S.C. 501)

(3) *Drug usage*. The isolated and infrequent use of drugs by itself will not be considered willful misconduct; however, the progressive and frequent use of drugs to the point of addiction will be considered willful misconduct.

Where drugs are used to enjoy or experience their effects and the effects result proximately and immediately in disability or death, such disability or death will be considered the result of the person's willful misconduct. Organic diseases and disabilities which are a secondary result of the chronic use of drugs and infections coinciding with the injection of drugs will not be considered of willful misconduct origin. (See paragraph (d) of this section regarding service connection where disability or death is a result of abuse of drugs.) Where drugs are used for therapeutic purposes or where use of drugs or addiction thereto, results from a service-connected disability, it will not be considered of misconduct origin.

(Authority: 38 U.S.C. 105, 1110, 1121, 1131, 1301, and 1521(a))

(d) *Line of duty; abuse of alcohol or drugs.* An injury or disease incurred during active military, naval, or air service shall not be deemed to have been incurred in line of duty if such injury or disease was a result of the abuse of alcohol or drugs by the person on whose service benefits are claimed. For the purpose of this paragraph, alcohol abuse means the use of alcoholic beverages over time, or such excessive use at any one time, sufficient to cause disability to or death of the user; drug abuse means the use of illegal drugs (including prescription drugs that are illegally or illicitly obtained), the intentional use of prescription or nonprescription drugs for a purpose other than the medically intended use, or the use of substances other than alcohol to enjoy their intoxicating effects.

(Authority: 38 U.S.C. 105(a))

CROSS REFERENCES: In line of duty. See § 3.1(m). Willful misconduct. See § 3.1(n). Extended period of eligibility. See §§ 21.1043 and 21.7051. Periods of entitlement. See § 21.5041.

[26 FR 1579, Feb. 24, 1961, as amended at 37 FR 24662, Nov. 18, 1972; 54 FR 31951, Aug. 3, 1989; 55 FR 13530, Apr. 11, 1990; 60 FR 27408, May 24, 1995]

§ 3.302 Service connection for mental unsoundness in suicide.

(a) *General.* (1) In order for suicide to constitute willful misconduct, the act of self-destruction must be intentional.

(2) A person of unsound mind is incapable of forming an intent (mens rea, or guilty mind, which is an essential element of crime or willful misconduct).

(3) It is a constant requirement for favorable action that the precipitating mental unsoundness be service connected.

(b) *Evidence of mental condition.* (1) Whether a person, at the time of suicide, was so unsound mentally that he or she did not realize the consequence of such an act, or was unable to resist such impulse is a question to be determined in each individual case, based on all available lay and medical evidence pertaining to his or her mental condition at the time of suicide.

(2) The act of suicide or a bona fide attempt is considered to be evidence of mental unsoundness. Therefore, where no reasonable adequate motive for suicide is shown by the evidence, the act will be considered to have resulted from mental unsoundness.

(3) A reasonable adequate motive for suicide may be established by affirmative evidence showing circumstances which could lead a rational person to self-destruction.

(c) *Evaluation of evidence.* (1) Affirmative evidence is necessary to justify reversal of service department findings of mental unsoundness where Department of Veterans Affairs criteria do not otherwise warrant contrary findings.

(2) In all instances any reasonable doubt should be resolved favorably to support a finding of service connection (see § 3.102).

CROSS REFERENCE: Cause of death. See § 3.312.

[28 FR 183, Jan. 8, 1963, as amended at 54 FR 31951, Aug. 3, 1989; 55 FR 13530, Apr. 11, 1990]

RATINGS AND EVALUATIONS; SERVICE CONNECTION

§ 3.303 Principles relating to service connection.

(a) *General.* Service connection connotes many factors but basically it means that the facts, shown by evidence, establish that a particular injury or disease resulting in disability was incurred coincident with service in the Armed Forces, or if preexisting such service, was aggravated therein.

This may be accomplished by affirmatively showing inception or aggravation during service or through the application of statutory presumptions. Each disabling condition shown by a veteran's service records, or for which he seeks a service connection must be considered on the basis of the places, types and circumstances of his service as shown by service records, the official history of each organization in which he served, his medical records and all pertinent medical and lay evidence. Determinations as to service connection will be based on review of the entire evidence of record, with due consideration to the policy of the Department of Veterans Affairs to administer the law under a broad and liberal interpretation consistent with the facts in each individual case.

(b) *Chronicity and continuity.* With chronic disease shown as such in service (or within the presumptive period under § 3.307) so as to permit a finding of service connection, subsequent manifestations of the same chronic disease at any later date, however remote, are service connected, unless clearly attributable to intercurrent causes. This rule does not mean that any manifestation of joint pain, any abnormality of heart action or heart sounds, any urinary findings of casts, or any cough, in service will permit service connection of arthritis, disease of the heart, nephritis, or pulmonary disease, first shown as a clearcut clinical entity, at some later date. For the showing of chronic disease in service there is required a combination of manifestations sufficient to identify the disease entity, and sufficient observation to establish chronicity at the time, as distinguished from merely isolated findings or a diagnosis including the word ''Chronic.'' When the disease identity is established (leprosy, tuberculosis, multiple sclerosis, etc.), there is no requirement of evidentiary showing of continuity. Continuity of symptomatology is required only where the condition noted during service (or in the presumptive period) is not, in fact, shown to be chronic or where the diagnosis of chronicity may be legitimately questioned. When the fact of chronicity in service is not adequately supported, then a showing of continuity after discharge is required to support the claim.

(c) *Preservice disabilities noted in service.* There are medical principles so universally recognized as to constitute fact (clear and unmistakable proof), and when in accordance with these principles existence of a disability prior to service is established, no additional or confirmatory evidence is necessary. Consequently with notation or discovery during service of such residual conditions (scars; fibrosis of the lungs; atrophies following disease of the central or peripheral nervous system; healed fractures; absent, displaced or resected parts of organs; supernumerary parts; congenital malformations or hemorrhoidal tags or tabs, etc.) with no evidence of the pertinent antecedent active disease or injury during service the conclusion must be that they preexisted service. Similarly, manifestation of lesions or symptoms of chronic disease from date of enlistment, or so close thereto that the disease could not have originated in so short a period will establish preservice existence thereof. Conditions of an infectious nature are to be considered with regard to the circumstances of the infection and if manifested in less than the respective incubation periods after reporting for duty, they will be held to have preexisted service. In the field of mental disorders, personality disorders which are characterized by developmental defects or pathological trends in the personality structure manifested by a lifelong pattern of action or behavior, chronic psychoneurosis of long duration or other psychiatric symptomatology shown to have existed prior to service with the same manifestations during service, which were the basis of the service diagnosis, will be accepted as showing preservice origin. Congenital or developmental defects, refractive error of the eye, personality disorders and mental deficiency as such are not diseases or injuries within the meaning of applicable legislation.

(d) *Postservice initial diagnosis of disease.* Service connection may be granted for any disease diagnosed after discharge, when all the evidence, including that pertinent to service, establishes that the disease was incurred in

service. Presumptive periods are not intended to limit service connection to diseases so diagnosed when the evidence warrants direct service connection. The presumptive provisions of the statute and Department of Veterans Affairs regulations implementing them are intended as liberalizations applicable when the evidence would not warrant service connection without their aid.

[26 FR 1579, Feb. 24, 1961]

§ 3.304 Direct service connection; wartime and peacetime.

(a) *General*. The basic considerations relating to service connection are stated in § 3.303. The criteria in this section apply only to disabilities which may have resulted from service in a period of war or service rendered on or after January 1, 1947.

(b) *Presumption of soundness*. The veteran will be considered to have been in sound condition when examined, accepted and enrolled for service, except as to defects, infirmities, or disorders noted at entrance into service, or where clear and unmistakable (obvious or manifest) evidence demonstrates that an injury or disease existed prior thereto and was not aggravated by such service. Only such conditions as are recorded in examination reports are to be considered as noted.

(Authority: 38 U.S.C. 1111)

(1) History of preservice existence of conditions recorded at the time of examination does not constitute a notation of such conditions but will be considered together with all other material evidence in determinations as to inception. Determinations should not be based on medical judgment alone as distinguished from accepted medical principles, or on history alone without regard to clinical factors pertinent to the basic character, origin and development of such injury or disease. They should be based on thorough analysis of the evidentiary showing and careful correlation of all material facts, with due regard to accepted medical principles pertaining to the history, manifestations, clinical course, and character of the particular injury or disease or residuals thereof.

(2) History conforming to accepted medical principles should be given due consideration, in conjunction with basic clinical data, and be accorded probative value consistent with accepted medical and evidentiary principles in relation to value consistent with accepted medical evidence relating to incurrence, symptoms and course of the injury or disease, including official and other records made prior to, during or subsequent to service, together with all other lay and medical evidence concerning the inception, development and manifestations of the particular condition will be taken into full account.

(3) Signed statements of veterans relating to the origin, or incurrence of any disease or injury made in service if against his or her own interest is of no force and effect if other data do not establish the fact. Other evidence will be considered as though such statement were not of record.

(Authority: 10 U.S.C. 1219)

(c) *Development*. The development of evidence in connection with claims for service connection will be accomplished when deemed necessary but it should not be undertaken when evidence present is sufficient for this determination. In initially rating disability of record at the time of discharge, the records of the service department, including the reports of examination at enlistment and the clinical records during service, will ordinarily suffice. Rating of combat injuries or other conditions which obviously had their inception in service may be accomplished pending receipt of copy of the examination at enlistment and all other service records.

(d) *Combat*. Satisfactory lay or other evidence that an injury or disease was incurred or aggravated in combat will be accepted as sufficient proof of service connection if the evidence is consistent with the circumstances, conditions or hardships of such service even though there is no official record of such incurrence or aggravation.

(Authority: 38 U.S.C. 1154(b))

(e) *Prisoners of war*. Where disability compensation is claimed by a former prisoner of war, omission of history or findings from clinical records made

upon repatriation is not determinative of service connection, particularly if evidence of comrades in support of the incurrence of the disability during confinement is available. Special attention will be given to any disability first reported after discharge, especially if poorly defined and not obviously of intercurrent origin. The circumstances attendant upon the individual veteran's confinement and the duration thereof will be associated with pertinent medical principles in determining whether disability manifested subsequent to service is etiologically related to the prisoner of war experience.

(f) *Posttraumatic stress disorder*. Service connection for posttraumatic stress disorder requires medical evidence diagnosing the condition in accordance with §4.125(a) of this chapter; a link, established by medical evidence, between current symptoms and an in-service stressor; and credible supporting evidence that the claimed in-service stressor occurred. The following provisions apply to claims for service connection of posttraumatic stress disorder diagnosed during service or based on the specified type of claimed stressor:

(1) If the evidence establishes a diagnosis of posttraumatic stress disorder during service and the claimed stressor is related to that service, in the absence of clear and convincing evidence to the contrary, and provided that the claimed stressor is consistent with the circumstances, conditions, or hardships of the veteran's service, the veteran's lay testimony alone may establish the occurrence of the claimed in-service stressor.

(2) If the evidence establishes that the veteran engaged in combat with the enemy and the claimed stressor is related to that combat, in the absence of clear and convincing evidence to the contrary, and provided that the claimed stressor is consistent with the circumstances, conditions, or hardships of the veteran's service, the veteran's lay testimony alone may establish the occurrence of the claimed in-service stressor.

(3) If a stressor claimed by a veteran is related to the veteran's fear of hostile military or terrorist activity and a VA psychiatrist or psychologist, or a psychiatrist or psychologist with whom VA has contracted, confirms that the claimed stressor is adequate to support a diagnosis of posttraumatic stress disorder and that the veteran's symptoms are related to the claimed stressor, in the absence of clear and convincing evidence to the contrary, and provided the claimed stressor is consistent with the places, types, and circumstances of the veteran's service, the veteran's lay testimony alone may establish the occurrence of the claimed in-service stressor. For purposes of this paragraph, ''fear of hostile military or terrorist activity'' means that a veteran experienced, witnessed, or was confronted with an event or circumstance that involved actual or threatened death or serious injury, or a threat to the physical integrity of the veteran or others, such as from an actual or potential improvised explosive device; vehicle-imbedded explosive device; incoming artillery, rocket, or mortar fire; grenade; small arms fire, including suspected sniper fire; or attack upon friendly military aircraft, and the veteran's response to the event or circumstance involved a psychological or psycho-physiological state of fear, helplessness, or horror.

(4) If the evidence establishes that the veteran was a prisoner-of-war under the provisions of §3.1(y) of this part and the claimed stressor is related to that prisoner-of-war experience, in the absence of clear and convincing evidence to the contrary, and provided that the claimed stressor is consistent with the circumstances, conditions, or hardships of the veteran's service, the veteran's lay testimony alone may establish the occurrence of the claimed in-service stressor.

(5) If a posttraumatic stress disorder claim is based on in-service personal assault, evidence from sources other than the veteran's service records may corroborate the veteran's account of the stressor incident. Examples of such evidence include, but are not limited to: records from law enforcement authorities, rape crisis centers, mental health counseling centers, hospitals, or physicians; pregnancy tests or tests for sexually transmitted diseases; and statements from family members, roommates, fellow service members, or

clergy. Evidence of behavior changes following the claimed assault is one type of relevant evidence that may be found in these sources. Examples of behavior changes that may constitute credible evidence of the stressor include, but are not limited to: a request for a transfer to another military duty assignment; deterioration in work performance; substance abuse; episodes of depression, panic attacks, or anxiety without an identifiable cause; or unexplained economic or social behavior changes. VA will not deny a posttraumatic stress disorder claim that is based on in-service personal assault without first advising the claimant that evidence from sources other than the veteran's service records or evidence of behavior changes may constitute credible supporting evidence of the stressor and allowing him or her the opportunity to furnish this type of evidence or advise VA of potential sources of such evidence. VA may submit any evidence that it receives to an appropriate medical or mental health professional for an opinion as to whether it indicates that a personal assault occurred.

(Authority: 38 U.S.C. 501(a), 1154)

[26 FR 1580, Feb. 24, 1961, as amended at 31 FR 4680, Mar. 19, 1966; 39 FR 34530, Sept. 26, 1974; 58 FR 29110, May 19, 1993; 64 FR 32808, June 18, 1999; 67 FR 10332, Mar. 7, 2002; 70 FR 23029, May 4, 2005; 73 FR 64210, Oct. 29, 2008; 75 FR 39852, July 13, 2010]

§ 3.305 Direct service connection; peacetime service before January 1, 1947.

(a) *General*. The basic considerations relating to service connection are stated in § 3.303. The criteria in this section apply only to disabilities which may have resulted from service other than in a period of war before January 1, 1947.

(b) *Presumption of soundness*. A peacetime veteran who has had active, continuous service of 6 months or more will be considered to have been in sound condition when examined, accepted and enrolled for service, except as to defects, infirmities or disorders noted at the time thereof, or where evidence or medical judgment, as distinguished from medical fact and principles, establishes that an injury or disease preexisted service. Any evidence acceptable as competent to indicate the time of existence or inception of the condition may be considered. Determinations based on medical judgment will take cognizance of the time of inception or manifestation of disease or injury following entrance into service, as shown by proper service authorities in service records, entries or reports. Such records will be accorded reasonable weight in consideration of other evidence and sound medical reasoning. Opinions may be solicited from Department of Veterans Affairs medical authorities when considered necessary.

(c) *Campaigns and expeditions*. In considering claims of veterans who engaged in combat during campaigns or expeditions satisfactory lay or other evidence of incurrence or aggravation in such combat of an injury or disease, if consistent with the circumstances, conditions or hardships of such service will be accepted as sufficient proof of service connection, even when there is no official record of incurrence or aggravation. Service connection for such injury or disease may be rebutted by clear and convincing evidence to the contrary.

[26 FR 1580, Feb. 24, 1961, as amended at 28 FR 3088, Mar. 29, 1963; 39 FR 34530, Sept. 26, 1974]

§ 3.306 Aggravation of preservice disability.

(a) *General*. A preexisting injury or disease will be considered to have been aggravated by active military, naval, or air service, where there is an increase in disability during such service, unless there is a specific finding that the increase in disability is due to the natural progress of the disease.

(Authority: 38 U.S.C. 1153)

(b) *Wartime service; peacetime service after December 31, 1946*. Clear and unmistakable evidence (obvious or manifest) is required to rebut the presumption of aggravation where the preservice disability underwent an increase in severity during service. This includes medical facts and principles which may be considered to determine

whether the increase is due to the natural progress of the condition. Aggravation may not be conceded where the disability underwent no increase in severity during service on the basis of all the evidence of record pertaining to the manifestations of the disability prior to, during and subsequent to service.

(1) The usual effects of medical and surgical treatment in service, having the effect of ameliorating disease or other conditions incurred before enlistment, including postoperative scars, absent or poorly functioning parts or organs, will not be considered service connected unless the disease or injury is otherwise aggravated by service.

(2) Due regard will be given the places, types, and circumstances of service and particular consideration will be accorded combat duty and other hardships of service. The development of symptomatic manifestations of a preexisting disease or injury during or proximately following action with the enemy or following a status as a prisoner of war will establish aggravation of a disability.

(Authority: 38 U.S.C. 1154)

(c) *Peacetime service prior to December 7, 1941.* The specific finding requirement that an increase in disability is due to the natural progress of the condition will be met when the available evidence of a nature generally acceptable as competent shows that the increase in severity of a disease or injury or acceleration in progress was that normally to be expected by reason of the inherent character of the condition, aside from any extraneous or contributing cause or influence peculiar to military service. Consideration will be given to the circumstances, conditions, and hardships of service.

[26 FR 1580, Feb. 24, 1961, as amended at 57 FR 59296, Dec. 15, 1992]

§ 3.307 Presumptive service connection for chronic, tropical, or prisoner-of-war related disease, disease associated with exposure to certain herbicide agents, or disease associated with exposure to contaminants in the water supply at Camp Lejeune; wartime and service on or after January 1, 1947.

(a) *General.* A chronic, tropical, or prisoner of war related disease, a disease associated with exposure to certain herbicide agents, or a disease associated with exposure to contaminants in the water supply at Camp Lejeune listed in § 3.309 will be considered to have been incurred in or aggravated by service under the circumstances outlined in this section even though there is no evidence of such disease during the period of service. No condition other than one listed in § 3.309(a) will be considered chronic.

(1) *Service.* The veteran must have served 90 days or more during a war period or after December 31, 1946. The requirement of 90 days' service means active, continuous service within or extending into or beyond a war period, or which began before and extended beyond December 31, 1946, or began after that date. Any period of service is sufficient for the purpose of establishing the presumptive service connection of a specified disease under the conditions listed in § 3.309(c) and (e). Any period of service is sufficient for the purpose of establishing the presumptive service connection of a specified disease under the conditions listed in § 3.309(f), as long as the period of service also satisfies the requirements to establish a presumption of exposure to contaminants in the water supply at Camp Lejeune under paragraph (a)(7)(iii) of this section.

(2) *Separation from service.* For the purpose of paragraph (a)(3) and (4) of this section the date of separation from wartime service will be the date of discharge or release during a war period, or if service continued after the war, the end of the war period. In claims based on service on or after January 1, 1947, the date of separation will be the date of discharge or release from the period of service on which the claim is based.

(3) *Chronic disease.* The disease must have become manifest to a degree of 10

percent or more within 1 year (for Hansen's disease (leprosy) and tuberculosis, within 3 years; multiple sclerosis, within 7 years) from the date of separation from service as specified in paragraph (a)(2) of this section.

(4) *Tropical disease*. The disease must have become manifest to a degree of 10 percent or more within 1 year from date of separation from service as specified in paragraph (a)(2) of this section, or at a time when standard accepted treatises indicate that the incubation period commenced during such service. The resultant disorders or diseases originating because of therapy administered in connection with a tropical disease or as a preventative may also be service connected.

(Authority: 38 U.S.C. 1112)

(5) *Diseases specific as to former prisoners of war*. The diseases listed in § 3.309(c) shall have become manifest to a degree of 10 percent or more at any time after discharge or release from active service.

(Authority: 38 U.S.C. 1112)

(6) *Diseases associated with exposure to certain herbicide agents*. (i) For the purposes of this section, the term ''herbicide agent'' means a chemical in an herbicide used in support of the United States and allied military operations in the Republic of Vietnam during the period beginning on January 9, 1962, and ending on May 7, 1975, specifically: 2,4–D; 2,4,5–T and its contaminant TCDD; cacodylic acid; and picloram.

(Authority: 38 U.S.C. 1116(a)(4))

(ii) The diseases listed at § 3.309(e) shall have become manifest to a degree of 10 percent or more at any time after service, except that chloracne or other acneform disease consistent with chloracne, porphyria cutanea tarda, and early-onset peripheral neuropathy shall have become manifest to a degree of 10 percent or more within a year after the last date on which the veteran was exposed to an herbicide agent during active military, naval, or air service.

(iii) A veteran who, during active military, naval, or air service, served in the Republic of Vietnam during the period beginning on January 9, 1962, and ending on May 7, 1975, shall be presumed to have been exposed during such service to an herbicide agent, unless there is affirmative evidence to establish that the veteran was not exposed to any such agent during that service. The last date on which such a veteran shall be presumed to have been exposed to an herbicide agent shall be the last date on which he or she served in the Republic of Vietnam during the period beginning on January 9, 1962, and ending on May 7, 1975. ''Service in the Republic of Vietnam'' includes service in the waters offshore and service in other locations if the conditions of service involved duty or visitation in the Republic of Vietnam.

(iv) A veteran who, during active military, naval, or air service, served between April 1, 1968, and August 31, 1971, in a unit that, as determined by the Department of Defense, operated in or near the Korean DMZ in an area in which herbicides are known to have been applied during that period, shall be presumed to have been exposed during such service to an herbicide agent, unless there is affirmative evidence to establish that the veteran was not exposed to any such agent during that service. *See also* 38 CFR 3.814(c)(2).

(v) An individual who performed service in the Air Force or Air Force Reserve under circumstances in which the individual concerned regularly and repeatedly operated, maintained, or served onboard C–123 aircraft known to have been used to spray an herbicide agent during the Vietnam era shall be presumed to have been exposed during such service to an herbicide agent. For purposes of this paragraph, ''regularly and repeatedly operated, maintained, or served onboard C–123 aircraft'' means that the individual was assigned to an Air Force or Air Force Reserve squadron when the squadron was permanently assigned one of the affected aircraft and the individual had an Air Force Specialty Code indicating duties as a flight, ground maintenance, or medical crew member on such aircraft. Such exposure constitutes an injury under 38 U.S.C. 101(24)(B) and (C). If an individual described in this paragraph develops a disease listed in 38 CFR 3.309(e) as specified in paragraph

(a)(6)(ii) of this section, it will be presumed that the individual concerned became disabled during that service for purposes of establishing that the individual served in the active military, naval, or air service.

(7) *Diseases associated with exposure to contaminants in the water supply at Camp Lejeune.* (i) For the purposes of this section, *contaminants in the water supply* means the volatile organic compounds trichloroethylene (TCE), perchloroethylene (PCE), benzene and vinyl chloride, that were in the on-base water-supply systems located at United States Marine Corps Base Camp Lejeune, during the period beginning on August 1, 1953, and ending on December 31, 1987.

(ii) The diseases listed in § 3.309(f) shall have become manifest to a degree of 10 percent or more at any time after service.

(iii) A veteran, or former reservist or member of the National Guard, who had no less than 30 days (consecutive or nonconsecutive) of service at Camp Lejeune during the period beginning on August 1, 1953, and ending on December 31, 1987, shall be presumed to have been exposed during such service to the contaminants in the water supply, unless there is affirmative evidence to establish that the individual was not exposed to contaminants in the water supply during that service. The last date on which such a veteran, or former reservist or member of the National Guard, shall be presumed to have been exposed to contaminants in the water supply shall be the last date on which he or she served at Camp Lejeune during the period beginning on August 1, 1953, and ending on December 31, 1987. For purposes of this section, *service at Camp Lejeune* means any service within the borders of the entirety of the United States Marine Corps Base Camp Lejeune and Marine Corps Air Station New River, North Carolina, during the period beginning on August 1, 1953, and ending on December 31, 1987, as established by military orders or other official service department records.

(iv) Exposure described in paragraph (a)(7)(iii) of this section is an injury under 38 U.S.C. 101(24)(B) and (C). If an individual described in paragraph (a)(7)(iii) of this section develops a disease listed in § 3.309(f), VA will presume that the individual concerned became disabled during that service for purposes of establishing that the individual served in the active military, naval, or air service.

(Authority: 38 U.S.C. 501(a), 1116(a)(3), and 1821)

(b) *Evidentiary basis.* The factual basis may be established by medical evidence, competent lay evidence or both. Medical evidence should set forth the physical findings and symptomatology elicited by examination within the applicable period. Lay evidence should describe the material and relevant facts as to the veteran's disability observed within such period, not merely conclusions based upon opinion. The chronicity and continuity factors outlined in § 3.303(b) will be considered. The diseases listed in § 3.309(a) will be accepted as chronic, even though diagnosed as acute because of insidious inception and chronic development, except: (1) Where they result from intercurrent causes, for example, cerebral hemorrhage due to injury, or active nephritis or acute endocarditis due to intercurrent infection (with or without identification of the pathogenic microorganism); or (2) where a disease is the result of drug ingestion or a complication of some other condition not related to service. Thus, leukemia will be accepted as a chronic disease whether diagnosed as acute or chronic. Unless the clinical picture is clear otherwise, consideration will be given as to whether an acute condition is an exacerbation of a chronic disease.

(Authority: 38 U.S.C. 1112)

(c) *Prohibition of certain presumptions.* No presumptions may be invoked on the basis of advancement of the disease when first definitely diagnosed for the purpose of showing its existence to a degree of 10 percent within the applicable period. This will not be interpreted as requiring that the disease be diagnosed in the presumptive period, but only that there be then shown by acceptable medical or lay evidence characteristic manifestations of the disease to the required degree, followed without unreasonable time lapse by definite

diagnosis. Symptomatology shown in the prescribed period may have no particular significance when first observed, but in the light of subsequent developments it may gain considerable significance. Cases in which a chronic condition is shown to exist within a short time following the applicable presumptive period, but without evidence of manifestations within the period, should be developed to determine whether there was symptomatology which in retrospect may be identified and evaluated as manifestation of the chronic disease to the required 10-percent degree.

(d) *Rebuttal of service incurrence or aggravation.* (1) Evidence which may be considered in rebuttal of service incurrence of a disease listed in § 3.309 will be any evidence of a nature usually accepted as competent to indicate the time of existence or inception of disease, and medical judgment will be exercised in making determinations relative to the effect of intercurrent injury or disease. The expression ''affirmative evidence to the contrary'' will not be taken to require a conclusive showing, but such showing as would, in sound medical reasoning and in the consideration of all evidence of record, support a conclusion that the disease was not incurred in service. As to tropical diseases the fact that the veteran had no service in a locality having a high incidence of the disease may be considered as evidence to rebut the presumption, as may residence during the period in question in a region where the particular disease is endemic. The known incubation periods of tropical diseases should be used as a factor in rebuttal of presumptive service connection as showing inception before or after service.

(2) The presumption of aggravation provided in this section may be rebutted by affirmative evidence that the preexisting condition was not aggravated by service, which may include affirmative evidence that any increase in disability was due to an intercurrent disease or injury suffered after separation from service or evidence sufficient, under § 3.306 of this part, to show that the increase in disability was due to the natural progress of the preexisting condition.

(Authority: 38 U.S.C. 101(24), 501(a), 1116(a)(3), and 1821)

[26 FR 1581, Feb. 24, 1961, as amended at 35 FR 18281, Dec. 1, 1970; 39 FR 34530, Sept. 26, 1974; 43 FR 45347, Oct. 2, 1978; 47 FR 11655, Mar. 18, 1982; 58 FR 29109, May 19, 1993; 59 FR 5106, Feb. 3, 1994; 59 FR 29724, June 9, 1994; 61 FR 57588, Nov. 7, 1996; 62 FR 35422, July 1, 1997; 67 FR 67793, Nov. 7, 2002; 68 FR 34541, June 10, 2003; 76 FR 4248, Jan. 25, 2011; 78 FR 54766, Sept. 6, 2013; 80 FR 35248, June 19, 2015; 82 FR 4184, Jan. 13, 2017]

§ 3.308 Presumptive service connection; peacetime service before January 1, 1947.

(a) *Chronic disease.* There is no provision for presumptive service connection for chronic disease as distinguished from tropical diseases referred to in paragraph (b) of this section based on peacetime service before January 1, 1947.

(b) *Tropical disease.* In claims based on peacetime service before January 1, 1947, a veteran of 6 months or more service who contracts a tropical disease listed in § 3.309(b) or a resultant disorder or disease originating because of therapy administered in connection with a tropical disease or as a preventative, will be considered to have incurred such disability in service when it is shown to exist to the degree of 10 percent or more within 1 year after separation from active service, or at a time when standard and accepted treatises indicate that the incubation period commenced during active service unless shown by clear and unmistakable evidence not to have been of service origin. The requirement of 6 months or more service means active, continuous service, during one or more enlistment periods.

(Authority: 38 U.S.C. 1133)

[39 FR 34530, Sept. 26, 1974]

§ 3.309 Disease subject to presumptive service connection.

(a) *Chronic diseases.* The following diseases shall be granted service connection although not otherwise established as incurred in or aggravated by service if manifested to a compensable degree within the applicable time limits under § 3.307 following service in a

period of war or following peacetime service on or after January 1, 1947, provided the rebuttable presumption provisions of § 3.307 are also satisfied.

Anemia, primary.
Arteriosclerosis.
Arthritis.
Atrophy, progressive muscular.
Brain hemorrhage.
Brain thrombosis.
Bronchiectasis.
Calculi of the kidney, bladder, or gallbladder.

Cardiovascular-renal disease, including hypertension. (This term applies to combination involvement of the type of arteriosclerosis, nephritis, and organic heart disease, and since hypertension is an early symptom long preceding the development of those diseases in their more obvious forms, a disabling hypertension within the 1-year period will be given the same benefit of service connection as any of the chronic diseases listed.)

Cirrhosis of the liver.
Coccidioidomycosis.
Diabetes mellitus.
Encephalitis lethargica residuals.
Endocarditis. (This term covers all forms of valvular heart disease.)
Endocrinopathies.
Epilepsies.
Hansen's disease.
Hodgkin's disease.
Leukemia.
Lupus erythematosus, systemic.
Myasthenia gravis.
Myelitis.
Myocarditis.
Nephritis.
Other organic diseases of the nervous system.
Osteitis deformans (Paget's disease).
Osteomalacia.
Palsy, bulbar.
Paralysis agitans.
Psychoses.
Purpura idiopathic, hemorrhagic.
Raynaud's disease.
Sarcoidosis.
Scleroderma.
Sclerosis, amyotrophic lateral.
Sclerosis, multiple.
Syringomyelia.
Thromboangiitis obliterans (Buerger's disease).
Tuberculosis, active.
Tumors, malignant, or of the brain or spinal cord or peripheral nerves.
Ulcers, peptic (gastric or duodenal) (A proper diagnosis of gastric or duodenal ulcer (peptic ulcer) is to be considered established if it represents a medically sound interpretation of sufficient clinical findings warranting such diagnosis and provides an adequate basis for a differential diagnosis from other conditions with like symptomatology; in short, where the preponderance of evidence indicates gastric or duodenal ulcer (peptic ulcer). Whenever possible, of course, laboratory findings should be used in corroboration of the clinical data.

(b) *Tropical diseases.* The following diseases shall be granted service connection as a result of tropical service, although not otherwise established as incurred in service if manifested to a compensable degree within the applicable time limits under § 3.307 or § 3.308 following service in a period of war or following peacetime service, provided the rebuttable presumption provisions of § 3.307 are also satisfied.

Amebiasis.
Blackwater fever.
Cholera.
Dracontiasis.
Dysentery.
Filariasis.
Leishmaniasis, including kala-azar.
Loiasis.
Malaria.
Onchocerciasis.
Oroya fever.
Pinta.
Plague.
Schistosomiasis.
Yaws.
Yellow fever.
Resultant disorders or diseases originating because of therapy administered in connection with such diseases or as a preventative thereof.

(c) *Diseases specific as to former prisoners of war.* (1) If a veteran is a former prisoner of war, the following diseases shall be service connected if manifest to a degree of disability of 10 percent or more at any time after discharge or release from active military, naval, or air service even though there is no record of such disease during service, provided the rebuttable presumption provisions of § 3.307 are also satisfied.

Psychosis.
Any of the anxiety states.
Dysthymic disorder (or depressive neurosis).
Organic residuals of frostbite, if it is determined that the veteran was interned in climatic conditions consistent with the occurrence of frostbite.
Post-traumatic osteoarthritis.

Atherosclerotic heart disease or hypertensive vascular disease (including hypertensive heart disease) and their complications (including myocardial infarction, congestive heart failure, arrhythmia).
Stroke and its complications.
On or after October 10, 2008, Osteoporosis, if the Secretary determines that the veteran has posttraumatic stress disorder (PTSD).

(2) If the veteran:

(i) Is a former prisoner of war and;

(ii) Was interned or detained for not less than 30 days, the following diseases shall be service connected if manifest to a degree of 10 percent or more at any time after discharge or release from active military, naval, or air service even though there is no record of such disease during service, provided the rebuttable presumption provisions of § 3.307 are also satisfied.

Avitaminosis.
Beriberi (including beriberi heart disease).
Chronic dysentery.
Helminthiasis.
Malnutrition (including optic atrophy associated with malnutrition).
Pellagra.
Any other nutritional deficiency.
Irritable bowel syndrome.
Peptic ulcer disease.
Peripheral neuropathy except where directly related to infectious causes.
Cirrhosis of the liver.
On or after September 28, 2009, Osteoporosis.

(Authority: 38 U.S.C. 1112(b))

(d) *Diseases specific to radiation-exposed veterans.* (1) The diseases listed in paragraph (d)(2) of this section shall be service-connected if they become manifest in a radiation-exposed veteran as defined in paragraph (d)(3) of this section, provided the rebuttable presumption provisions of § 3.307 of this part are also satisfied.

(2) The diseases referred to in paragraph (d)(1) of this section are the following:

(i) Leukemia (other than chronic lymphocytic leukemia).

(ii) Cancer of the thyroid.

(iii) Cancer of the breast.

(iv) Cancer of the pharynx.

(v) Cancer of the esophagus.

(vi) Cancer of the stomach.

(vii) Cancer of the small intestine.

(viii) Cancer of the pancreas.

(ix) Multiple myeloma.

(x) Lymphomas (except Hodgkin's disease).

(xi) Cancer of the bile ducts.

(xii) Cancer of the gall bladder.

(xiii) Primary liver cancer (except if cirrhosis or hepatitis B is indicated).

(xiv) Cancer of the salivary gland.

(xv) Cancer of the urinary tract.

(xvi) Bronchiolo-alveolar carcinoma.

(xvii) Cancer of the bone.

(xviii) Cancer of the brain.

(xix) Cancer of the colon.

(xx) Cancer of the lung.

(xxi) Cancer of the ovary.

NOTE: For the purposes of this section, the term ''urinary tract'' means the kidneys, renal pelves, ureters, urinary bladder, and urethra.

(Authority: 38 U.S.C. 1112(c)(2))

(3) For purposes of this section:

(i) The term *radiation-exposed veteran* means either a veteran who while serving on active duty, or an individual who while a member of a reserve component of the Armed Forces during a period of active duty for training or inactive duty training, participated in a radiation-risk activity.

(ii) The term *radiation-risk activity* means:

(A) Onsite participation in a test involving the atmospheric detonation of a nuclear device.

(B) The occupation of Hiroshima or Nagasaki, Japan, by United States forces during the period beginning on August 6, 1945, and ending on July 1, 1946.

(C) Internment as a prisoner of war in Japan (or service on active duty in Japan immediately following such internment) during World War II which resulted in an opportunity for exposure to ionizing radiation comparable to that of the United States occupation forces in Hiroshima or Nagasaki, Japan, during the period beginning on August 6, 1945, and ending on July 1, 1946.

(D)(*1*) Service in which the service member was, as part of his or her official military duties, present during a total of at least 250 days before February 1, 1992, on the grounds of a gaseous diffusion plant located in Paducah, Kentucky, Portsmouth, Ohio, or the area identified as K25 at Oak Ridge, Tennessee, if, during such service the veteran:

(*i*) Was monitored for each of the 250 days of such service through the use of

dosimetry badges for exposure at the plant of the external parts of veteran's body to radiation; or

(*ii*) Served for each of the 250 days of such service in a position that had exposures comparable to a job that is or was monitored through the use of dosimetry badges; or

(*2*) Service before January 1, 1974, on Amchitka Island, Alaska, if, during such service, the veteran was exposed to ionizing radiation in the performance of duty related to the Long Shot, Milrow, or Cannikin underground nuclear tests.

(*3*) For purposes of paragraph (d)(3)(ii)(D)(1) of this section, the term ''day'' refers to all or any portion of a calendar day.

(E) Service in a capacity which, if performed as an employee of the Department of Energy, would qualify the individual for inclusion as a member of the Special Exposure Cohort under section 3621(14) of the Energy Employees Occupational Illness Compensation Program Act of 2000 (42 U.S.C. 7384l(14)).

(iii) The term *atmospheric detonation* includes underwater nuclear detonations.

(iv) The term *onsite participation* means:

(A) During the official operational period of an atmospheric nuclear test, presence at the test site, or performance of official military duties in connection with ships, aircraft or other equipment used in direct support of the nuclear test.

(B) During the six month period following the official operational period of an atmospheric nuclear test, presence at the test site or other test staging area to perform official military duties in connection with completion of projects related to the nuclear test including decontamination of equipment used during the nuclear test.

(C) Service as a member of the garrison or maintenance forces on Eniwetok during the periods June 21, 1951, through July 1, 1952, August 7, 1956, through August 7, 1957, or November 1, 1958, through April 30, 1959.

(D) Assignment to official military duties at Naval Shipyards involving the decontamination of ships that participated in Operation Crossroads.

(v) For tests conducted by the United States, the term *operational period* means:

(A) For Operation *TRINITY* the period July 16, 1945 through August 6, 1945.

(B) For Operation *CROSSROADS* the period July 1, 1946 through August 31, 1946.

(C) For Operation *SANDSTONE* the period April 15, 1948 through May 20, 1948.

(D) For Operation *RANGER* the period January 27, 1951 through February 6, 1951.

(E) For Operation *GREENHOUSE* the period April 8, 1951 through June 20, 1951.

(F) For Operation *BUSTER-JANGLE* the period October 22, 1951 through December 20, 1951.

(G) For Operation *TUMBLER-SNAPPER* the period April 1, 1952 through June 20, 1952.

(H) For Operation *IVY* the period November 1, 1952 through December 31, 1952.

(I) For Operation *UPSHOT-KNOTHOLE* the period March 17, 1953 through June 20, 1953.

(J) For Operation *CASTLE* the period March 1, 1954 through May 31, 1954.

(K) For Operation *TEAPOT* the period February 18, 1955 through June 10, 1955.

(L) For Operation *WIGWAM* the period May 14, 1955 through May 15, 1955.

(M) For Operation *REDWING* the period May 5, 1956 through August 6, 1956.

(N) For Operation *PLUMBBOB* the period May 28, 1957 through October 22, 1957.

(O) For Operation *HARDTACK I* the period April 28, 1958 through October 31, 1958.

(P) For Operation *ARGUS* the period August 27, 1958 through September 10, 1958.

(Q) For Operation *HARDTACK II* the period September 19, 1958 through October 31, 1958.

(R) For Operation *DOMINIC I* the period April 25, 1962 through December 31, 1962.

(S) For Operation *DOMINIC II/PLOWSHARE* the period July 6, 1962 through August 15, 1962.

(vi) The term ''occupation of Hiroshima or Nagasaki, Japan, by United States forces'' means official military

duties within 10 miles of the city limits of either Hiroshima or Nagasaki, Japan, which were required to perform or support military occupation functions such as occupation of territory, control of the population, stabilization of the government, demilitarization of the Japanese military, rehabilitation of the infrastructure or deactivation and conversion of war plants or materials.

(vii) Former prisoners of war who had an opportunity for exposure to ionizing radiation comparable to that of veterans who participated in the occupation of Hiroshima or Nagasaki, Japan, by United States forces shall include those who, at any time during the period August 6, 1945, through July 1, 1946:

(A) Were interned within 75 miles of the city limits of Hiroshima or within 150 miles of the city limits of Nagasaki, or

(B) Can affirmatively show they worked within the areas set forth in paragraph (d)(3)(vii)(A) of this section although not interned within those areas, or

(C) Served immediately following internment in a capacity which satisfies the definition in paragraph (d)(3)(vi) of this section, or

(D) Were repatriated through the port of Nagasaki.

(Authority: 38 U.S.C. 1110, 1112, 1131)

(e) *Disease associated with exposure to certain herbicide agents.* If a veteran was exposed to an herbicide agent during active military, naval, or air service, the following diseases shall be service-connected if the requirements of § 3.307(a)(6) are met even though there is no record of such disease during service, provided further that the rebuttable presumption provisions of § 3.307(d) are also satisfied.

AL amyloidosis
Chloracne or other acneform disease consistent with chloracne
Type 2 diabetes (also known as Type II diabetes mellitus or adult-onset diabetes)
Hodgkin's disease
Ischemic heart disease (including, but not limited to, acute, subacute, and old myocardial infarction; atherosclerotic cardiovascular disease including coronary artery disease (including coronary spasm) and coronary bypass surgery; and stable, unstable and Prinzmetal's angina)
All chronic B-cell leukemias (including, but not limited to, hairy-cell leukemia and chronic lymphocytic leukemia)
Multiple myeloma
Non-Hodgkin's lymphoma
Parkinson's disease
Early-onset peripheral neuropathy
Porphyria cutanea tarda
Prostate cancer
Respiratory cancers (cancer of the lung, bronchus, larynx, or trachea)
Soft-tissue sarcoma (other than osteosarcoma, chondrosarcoma, Kaposi's sarcoma, or mesothelioma)

NOTE 1: The term ''soft-tissue sarcoma'' includes the following:
Adult fibrosarcoma
Dermatofibrosarcoma protuberans
Malignant fibrous histiocytoma
Liposarcoma
Leiomyosarcoma
Epithelioid leiomyosarcoma (malignant leiomyoblastoma)
Rhabdomyosarcoma
Ectomesenchymoma
Angiosarcoma (hemangiosarcoma and lymphangiosarcoma)
Proliferating (systemic) angioendotheliomatosis
Malignant glomus tumor
Malignant hemangiopericytoma
Synovial sarcoma (malignant synovioma)
Malignant giant cell tumor of tendon sheath
Malignant schwannoma, including malignant schwannoma with rhabdomyoblastic differentiation (malignant Triton tumor), glandular and epithelioid malignant schwannomas
Malignant mesenchymoma
Malignant granular cell tumor
Alveolar soft part sarcoma
Epithelioid sarcoma
Clear cell sarcoma of tendons and aponeuroses
Extraskeletal Ewing's sarcoma
Congenital and infantile fibrosarcoma
Malignant ganglioneuroma

NOTE 2: For purposes of this section, the term ischemic heart disease does not include hypertension or peripheral manifestations of arteriosclerosis such as peripheral vascular disease or stroke, or any other condition that does not qualify within the generally accepted medical definition of Ischemic heart disease.

(f) *Disease associated with exposure to contaminants in the water supply at Camp Lejeune.* If a veteran, or former reservist or member of the National Guard, was exposed to contaminants in the water supply at Camp Lejeune during military service and the exposure meets the requirements of § 3.307(a)(7),

the following diseases shall be service-connected even though there is no record of such disease during service, subject to the rebuttable presumption provisions of §3.307(d).

(1) Kidney cancer.
(2) Liver cancer.
(3) Non-Hodgkin's lymphoma.
(4) Adult leukemia.
(5) Multiple myeloma.
(6) Parkinson's disease.
(7) Aplastic anemia and other myelodysplastic syndromes.
(8) Bladder cancer.

(Authority: 38 U.S.C. 501(a) and 1112(b))

[41 FR 55873, Dec. 23, 1976]

EDITORIAL NOTE: For FEDERAL REGISTER citations affecting §3.309, see the List of CFR Sections Affected, which appears in the Finding Aids section of the printed volume and at *www.fdsys.gov*.

§3.310 Disabilities that are proximately due to, or aggravated by, service-connected disease or injury.

(a) *General*. Except as provided in §3.300(c), disability which is proximately due to or the result of a service-connected disease or injury shall be service connected. When service connection is thus established for a secondary condition, the secondary condition shall be considered a part of the original condition.

(b) *Aggravation of nonservice-connected disabilities*. Any increase in severity of a nonservice-connected disease or injury that is proximately due to or the result of a service-connected disease or injury, and not due to the natural progress of the nonservice-connected disease, will be service connected. However, VA will not concede that a nonservice-connected disease or injury was aggravated by a service-connected disease or injury unless the baseline level of severity of the nonservice-connected disease or injury is established by medical evidence created before the onset of aggravation or by the earliest medical evidence created at any time between the onset of aggravation and the receipt of medical evidence establishing the current level of severity of the nonservice-connected disease or injury. The rating activity will determine the baseline and current levels of severity under the Schedule for Rating Disabilities (38 CFR part 4) and determine the extent of aggravation by deducting the baseline level of severity, as well as any increase in severity due to the natural progress of the disease, from the current level.

(Authority: 38 U.S.C. 1110 and 1131)

(c) *Cardiovascular disease*. Ischemic heart disease or other cardiovascular disease developing in a veteran who has a service-connected amputation of one lower extremity at or above the knee or service-connected amputations of both lower extremities at or above the ankles, shall be held to be the proximate result of the service-connected amputation or amputations.

(d) *Traumatic brain injury*. (1) In a veteran who has a service-connected traumatic brain injury, the following shall be held to be the proximate result of the service-connected traumatic brain injury (TBI), in the absence of clear evidence to the contrary:

(i) Parkinsonism, including Parkinson's disease, following moderate or severe TBI;

(ii) Unprovoked seizures following moderate or severe TBI;

(iii) Dementias of the following types: presenile dementia of the Alzheimer type, frontotemporal dementia, and dementia with Lewy bodies, if manifest within 15 years following moderate or severe TBI;

(iv) Depression if manifest within 3 years of moderate or severe TBI, or within 12 months of mild TBI; or

(v) Diseases of hormone deficiency that result from hypothalamo-pituitary changes if manifest within 12 months of moderate or severe TBI.

(2) Neither the severity levels nor the time limits in paragraph (d)(1) of this section preclude a finding of service connection for conditions shown by evidence to be proximately due to service-connected TBI. If a claim does not meet the requirements of paragraph (d)(1) with respect to the time of manifestation or the severity of the TBI, or both, VA will develop and decide the claim under generally applicable principles of service connection without regard to paragraph (d)(1).

(3)(i) For purposes of this section VA will use the following table for determining the severity of a TBI:

Mild	Moderate	Severe
Normal structural imaging LOC = 0–30 min	Normal or abnormal structural imaging LOC > 30 min and < 24 hours	Normal or abnormal structural imaging. LOC > 24 hrs.
AOC = a moment up to 24 hrs	AOC > 24 hours. Severity based on other criteria.	
PTA = 0–1 day GCS = 13–15	PTA > 1 and < 7 days GCS = 9–12	PTA > 7 days. GCS = 3–8.

NOTE: The factors considered are:

Structural imaging of the brain.

LOC—Loss of consciousness.

AOC—Alteration of consciousness/mental state.

PTA—Post-traumatic amnesia.

GCS—Glasgow Coma Scale. (For purposes of injury stratification, the Glasgow Coma Scale is measured at or after 24 hours.)

(ii) The determination of the severity level under this paragraph is based on the TBI symptoms at the time of injury or shortly thereafter, rather than the current level of functioning. VA will not require that the TBI meet all the criteria listed under a certain severity level in order to classify the TBI at that severity level. If a TBI meets the criteria in more than one category of severity, then VA will rank the TBI at the highest level in which a criterion is met, except where the qualifying criterion is the same at both levels.

(Authority: 38 U.S.C. 501, 1110 and 1131)

[44 FR 50340, Aug. 28, 1979, as amended at 66 FR 18198, Apr. 6, 2001; 71 FR 52747, Sept. 7, 2006; 78 FR 76208, Dec. 17, 2013]

§ 3.311 Claims based on exposure to ionizing radiation.

(a) *Determinations of exposure and dose*—(1) *Dose assessment*. In all claims in which it is established that a radiogenic disease first became manifest after service and was not manifest to a compensable degree within any applicable presumptive period as specified in § 3.307 or § 3.309, and it is contended the disease is a result of exposure to ionizing radiation in service, an assessment will be made as to the size and nature of the radiation dose or doses. When dose estimates provided pursuant to paragraph (a)(2) of this section are reported as a range of doses to which a veteran may have been exposed, exposure at the highest level of the dose range reported will be presumed.

(Authority: 38 U.S.C. 501)

(2) *Request for dose information*. Where necessary pursuant to paragraph (a)(1) of this section, dose information will be requested as follows:

(i) *Atmospheric nuclear weapons test participation claims*. In claims based upon participation in atmospheric nuclear testing, dose data will in all cases be requested from the appropriate office of the Department of Defense.

(ii) *Hiroshima and Nagasaki occupation claims*. In all claims based on participation in the American occupation of Hiroshima or Nagasaki, Japan, prior to July 1, 1946, dose data will be requested from the Department of Defense.

(iii) *Other exposure claims*. In all other claims involving radiation exposure, a request will be made for any available records concerning the veteran's exposure to radiation. These records normally include but may not be limited to the veteran's Record of Occupational Exposure to Ionizing Radiation (DD Form 1141), if maintained, service medical records, and other records which may contain information pertaining to the veteran's radiation dose in service. All such records will be forwarded to the Under Secretary for Health, who will be responsible for preparation of a dose estimate, to the extent feasible, based on available methodologies.

(3) *Referral to independent expert*. When necessary to reconcile a material difference between an estimate of dose, from a credible source, submitted by or on behalf of a claimant, and dose data derived from official military records, the estimates and supporting documentation shall be referred to an independent expert, selected by the Director of the National Institutes of Health, who shall prepare a separate

radiation dose estimate for consideration in adjudication of the claim. For purposes of this paragraph:

(i) The difference between the claimant's estimate and dose data derived from official military records shall ordinarily be considered material if one estimate is at least double the other estimate.

(ii) A dose estimate shall be considered from a ''credible source'' if prepared by a person or persons certified by an appropriate professional body in the field of health physics, nuclear medicine or radiology and if based on analysis of the facts and circumstances of the particular claim.

(4) *Exposure.* In cases described in paragraph (a)(2)(i) and (ii) of this section:

(i) If military records do not establish presence at or absence from a site at which exposure to radiation is claimed to have occurred, the veteran's presence at the site will be conceded.

(ii) Neither the veteran nor the veteran's survivors may be required to produce evidence substantiating exposure if the information in the veteran's service records or other records maintained by the Department of Defense is consistent with the claim that the veteran was present where and when the claimed exposure occurred.

(b) *Initial review of claims.* (1) When it is determined:

(i) A veteran was exposed to ionizing radiation as a result of participation in the atmospheric testing of nuclear weapons, the occupation of Hiroshima or Nagasaki, Japan, from September 1945 until July 1946, or other activities as claimed;

(ii) The veteran subsequently developed a radiogenic disease; and

(iii) Such disease first became manifest within the period specified in paragraph (b)(5) of this section; before its adjudication the claim will be referred to the Under Secretary for Benefits for further consideration in accordance with paragraph (c) of this section. If any of the foregoing 3 requirements has not been met, it shall not be determined that a disease has resulted from exposure to ionizing radiation under such circumstances.

(2) For purposes of this section the term ''radiogenic disease'' means a disease that may be induced by ionizing radiation and shall include the following:

(i) All forms of leukemia except chronic lymphatic (lymphocytic) leukemia;

(ii) Thyroid cancer;

(iii) Breast cancer;

(iv) Lung cancer;

(v) Bone cancer;

(vi) Liver cancer;

(vii) Skin cancer;

(viii) Esophageal cancer;

(ix) Stomach cancer;

(x) Colon cancer;

(xi) Pancreatic cancer;

(xii) Kidney cancer;

(xiii) Urinary bladder cancer;

(xiv) Salivary gland cancer;

(xv) Multiple myeloma;

(xvi) Posterior subcapsular cataracts;

(xvii) Non-malignant thyroid nodular disease;

(xviii) Ovarian cancer;

(xix) Parathyroid adenoma;

(xx) Tumors of the brain and central nervous system;

(xxi) Cancer of the rectum;

(xxii) Lymphomas other than Hodgkin's disease;

(xxiii) Prostate cancer; and

(xxiv) Any other cancer.

(Authority: 38 U.S.C. 501)

(3) Public Law 98–542 requires VA to determine whether sound medical and scientific evidence supports establishing a rule identifying polycythemia vera as a radiogenic disease. VA has determined that sound medical and scientific evidence does not support including polycythemia vera on the list of known radiogenic diseases in this regulation. Even so, VA will consider a claim based on the assertion that polycythemia vera is a radiogenic disease under the provisions of paragraph (b)(4) of this section.

(Authority: Pub. L. 98–542, section 5(b)(2)(A)(i), (iii)).

(4) If a claim is based on a disease other than one of those listed in paragraph (b)(2) of this section, VA shall nevertheless consider the claim under the provisions of this section provided that the claimant has cited or submitted competent scientific or medical

evidence that the claimed condition is a radiogenic disease.

(5) For the purposes of paragraph (b)(1) of this section:

(i) Bone cancer must become manifest within 30 years after exposure;

(ii) Leukemia may become manifest at any time after exposure;

(iii) Posterior subcapsular cataracts must become manifest 6 months or more after exposure; and

(iv) Other diseases specified in paragraph (b)(2) of this section must become manifest 5 years or more after exposure.

(Authority: 38 U.S.C. 501; Pub. L. 98–542)

(c) *Review by Under Secretary for Benefits.* (1) When a claim is forwarded for review pursuant to paragraph (b)(1) of this section, the Under Secretary for Benefits shall consider the claim with reference to the factors specified in paragraph (e) of this section and may request an advisory medical opinion from the Under Secretary for Health.

(i) If after such consideration the Under Secretary for Benefits is convinced sound scientific and medical evidence supports the conclusion it is at least as likely as not the veteran's disease resulted from exposure to radiation in service, the Under Secretary for Benefits shall so inform the regional office of jurisdiction in writing. The Under Secretary for Benefits shall set forth the rationale for this conclusion, including an evaluation of the claim under the applicable factors specified in paragraph (e) of this section.

(ii) If the Under Secretary for Benefits determines there is no reasonable possibility that the veteran's disease resulted from radiation exposure in service, the Under Secretary for Benefits shall so inform the regional office of jurisidiction in writing, setting forth the rationale for this conclusion.

(2) If the Under Secretary for Benefits, after considering any opinion of the Under Secretary for Health, is unable to conclude whether it is at least as likely as not, or that there is no reasonable possibility, the veteran's disease resulted from radiation exposure in service, the Under Secretary for Benefits shall refer the matter to an outside consultant in accordance with paragraph (d) of this section.

(3) For purposes of paragraph (c)(1) of this section, ''sound scientific evidence'' means observations, findings, or conclusions which are statistically and epidemiologically valid, are statistically significant, are capable of replication, and withstand peer review, and ''sound medical evidence'' means observations, findings, or conclusions which are consistent with current medical knowledge and are so reasonable and logical as to serve as the basis of management of a medical condition.

(d) *Referral to outside consultants.* (1) Referrals pursuant to paragraph (c) of this section shall be to consultants selected by the Under Secretary for Health from outside VA, upon the recommendation of the Director of the National Cancer Institute. The consultant will be asked to evaluate the claim and provide an opinion as to the likelihood the disease is a result of exposure as claimed.

(2) The request for opinion shall be in writing and shall include a description of:

(i) The disease, including the specific cell type and stage, if known, and when the disease first became manifest;

(ii) The circumstances, including date, of the veteran's exposure;

(iii) The veteran's age, gender, and pertinent family history;

(iv) The veteran's history of exposure to known carcinogens, occupationally or otherwise;

(v) Evidence of any other effects radiation exposure may have had on the veteran; and

(vi) Any other information relevant to determination of causation of the veteran's disease.

The Under Secretary for Benefits shall forward, with the request, copies of pertinent medical records and, where available, dose assessments from official sources, from credible sources as defined in paragraph (a)(3)(ii) of this section, and from an independent expert pursuant to paragraph (a)(3) of this section.

(3) The consultant shall evaluate the claim under the factors specified in paragraph (e) of this section and respond in writing, stating whether it is

either likely, unlikely, or approximately as likely as not the veteran's disease resulted from exposure to ionizing radiation in service. The response shall set forth the rationale for the consultant's conclusion, including the consultant's evaluation under the applicable factors specified in paragraph (e) of this section. The Under Secretary for Benefits shall review the consultant's response and transmit it with any comments to the regional office of jurisdiction for use in adjudication of the claim.

(e) *Factors for consideration.* Factors to be considered in determining whether a veteran's disease resulted from exposure to ionizing radiation in service include:

(1) The probable dose, in terms of dose type, rate and duration as a factor in inducing the disease, taking into account any known limitations in the dosimetry devices employed in its measurement or the methodologies employed in its estimation;

(2) The relative sensitivity of the involved tissue to induction, by ionizing radiation, of the specific pathology;

(3) The veteran's gender and pertinent family history;

(4) The veteran's age at time of exposure;

(5) The time-lapse between exposure and onset of the disease; and

(6) The extent to which exposure to radiation, or other carcinogens, outside of service may have contributed to development of the disease.

(f) *Adjudication of claim.* The determination of service connection will be made under the generally applicable provisions of this part, giving due consideration to all evidence of record, including any opinion provided by the Under Secretary for Health or an outside consultant, and to the evaluations published pursuant to §1.17 of this title. With regard to any issue material to consideration of a claim, the provisions of §3.102 of this title apply.

(g) *Willful misconduct and supervening cause.* In no case will service connection be established if the disease is due to the veteran's own willful misconduct, or if there is affirmative evidence to establish that a supervening, nonservice-related condition or event is more likely the cause of the disease.

(Authority: Pub. L. 98–542)

[50 FR 34459, Aug. 26, 1985, as amended at 54 FR 42803, Oct. 18, 1989; 58 FR 16359, Mar. 26, 1993. Redesignated at 59 FR 5107, Feb. 3, 1994, and amended at 59 FR 45975, Sept. 6, 1994; 60 FR 9628, Feb. 21, 1995; 60 FR 53277, Oct. 13, 1995; 63 FR 50994, Sept. 24, 1998; 67 FR 6871, Feb. 14, 2002]

§3.312 Cause of death.

(a) *General.* The death of a veteran will be considered as having been due to a service-connected disability when the evidence establishes that such disability was either the principal or a contributory cause of death. The issue involved will be determined by exercise of sound judgment, without recourse to speculation, after a careful analysis has been made of all the facts and circumstances surrounding the death of the veteran, including, particularly, autopsy reports.

(b) *Principal cause of death.* The service-connected disability will be considered as the principal (primary) cause of death when such disability, singly or jointly with some other condition, was the immediate or underlying cause of death or was etiologically related thereto.

(c) *Contributory cause of death.* (1) Contributory cause of death is inherently one not related to the principal cause. In determining whether the service-connected disability contributed to death, it must be shown that it contributed substantially or materially; that it combined to cause death; that it aided or lent assistance to the production of death. It is not sufficient to show that it casually shared in producing death, but rather it must be shown that there was a causal connection.

(2) Generally, minor service-connected disabilities, particularly those of a static nature or not materially affecting a vital organ, would not be held to have contributed to death primarily due to unrelated disability. In the same category there would be included service-connected disease or injuries of any evaluation (even though evaluated as

100 percent disabling) but of a quiescent or static nature involving muscular or skeletal functions and not materially affecting other vital body functions.

(3) Service-connected diseases or injuries involving active processes affecting vital organs should receive careful consideration as a contributory cause of death, the primary cause being unrelated, from the viewpoint of whether there were resulting debilitating effects and general impairment of health to an extent that would render the person materially less capable of resisting the effects of other disease or injury primarily causing death. Where the service-connected condition affects vital organs as distinguished from muscular or skeletal functions and is evaluated as 100 percent disabling, debilitation may be assumed.

(4) There are primary causes of death which by their very nature are so overwhelming that eventual death can be anticipated irrespective of coexisting conditions, but, even in such cases, there is for consideration whether there may be a reasonable basis for holding that a service-connected condition was of such severity as to have a material influence in accelerating death. In this situation, however, it would not generally be reasonable to hold that a service-connected condition accelerated death unless such condition affected a vital organ and was of itself of a progressive or debilitating nature.

CROSS REFERENCES: Reasonable doubt. See § 3.102. Service connection for mental unsoundness in suicide. See § 3.302.

[26 FR 1582, Feb. 24, 1961, as amended at 54 FR 34981, Aug. 23, 1989; 54 FR 42803, Oct. 18, 1989]

§ 3.313 Claims based on service in Vietnam.

(a) *Service in Vietnam. Service in Vietnam* includes service in the waters offshore, or service in other locations if the conditions of service involved duty or visitation in Vietnam.

(b) *Service connection based on service in Vietnam.* Service in Vietnam during the Vietnam Era together with the development of non-Hodgkin's lymphoma manifested subsequent to such service is sufficient to establish service connection for that disease.

(Authority: 38 U.S.C. 501)

[55 FR 43124, Oct. 26, 1990]

§ 3.314 Basic pension determinations.

(a) *Prior to the Mexican border period.* While pensions are granted based on certain service prior to the Mexican border period, the only rating factors in claims therefor are:

(1) Claims based on service of less than 90 days in the Spanish-American War require a rating determination as to whether the veteran was discharged or released from service for a service-connected disability or had at the time of separation from service a service-connected disability, shown by official service records, which in medical judgment would have warranted a discharge for disability. Eligibility in such cases requires a finding that the disability was incurred in or aggravated by service in line of duty without benefit of presumptive provisions of law or Department of Veterans Affairs regulations.

(Authority: 38 U.S.C. 1512)

(2) Veterans entitled to pension on the basis of service in the Spanish-American War may be entitled to an increased rate of pension if rated as being in need of regular aid and attendance. Veterans who have elected pension under Pub. L. 86–211 (73 Stat. 432) who are not rated as being in need of regular aid and attendance may be entitled to increased pension based on 100 percent permanent disability together with independent disability of 60 percent or more or by reason of being permanently housebound as provided in § 3.351 (d).

(Authority: 38 U.S.C. 1502 (b), (c), 512)

(b) *Mexican border period and later war periods.* Non-service-connected disability and death pension may be paid based on service in the Mexican border period, World War I, World War II, the Korean conflict and the Vietnam era. Rating determinations in such claims will be required in the following situations:

(1) Claims based on service of less than 90 days may require a determination as to whether the veteran was discharged or released from service for a service-connected disability or had at the time of separation from service a service-connected disability, shown by official service records, which in medical judgment would have warranted a discharge for disability. Eligibility in such cases requires a finding that the disability was incurred in or aggravated by service in line of duty without benefit of presumptive provisions of law or Department of Veterans Affairs regulations (38 U.S.C. 1521(g)(2)) unless, in the case of death pension, the veteran was, at the time of death, receiving (or entitled to receive) compensation or retirement pay based upon a wartime service-connected disability.

(Authority: 38 U.S.C. 1541(a) and 1542(a))

(2) Determinations of permanent total disability for pension purposes will be based on non-service-connected disability or combined non-service-connected and service-connected disabilities not the result of willful misconduct. However, for pension under Pub. L. 86–211 (73 Stat. 432), permanent and total disability will be presumed where the veteran has attained age 65 or effective January 1, 1977, where the veteran became unemployable after age 65.

(Authority: 38 U.S.C. 1502(a), 1523(a))

(3) Veterans entitled to nonservice-connected disability pension may be entitled to an increased rate of pension if rated as being in need of regular aid and attendance. Veterans entitled to protected pension or pension under Pub. L. 86–211 (73 Stat. 432) who are not rated as being in need of regular aid and attendance may be entitled to increased pension based on a 100 percent permanent disability together with independent disability of 60 percent or more or by reason of being permanently housebound as provided in §3.351 (d) or (e).

(Authority: 38 U.S.C. 1502 (b), (c), 1521)

[31 FR 4680, Mar. 19, 1966, as amended at 32 FR 13224, Sept. 19, 1967; 36 FR 8446, May 6, 1971; 40 FR 56434, Dec. 3, 1975; 41 FR 56804, Dec. 30, 1976; 61 FR 20438, May 7, 1996]

§3.315 Basic eligibility determinations; dependents, loans, education.

(a) *Child over 18 years.* A child of a veteran may be considered a ''child'' after age 18 for purposes of benefits under title 38, United States Code (except ch. 19 and sec. 8502(b) of ch. 85), if found by a rating determination to have become, prior to age 18, permanently incapable of self-support.

(Authority: 38 U.S.C. 101(4)(B))

(b) *Loans.* If a veteran of World War II the Korean conflict or the Vietnam era had less than 90 days of service, or if a veteran who served after July 25, 1947, and prior to June 27, 1950, or after January 31, 1955, and prior to August 5, 1964, or after May 7, 1975, has less than 181 days of service on active duty as defined in §§36.4301 and 36.4501, eligibility of the veteran for a loan under 38 U.S.C. ch. 37 requires a determination that the veteran was discharged or released because of a service-connected disability or that the official service department records show that he or she had at the time of separation from service a service-connected disability which in medical judgment would have warranted a discharge for disability. These determinations are subject to the presumption of incurrence under §3.304(b). Determinations based on World War II, Korean conflict and Vietnam era service are also subject to the presumption of aggravation under §3.306(b) while determination based on service on or after February 1, 1955, and before August 5, 1964, or after May 7, 1975, are subject to the presumption of aggravation under §3.306 (a) and (c). The provisions of this paragraph are also applicable, regardless of length of service, in determining eligibility to the maximum period of entitlement based on discharge or release for a service-connected disability. (See also the minimum service requirements of §3.12a.)

(Authority: 38 U.S.C. 3702, 3707)

(c) *Veterans' educational assistance.* (1) A determination is required as to whether a veteran was discharged or released from active duty service because of a service-connected disability

(or whether the official service department records show that the veteran had at time of separation from service a service-connected disability which in medical judgment would have warranted discharge for disability) whenever any of the following circumstances exist:

(i) The veteran applies for benefits under 38 U.S.C. chapter 32, the minimum active duty service requirements of 38 U.S.C. 5303A apply to him or her, and the veteran would be eligible for such benefits only if—

(A) He or she was discharged or released from active duty for a disability incurred or aggravated in line of duty, or

(B) He or she has a disability that VA has determined to be compensable under 38 U.S.C. chapter 11; or

(ii) The veteran applies for benefits under 38 U.S.C. chapter 30 and—

(A) The evidence of record does not clearly show either that the veteran was discharged or released from active duty for disability or that the veteran's discharge or release from active duty was unrelated to disability, and

(B) The veteran is eligible for basic educational assistance except for the minimum length of active duty service requirements of § 21.7042(a) or § 21.7044(a) of this chapter.

(2) A determination is required as to whether a veteran was discharged or released from service in the Selected Reserve for a service-connected disability or for a medical condition which preexisted the veteran's having become a member of the Selected Reserve and which VA determines is not service connected when the veteran applies for benefits under 38 U.S.C. chapter 30 and—

(i) Either the veteran would be eligible for basic educational assistance under that chapter only if he or she was discharged from the Selected Reserve for a service-connected disability, or for a medical condition which preexisted the veteran's having become a member of the Selected Reserve and which VA finds is not service connected, or

(ii) The veteran is entitled to basic educational assistance and would be entitled to receive it at the rates stated in § 21.7136(a) or § 21.7137(a) of this chapter only if he or she was discharged from the Selected Reserve for a service-connected disability or for a medical condition which preexisted the veteran's having become a member of the Selected Reserve and which VA finds is not service connected.

(3) A determination is required as to whether a reservist has been unable to pursue a program of education due to a disability which has been incurred in or aggravated by service in the Selected Reserve when—

(i) The reservist is otherwise entitled to educational assistance under 10 U.S.C. chapter 1606, and

(ii) He or she applies for an extension of his or her eligibility period.

(4) The determinations required by paragraphs (c)(1) through (c)(3) of this section are subject to the presumptions of incurrence under § 3.304(b) and aggravation under § 3.306 (a) and (c) of this part, based on service rendered after May 7, 1975.

(Authority: 38 U.S.C. 3011(a)(1)(A)(ii), 3012(b)(1), 3202(1)(A), 10 U.S.C. 16133(b))

[38 FR 871, Jan. 5, 1973, as amended at 42 FR 22869, May 5, 1977; 50 FR 53315, Dec. 31, 1985; 51 FR 1510, Jan. 14, 1986; 55 FR 25974, June 26, 1990; 61 FR 67950, Dec. 26, 1996]

§ 3.316 Claims based on chronic effects of exposure to mustard gas and Lewisite.

(a) Except as provided in paragraph (b) of this section, exposure to the specified vesicant agents during active military service under the circumstances described below together with the subsequent development of any of the indicated conditions is sufficient to establish service connection for that condition:

(1) Full-body exposure to nitrogen or sulfur mustard during active military service together with the subsequent development of chronic conjunctivitis, keratitis, corneal opacities, scar formation, or the following cancers: Nasopharyngeal; laryngeal; lung (except mesothelioma); or squamous cell carcinoma of the skin.

(2) Full-body exposure to nitrogen or sulfur mustard or Lewisite during active military service together with the subsequent development of a chronic

form of laryngitis, bronchitis, emphysema, asthma or chronic obstructive pulmonary disease.

(3) Full-body exposure to nitrogen mustard during active military service together with the subsequent development of acute nonlymphocytic leukemia.

(b) Service connection will not be established under this section if the claimed condition is due to the veteran's own willful misconduct (See §3.301(c)) or there is affirmative evidence that establishes a nonservice-related supervening condition or event as the cause of the claimed condition (See §3.303).

[59 FR 42499, Aug. 18, 1994]

§3.317 Compensation for certain disabilities occurring in Persian Gulf veterans.

(a) *Compensation for disability due to undiagnosed illness and medically unexplained chronic multisymptom illnesses.* (1) Except as provided in paragraph (a)(7) of this section, VA will pay compensation in accordance with chapter 11 of title 38, United States Code, to a Persian Gulf veteran who exhibits objective indications of a qualifying chronic disability, provided that such disability:

(i) Became manifest either during active military, naval, or air service in the Southwest Asia theater of operations, or to a degree of 10 percent or more not later than December 31, 2021; and

(ii) By history, physical examination, and laboratory tests cannot be attributed to any known clinical diagnosis.

(2)(i) For purposes of this section, a *qualifying chronic disability* means a chronic disability resulting from any of the following (or any combination of the following):

(A) An undiagnosed illness;

(B) A medically unexplained chronic multisymptom illness that is defined by a cluster of signs or symptoms, such as:

(*1*) Chronic fatigue syndrome;

(*2*) Fibromyalgia;

(*3*) Functional gastrointestinal disorders (excluding structural gastrointestinal diseases).

NOTE TO PARAGRAPH (a)(2)(i)(B)(*3*): Functional gastrointestinal disorders are a group of conditions characterized by chronic or recurrent symptoms that are unexplained by any structural, endoscopic, laboratory, or other objective signs of injury or disease and may be related to any part of the gastrointestinal tract. Specific functional gastrointestinal disorders include, but are not limited to, irritable bowel syndrome, functional dyspepsia, functional vomiting, functional constipation, functional bloating, functional abdominal pain syndrome, and functional dysphagia. These disorders are commonly characterized by symptoms including abdominal pain, substernal burning or pain, nausea, vomiting, altered bowel habits (including diarrhea, constipation), indigestion, bloating, postprandial fullness, and painful or difficult swallowing. Diagnosis of specific functional gastrointestinal disorders is made in accordance with established medical principles, which generally require symptom onset at least 6 months prior to diagnosis and the presence of symptoms sufficient to diagnose the specific disorder at least 3 months prior to diagnosis.

(ii) For purposes of this section, the term *medically unexplained chronic multisymptom illness* means a diagnosed illness without conclusive pathophysiology or etiology, that is characterized by overlapping symptoms and signs and has features such as fatigue, pain, disability out of proportion to physical findings, and inconsistent demonstration of laboratory abnormalities. Chronic multisymptom illnesses of partially understood etiology and pathophysiology, such as diabetes and multiple sclerosis, will not be considered medically unexplained.

(3) For purposes of this section, ''objective indications of chronic disability'' include both ''signs,'' in the medical sense of objective evidence perceptible to an examining physician, and other, non-medical indicators that are capable of independent verification.

(4) For purposes of this section, disabilities that have existed for 6 months or more and disabilities that exhibit intermittent episodes of improvement and worsening over a 6-month period will be considered chronic. The 6-month period of chronicity will be measured from the earliest date on which the pertinent evidence establishes that the signs or symptoms of the disability first became manifest.

(5) A qualifying chronic disability referred to in this section shall be rated using evaluation criteria from part 4 of this chapter for a disease or injury in

which the functions affected, anatomical localization, or symptomatology are similar.

(6) A qualifying chronic disability referred to in this section shall be considered service connected for purposes of all laws of the United States.

(7) Compensation shall not be paid under this section for a chronic disability:

(i) If there is affirmative evidence that the disability was not incurred during active military, naval, or air service in the Southwest Asia theater of operations; or

(ii) If there is affirmative evidence that the disability was caused by a supervening condition or event that occurred between the veteran's most recent departure from active duty in the Southwest Asia theater of operations and the onset of the disability; or

(iii) If there is affirmative evidence that the disability is the result of the veteran's own willful misconduct or the abuse of alcohol or drugs.

(b) *Signs or symptoms of undiagnosed illness and medically unexplained chronic multisymptom illnesses.* For the purposes of paragraph (a)(1) of this section, signs or symptoms which may be manifestations of undiagnosed illness or medically unexplained chronic multisymptom illness include, but are not limited to:

(1) Fatigue.

(2) Signs or symptoms involving skin.

(3) Headache.

(4) Muscle pain.

(5) Joint pain.

(6) Neurological signs or symptoms.

(7) Neuropsychological signs or symptoms.

(8) Signs or symptoms involving the respiratory system (upper or lower).

(9) Sleep disturbances.

(10) Gastrointestinal signs or symptoms.

(11) Cardiovascular signs or symptoms.

(12) Abnormal weight loss.

(13) Menstrual disorders.

(c) *Presumptive service connection for infectious diseases.* (1) Except as provided in paragraph (c)(4) of this section, a disease listed in paragraph (c)(2) of this section will be service connected if it becomes manifest in a veteran with a qualifying period of service, provided the provisions of paragraph (c)(3) of this section are also satisfied.

(2) The diseases referred to in paragraph (c)(1) of this section are the following:

(i) Brucellosis.

(ii) Campylobacter jejuni.

(iii) Coxiella burnetii (Q fever).

(iv) Malaria.

(v) Mycobacterium tuberculosis.

(vi) Nontyphoid Salmonella.

(vii) Shigella.

(viii) Visceral leishmaniasis.

(ix) West Nile virus.

(3) The diseases listed in paragraph (c)(2) of this section will be considered to have been incurred in or aggravated by service under the circumstances outlined in paragraphs (c)(3)(i) and (ii) of this section even though there is no evidence of such disease during the period of service.

(i) With three exceptions, the disease must have become manifest to a degree of 10 percent or more within 1 year from the date of separation from a qualifying period of service as specified in paragraph (c)(3)(ii) of this section. Malaria must have become manifest to a degree of 10 percent or more within 1 year from the date of separation from a qualifying period of service or at a time when standard or accepted treatises indicate that the incubation period commenced during a qualifying period of service. There is no time limit for visceral leishmaniasis or tuberculosis to have become manifest to a degree of 10 percent or more.

(ii) For purposes of this paragraph (c), the term *qualifying period of service* means a period of service meeting the requirements of paragraph (e) of this section or a period of active military, naval, or air service on or after September 19, 2001, in Afghanistan.

(4) A disease listed in paragraph (c)(2) of this section shall not be presumed service connected:

(i) If there is affirmative evidence that the disease was not incurred during a qualifying period of service; or

(ii) If there is affirmative evidence that the disease was caused by a supervening condition or event that occurred between the veteran's most recent departure from a qualifying period

of service and the onset of the disease; or

(iii) If there is affirmative evidence that the disease is the result of the veteran's own willful misconduct or the abuse of alcohol or drugs.

(d) *Long-term health effects potentially associated with infectious diseases.* (1) A report of the Institute of Medicine of the National Academy of Sciences has identified the following long-term health effects that potentially are associated with the infectious diseases listed in paragraph (c)(2) of this section. These health effects and diseases are listed alphabetically and are not categorized by the level of association stated in the National Academy of Sciences report (*see* Table to § 3.317). If a veteran who has or had an infectious disease identified in column A also has a condition identified in column B as potentially related to that infectious disease, VA must determine, based on the evidence in each case, whether the column B condition was caused by the infectious disease for purposes of paying disability compensation. This does not preclude a finding that other manifestations of disability or secondary conditions were caused by an infectious disease.

(2) If a veteran presumed service connected for one of the diseases listed in paragraph (c)(2) of this section is diagnosed with one of the diseases listed in column ''B'' in the table within the time period specified for the disease in the same table, if a time period is specified or, otherwise, at any time, VA will request a medical opinion as to whether it is at least as likely as not that the condition was caused by the veteran having had the associated disease in column ''A'' in that same table.

TABLE TO § 3.317—LONG-TERM HEALTH EFFECTS POTENTIALLY ASSOCIATED WITH INFECTIOUS DISEASES

A	B
	Disease
Brucellosis	• Arthritis. • Cardiovascular, nervous, and respiratory system infections. • Chronic meningitis and meningoencephalitis. • Deafness. • Demyelinating meningovascular syndromes. • Episcleritis. • Fatigue, inattention, amnesia, and depression. • Guillain-Barré syndrome. • Hepatic abnormalities, including granulomatous hepatitis. • Multifocal choroiditis. • Myelitis-radiculoneuritis. • Nummular keratitis. • Papilledema. • Optic neuritis. • Orchioepididymitis and infections of the genitourinary system. • Sensorineural hearing loss. • Spondylitis. • Uveitis.
Campylobacter jejuni	• Guillain-Barré syndrome *if manifest within 2 months of the infection.* • Reactive Arthritis *if manifest within 3 months of the infection.* • Uveitis *if manifest within 1 month of the infection.*
Coxiella burnetii (Q fever)	• Chronic hepatitis. • Endocarditis. • Osteomyelitis. • Post-Q-fever chronic fatigue syndrome. • Vascular infection.
Malaria	• Demyelinating polyneuropathy. • Guillain-Barré syndrome. • Hematologic manifestations (particularly anemia after falciparum malaria and splenic rupture after vivax malaria). • Immune-complex glomerulonephritis. • Neurologic disease, neuropsychiatric disease, or both. • Ophthalmologic manifestations, particularly retinal hemorrhage and scarring. • *Plasmodium falciparum.* • *Plasmodium malariae.* • *Plasmodium ovale.* • *Plasmodium vivax.* • Renal disease, especially nephrotic syndrome.
Mycobacterium tuberculosis	• Active tuberculosis.

TABLE TO § 3.317—LONG-TERM HEALTH EFFECTS POTENTIALLY ASSOCIATED WITH INFECTIOUS DISEASES—Continued

A	B
	Disease
	• Long-term adverse health outcomes due to irreversible tissue damage from severe forms of pulmonary and extrapulmonary tuberculosis and active tuberculosis.
Nontyphoid Salmonella	• Reactive Arthritis *if manifest within 3 months of the infection.*
Shigella	• Hemolytic-uremic syndrome *if manifest within 1 month of the infection.*
	• Reactive Arthritis *if manifest within 3 months of the infection.*
Visceral leishmaniasis	• Delayed presentation of the acute clinical syndrome.
	• Post-kala-azar dermal leishmaniasis *if manifest within 2 years of the infection.*
	• Reactivation of visceral leishmaniasis in the context of future immunosuppression.
West Nile virus	• Variable physical, functional, or cognitive disability.

(e) *Service*. For purposes of this section:

(1) The term *Persian Gulf veteran* means a veteran who served on active military, naval, or air service in the Southwest Asia theater of operations during the Persian Gulf War.

(2) The *Southwest Asia theater of operations* refers to Iraq, Kuwait, Saudi Arabia, the neutral zone between Iraq and Saudi Arabia, Bahrain, Qatar, the United Arab Emirates, Oman, the Gulf of Aden, the Gulf of Oman, the Persian Gulf, the Arabian Sea, the Red Sea, and the airspace above these locations.

(Authority: 38 U.S.C. 1117, 1118)

[75 FR 59970, Sept. 29, 2010, as amended at 75 FR 61356, Oct. 5, 2010; 75 FR 61997, Oct. 7, 2010; 76 FR 41698, July 15, 2011; 76 FR 81836, Dec. 29, 2011; 81 FR 71384, Oct. 17, 2016]

§ 3.318 Presumptive service connection for amyotrophic lateral sclerosis.

(a) Except as provided in paragraph (b) of this section, the development of amyotrophic lateral sclerosis manifested at any time after discharge or release from active military, naval, or air service is sufficient to establish service connection for that disease.

(b) Service connection will not be established under this section:

(1) If there is affirmative evidence that amyotrophic lateral sclerosis was not incurred during or aggravated by active military, naval, or air service;

(2) If there is affirmative evidence that amyotrophic lateral sclerosis is due to the veteran's own willful misconduct; or

(3) If the veteran did not have active, continuous service of 90 days or more.

(Authority: 38 U.S.C. 501(a)(1))

[73 FR 54693, Sept. 23, 2008]

§§ 3.319–3.320 [Reserved]

CROSS REFERENCES:[1]

Permanent and total disability ratings for pension purposes. See § 3.342. Special monthly dependency and indemnity compensation, death compensation and pension ratings. See § 3.351. Determination of permanent need for regular aid and attendance and ''permanently bedridden.'' See § 3.352. Conditions which determine permanent incapacity for self-support. See § 3.356.

§ 3.321 General rating considerations.

(a) *Use of rating schedule*. The 1945 Schedule for Rating Disabilities will be used for evaluating the degree of disabilities in claims for disability compensation, disability and death pension, and in eligibility determinations. The provisions contained in the rating schedule will represent as far as can practicably be determined, the average impairment in earning capacity in civil occupations resulting from disability.

(Authority: 38 U.S.C. 1155)

(b) *Extra-schedular ratings in unusual cases*—(1) *Disability compensation*. Ratings shall be based, as far as practicable, upon the average impairments of earning capacity with the additional proviso that the Secretary shall from time to time readjust this schedule of ratings in accordance with experience. To accord justice to the exceptional case where the schedular evaluation is

[1] 39 FR 5315, Feb. 12, 1974.

inadequate to rate a single service-connected disability, the Director of Compensation Service or his or her delegate is authorized to approve on the basis of the criteria set forth in this paragraph (b), an extra-schedular evaluation commensurate with the average impairment of earning capacity due exclusively to the disability. The governing norm in these exceptional cases is a finding by the Director of Compensation Service or delegatee that application of the regular schedular standards is impractical because the disability is so exceptional or unusual due to such related factors as marked interference with employment or frequent periods of hospitalization.

(2) *Pension*. Where the evidence of record establishes that an applicant for pension who is basically eligible fails to meet the disability requirements based on the percentage standards of the rating schedule but is found to be unemployable by reason of his or her disability(ies), age, occupational background and other related factors, the following are authorized to approve on an extra-schedular basis a permanent and total disability rating for pension purposes: the Veterans Service Center Manager or the Pension Management Center Manager; or where regular schedular standards are met as of the date of the rating decision, the rating board.

(3) *Effective dates*. The effective date of these extra-schedular evaluations granting or increasing benefits will be in accordance with § 3.400(b)(1) and (2) as to original and supplemental claims and in accordance with § 3.400(o) in claims for increased benefits.

(c) *Advisory opinion*. Cases in which application of the schedule is not understood or the propriety of an extra-schedular rating is questionable may be submitted to Central Office for advisory opinion.

CROSS REFERENCES: Effective dates; disability benefits. See § 3.400(b). Effective dates; increases. See § 3.400(o).

[26 FR 1583, Feb. 24, 1961, as amended at 29 FR 1463, Jan. 29, 1964; 37 FR 10442, May 23, 1972; 39 FR 5315, Feb. 12, 1974; 39 FR 32988, Sept. 13, 1974; 40 FR 57459, Dec. 10, 1975; 61 FR 20727, May 8, 1996; 74 FR 26959, June 5, 2009; 79 FR 2100, Jan. 13, 2014; 82 FR 57835, Dec. 8, 2017; 84 FR 170, Jan. 18, 2019]

§ 3.322 Rating of disabilities aggravated by service.

(a) *Aggravation of preservice disability*. In cases involving aggravation by active service, the rating will reflect only the degree of disability over and above the degree of disability existing at the time of entrance into active service, whether the particular condition was noted at the time of entrance into active service, or whether it is determined upon the evidence of record to have existed at that time. It is necessary to deduct from the present evaluation the degree, if ascertainable, of the disability existing at the time of entrance into active service, in terms of the rating schedule except that if the disability is total (100 percent) no deduction will be made. If the degree of disability at the time of entrance into service is not ascertainable in terms of the schedule, no deduction will be made.

(b) *Aggravation of service-connected disability*. Where a disease or injury incurred in peacetime service is aggravated during service in a period of war, or conversely, where a disease or injury incurred in service during a period of war is aggravated during peacetime service, the entire disability flowing from the disease or injury will be service connected based on the war service.

CROSS REFERENCES: Principles relating to service connection. See § 3.303. Aggravation of preservice disability. See § 3.306.

[26 FR 1583, Feb. 24, 1961]

§ 3.323 Combined ratings.

(a) *Compensation*—(1) *Same type of service*. When there are two or more service-connected compensable disabilities a combined evaluation will be made following the tables and rules prescribed in the 1945 Schedule for Rating Disabilities.

(2) *Wartime and peacetime service*. Evaluation of wartime and peacetime service-connected compensable disabilities will be combined to provide for the payment of wartime rates of compensation. (38 U.S.C. 1157) Effective July 1, 1973, it is immaterial whether the disabilities are wartime or peacetime service-connected since all disabilities are compensable under 38

U.S.C. 1114 and 1115 on and after that date.

(b) *Pension*—(1) *Nonservice-connected disabilities*. Evaluation of two or more nonservice-connected disabilities not the result of the veteran's own willful misconduct will be combined as provided in paragraph (a)(1) of this section.

(2) *Service-connected and nonservice-connected disabilities*. Evaluations for service-connected disabilities may be combined with evaluations for disabilities not shown to be service connected and not the result of the veteran's own willful misconduct.

CROSS REFERENCES: ''Willful misconduct.'' See §3.1(n). Pension. See §3.3. Line of duty and misconduct. See §3.301. Service connection for mental unsoundness in suicide. See §3.302.

[26 FR 1583, Feb. 24, 1961, as amended at 38 FR 21923, Aug. 14, 1973; 61 FR 20438, May 7, 1996]

§ 3.324 Multiple noncompensable service-connected disabilities.

Whenever a veteran is suffering from two or more separate permanent service-connected disabilities of such character as clearly to interfere with normal employability, even though none of the disabilities may be of compensable degree under the 1945 Schedule for Rating Disabilities the rating agency is authorized to apply a 10-percent rating, but not in combination with any other rating.

[40 FR 56435, Dec. 3, 1975]

§ 3.325 [Reserved]

§ 3.326 Examinations.

For purposes of this section, the term examination includes periods of hospital observation when required by VA.

(a) Where there is a claim for disability compensation or pension but medical evidence accompanying the claim is not adequate for rating purposes, a Department of Veterans Affairs examination will be authorized. This paragraph applies to original and supplemental claims as well as claims for increase submitted by a veteran, surviving spouse, parent, or child. Individuals for whom an examination has been scheduled are required to report for the examination.

(b) Provided that it is otherwise adequate for rating purposes, any hospital report, or any examination report, from any government or private institution may be accepted for rating a claim without further examination. However, monetary benefits to a former prisoner of war will not be denied unless the claimant has been offered a complete physical examination conducted at a Department of Veterans Affairs hospital or outpatient clinic.

(c) Provided that it is otherwise adequate for rating purposes, a statement from a private physician may be accepted for rating a claim without further examination.

(Authority: 38 U.S.C. 5107(a))

CROSS REFERENCE: Failure to report for VA examination. See §3.655.

[60 FR 52864, Oct. 11, 1995, as amended at 66 FR 45632, Aug. 29, 2001; 84 FR 170, Jan. 18, 2019]

§ 3.327 Reexaminations.

(a) *General*. Reexaminations, including periods of hospital observation, will be requested whenever VA determines there is a need to verify either the continued existence or the current severity of a disability. Generally, reexaminations will be required if it is likely that a disability has improved, or if evidence indicates there has been a material change in a disability or that the current rating may be incorrect. Individuals for whom reexaminations have been authorized and scheduled are required to report for such reexaminations. Paragraphs (b) and (c) of this section provide general guidelines for requesting reexaminations, but shall not be construed as limiting VA's authority to request reexaminations, or periods of hospital observation, at any time in order to ensure that a disability is accurately rated.

(Authority: 38 U.S.C. 501)

(b) *Compensation cases*—(1) *Scheduling reexaminations*. Assignment of a prestabilization rating requires reexamination within the second 6 months period following separation from service. Following initial Department of Veterans Affairs examination, or any scheduled future or other examination, reexamination, if in order, will be

scheduled within not less than 2 years nor more than 5 years within the judgment of the rating board, unless another time period is elsewhere specified.

(2) No periodic future examinations will be requested. In service-connected cases, no periodic reexamination will be scheduled: (i) When the disability is established as static;

(ii) When the findings and symptoms are shown by examinations scheduled in paragraph (b)(2)(i) of this section or other examinations and hospital reports to have persisted without material improvement for a period of 5 years or more;

(iii) Where the disability from disease is permanent in character and of such nature that there is no likelihood of improvement;

(iv) In cases of veterans over 55 years of age, except under unusual circumstances;

(v) When the rating is a prescribed scheduled minimum rating; or

(vi) Where a combined disability evaluation would not be affected if the future examination should result in reduced evaluation for one or more conditions.

(c) *Pension cases.* In nonservice-connected cases in which the permanent total disability has been confirmed by reexamination or by the history of the case, or with obviously static disabilities, further reexaminations will not generally be requested. In other cases further examination will not be requested routinely and will be accomplished only if considered necessary based upon the particular facts of the individual case. In the cases of veterans over 55 years of age, reexamination will be requested only under unusual circumstances.

CROSS REFERENCE: Failure to report for VA examination. See § 3.655.

[26 FR 1585, Feb. 24, 1961, as amended at 30 FR 11855, Sept. 16, 1965; 36 FR 14467, Aug. 6, 1971; 55 FR 49521, Nov. 29, 1990; 60 FR 27409, May 24, 1995]

§ 3.328 Independent medical opinions.

(a) *General.* When warranted by the medical complexity or controversy involved in a pending claim, an advisory medical opinion may be obtained from one or more medical experts who are not employees of VA. Opinions shall be obtained from recognized medical schools, universities, clinics or medical institutions with which arrangements for such opinions have been made, and an appropriate official of the institution shall select the individual expert(s) to render an opinion.

(b) *Requests.* A request for an independent medical opinion in conjunction with a claim pending before VA may be initiated by the office having jurisdiction over the claim, by the claimant, or by his or her duly appointed representative. The request must be submitted in writing and must set forth in detail the reasons why the opinion is necessary. All such requests shall be submitted through the Veterans Service Center Manager or Pension Management Center Manager of the office having jurisdiction over the claim, and those requests which in the judgment of the Veterans Service Center Manager or Pension Management Center Manager merit consideration shall be referred to the Compensation Service or the Pension and Fiduciary Service for approval.

(c) *Approval.* (1) Requests for independent medical opinions shall be approved when one of the following conditions is met:

(i) The director of each Service from which a benefit is sought, or his or her designee, determines that the issue under consideration poses a medical problem of such complexity or controversy as to justify solicitation of an independent medical opinion; or

(ii) The independent medical opinion is required to fulfill the instructions contained in a remand order from the Board of Veterans' Appeals.

(2) A determination that an independent medical opinion is not warranted may be contested only as part of an appeal to the Board of Veterans' Appeals on the merits of the decision rendered on the primary issue by VA.

(d) *Notification.* The Compensation Service or the Pension and Fiduciary Service shall notify the claimant when the request for an independent medical opinion has been approved with regard to his or her claim and shall furnish the claimant with a copy of the opinion when it is received. If, in the judgment

of the Secretary, disclosure of the independent medical opinion would be harmful to the physical or mental health of the claimant, disclosure shall be subject to the special procedures set forth in § 1.577 of this chapter.

(Authority: 38 U.S.C. 5109, 5701(b)(1); 5 U.S.C. 552a(f)(3))

[55 FR 18602, May 3, 1990, as amended at 79 FR 2100, Jan. 13, 2014; 84 FR 170, Jan. 18, 2019]

§ 3.329 [Reserved]

§ 3.330 Resumption of rating when veteran subsequently reports for Department of Veterans Affairs examination.

Such ratings will be governed by the provisions of § 3.158, ''Abandoned Claims,'' and § 3.655, ''Failure to report for Department of Veterans Affairs examination.'' The period following the termination or reduction for which benefits are precluded by the cited regulations will be stated in the rating. If the evidence is insufficient to evaluate disability during any period following the termination or reduction for which payments are not otherwise precluded, the rating will contain a notation reading ''Evidence insufficient to evaluate from _____ to _____.

CROSS REFERENCE: Failure to report for Department of Veterans Affairs examination. See § 3.655.

[29 FR 3623, Mar. 21, 1964]

§§ 3.331–3.339 [Reserved]

§ 3.340 Total and permanent total ratings and unemployability.

(a) *Total disability ratings*—(1) *General*. Total disability will be considered to exist when there is present any impairment of mind or body which is sufficient to render it impossible for the average person to follow a substantially gainful occupation. Total disability may or may not be permanent. Total ratings will not be assigned, generally, for temporary exacerbations or acute infectious diseases except where specifically prescribed by the schedule.

(2) *Schedule for rating disabilities*. Total ratings are authorized for any disability or combination of disabilities for which the Schedule for Rating Disabilities prescribes a 100 percent evaluation or, with less disability, where the requirements of paragraph 16, page 5 of the rating schedule are present or where, in pension cases, the requirements of paragraph 17, page 5 of the schedule are met.

(3) *Ratings of total disability on history*. In the case of disabilities which have undergone some recent improvement, a rating of total disability may be made, provided:

(i) That the disability must in the past have been of sufficient severity to warrant a total disability rating;

(ii) That it must have required extended, continuous, or intermittent hospitalization, or have produced total industrial incapacity for at least 1 year, or be subject to recurring, severe, frequent, or prolonged exacerbations; and

(iii) That it must be the opinion of the rating agency that despite the recent improvement of the physical condition, the veteran will be unable to effect an adjustment into a substantially gainful occupation. Due consideration will be given to the frequency and duration of totally incapacitating exacerbations since incurrence of the original disease or injury, and to periods of hospitalization for treatment in determining whether the average person could have reestablished himself or herself in a substantially gainful occupation.

(b) *Permanent total disability*. Permanence of total disability will be taken to exist when such impairment is reasonably certain to continue throughout the life of the disabled person. The permanent loss or loss of use of both hands, or of both feet, or of one hand and one foot, or of the sight of both eyes, or becoming permanently helpless or bedridden constitutes permanent total disability. Diseases and injuries of long standing which are actually totally incapacitating will be regarded as permanently and totally disabling when the probability of permanent improvement under treatment is remote. Permanent total disability ratings may not be granted as a result of any incapacity from acute infectious disease, accident, or injury, unless there is present one of the recognized combinations or permanent loss of use of extremities or sight, or the person is

in the strict sense permanently helpless or bedridden, or when it is reasonably certain that a subsidence of the acute or temporary symptoms will be followed by irreducible totality of disability by way of residuals. The age of the disabled person may be considered in determining permanence.

(c) *Insurance ratings.* A rating of permanent and total disability for insurance purposes will have no effect on ratings for compensation or pension.

[26 FR 1585, Feb. 24, 1961, as amended at 46 FR 47541, Sept. 29, 1981]

§ 3.341 Total disability ratings for compensation purposes.

(a) *General.* Subject to the limitation in paragraph (b) of this section, total-disability compensation ratings may be assigned under the provisions of § 3.340. However, if the total rating is based on a disability or combination of disabilities for which the Schedule for Rating Disabilities provides an evaluation of less than 100 percent, it must be determined that the service-connected disabilities are sufficient to produce unemployability without regard to advancing age.

(Authority: 38 U.S.C. 1155)

(b) *Incarcerated veterans.* A total rating for compensation purposes based on individual unemployability which would first become effective while a veteran is incarcerated in a Federal, State or local penal institution for conviction of a felony, shall not be assigned during such period of incarceration. However, where a rating for individual unemployability exists prior to incarceration for a felony and routine review is required, the case will be reconsidered to determine if continued eligibility for such rating exists.

(Authority: 38 U.S.C. 5313(c))

(c) *Program for vocational rehabilitation.* Each time a veteran is rated totally disabled on the basis of individual unemployability during the period beginning after January 31, 1985, the Vocational Rehabilitation and Employment Service will be notified so that an evaluation may be offered to determine whether the achievement of a vocational goal by the veteran is reasonably feasible.

(Authority: 38 U.S.C. 1163)

[46 FR 47541, Sept. 29, 1981, as amended at 50 FR 52774, Dec. 26, 1985; 55 FR 17271, Apr. 24, 19901; 58 FR 32445, June 10, 1993; 68 FR 34542, June 10, 2003]

§ 3.342 Permanent and total disability ratings for pension purposes.

(a) *General.* Permanent total disability ratings for pension purposes are authorized for disabling conditions not the result of the veteran's own willful misconduct whether or not they are service connected.

(Authority: 38 U.S.C. 1502(a))

(b) *Criteria.* In addition to the criteria for determining total disability and permanency of total disability contained in § 3.340, the following special considerations apply in pension cases:

(1) Permanent total disability pension ratings will be authorized for congenital, developmental, hereditary or familial conditions, provided the other requirements for entitlement are met.

(2) The permanence of total disability will be established as of the earliest date consistent with the evidence in the case. Active pulmonary tuberculosis not otherwise established as permanently and totally disabling will be presumed so after 6 months' hospitalization without improvement. The same principle may be applied with other types of disabilities requiring hospitalization for indefinite periods. The need for hospitalization for periods shorter or longer than 6 months may be a proper basis for determining permanence. Where, in application of this principle, it is necessary to employ a waiting period to determine permanence of totality of disability and a report received at the end of such period shows the veteran's condition is unimproved, permanence may be established as of the date of entrance into the hospital. Similarly, when active pulmonary tuberculosis is improved after 6 months' hospitalization but still diagnosed as active after 12 months' hospitalization permanence will also be established as of the date of entrance into the hospital. In other cases the

rating will be effective the date the evidence establishes permanence.

(3) Special consideration must be given the question of permanence in the case of veterans under 40 years of age. For such veterans, permanence of total disability requires a finding that the end result of treatment and adjustment to residual handicaps (rehabilitation) will be permanent disability of the required degree precluding more than marginal employment. Severe diseases and injuries, including multiple fractures or the amputation of a single extremity, should not be taken to establish permanent and total disability until it is shown that the veteran after treatment and convalescence, has been unable to secure or follow employment because of the disability and through no fault of the veteran.

(4) The following shall not be considered as evidence of employability:

(i) Employment as a member-employer or similar employment obtained only in competition with disabled persons.

(ii) Participation in, or the receipt of a distribution of funds as a result of participation in, a therapeutic or rehabilitation activity under 38 U.S.C. 1718.

(Authority: 38 U.S.C. 1718(f))

(5) The authority granted the Secretary under 38 U.S.C. 1502(a)(2) to classify as permanent and total those diseases and disorders, the nature and extent of which, in the Secretary judgment, will justify such determination, will be exercised under § 3.321(b).

(c) *Temporary program of vocational rehabilitation training for certain pension recipients.* (1) When a veteran under age 45 is awarded disability pension during the period beginning on February 1, 1985, and ending on December 31, 1995, the Vocational Rehabilitation and Employment Division will be notified so that an evaluation may be made, as provided in § 21.6050, to determine that veteran's potential for rehabilitation.

(2) If a veteran secures employment within the scope of a vocational goal identified in his or her individualized written vocational rehabilitation plan, or in a related field which requires reasonably developed skills and the use of some or all of the training or services furnished the veteran under such plan, not later than one year after eligibility to counseling under § 21.6040(b)(1) of this chapter expires, the veteran's permanent and total evaluation for pension purposes shall not be terminated by reason of the veteran's capacity to engage in such employment until the veteran has maintained that employment for a period of not less than 12 consecutive months.

(Authority: 38 U.S.C. 1524(c))

[26 FR 1586, Feb. 24, 1961, as amended at 26 FR 9674, Oct. 13, 1961; 29 FR 3624, Mar. 21, 1964; 39 FR 14944, Apr. 18, 1974; 46 FR 47541, Sept. 29, 1981; 50 FR 52775, Dec. 26, 1985; 53 FR 23235, June 21, 1988; 55 FR 17271, Apr. 24, 1990; 56 FR 25044, June 3, 1991; 56 FR 65851, Dec. 19, 1991; 58 FR 32445, June 10, 1993]

§ 3.343 Continuance of total disability ratings.

(a) *General.* Total disability ratings, when warranted by the severity of the condition and not granted purely because of hospital, surgical, or home treatment, or individual unemployability will not be reduced, in the absence of clear error, without examination showing material improvement in physical or mental condition. Examination reports showing material improvement must be evaluated in conjunction with all the facts of record, and consideration must be given particularly to whether the veteran attained improvement under the ordinary conditions of life, *i.e.*, while working or actively seeking work or whether the symptoms have been brought under control by prolonged rest, or generally, by following a regimen which precludes work, and, if the latter, reduction from total disability ratings will not be considered pending reexamination after a period of employment (3 to 6 months).

(b) *Tuberculosis; compensation.* In service-connected cases, evaluations for active or inactive tuberculosis will be governed by the Schedule for Rating Disabilities (part 4 of this chapter). Where in the opinion of the rating board the veteran at the expiration of the period during which a total rating is provided will not be able to maintain inactivity of the disease process under the ordinary conditions of life, the case will be submitted under § 3.321.

(c) *Individual unemployability.* (1) In reducing a rating of 100 percent service-connected disability based on individual unemployability, the provisions of § 3.105(e) are for application but caution must be exercised in such a determination that actual employability is established by clear and convincing evidence. When in such a case the veteran is undergoing vocational rehabilitation, education or training, the rating will not be reduced by reason thereof unless there is received evidence of marked improvement or recovery in physical or mental conditions or of employment progress, income earned, and prospects of economic rehabilitation, which demonstrates affirmatively the veteran's capacity to pursue the vocation or occupation for which the training is intended to qualify him or her, or unless the physical or mental demands of the course are obviously incompatible with total disability. Neither participation in, nor the receipt of remuneration as a result of participation in, a therapeutic or rehabilitation activity under 38 U.S.C. 1718 shall be considered evidence of employability.

(Authority: 38 U.S.C. 1718(f))

(2) If a veteran with a total disability rating for compensation purposes based on individual unemployability begins to engage in a substantially gainful occupation during the period beginning after January 1, 1985, the veteran's rating may not be reduced solely on the basis of having secured and followed such substantially gainful occupation unless the veteran maintains the occupation for a period of 12 consecutive months. For purposes of this subparagraph, temporary interruptions in employment which are of short duration shall not be considered breaks in otherwise continuous employment.

(Authority: 38 U.S.C. 1163(a))

CROSS REFERENCE: Protection, total disability. See § 3.951(b).

[33 FR 16273, Nov. 6, 1968, as amended at 39 FR 14944, Apr. 29, 1974; 50 FR 52775, Dec. 26, 1985; 53 FR 23236, June 21, 1988; 55 FR 17271, Apr. 24, 1990; 57 FR 10426, Mar. 26, 1992; 58 FR 32445, June 10, 1993; 58 FR 46865, Sept. 3, 1993]

§ 3.344 Stabilization of disability evaluations.

(a) *Examination reports indicating improvement.* Rating agencies will handle cases affected by change of medical findings or diagnosis, so as to produce the greatest degree of stability of disability evaluations consistent with the laws and Department of Veterans Affairs regulations governing disability compensation and pension. It is essential that the entire record of examinations and the medical-industrial history be reviewed to ascertain whether the recent examination is full and complete, including all special examinations indicated as a result of general examination and the entire case history. This applies to treatment of intercurrent diseases and exacerbations, including hospital reports, bedside examinations, examinations by designated physicians, and examinations in the absence of, or without taking full advantage of, laboratory facilities and the cooperation of specialists in related lines. Examinations less full and complete than those on which payments were authorized or continued will not be used as a basis of reduction. Ratings on account of diseases subject to temporary or episodic improvement, e.g., manic depressive or other psychotic reaction, epilepsy, psychoneurotic reaction, arteriosclerotic heart disease, bronchial asthma, gastric or duodenal ulcer, many skin diseases, etc., will not be reduced on any one examination, except in those instances where all the evidence of record clearly warrants the conclusion that sustained improvement has been demonstrated. Ratings on account of diseases which become comparatively symptom free (findings absent) after prolonged rest, e.g. residuals of phlebitis, arteriosclerotic heart disease, etc., will not be reduced on examinations reflecting the results of bed rest. Moreover, though material improvement in the physical or mental condition is clearly reflected the rating agency will consider whether the evidence makes it reasonably certain that the improvement will be maintained under the ordinary conditions of life. When syphilis of the central nervous system or alcoholic deterioration is diagnosed following a long prior history

of psychosis, psychoneurosis, epilepsy, or the like, it is rarely possible to exclude persistence, in masked form, of the preceding innocently acquired manifestations. Rating boards encountering a change of diagnosis will exercise caution in the determination as to whether a change in diagnosis represents no more than a progression of an earlier diagnosis, an error in prior diagnosis or possibly a disease entity independent of the service-connected disability. When the new diagnosis reflects mental deficiency or personality disorder only, the possibility of only temporary remission of a super-imposed psychiatric disease will be borne in mind.

(b) *Doubtful cases.* If doubt remains, after according due consideration to all the evidence developed by the several items discussed in paragraph (a) of this section, the rating agency will continue the rating in effect, citing the former diagnosis with the new diagnosis in parentheses, and following the appropriate code there will be added the reference ''Rating continued pending reexamination _____ months from this date, § 3.344.'' The rating agency will determine on the basis of the facts in each individual case whether 18, 24 or 30 months will be allowed to elapse before the reexamination will be made.

(c) *Disabilities which are likely to improve.* The provisions of paragraphs (a) and (b) of this section apply to ratings which have continued for long periods at the same level (5 years or more). They do not apply to disabilities which have not become stabilized and are likely to improve. Reexaminations disclosing improvement, physical or mental, in these disabilities will warrant reduction in rating.

[26 FR 1586, Feb. 24, 1961; 58 FR 53660, Oct. 18, 1993]

RATINGS FOR SPECIAL PURPOSES

§ 3.350 Special monthly compensation ratings.

The rates of special monthly compensation stated in this section are those provided under 38 U.S.C. 1114.

(a) *Ratings under 38 U.S.C. 1114(k).* Special monthly compensation under 38 U.S.C. 1114(k) is payable for each anatomical loss or loss of use of one hand, one foot, both buttocks, one or more creative organs, blindness of one eye having only light perception, deafness of both ears, having absence of air and bone conduction, complete organic aphonia with constant inability to communicate by speech or, in the case of a woman veteran, loss of 25% or more of tissue from a single breast or both breasts in combination (including loss by mastectomy or partial mastectomy), or following receipt of radiation treatment of breast tissue. This special compensation is payable in addition to the basic rate of compensation otherwise payable on the basis of degree of disability, provided that the combined rate of compensation does not exceed the monthly rate set forth in 38 U.S.C. 1114(l) when authorized in conjunction with any of the provisions of 38 U.S.C. 1114 (a) through (j) or (s). When there is entitlement under 38 U.S.C. 1114 (l) through (n) or an intermediate rate under (p) such additional allowance is payable for each such anatomical loss or loss of use existing in addition to the requirements for the basic rates, provided the total does not exceed the monthly rate set forth in 38 U.S.C. 1114(o). The limitations on the maximum compensation payable under this paragraph are independent of and do not preclude payment of additional compensation for dependents under 38 U.S.C. 1115, or the special allowance for aid and attendance provided by 38 U.S.C. 1114(r).

(1) *Creative organ.* (i) Loss of a creative organ will be shown by acquired absence of one or both testicles (other than undescended testicles) or ovaries or other creative organ. Loss of use of one testicle will be established when examination by a board finds that:

(*a*) The diameters of the affected testicle are reduced to one-third of the corresponding diameters of the paired normal testicle, or

(*b*) The diameters of the affected testicle are reduced to one-half or less of the corresponding normal testicle and there is alteration of consistency so that the affected testicle is considerably harder or softer than the corresponding normal testicle; or

(*c*) If neither of the conditions (*a*) or (*b*) is met, when a biopsy, recommended by a board including a

genitourologist and accepted by the veteran, establishes the absence of spermatozoa.

(ii) When loss or loss of use of a creative organ resulted from wounds or other trauma sustained in service, or resulted from operations in service for the relief of other conditions, the creative organ becoming incidentally involved, the benefit may be granted.

(iii) Loss or loss of use traceable to an elective operation performed subsequent to service, will not establish entitlement to the benefit. If, however, the operation after discharge was required for the correction of a specific injury caused by a preceding operation in service, it will support authorization of the benefit. When the existence of disability is established meeting the above requirements for nonfunctioning testicle due to operation after service, resulting in loss of use, the benefit may be granted even though the operation is one of election. An operation is not considered to be one of election where it is advised on sound medical judgment for the relief of a pathological condition or to prevent possible future pathological consequences.

(iv) Atrophy resulting from mumps followed by orchitis in service is service connected. Since atrophy is usually perceptible within 1 to 6 months after infection subsides, an examination more than 6 months after the subsidence of orchitis demonstrating a normal genitourinary system will be considered in determining rebuttal of service incurrence of atrophy later demonstrated. Mumps not followed by orchitis in service will not suffice as the antecedent cause of subsequent atrophy for the purpose of authorizing the benefit.

(2) *Foot and hand.* (i) Loss of use of a hand or a foot will be held to exist when no effective function remains other than that which would be equally well served by an amputation stump at the site of election below elbow or knee with use of a suitable prosthetic appliance. The determination will be made on the basis of the actual remaining function, whether the acts of grasping, manipulation, etc., in the case of the hand, or of balance, propulsion, etc., in the case of the foot, could be accomplished equally well by an amputation stump with prosthesis; for example:

(*a*) Extremely unfavorable complete ankylosis of the knee, or complete ankylosis of two major joints of an extremity, or shortening of the lower extremity of 3½ inches or more, will constitute loss of use of the hand or foot involved.

(*b*) Complete paralysis of the external popliteal nerve (common peroneal) and consequent footdrop, accompanied by characteristic organic changes including trophic and circulatory disturbances and other concomitants confirmatory of complete paralysis of this nerve, will be taken as loss of use of the foot.

(3) *Both buttocks.* (i) Loss of use of both buttocks shall be deemed to exist when there is severe damage by disease or injury to muscle group XVII, bilateral, (diagnostic code 5317) and additional disability making it impossible for the disabled person, without assistance, to rise from a seated position and from a stooped position (fingers to toes position) and to maintain postural stability (the pelvis upon head of femur). The assistance may be done by the person's own hands or arms, and, in the matter of postural stability, by a special appliance.

(Authority: 38 U.S.C. 1114(k))

(ii) Special monthly compensation for loss or loss of use of both lower extremities (38 U.S.C. 1114(l) through (n)) will not preclude additional compensation under 38 U.S.C. 1114(k) for loss of use of both buttocks where appropriate tests clearly substantiate that there is such additional loss.

(4) *Eye.* Loss of use or blindness of one eye, having only light perception, will be held to exist when there is inability to recognize test letters at 1 foot and when further examination of the eye reveals that perception of objects, hand movements, or counting fingers cannot be accomplished at 3 feet. Lesser extents of vision, particularly perception of objects, hand movements, or counting fingers at distances less than 3 feet is considered of negligible utility.

(5) *Deafness*. Deafness of both ears, having absence of air and bone conduction will be held to exist where examination in a Department of Veterans Affairs authorized audiology clinic under current testing criteria shows bilateral hearing loss is equal to or greater than the minimum bilateral hearing loss required for a maximum rating evaluation under the rating schedule.

(Authority: Pub. L. 88–20)

(6) *Aphonia*. Complete organic aphonia will be held to exist where there is a disability of the organs of speech which constantly precludes communication by speech.

(Authority: Pub. L. 88–22)

(b) *Ratings under 38 U.S.C. 1114(l)*. The special monthly compensation provided by 38 U.S.C. 1114(l) is payable for anatomical loss or loss of use of both feet, one hand and one foot, blindness in both eyes with visual acuity of 5/200 or less or being permanently bedridden or so helpless as to be in need of regular aid and attendance.

(1) *Extremities*. The criteria for loss and loss of use of an extremity contained in paragraph (a)(2) of this section are applicable.

(2) *Eyes, bilateral*. 5/200 visual acuity or less bilaterally qualifies for entitlement under 38 U.S.C. 1114(l). However, evaluation of 5/200 based on acuity in excess of that degree but less than 10/200 (§ 4.83 of this chapter), does not qualify. Concentric contraction of the field of vision beyond 5 degrees in both eyes is the equivalent of 5/200 visual acuity.

(3) *Need for aid and attendance*. The criteria for determining that a veteran is so helpless as to be in need of regular aid and attendance are contained in § 3.352(a).

(4) *Permanently bedridden*. The criteria for rating are contained in § 3.352(a). Where possible, determinations should be on the basis of permanently bedridden rather than for need of aid and attendance (except where 38 U.S.C. 1114(r) is involved) to avoid reduction during hospitalization where aid and attendance is provided in kind.

(c) *Ratings under 38 U.S.C. 1114(m)*. (1) The special monthly compensation provided by 38 U.S.C. 1114(m) is payable for any of the following conditions:

(i) Anatomical loss or loss of use of both hands;

(ii) Anatomical loss or loss of use of both legs at a level, or with complications, preventing natural knee action with prosthesis in place;

(iii) Anatomical loss or loss of use of one arm at a level, or with complications, preventing natural elbow action with prosthesis in place with anatomical loss or loss of use of one leg at a level, or with complications, preventing natural knee action with prosthesis in place;

(iv) Blindness in both eyes having only light perception;

(v) Blindness in both eyes leaving the veteran so helpless as to be in need of regular aid and attendance.

(2) *Natural elbow or knee action*. In determining whether there is natural elbow or knee action with prosthesis in place, consideration will be based on whether use of the proper prosthetic appliance requires natural use of the joint, or whether necessary motion is otherwise controlled, so that the muscles affecting joint motion, if not already atrophied, will become so. If there is no movement in the joint, as in ankylosis or complete paralysis, use of prosthesis is not to be expected, and the determination will be as though there were one in place.

(3) *Eyes, bilateral*. With visual acuity 5/200 or less or the vision field reduced to 5 degree concentric contraction in both eyes, entitlement on account of need for regular aid and attendance will be determined on the facts in the individual case.

(d) *Ratings under 38 U.S.C. 1114(n)*. The special monthly compensation provided by 38 U.S.C. 1114(n) is payable for any of the conditions which follow: Amputation is a prerequisite except for loss of use of both arms and blindness without light perception in both eyes. If a prosthesis cannot be worn at the present level of amputation but could be applied if there were a reamputation at a higher level, the requirements of this paragraph are not met; instead, consideration will be given to loss of natural elbow or knee action.

(1) Anatomical loss or loss of use of both arms at a level or with complications, preventing natural elbow action with prosthesis in place;

(2) Anatomical loss of both legs so near the hip as to prevent use of a prosthetic appliance;

(3) Anatomical loss of one arm so near the shoulder as to prevent use of a prosthetic appliance with anatomical loss of one leg so near the hip as to prevent use of a prosthetic appliance;

(4) Anatomical loss of both eyes or blindness without light perception in both eyes.

(e) *Ratings under 38 U.S.C. 1114 (o).* (1) The special monthly compensation provided by 38 U.S.C. 1114(o) is payable for any of the following conditions:

(i) Anatomical loss of both arms so near the shoulder as to prevent use of a prosthetic appliance;

(ii) Conditions entitling to two or more of the rates (no condition being considered twice) provided in 38 U.S.C. 1114(l) through (n);

(iii) Bilateral deafness rated at 60 percent or more disabling (and the hearing impairment in either one or both ears is service connected) in combination with service-connected blindness with bilateral visual acuity 20/200 or less.

(iv) Service-connected total deafness in one ear or bilateral deafness rated at 40 percent or more disabling (and the hearing impairment in either one of both ears is service-connected) in combination with service-connected blindness of both eyes having only light perception or less.

(2) *Paraplegia.* Paralysis of both lower extremities together with loss of anal and bladder sphincter control will entitle to the maximum rate under 38 U.S.C. 1114(o), through the combination of loss of use of both legs and helplessness. The requirement of loss of anal and bladder sphincter control is met even though incontinence has been overcome under a strict regimen of rehabilitation of bowel and bladder training and other auxiliary measures.

(3) *Combinations.* Determinations must be based upon separate and distinct disabilities. This requires, for example, that where a veteran who had suffered the loss or loss of use of two extremities is being considered for the maximum rate on account of helplessness requiring regular aid and attendance, the latter must be based on need resulting from pathology other than that of the extremities. If the loss or loss of use of two extremities or being permanently bedridden leaves the person helpless, increase is not in order on account of this helplessness. Under no circumstances will the combination of ''being permanently bedridden'' and ''being so helpless as to require regular aid and attendance'' without separate and distinct anatomical loss, or loss of use, of two extremities, or blindness, be taken as entitling to the maximum benefit. The fact, however, that two separate and distinct entitling disabilities, such as anatomical loss, or loss of use of both hands and both feet, result from a common etiological agent, for example, one injury or rheumatoid arthritis, will not preclude maximum entitlement.

(4) *Helplessness.* The maximum rate, as a result of including helplessness as one of the entitling multiple disabilities, is intended to cover, in addition to obvious losses and blindness, conditions such as the loss of use of two extremities with absolute deafness and nearly total blindness or with severe multiple injuries producing total disability outside the useless extremities, these conditions being construed as loss of use of two extremities and helplessness.

(f) *Intermediate or next higher rate.* An intermediate rate authorized by this paragraph shall be established at the arithmetic mean, rounded to the nearest dollar, between the two rates concerned.

(Authority: 38 U.S.C. 1114 (p))

(1) *Extremities.* (i) Anatomical loss or loss of use of one foot with anatomical loss or loss of use of one leg at a level, or with complications preventing natural knee action with prosthesis in place, shall entitle to the rate between 38 U.S.C. 1114(l) and (m).

(ii) Anatomical loss or loss of use of one foot with anatomical loss of one leg so near the hip as to prevent use of prosthetic appliance shall entitle to the rate under 38 U.S.C. 1114(m).

(iii) Anatomical loss or loss of use of one foot with anatomical loss or loss of

use of one arm at a level, or with complications, preventing natural elbow action with prosthesis in place, shall entitle to the rate between 38 U.S.C. 1114(l) and (m).

(iv) Anatomical loss or loss of use of one foot with anatomical loss or loss of use of one arm so near the shoulder as to prevent use of a prosthetic appliance shall entitle to the rate under 38 U.S.C. 1114(m).

(v) Anatomical loss or loss of use of one leg at a level, or with complications, preventing natural knee action with prosthesis in place with anatomical loss of one leg so near the hip as to prevent use of a prosthetic appliance, shall entitle to the rate between 38 U.S.C. 1114(m) and (n).

(vi) Anatomical loss or loss of use of one leg at a level, or with complications, preventing natural knee action with prosthesis in place with anatomical loss or loss of use of one hand, shall entitle to the rate between 38 U.S.C. 1114 (l) and (m).

(vii) Anatomical loss or loss of use of one leg at a level, or with complications, preventing natural knee action with prosthesis in place with anatomical loss of one arm so near the shoulder as to prevent use of a prosthetic appliance, shall entitle to the rate between 38 U.S.C. 1114 (m) and (n).

(viii) Anatomical loss of one leg so near the hip as to prevent use of a prosthetic appliance with anatomical loss or loss of use of one hand shall entitle to the rate under 38 U.S.C. 1114(m).

(ix) Anatomical loss of one leg so near the hip as to prevent use of a prosthetic appliance with anatomical loss or loss of use of one arm at a level, or with complications, preventing natural elbow action with prosthesis in place, shall entitle to the rate between 38 U.S.C. 1114 (m) and (n).

(x) Anatomical loss or loss of use of one hand with anatomical loss or loss of use of one arm at a level, or with complications, preventing natural elbow action with prosthesis in place, shall entitle to the rate between 38 U.S.C. 1114 (m) and (n).

(xi) Anatomical loss or loss of use of one hand with anatomical loss of one arm so near the shoulder as to prevent use of a prosthetic appliance shall entitle to the rate under 38 U.S.C. 1114(n).

(xii) Anatomical loss or loss of use of one arm at a level, or with complications, preventing natural elbow action with prosthesis in place with anatomical loss of one arm so near the shoulder as to prevent use of a prosthetic appliance, shall entitle to the rate between 38 U.S.C. 1114 (n) and (o).

(2) Eyes, bilateral, and blindness in connection with deafness and/or loss or loss of use of a hand or foot.

(i) Blindness of one eye with 5/200 visual acuity or less and blindness of the other eye having only light perception will entitle to the rate between 38 U.S.C. 1114 (l) and (m).

(ii) Blindness of one eye with 5/200 visual acuity or less and anatomical loss of, or blindness having no light perception in the other eye, will entitle to a rate equal to 38 U.S.C. 1114(m).

(iii) Blindness of one eye having only light perception and anatomical loss of, or blindness having no light perception in the other eye, will entitle to a rate between 38 U.S.C. 1114 (m) and (n).

(iv) Blindness in both eyes with visual acuity of 5/200 or less, or blindness in both eyes rated under subparagraph (2) (i) or (ii) of this paragraph, when accompanied by service-connected total deafness in one ear, will afford entitlement to the next higher intermediate rate of if the veteran is already entitled to an intermediate rate, to the next higher statutory rate under 38 U.S.C. 1114, but in no event higher than the rate for (o).

(v) Blindness in both eyes having only light perception or less, or rated under subparagraph (2)(iii) of this paragraph, when accompanied by bilateral deafness (and the hearing impairment in either one or both ears is service-connected) rated at 10 or 20 percent disabling, will afford entitlement to the next higher intermediate rate, or if the veteran is already entitled to an intermediate rate, to the next higher statutory rate under 38 U.S.C. 1114, but in no event higher than the rate for (o).

(Authority: Sec. 112, Pub. L. 98–223)

(vi) Blindness in both eyes rated under 38 U.S.C. 1114 (l), (m) or (n), or rated under subparagraphs (2)(i), (ii) or (iii) of this paragraph, when accompanied by bilaterial deafness rated at no less than 30 percent, and the hearing

impairment in one or both ears is service-connected, will afford entitlement to the next higher statutory rate under 38 U.S.C. 1114, or if the veteran is already entitled to an intermediate rate, to the next higher intermediate rate, but in no event higher than the rate for (o).

(Authority: 38 U.S.C. 1114(p))

(vii) Blindness in both eyes rated under 38 U.S.C. 1114 (l), (m), or (n), or under the intermediate or next higher rate provisions of this subparagraph, when accompanied by:

(A) Service-connected loss or loss of use of one hand, will afford entitlement to the next higher statutory rate under 38 U.S.C. 1114 or, if the veteran is already entitled to an intermediate rate, to the next higher intermediate rate, but in no event higher than the rate for (o); or

(B) Service-connected loss or loss of use of one foot which by itself or in combination with another compensable disability would be ratable at 50 percent or more, will afford entitlement to the next higher statutory rate under 38 U.S.C. 1114 or, if the veteran is already entitled to an intermediate rate, to the next higher intermediate rate, but in no event higher than the rate for (o); or

(C) Service-connected loss or loss of use of one foot which is ratable at less than 50 percent and which is the only compensable disability other than bilateral blindness, will afford entitlement to the next higher intermediate rate or, if the veteran is already entitled to an intermediate rate, to the next higher statutory rate under 38 U.S.C. 1114, but in no event higher than the rate for (o).

(Authority: 38 U.S.C. 1114(p))

(3) *Additional independent 50 percent disabilities.* In addition to the statutory rates payable under 38 U.S.C. 1114 (l) through (n) and the intermediate or next higher rate provisions outlined above, additional single permanent disability or combinations of permanent disabilities independently ratable at 50 percent or more will afford entitlement to the next higher intermediate rate or if already entitled to an intermediate rate to the next higher statutory rate under 38 U.S.C. 1114, but not above the (o) rate. In the application of this subparagraph the disability or disabilities independently ratable at 50 percent or more must be separate and distinct and involve different anatomical segments or bodily systems from the conditions establishing entitlement under 38 U.S.C. 1114 (l) through (n) or the intermediate rate provisions outlined above. The graduated ratings for arrested tuberculosis will not be utilized in this connection, but the permanent residuals of tuberculosis may be utilized.

(4) *Additional independent 100 percent ratings.* In addition to the statutory rates payable under 38 U.S.C. 1114 (l) through (n) and the intermediate or next higher rate provisions outlined above additional single permanent disability independently ratable at 100 percent apart from any consideration of individual unemployability will afford entitlement to the next higher statutory rate under 38 U.S.C. 1114 or if already entitled to an intermediate rate to the next higher intermediate rate, but in no event higher than the rate for (o). In the application of this subparagraph the single permanent disability independently ratable at 100 percent must be separate and distinct and involve different anatomical segments or bodily systems from the conditions establishing entitlement under 38 U.S.C. 1114 (l) through (n) or the intermediate rate provisions outlined above.

(i) Where the multiple loss or loss of use entitlement to a statutory or intermediate rate between 38 U.S.C. 1114 (l) and (o) is caused by the same etiological disease or injury, that disease or injury may not serve as the basis for the independent 50 percent or 100 percent unless it is so rated without regard to the loss or loss of use.

(ii) The graduated ratings for arrested tuberculosis will not be utilized in this connection, but the permanent residuals of tuberculosis may be utilized.

(5) *Three extremities.* Anatomical loss or loss of use, or a combination of anatomical loss and loss of use, of three extremities shall entitle a veteran to the next higher rate without regard to whether that rate is a statutory rate or an intermediate rate. The maximum

monthly payment under this provision may not exceed the amount stated in 38 U.S.C. 1114(p).

(g) *Inactive tuberculosis* (*complete arrest*). The rating criteria for determining inactivity of tuberculosis are set out in § 3.375.

(1) For a veteran who was receiving or entitled to receive compensation for tuberculosis on August 19, 1968, the minimum monthly rate is $67. This minimum special monthly compensation is not to be combined with or added to any other disability compensation.

(2) For a veteran who was not receiving or entitled to receive compensation for tuberculosis on August 19, 1968, the special monthly compensation authorized by paragraph (g)(1) of this section is not payable.

(h) *Special aid and attendance benefit; 38 U.S.C. 1114(r)*—(1) Maximum compensation cases. A veteran receiving the maximum rate under 38 U.S.C. 1114 (o) or (p) who is in need of regular aid and attendance or a higher level of care is entitled to an additional allowance during periods he or she is not hospitalized at United States Government expense. (See § 3.552(b)(2) as to continuance following admission for hospitalization.) Determination of this need is subject to the criteria of § 3.352. The regular or higher level aid and attendance allowance is payable whether or not the need for regular aid and attendance or a higher level of care was a partial basis for entitlement to the maximum rate under 38 U.S.C. 1114 (o) or (p), or was based on an independent factual determination.

(2) *Entitlement to compensation at the intermediate rate between 38 U.S.C. 1114 (n) and (o) plus special monthly compensation under 38 U.S.C. 1114(k).* A veteran receiving compensation at the intermediate rate between 38 U.S.C. 1114 (n) and (o) plus special monthly compensation under 38 U.S.C. 1114(k) who establishes a factual need for regular aid and attendance or a higher level of care, is also entitled to an additional allowance during periods he or she is not hospitalized at United States Government expense. (See § 3.552(b)(2) as to continuance following admission for hospitalization.) Determination of the factual need for aid and attendance is subject to the criteria of § 3.352:

(3) *Amount of the allowance.* The amount of the additional allowance payable to a veteran in need of regular aid and attendance is specified in 38 U.S.C. 1114(r)(1). The amount of the additional allowance payable to a veteran in need of a higher level of care is specified in 38 U.S.C. 1114(r)(2). The higher level aid and attendance allowance authorized by 38 U.S.C. 1114(r)(2) is payable in lieu of the regular aid and attendance allowance authorized by 38 U.S.C. 1114(r)(1).

(i) *Total plus 60 percent, or housebound; 38 U.S.C. 1114(s).* The special monthly compensation provided by 38 U.S.C. 1114(s) is payable where the veteran has a single service-connected disability rated as 100 percent and,

(1) Has additional service-connected disability or disabilities independently ratable at 60 percent, separate and distinct from the 100 percent service-connected disability and involving different anatomical segments or bodily systems, or

(2) Is permanently housebound by reason of service-connected disability or disabilities. This requirement is met when the veteran is substantially confined as a direct result of service-connected disabilities to his or her dwelling and the immediate premises or, if institutionalized, to the ward or clinical areas, and it is reasonably certain that the disability or disabilities and resultant confinement will continue throughout his or her lifetime.

(j) *Special aid and attendance benefit for residuals of traumatic brain injury (38 U.S.C. 1114(t)).* The special monthly compensation provided by 38 U.S.C. 1114(t) is payable to a veteran who, as the result of service-connected disability, is in need of regular aid and attendance for the residuals of traumatic brain injury, is not eligible for compensation under 38 U.S.C. 1114(r)(2), and in the absence of such regular aid and attendance would require hospitalization, nursing home care, or other residential institutional care. Determination of this need is subject to the criteria of § 3.352.

(1) A veteran described in this paragraph (j) shall be entitled to the

amount equal to the compensation authorized under 38 U.S.C. 1114(o) or the maximum rate authorized under 38 U.S.C. 1114(p) and, in addition to such compensation, a monthly allowance equal to the rate described in 38 U.S.C. 1114(r)(2) during periods he or she is not hospitalized at United States Government expense. (*See* §3.552(b)(2) as to continuance following admission for hospitalization.)

(2) An allowance authorized under 38 U.S.C. 1114(t) shall be paid in lieu of any allowance authorized by 38 U.S.C. 1114(r)(1).

(Authority: 38 U.S.C. 501, 38 U.S.C. 1114(t))

[26 FR 1587, Feb. 24, 1961, as amended at 27 FR 4739, May 18, 1962; 28 FR 1587, Feb. 20, 1963; 28 FR 5671, June 11, 1963; 40 FR 54245, Nov. 21, 1975; 45 FR 25392, Apr. 15, 1980; 46 FR 47541, Sept. 29, 1981; 48 FR 41161, Sept. 14, 1983; 49 FR 47003, Nov. 30, 1984; 54 FR 34981, Aug. 23, 1989; 60 FR 12886, Mar. 9, 1995; 67 FR 6873, Feb. 14, 2002; 68 FR 55467, Sept. 26, 2003; 74 FR 11483, Mar. 18, 2009; 83 FR 20736, May 8, 2018]

§3.351 Special monthly dependency and indemnity compensation, death compensation, pension and spouse's compensation ratings.

(a) *General*. This section sets forth criteria for determining whether:

(1) Increased pension is payable to a veteran by reason of need for aid and attendance or by reason of being housebound.

(Authority: 38 U.S.C. 1521(d), (e))

(2) Increased compensation is payable to a veteran by reason of the veteran's spouse being in need of aid and attendance.

(Authority: 38 U.S.C. 1115(1)(E))

(3) Increased dependency and indemnity compensation is payable to a surviving spouse or parent by reason of being in need of aid and attendance.

(Authority: 38 U.S.C. 1311(c), 1315(h))

(4) Increased dependency and indemnity compensation is payable to a surviving spouse who is not in need of aid and attendance but is housebound.

(Authority: 38 U.S.C. 1311(d))

(5) Increased pension is payable to a surviving spouse by reason of need for aid and attendance, or if not in need of aid and attendance, by reason of being housebound.

(Authority: 38 U.S.C. 1541(d), (e))

(6) Increased death compensation is payable to a surviving spouse by reason of being in need of aid and attendance.

(Authority: 38 U.S.C. 1122)

(b) *Aid and attendance; need*. Need for aid and attendance means helplessness or being so nearly helpless as to require the regular aid and attendance of another person. The criteria set forth in paragraph (c) of this section will be applied in determining whether such need exists.

(c) *Aid and attendance; criteria*. The veteran, spouse, surviving spouse or parent will be considered in need of regular aid and attendance if he or she:

(1) Is blind or so nearly blind as to have corrected visual acuity of 5/200 or less, in both eyes, or concentric contraction of the visual field to 5 degrees or less; or

(2) Is a patient in a nursing home because of mental or physical incapacity; or

(3) Establishes a factual need for aid and attendance under the criteria set forth in §3.352(a).

(Authority: 38 U.S.C. 1502(b))

(d) *Housebound, or permanent and total plus 60 percent; disability pension*. The rate of pension payable to a veteran who is entitled to pension under 38 U.S.C. 1521 and who is not in need of regular aid and attendance shall be as prescribed in 38 U.S.C. 1521(e) if, in addition to having a single permanent disability rated 100 percent disabling under the Schedule for Rating Disabilities (not including ratings based upon unemployability under §4.17 of this chapter) the veteran:

(1) Has additional disability or disabilities independently ratable at 60 percent or more, separate and distinct from the permanent disability rated as 100 percent disabling and involving different anatomical segments or bodily systems, or

(2) Is ''permanently housebound'' by reason of disability or disabilities. This requirement is met when the veteran is substantially confined to his or her dwelling and the immediate premises or, if institutionalized, to the ward or clinical area, and it is reasonably certain that the disability or disabilities and resultant confinement will continue throughout his or her lifetime.

(Authority: 38 U.S.C. 1502(c), 1521(e))

(e) *Housebound; dependency and indemnity compensation.* The monthly rate of dependency and indemnity compensation payable to a surviving spouse who does not qualify for increased dependency and indemnity compensation under 38 U.S.C. 1311(c) based on need for regular aid and attendance shall be increased by the amount specified in 38 U.S.C. 1311(d) if the surviving spouse is permanently housebound by reason of disability. The ''permanently housebound'' requirement is met when the surviving spouse is substantially confined to his or her home (ward or clinical areas, if institutionalized) or immediate premises by reason of disability or disabilities which it is reasonably certain will remain throughout the surviving spouse's lifetime.

(Authority: 38 U.S.C. 1311(d))

(f) *Housebound; improved pension; death.* The annual rate of death pension payable to a surviving spouse who does not qualify for an annual rate of death pension payable under § 3.23(a)(6) based on need for aid and attendance shall be as set forth in § 3.23(a)(7) if the surviving spouse is permanently housebound by reason of disability. The ''permanently housebound'' requirement is met when the surviving spouse is substantially confined to his or her home (ward or clinical areas, if institutionalized) or immediate premises by reason of disability or disabilities which it is reasonably certain will remain throughout the surviving spouse's lifetime.

(Authority: 38 U.S.C. 1541(e))

[44 FR 45939, Aug. 6, 1979]

§ 3.352 Criteria for determining need for aid and attendance and "permanently bedridden."

(a) *Basic criteria for regular aid and attendance and permanently bedridden.* The following will be accorded consideration in determining the need for regular aid and attendance (§ 3.351(c)(3): inability of claimant to dress or undress himself (herself), or to keep himself (herself) ordinarily clean and presentable; frequent need of adjustment of any special prosthetic or orthopedic appliances which by reason of the particular disability cannot be done without aid (this will not include the adjustment of appliances which normal persons would be unable to adjust without aid, such as supports, belts, lacing at the back, etc.); inability of claimant to feed himself (herself) through loss of coordination of upper extremities or through extreme weakness; inability to attend to the wants of nature; or incapacity, physical or mental, which requires care or assistance on a regular basis to protect the claimant from hazards or dangers incident to his or her daily environment. ''Bedridden'' will be a proper basis for the determination. For the purpose of this paragraph ''bedridden'' will be that condition which, through its essential character, actually requires that the claimant remain in bed. The fact that claimant has voluntarily taken to bed or that a physician has prescribed rest in bed for the greater or lesser part of the day to promote convalescence or cure will not suffice. It is not required that all of the disabling conditions enumerated in this paragraph be found to exist before a favorable rating may be made. The particular personal functions which the veteran is unable to perform should be considered in connection with his or her condition as a whole. It is only necessary that the evidence establish that the veteran is so helpless as to need regular aid and attendance, not that there be a constant need. Determinations that the veteran is so helpless, as to be in need of regular aid and attendance will not be based solely upon an opinion that the claimant's condition is such as would require him or her to be in bed. They must be based on the actual requirement of personal assistance from others.

(b) *Basic criteria for the higher level aid and attendance allowance.* (1) A veteran is entitled to the higher level aid and attendance allowance authorized by § 3.350(h) in lieu of the regular aid and attendance allowance when all of the following conditions are met:

(i) The veteran is entitled to the compensation authorized under 38 U.S.C. 1114(o), or the maximum rate of compensation authorized under 38 U.S.C. 1114(p).

(ii) The veteran meets the requirements for entitlement to the regular aid and attendance allowance in paragraph (a) of this section.

(iii) The veteran needs a ''higher level of care'' (as defined in paragraph (b)(3) of this section) than is required to establish entitlement to the regular aid and attendance allowance, and in the absence of the provision of such higher level of care the veteran would require hospitalization, nursing home care, or other residential institutional care.

(2) A veteran is entitled to the higher level aid and attendance allowance authorized by § 3.350(j) in lieu of the regular aid and attendance allowance when all of the following conditions are met:

(i) As a result of service-connected residuals of traumatic brain injury, the veteran meets the requirements for entitlement to the regular aid and attendance allowance in paragraph (a) of this section.

(ii) As a result of service-connected residuals of traumatic brain injury, the veteran needs a ''higher level of care'' (as defined in paragraph (b)(3) of this section) than is required to establish entitlement to the regular aid and attendance allowance, and in the absence of the provision of such higher level of care the veteran would require hospitalization, nursing home care, or other residential institutional care.

(3) Need for a higher level of care shall be considered to be need for personal health-care services provided on a daily basis in the veteran's home by a person who is licensed to provide such services or who provides such services under the regular supervision of a licensed health-care professional. Personal health-care services include (but are not limited to) such services as physical therapy, administration of injections, placement of indwelling catheters, and the changing of sterile dressings, or like functions which require professional health-care training or the regular supervision of a trained health-care professional to perform. A licensed health-care professional includes (but is not limited to) a doctor of medicine or osteopathy, a registered nurse, a licensed practical nurse, or a physical therapist licensed to practice by a State or political subdivision thereof.

(4) The term ''under the regular supervision of a licensed health-care professional'', as used in paragraph (b)(3) of this section, means that an unlicensed person performing personal health-care services is following a regimen of personal health-care services prescribed by a health-care professional, and that the health-care professional consults with the unlicensed person providing the health-care services at least once each month to monitor the prescribed regimen. The consultation need not be in person; a telephone call will suffice.

(5) A person performing personal health-care services who is a relative or other member of the veteran's household is not exempted from the requirement that he or she be a licensed health-care professional or be providing such care under the regular supervision of a licensed health-care professional.

(6) The provisions of paragraph (b) of this section are to be strictly construed. The higher level aid-and-attendance allowance is to be granted only when the veteran's need is clearly established and the amount of services required by the veteran on a daily basis is substantial.

(c) *Attendance by relative.* The performance of the necessary aid and attendance service by a relative of the beneficiary or other member of his or her household will not prevent the granting of the additional allowance.

(Authority: 38 U.S.C. 501, 1114(r)(2), 1114(t))

[41 FR 29680, July 19, 1976, as amended at 44 FR 22720, Apr. 17, 1979; 60 FR 27409, May 24, 1995; 83 FR 20737, May 8, 2018]

§ 3.353 Determinations of incompetency and competency.

(a) *Definition of mental incompetency.* A mentally incompetent person is one who because of injury or disease lacks the mental capacity to contract or to manage his or her own affairs, including disbursement of funds without limitation.

(b) *Authority.* (1) Rating agencies have sole authority to make official determinations of competency and incompetency for purposes of: insurance (38 U.S.C. 1922), and, subject to § 13.110 of this chapter, disbursement of benefits. Such determinations are final and binding on field stations for these purposes.

(2) Where the beneficiary is rated incompetent, the Veterans Service Center Manager will develop information as to the beneficiary's social, economic and industrial adjustment; appoint (or recommend appointment of) a fiduciary as provided in § 13.100 of this chapter; select a method of disbursing payment as provided in § 13.100 of this chapter, or in the case of a married beneficiary, appoint the beneficiary's spouse to receive payments as provided in § 13.100 of this chapter; and authorize disbursement of the benefit.

(3) If in the course of fulfilling the responsibilities assigned in paragraph (b)(2) the Veterans Service Center Manager develops evidence indicating that the beneficiary may be capable of administering the funds payable without limitation, he or she will refer that evidence to the rating agency with a statement as to his or her findings. The rating agency will consider this evidence, together with all other evidence of record, to determine whether its prior determination of incompetency should remain in effect. Reexamination may be requested as provided in § 3.327(a) if necessary to properly evaluate the beneficiary's mental capacity to contract or manage his or her own affairs.

(c) *Medical opinion.* Unless the medical evidence is clear, convincing and leaves no doubt as to the person's incompetency, the rating agency will make no determination of incompetency without a definite expression regarding the question by the responsible medical authorities. Considerations of medical opinions will be in accordance with the principles in paragraph (a) of this section. Determinations relative to incompetency should be based upon all evidence of record and there should be a consistent relationship between the percentage of disability, facts relating to commitment or hospitalization and the holding of incompetency.

(d) *Presumption in favor of competency.* Where reasonable doubt arises regarding a beneficiary's mental capacity to contract or to manage his or her own affairs, including the disbursement of funds without limitation, such doubt will be resolved in favor of competency (see § 3.102 on reasonable doubt).

(e) *Due process.* Whenever it is proposed to make an incompetency determination, the beneficiary will be notified of the proposed action and of the right to a hearing as provided in § 3.103. Such notice is not necessary if the beneficiary has been declared incompetent by a court of competent jurisdiction or if a guardian has been appointed for the beneficiary based upon a court finding of incompetency. If a hearing is requested it must be held prior to a rating decision of incompetency. Failure or refusal of the beneficiary after proper notice to request or cooperate in such a hearing will not preclude a rating decision based on the evidence of record.

(Authority: 38 U.S.C. 501(a))

[36 FR 19020, Sept. 25, 1971, and 40 FR 1241, Jan. 7, 1975, as amended at 42 FR 2069, Jan. 10, 1977; 58 FR 37856, July 14, 1993; 60 FR 55792, Nov. 3, 1995; 66 FR 48560, Sept. 21, 2001; 67 FR 46868, July 17, 2002; 68 FR 34542, June 10, 2003; 83 FR 32738, July 13, 2018]

§ 3.354 Determinations of insanity.

(a) *Definition of insanity.* An insane person is one who, while not mentally defective or constitutionally psychopathic, except when a psychosis has been engrafted upon such basic condition, exhibits, due to disease, a more or less prolonged deviation from his normal method of behavior; or who interferes with the peace of society; or who has so departed (become antisocial) from the accepted standards of the community to which by birth and education he belongs as to lack the adaptability to make further adjustment to

the social customs of the community in which he resides.

(b) *Insanity causing discharge.* When a rating agency is concerned with determining whether a veteran was insane at the time he committed an offense leading to his court-martial, discharge or resignation (38 U.S.C. 5303(b)), it will base its decision on all the evidence procurable relating to the period involved, and apply the definition in paragraph (a) of this section.

[26 FR 1589, Feb. 24, 1961]

§ 3.355 Testamentary capacity for insurance purposes.

When cases are referred to a rating agency involving the testamentary capacity of the insured to execute designations or changes of beneficiary, or designations or changes of option, the following considerations will apply:

(a) Testamentary capacity is that degree of mental capacity necessary to enable a person to perform a testamentary act. This, in general, requires that the testator reasonably comprehend the nature and significance of his act, that is, the subject and extent of his disposition, recognition of the object of his bounty, and appreciation of the consequence of his act, uninfluenced by any material delusion as to the property or persons involved.

(b) Due consideration should be given to all facts of record, with emphasis being placed on those facts bearing upon the mental condition of the testator (insured) at the time or nearest the time he executed the designation or change. In this connection, consideration should be given to lay as well as medical evidence.

(c) Lack of testamentary capacity should not be confused with insanity or mental incompetence. An insane person might have a lucid interval during which he would possess testamentary capacity. On the other hand, a sane person might suffer a temporary mental aberration during which he would not possess testamentary capacity. There is a general but rebuttable presumption that every testator possesses testamentary capacity. Therefore, reasonable doubts should be resolved in favor of testamentary capacity.

[26 FR 1590, Feb. 24, 1961]

§ 3.356 Conditions which determine permanent incapacity for self-support.

(a) *Basic determinations.* A child must be shown to be permanently incapable of self-support by reason of mental or physical defect at the date of attaining the age of 18 years.

(b) *Rating criteria.* Rating determinations will be made solely on the basis of whether the child is permanently incapable of self-support through his own efforts by reason of physical or mental defects. The question of permanent incapacity for self-support is one of fact for determination by the rating agency on competent evidence of record in the individual case. Rating criteria applicable to disabled veterans are not controlling. Principal factors for consideration are:

(1) The fact that a claimant is earning his or her own support is prima facie evidence that he or she is not incapable of self-support. Incapacity for self-support will not be considered to exist when the child by his or her own efforts is provided with sufficient income for his or her reasonable support.

(2) A child shown by proper evidence to have been permanently incapable of self-support prior to the date of attaining the age of 18 years, may be so held at a later date even though there may have been a short intervening period or periods when his or her condition was such that he or she was employed, provided the cause of incapacity is the same as that upon which the original determination was made and there were no intervening diseases or injuries that could be considered as major factors. Employment which was only casual, intermittent, tryout, unsuccessful, or terminated after a short period by reason of disability, should not be considered as rebutting permanent incapability of self-support otherwise established.

(3) It should be borne in mind that employment of a child prior or subsequent to the delimiting age may or may not be a normal situation, depending on the educational progress of the child, the economic situation of the family, indulgent attitude of parents, and the like. In those cases where the extent and nature of disability raises some doubt as to whether they would

render the average person incapable of self-support, factors other than employment are for consideration. In such cases there should be considered whether the daily activities of the child in the home and community are equivalent to the activities of employment of any nature within the physical or mental capacity of the child which would provide sufficient income for reasonable support. Lack of employment of the child either prior to the delimiting age or thereafter should not be considered as a major factor in the determination to be made, unless it is shown that it was due to physical or mental defect and not to mere disinclination to work or indulgence of relatives or friends.

(4) The capacity of a child for self-support is not determinable upon employment afforded solely upon sympathetic or charitable considerations and which involved no actual or substantial rendition of services.

CROSS REFERENCE: Basic pension and eligibility determinations. See § 3.314.

[26 FR 1590, Feb. 24, 1961, as amended at 38 FR 871, Jan. 5, 1973]

§ 3.357 Civil service preference ratings.

For the purpose of certifying civil service disability preference only, a service-connected disability may be assigned an evaluation of ''less than ten percent.'' Any directly or presumptively service-connected disease or injury which exhibits some extent of actual impairment may be held to exist at the level of less than ten percent. For disabilities incurred in combat, however, no actual impairment is required.

[58 FR 52018, Oct. 6, 1993]

§ 3.358 Compensation for disability or death from hospitalization, medical or surgical treatment, examinations or vocational rehabilitation training (§ 3.800).

(a) *General*. This section applies to claims received by VA before October 1, 1997. If it is determined that there is additional disability resulting from a disease or injury or aggravation of an existing disease or injury suffered as a result of hospitalization, medical or surgical treatment, examination, or vocational rehabilitation training, compensation will be payable for such additional disability. For claims received by VA on or after October 1, 1997, see § 3.361.

(b) *Additional disability*. In determining that additional disability exists, the following considerations will govern:

(1) The veteran's physical condition immediately prior to the disease or injury on which the claim for compensation is based will be compared with the subsequent physical condition resulting from the disease or injury, each body part involved being considered separately.

(i) As applied to examinations, the physical condition prior to the disease or injury will be the condition at time of beginning the physical examination as a result of which the disease or injury was sustained.

(ii) As applied to medical or surgical treatment, the physical condition prior to the disease or injury will be the condition which the specific medical or surgical treatment was designed to relieve.

(2) Compensation will not be payable under this section for the continuance or natural progress of a disease or injury for which the hospitalization, medical or surgical treatment, or examination was furnished, unless VA's failure to exercise reasonable skill and care in the diagnosis or treatment of the disease or injury caused additional disability or death that probably would have been prevented by proper diagnosis or treatment. Compensation will not be payable under this section for the continuance or natural progress of a disease or injury for which vocational rehabilitation training was provided.

(c) *Cause*. In determining whether such additional disability resulted from a disease or an injury or an aggravation of an existing disease or injury suffered as a result of training, hospitalization, medical or surgical treatment, or examination, the following considerations will govern:

(1) It will be necessary to show that the additional disability is actually the result of such disease or injury or an aggravation of an existing disease or injury and not merely coincidental therewith.

(2) The mere fact that aggravation occurred will not suffice to make the additional disability compensable in the absence of proof that it resulted from disease or injury or an aggravation of an existing disease or injury suffered as the result of training, hospitalization, medical or surgical treatment, or examination.

(3) Compensation is not payable for the necessary consequences of medical or surgical treatment or examination properly administered with the express or implied consent of the veteran, or, in appropriate cases, the veteran's representative. ''Necessary consequences'' are those which are certain to result from, or were intended to result from, the examination or medical or surgical treatment administered. Consequences otherwise certain or intended to result from a treatment will not be considered uncertain or unintended solely because it had not been determined at the time consent was given whether that treatment would in fact be administered.

(4) When the proximate cause of the injury suffered was the veteran's willful misconduct or failure to follow instructions, it will bar him (or her) from receipt of compensation hereunder except in the case of incompetent veterans.

(5) Compensation for disability resulting from the pursuit of vocational rehabilitation is not payable unless there is established a direct (proximate) causal connection between the injury or aggravation of an existing injury and some essential activity or function which is within the scope of the vocational rehabilitation course, not necessarily limited to activities or functions specifically designated by the Department of Veterans Affairs in the individual case, since ordinarily it is not to be expected that each and every different function and act of a veteran pursuant to his or her course of training will be particularly specified in the outline of the course or training program. For example, a disability resulting from the use of an item of mechanical or other equipment is within the purview of the statute if training in its use is implicit within the prescribed program or course outlined or if its use is implicit in the performance of some task or operation the trainee must learn to perform, although such use may not be especially mentioned in the training program. In determining whether the element of direct or proximate causation is present, it remains necessary for a distinction to be made between an injury arising out of an act performed in pursuance of the course of training, that is, a required ''learning activity'', and one arising out of an activity which is incident to, related to, or coexistent with the pursuit of the program of training. For a case to fall within the statute there must have been sustained an injury which, but for the performance of a ''learning activity'' in the prescribed course of training, would not have been sustained. A meticulous examination into all the circumstances is required, including a consideration of the time and place of the incident producing the injury.

(6) Nursing home care furnished under section 1720 of title 38, United States Code is not hospitalization within the meaning of this section. Such a nursing home is an independent contractor and, accordingly, its agents and employees are not to be deemed agents and employees of the Department of Veterans Affairs. If additional disability results from medical or surgical treatment or examination through negligence or other wrongful acts or omissions on the part of such a nursing home, its employees, or its agents, entitlement does not exist under this section unless there was an act or omission on the part of the Department of Veterans Affairs independently giving rise to such entitlement and such acts on the part of both proximately caused the additional disability.

(Authority: 38 U.S.C. 1151, 1720)

[26 FR 1590, Feb. 24, 1961, as amended at 36 FR 7659, Apr. 23, 1971; 39 FR 34531, Sept. 26, 1974; 43 FR 51015, Nov. 2, 1978; 60 FR 14223, Mar. 16, 1995; 61 FR 25788, May 23, 1996; 64 FR 1131, Jan. 8, 1999; 69 FR 46433, Aug. 3, 2004]

§ 3.359 Determination of service connection for former members of the Armed Forces of Czechoslovakia or Poland.

Rating boards will determine whether or not the condition for which treatment is claimed by former members of the Armed Forces of Czechoslovakia or Poland under 38 U.S.C. 109(c) is service connected. This determination will be made using the same criteria that applies to determinations of service connection based on service in the Armed Forces of the United States.

[43 FR 4424, Feb. 2, 1978]

§ 3.360 Service-connected health-care eligibility of certain persons administratively discharged under other than honorable condition.

(a) *General.* The health-care and related benefits authorized by chapter 17 of title 38 U.S.C. shall be provided to certain former service persons with administrative discharges under other than honorable conditions for any disability incurred or aggravated during active military, naval, or air service in line of duty.

(b) *Discharge categorization.* With certain exceptions such benefits shall be furnished for any disability incurred or aggravated during a period of service terminated by a discharge under other than honorable conditions. Specifically, they may not be furnished for any disability incurred or aggravated during a period of service terminated by a bad conduct discharge or when one of the bars listed in § 3.12(c) applies.

(c) *Eligibility criteria.* In making determinations of health-care eligibility the same criteria will be used as is now applicable to determinations of service incurrence and in line of duty when there is no character of discharge bar.

[43 FR 15154, Apr. 11, 1978]

§ 3.361 Benefits under 38 U.S.C. 1151(a) for additional disability or death due to hospital care, medical or surgical treatment, examination, training and rehabilitation services, or compensated work therapy program.

(a) *Claims subject to this section*—(1) *General.* Except as provided in paragraph (2), this section applies to claims received by VA on or after October 1, 1997. This includes original claims and claims to reopen or otherwise readjudicate a previous claim for benefits under 38 U.S.C. 1151 or its predecessors. The effective date of benefits is subject to the provisions of § 3.400(i). For claims received by VA before October 1, 1997, see § 3.358.

(2) *Compensated Work Therapy.* With respect to claims alleging disability or death due to compensated work therapy, this section applies to claims that were pending before VA on November 1, 2000, or that were received by VA after that date. The effective date of benefits is subject to the provisions of §§ 3.114(a) and 3.400(i), and shall not be earlier than November 1, 2000.

(b) *Determining whether a veteran has an additional disability.* To determine whether a veteran has an additional disability, VA compares the veteran's condition immediately before the beginning of the hospital care, medical or surgical treatment, examination, training and rehabilitation services, or compensated work therapy (CWT) program upon which the claim is based to the veteran's condition after such care, treatment, examination, services, or program has stopped. VA considers each involved body part or system separately.

(c) *Establishing the cause of additional disability or death.* Claims based on additional disability or death due to hospital care, medical or surgical treatment, or examination must meet the causation requirements of this paragraph and paragraph (d)(1) or (d)(2) of this section. Claims based on additional disability or death due to training and rehabilitation services or compensated work therapy program must meet the causation requirements of paragraph (d)(3) of this section.

(1) *Actual causation required.* To establish causation, the evidence must show that the hospital care, medical or surgical treatment, or examination resulted in the veteran's additional disability or death. Merely showing that a veteran received care, treatment, or examination and that the veteran has an additional disability or died does not establish cause.

(2) *Continuance or natural progress of a disease or injury.* Hospital care, medical or surgical treatment, or examination

cannot cause the continuance or natural progress of a disease or injury for which the care, treatment, or examination was furnished unless VA's failure to timely diagnose and properly treat the disease or injury proximately caused the continuance or natural progress. The provision of training and rehabilitation services or CWT program cannot cause the continuance or natural progress of a disease or injury for which the services were provided.

(3) *Veteran's failure to follow medical instructions.* Additional disability or death caused by a veteran's failure to follow properly given medical instructions is not caused by hospital care, medical or surgical treatment, or examination.

(d) *Establishing the proximate cause of additional disability or death.* The proximate cause of disability or death is the action or event that directly caused the disability or death, as distinguished from a remote contributing cause.

(1) *Care, treatment, or examination.* To establish that carelessness, negligence, lack of proper skill, error in judgment, or similar instance of fault on VA's part in furnishing hospital care, medical or surgical treatment, or examination proximately caused a veteran's additional disability or death, it must be shown that the hospital care, medical or surgical treatment, or examination caused the veteran's additional disability or death (as explained in paragraph (c) of this section); and

(i) VA failed to exercise the degree of care that would be expected of a reasonable health care provider; or

(ii) VA furnished the hospital care, medical or surgical treatment, or examination without the veteran's or, in appropriate cases, the veteran's representative's informed consent. To determine whether there was informed consent, VA will consider whether the health care providers substantially complied with the requirements of §17.32 of this chapter. Minor deviations from the requirements of §17.32 of this chapter that are immaterial under the circumstances of a case will not defeat a finding of informed consent. Consent may be express (*i.e.*, given orally or in writing) or implied under the circumstances specified in §17.32(b) of this chapter, as in emergency situations.

(2) *Events not reasonably foreseeable.* Whether the proximate cause of a veteran's additional disability or death was an event not reasonably foreseeable is in each claim to be determined based on what a reasonable health care provider would have foreseen. The event need not be completely unforeseeable or unimaginable but must be one that a reasonable health care provider would not have considered to be an ordinary risk of the treatment provided. In determining whether an event was reasonably foreseeable, VA will consider whether the risk of that event was the type of risk that a reasonable health care provider would have disclosed in connection with the informed consent procedures of §17.32 of this chapter.

(3) *Training and rehabilitation services or compensated work therapy program.* To establish that the provision of training and rehabilitation services or a CWT program proximately caused a veteran's additional disability or death, it must be shown that the veteran's participation in an essential activity or function of the training, services, or CWT program provided or authorized by VA proximately caused the disability or death. The veteran must have been participating in such training, services, or CWT program provided or authorized by VA as part of an approved rehabilitation program under 38 U.S.C. chapter 31 or as part of a CWT program under 38 U.S.C. 1718. It need not be shown that VA approved that specific activity or function, as long as the activity or function is generally accepted as being a necessary component of the training, services, or CWT program that VA provided or authorized.

(e) *Department employees and facilities.* (1) A *Department employee is an individual—*

(i) Who is appointed by the Department in the civil service under title 38, United States Code, or title 5, United States Code, as an employee as defined in 5 U.S.C. 2105;

(ii) Who is engaged in furnishing hospital care, medical or surgical treatment, or examinations under authority of law; and

(iii) Whose day-to-day activities are subject to supervision by the Secretary of Veterans Affairs.

(2) A *Department facility* is a facility over which the Secretary of Veterans Affairs has direct jurisdiction.

(f) *Activities that are not hospital care, medical or surgical treatment, or examination furnished by a Department employee or in a Department facility*. The following are not hospital care, medical or surgical treatment, or examination furnished by a Department employee or in a Department facility within the meaning of 38 U.S.C. 1151(a):

(1) Hospital care or medical services furnished under a contract made under 38 U.S.C. 1703.

(2) Nursing home care furnished under 38 U.S.C. 1720.

(3) Hospital care or medical services, including examination, provided under 38 U.S.C. 8153 in a facility over which the Secretary does not have direct jurisdiction.

(g) *Benefits payable under 38 U.S.C. 1151 for a veteran's death. (1) Death before January 1, 1957*. The benefit payable under 38 U.S.C. 1151(a) to an eligible survivor for a veteran's death occurring before January 1, 1957, is death compensation. See §§ 3.5(b)(2) and 3.702 for the right to elect dependency and indemnity compensation.

(2) *Death after December 31, 1956*. The benefit payable under 38 U.S.C. 1151(a) to an eligible survivor for a veteran's death occurring after December 31, 1956, is dependency and indemnity compensation.

(Authority: 38 U.S.C. 1151)

[69 FR 46433, Aug. 3, 2004]

§ 3.362 Offsets under 38 U.S.C. 1151(b) of benefits awarded under 38 U.S.C. 1151(a).

(a) *Claims subject to this section*. This section applies to claims received by VA on or after October 1, 1997. This includes original claims and claims to reopen or otherwise readjudicate a previous claim for benefits under 38 U.S.C. 1151 or its predecessors.

(b) *Offset of veterans' awards of compensation*. If a veteran's disability is the basis of a judgment under 28 U.S.C. 1346(b) awarded, or a settlement or compromise under 28 U.S.C. 2672 or 2677 entered, on or after December 1, 1962, the amount to be offset under 38 U.S.C. 1151(b) from any compensation awarded under 38 U.S.C. 1151(a) is the entire amount of the veteran's share of the judgment, settlement, or compromise, including the veteran's proportional share of attorney fees.

(c) *Offset of survivors' awards of dependency and indemnity compensation*. If a veteran's death is the basis of a judgment under 28 U.S.C. 1346(b) awarded, or a settlement or compromise under 28 U.S.C. 2672 or 2677 entered, on or after December 1, 1962, the amount to be offset under 38 U.S.C. 1151(b) from any dependency and indemnity compensation awarded under 38 U.S.C. 1151(a) to a survivor is only the amount of the judgment, settlement, or compromise representing damages for the veteran's death the survivor receives in an individual capacity or as distribution from the decedent veteran's estate of sums included in the judgment, settlement, or compromise to compensate for harm suffered by the survivor, plus the survivor's proportional share of attorney fees.

(d) *Offset of structured settlements*. This paragraph applies if a veteran's disability or death is the basis of a structured settlement or structured compromise under 28 U.S.C. 2672 or 2677 entered on or after December 1, 1962.

(1) *The amount to be offset*. The amount to be offset under 38 U.S.C. 1151(b) from benefits awarded under 38 U.S.C. 1151(a) is the veteran's or survivor's proportional share of the cost to the United States of the settlement or compromise, including the veteran's or survivor's proportional share of attorney fees.

(2) *When the offset begins*. The offset of benefits awarded under 38 U.S.C. 1151(a) begins the first month after the structured settlement or structured compromise has become final that such benefits would otherwise be paid.

(e) *Offset of award of benefits under 38 U.S.C. chapter 21 or 38 U.S.C. chapter 39*. (1) If a judgment, settlement, or compromise covered in paragraphs (b) through (d) of this section becomes final on or after December 10, 2004, and includes an amount that is specifically designated for a purpose for which benefits are provided under 38 U.S.C. chapter 21 (38 CFR 3.809 and 3.809a) or 38

U.S.C. chapter 39 (38 CFR 3.808), and if VA awards 38 U.S.C. chapter 21 or 38 U.S.C. chapter 39 benefits after the date on which the judgment, settlement, or compromise becomes final, the amount of the award will be reduced by the amount received under the judgment, settlement, or compromise for the same purpose.

(2) If the amount described in paragraph (e)(1) of this section is greater than the amount of an award under 38 U.S.C. chapter 21 or 38 U.S.C. chapter 39, the excess amount received under the judgment, settlement, or compromise will be offset against benefits otherwise payable under 38 U.S.C. chapter 11.

[69 FR 46434, Aug. 3, 2004, as amended at 71 FR 44918, Aug. 8, 2006; 75 FR 57861, Sept. 23, 2010]

§3.363 Bar to benefits under 38 U.S.C. 1151.

(a) *Claims subject to this section.* This section applies to claims received by VA on or after October 1, 1997. This includes original claims and claims to reopen or otherwise readjudicate a previous claim for benefits under 38 U.S.C. 1151 or its predecessors.

(b) *Administrative award, compromises, or settlements, or judgments that bar benefits under 38 U.S.C. 1151.* If a veteran's disability or death was the basis of an administrative award under 28 U.S.C. 1346(b) made, or a settlement or compromise under 28 U.S.C. 2672 or 2677 finalized, before December 1, 1962, VA may not award benefits under 38 U.S.C. 1151 for any period after such award, settlement, or compromise was made or became final. If a veteran's disability or death was the basis of a judgment that became final before December 1, 1962, VA may award benefits under 38 U.S.C. 1151 for the disability or death unless the terms of the judgment provide otherwise.

(Authority: 38 U.S.C. 1151)

[69 FR 46434, Aug. 3, 2004]

RATING CONSIDERATIONS RELATIVE TO SPECIFIC DISEASES

§3.370 Pulmonary tuberculosis shown by X-ray in active service.

(a) *Active disease.* X-ray evidence alone may be adequate for grant of direct service connection for pulmonary tuberculosis. When under consideration, all available service department films and subsequent films will be secured and read by specialists at designated stations who should have a current examination report and X-ray. Resulting interpretations of service films will be accorded the same consideration for service-connection purposes as if clinically established, however, a compensable rating will not be assigned prior to establishment of an active condition by approved methods.

(b) *Inactive disease.* Where the veteran was examined at time of entrance into active service but X-ray was not made, or if made, is not available and there was no notation or other evidence of active or inactive reinfection type pulmonary tuberculosis existing prior to such entrance, it will be assumed that the condition occurred during service and direct service connection will be in order for inactive pulmonary tuberculosis shown by X-ray evidence during service in the manner prescribed in paragraph (a) of this section, unless lesions are first shown so soon after entry on active service as to compel the conclusion, on the basis of sound medical principles, that they existed prior to entry on active service.

(c) *Primary lesions.* Healed primary type tuberculosis shown at the time of entrance into active service will not be taken as evidence to rebut direct or presumptive service connection for active reinfection type pulmonary tuberculosis.

[26 FR 1591, Feb. 24, 1961, as amended at 43 FR 45347, Oct. 2, 1978]

§3.371 Presumptive service connection for tuberculous disease; wartime and service on or after January 1, 1947.

(a) *Pulmonary tuberculosis.* (1) Evidence of activity on comparative study of X-ray films showing pulmonary tuberculosis within the 3-year presumptive period provided by §3.307(a)(3) will

be taken as establishing service connection for active pulmonary tuberculosis subsequently diagnosed by approved methods but service connection and evaluation may be assigned only from the date of such diagnosis or other evidence of clinical activity.

(2) A notation of inactive tuberculosis of the reinfection type at induction or enlistment definitely prevents the grant of service connection under § 3.307 for active tuberculosis, regardless of the fact that it was shown within the appropriate presumptive period.

(b) *Pleurisy with effusion without obvious cause.* Pleurisy with effusion with evidence of diagnostic studies ruling out obvious nontuberculous causes will qualify as active tuberculosis. The requirements for presumptive service connection will be the same as those for tuberculous pleurisy.

(c) *Tuberculous pleurisy and endobronchial tuberculosis.* Tuberculous pleurisy and endobronchial tuberculosis fall within the category of pulmonary tuberculosis for the purpose of service connection on a presumptive basis. Either will be held incurred in service when initially manifested within 36 months after the veteran's separation from service as determined under § 3.307(a)(2).

(d) *Miliary tuberculosis.* Service connection for miliary tuberculosis involving the lungs is to be determined in the same manner as for other active pulmonary tuberculosis.

[26 FR 1591, Feb. 24, 1961, as amended at 27 FR 6387, July 6, 1962; 31 FR 4681, Mar. 19, 1966; 39 FR 34532, Sept. 26, 1974; 43 FR 45347, Oct. 2, 1978; 54 FR 34981, Aug. 23, 1989]

§ 3.372 Initial grant following inactivity of tuberculosis.

When service connection is granted initially on an original or supplemental claim for pulmonary or nonpulmonary tuberculosis and there is satisfactory evidence that the condition was active previously but is now inactive (arrested), it will be presumed that the disease continued to be active for 1 year after the last date of established activity, provided there is no evidence to establish activity or inactivity in the intervening period. For a veteran entitled to receive compensation on August 19, 1968, the beginning date of graduated ratings will commence at the end of the 1-year period. For a veteran who was not receiving or entitled to receive compensation on August 19, 1968, ratings will be assigned in accordance with the Schedule for Rating Disabilities (part 4 of this chapter). This section is not applicable to running award cases.

[33 FR 16275, Nov. 6, 1968, as amended at 84 FR 170, Jan. 18, 2019]

§ 3.373 [Reserved]

§ 3.374 Effect of diagnosis of active tuberculosis.

(a) *Service diagnosis.* Service department diagnosis of active pulmonary tuberculosis will be accepted unless a board of medical examiners, Clinic Director or Chief, Outpatient Service certifies, after considering all the evidence, including the favoring or opposing tuberculosis and activity, that such diagnosis was incorrect. Doubtful cases may be referred to the Chief Medical Director in Central Office.

(b) *Department of Veterans Affairs diagnosis.* Diagnosis of active pulmonary tuberculosis by the medical authorities of the Department of Veterans Affairs as the result of examination, observation, or treatment will be accepted for rating purposes. Reference to the Clinic Director or Chief, Outpatient Service, will be in order in questionable cases and, if necessary, to the Chief Medical Director in Central Office.

(c) *Private physician's diagnosis.* Diagnosis of active pulmonary tuberculosis by private physicians on the basis of their examination, observation or treatment will not be accepted to show the disease was initially manifested after discharge from active service unless confirmed by acceptable clinical, X-ray or laboratory studies, or by findings of active tuberculosis based upon acceptable hospital observation or treatment.

[26 FR 1591, Feb. 24, 1961, as amended at 27 FR 6387, July 6, 1962; 33 FR 16275, Nov. 6, 1968; 43 FR 45348, Oct. 2, 1978]

§ 3.375 Determination of inactivity (complete arrest) in tuberculosis.

(a) *Pulmonary tuberculosis.* A veteran shown to have had pulmonary tuberculosis will be held to have reached a

condition of ''complete arrest'' when a diagnosis of inactive is made.

(b) *Nonpulmonary disease.* Determination of complete arrest of nonpulmonary tuberculosis requires absence of evidence of activity for 6 months. If there are two or more foci of such tuberculosis, one of which is active, the condition will not be considered to be inactive until the tuberculous process has reached arrest in its entirety.

(c) *Arrest following surgery.* Where there has been surgical excision of the lesion or organ, the date of complete arrest will be the date of discharge from the hospital, or 6 months from the date of excision, whichever is later.

[33 FR 16275, Nov. 6, 1968, as amended at 43 FR 45348, Oct. 2, 1978]

§§3.376–3.377 [Reserved]

§3.378 Changes from activity in pulmonary tuberculosis pension cases.

A permanent and total disability rating in effect during hospitalization will not be discontinued before hospital discharge on the basis of a change in classification from active. At hospital discharge, the permanent and total rating will be discontinued unless (a) the medical evidence does not support a finding of complete arrest (§3.375), or (b) where complete arrest is shown but the medical authorities recommend that employment not be resumed or be resumed only for short hours (not more than 4 hours a day for a 5-day week). If either of the two aforementioned conditions is met, discontinuance will be deferred pending examination in 6 months. Although complete arrest may be established upon that examination, the permanent and total rating may be extended for a further period of 6 months provided the veteran's employment is limited to short hours as recommended by the medical authorities (not more than 4 hours a day for a 5-day week). Similar extensions may be granted under the same conditions at the end of 12 and 18 months periods. At the expiration of 24 months after hospitalization, the case will be considered under §3.321(b) if continued short hours of employment is recommended or if other evidence warrants submission.

[43 FR 45348, Oct. 2, 1978]

§3.379 Anterior poliomyelitis.

If the first manifestations of acute anterior poliomyelitis present themselves in a veteran within 35 days of termination of active military service, it is probable that the infection occurred during service. If they first appear after this period, it is probable that the infection was incurred after service.

[26 FR 1592, Feb. 24, 1961]

§3.380 Diseases of allergic etiology.

Diseases of allergic etiology, including bronchial asthma and urticaria, may not be disposed of routinely for compensation purposes as constitutional or developmental abnormalities. Service connection must be determined on the evidence as to existence prior to enlistment and, if so existent, a comparative study must be made of its severity at enlistment and subsequently. Increase in the degree of disability during service may not be disposed of routinely as natural progress nor as due to the inherent nature of the disease. Seasonal and other acute allergic manifestations subsiding on the absence of or removal of the allergen are generally to be regarded as acute diseases, healing without residuals. The determination as to service incurrence or aggravation must be on the whole evidentiary showing.

[26 FR 1592, Feb. 24, 1961]

§3.381 Service connection of dental conditions for treatment purposes.

(a) The Veterans Benefits Administration (VBA) will adjudicate a claim for service connection of a dental condition for treatment purposes after the Veterans Health Administration determines a veteran meets the basic eligibility requirements of §17.161 of this chapter and requests VBA make a determination on questions that include, but are not limited to, any of the following:

(1) Former Prisoner of War status;

(2) Whether the veteran has a compensable or noncompensable service-connected dental condition or disability;

(3) Whether the dental condition or disability is a result of combat wounds;

(4) Whether the dental condition or disability is a result of service trauma; or

(5) Whether the veteran is totally disabled due to a service-connected disability.

(b) Treatable carious teeth, replaceable missing teeth, dental or alveolar abscesses, and periodontal disease are not compensable disabilities, but may nevertheless be service connected solely for the purpose of establishing eligibility for outpatient dental treatment as provided for in § 17.161 of this chapter. These conditions and other dental conditions or disabilities that are noncompensably rated under § 4.150 of this chapter may be service connected for purposes of Class II or Class II (a) dental treatment under § 17.161 of this chapter.

(c) The rating activity will consider each defective or missing tooth and each disease of the teeth and periodontal tissues separately to determine whether the condition was incurred or aggravated in line of duty during active service

(d) In determining service connection, the condition of teeth and periodontal tissues at the time of entry into active duty will be considered. Treatment during service, including filling or extraction of a tooth, or placement of a prosthesis, will not be considered evidence of aggravation of a condition that was noted at entry, unless additional pathology developed after 180 days or more of active service.

(e) The following principles apply to dental conditions noted at entry and treated during service:

(1) Teeth noted as normal at entry will be service-connected if they were filled or extracted after 180 days or more of active service.

(2) Teeth noted as filled at entry will be service-connected if they were extracted, or if the existing filling was replaced, after 180 days or more of active service.

(3) Teeth noted as carious but restorable at entry will not be service-connected on the basis that they were filled during service. However, new caries that developed 180 days or more after such a tooth was filled will be service-connected.

(4) Teeth noted as carious but restorable at entry, whether or not filled, will be service-connected if extraction was required after 180 days or more of active service.

(5) Teeth noted at entry as non-restorable will not be service-connected, regardless of treatment during service.

(6) Teeth noted as missing at entry will not be service connected, regardless of treatment during service.

(f) The following will not be considered service-connected for treatment purposes:

(1) Calculus;

(2) Acute periodontal disease;

(3) Third molars, unless disease or pathology of the tooth developed after 180 days or more of active service, or was due to combat or in-service trauma; and

(4) Impacted or malposed teeth, and other developmental defects, unless disease or pathology of these teeth developed after 180 days or more of active service.

(g) Teeth extracted because of chronic periodontal disease will be service-connected only if they were extracted after 180 days or more of active service.

(Authority: 38 U.S.C. 1712)

[64 FR 30393, June 8, 1999, as amended at 77 FR 4470, Jan. 30, 2012]

§ 3.382 [Reserved]

§ 3.383 Special consideration for paired organs and extremities.

(a) *Entitlement criteria.* Compensation is payable for the combinations of service-connected and nonservice-connected disabilities specified in paragraphs (a)(1) through (a)(5) of this section as if both disabilities were service-connected, provided the nonservice-connected disability is not the result of the veteran's own willful misconduct.

(1) Impairment of vision in one eye as a result of service-connected disability and impairment of vision in the other eye as a result of non-service-connected disability and

(i) The impairment of vision in each eye is rated at a visual acuity of 20/200 or less; or

(ii) The peripheral field of vision for each eye is 20 degrees or less.

(2) Loss or loss of use of one kidney as a result of service-connected disability and involvement of the other kidney as a result of nonservice-connected disability.

(3) Hearing impairment in one ear compensable to a degree of 10 percent or more as a result of service-connected disability and hearing impairment as a result of nonservice-connected disability that meets the provisions of § 3.385 in the other ear.

(4) Loss or loss of use of one hand or one foot as a result of service-connected disability and loss or loss of use of the other hand or foot as a result of nonservice-connected disability.

(5) Permanent service-connected disability of one lung, rated 50 percent or more disabling, in combination with a nonservice-connected disability of the other lung.

(b) *Effect of judgment or settlement.* (1) If a veteran receives any money or property of value pursuant to an award in a judicial proceeding based upon, or a settlement or compromise of, any cause of action for damages for the nonservice-connected disability which established entitlement under this section, the increased compensation payable by reason of this section shall not be paid for any month following the month in which any such money or property is received until such time as the total amount of such increased compensation that would otherwise have been payable equals the total of the amount of any such money received and the fair market value of any such property received. The provisions of this paragraph do not apply, however, to any portion of such increased compensation payable for any period preceding the end of the month in which such money or property of value was received.

(2) With respect to the disability combinations specified in paragraphs (a)(1), (a)(2), (a)(3) and (a)(5) of this section, the provisions of this paragraph apply only to awards of increased compensation made on or after October 28, 1986.

(c) *Social security and workers' compensation.* Benefits received under social security or workers' compensation are not subject to recoupment under paragraph (b) of this section even though such benefits may have been awarded pursuant to a judicial proceeding.

(d) *Veteran's duty to report.* Any person entitled to increased compensation under this section shall promptly report to VA the receipt of any money or property received pursuant to a judicial proceeding based upon, or a settlement or compromise of, any cause of action or other right of recovery for damages for the nonservice-connected loss or loss of use of the impaired extremity upon which entitlement under this section is based. The amount to be reported is the total of the amount of money received and the fair market value of property received. Expenses incident to recovery, such as attorneys' fees, may not be deducted from the amount to be reported.

(Authority: 38 U.S.C. 501(a), 1160)

CROSS REFERENCES: § 3.385 Disability due to impaired hearing; § 4.85 Evaluation of hearing impairment.

[53 FR 23236, June 21, 1988, as amended at 69 FR 48149, Aug. 9, 2004; 74 FR 11483, Mar. 18, 2009]

§ 3.384 Psychosis.

For purposes of this part, the term ''psychosis'' means any of the following disorders listed in the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM–5) (see § 4.125 for availability information):

(a) Brief Psychotic Disorder;

(b) Delusional Disorder;

(c) Psychotic Disorder Due to Another Medical Condition;

(d) Other Specified Schizophrenia Spectrum and Other Psychotic Disorder;

(e) Schizoaffective Disorder;

(f) Schizophrenia;

(g) Schizophreniform Disorder; and

(h) Substance/Medication-Induced Psychotic Disorder.

(Authority: 38 U.S.C. 501(a), 1101, 1112(a) and (b))

[79 FR 45099, Aug. 4, 2014]

§ 3.385 Disability due to impaired hearing.

For the purposes of applying the laws administered by VA, impaired hearing will be considered to be a disability

when the auditory threshold in any of the frequencies 500, 1000, 2000, 3000, 4000 Hertz is 40 decibels or greater; or when the auditory thresholds for at least three of the frequencies 500, 1000, 2000, 3000, or 4000 Hertz are 26 decibels or greater; or when speech recognition scores using the Maryland CNC Test are less than 94 percent.

[59 FR 60560, Nov. 25, 1994]

EFFECTIVE DATES

§ 3.400 General.

Except as otherwise provided, the effective date of an evaluation and award of pension, compensation, or dependency and indemnity compensation based on an initial claim or supplemental claim will be the date of receipt of the claim or the date entitlement arose, whichever is later. For effective date provisions regarding revision of a decision based on a supplemental claim or higher-level review, see § 3.2500.

(Authority: 38 U.S.C. 5110(a))

(a) *Unless specifically provided.* On basis of facts found.

(b) *Disability benefits*—(1) *Disability pension (§ 3.3).* An award of disability pension may not be effective prior to the date entitlement arose.

(i) *Claims received prior to October 1, 1984.* Date of receipt of claim or date on which the veteran became permanently and totally disabled, if claim is filed within one year from such date, whichever is to the advantage of the veteran.

(ii) *Claims received on or after October 1, 1984.* (A) Except as provided in paragraph (b)(1)(ii)(B) of this section, date of receipt of claim.

(B) If, within one year from the date on which the veteran became permanently and totally disabled, the veteran files a claim for a retroactive award and establishes that a physical or mental disability, which was not the result of the veteran's own willful misconduct, was so incapacitating that it prevented him or her from filing a disability pension claim for at least the first 30 days immediately following the date on which the veteran became permanently and totally disabled, the disability pension award may be effective from the date of receipt of claim or the date on which the veteran became permanently and totally disabled, whichever is to the advantage of the veteran. While rating board judgment must be applied to the facts and circumstances of each case, extensive hospitalization will generally qualify as sufficiently incapacitating to have prevented the filing of a claim. For the purposes of this subparagraph, the presumptive provisions of § 3.342(a) do not apply.

(2) *Disability compensation*—(i) *Direct service connection (§ 3.4(b)).* Day following separation from active service or date entitlement arose if claim is received within 1 year after separation from service; otherwise, date of receipt of claim, or date entitlement arose, whichever is later. Separation from service means separation under conditions other than dishonorable from continuous active service which extended from the date the disability was incurred or aggravated.

(ii) *Presumptive service connection* (§§ *3.307, 3.308, 3.309*). Date entitlement arose, if claim is received within 1 year after separation from active duty; otherwise date of receipt of claim, or date entitlement arose, whichever is later. Where the requirements for service connection are met during service, the effective date will be the day following separation from service if there was continuous active service following the period of service on which the presumption is based and a claim is received within 1 year after separation from active duty.

(c) *Death benefits*—(1) *Death in service (38 U.S.C. 5110(j), Pub. L. 87–825) (§§ 3.4(c), 3.5(b)).* First day of the month fixed by the Secretary concerned as the date of actual or presumed death, if claim is received with 1 year after the date the initial report of actual death or finding of presumed death was made; however benefits based on a report of actual death are not payable for any period for which the claimant has received, or is entitled to receive an allowance, allotment, or service pay of the veteran.

(2) *Service-connected death after separation from service (38 U.S.C. 5110(d), Pub. L. 87–825) (§§ 3.4(c), 3.5(b)).* First day of the month in which the veteran's death occurred if claim is received within 1 year after the date of

death; otherwise, date of receipt of claim.

(3) *Nonservice-connected death after separation from service.* (i) For awards based on claims received prior to October 1, 1984, or on or after December 10, 2004, first day of the month in which the veteran's death occurred if claim is received within one year after the date of death; otherwise, date of receipt of claim.

(ii) For awards based on claims received between October 1, 1984, and December 9, 2004, first day of the month in which the veteran's death occurred if claim is received within 45 days after the date of death; otherwise, date of receipt of claim.

(Authority: 38 U.S.C. 5110(d))

(4) *Dependency and indemnity compensation*—(i) *Deaths prior to January 1, 1957 (§ 3.702).* Date of receipt of election.

(ii) *Child (38 U.S.C. 5110(e), Pub. L. 87–835).* First day of the month in which entitlement arose if claim is received within 1 year after the date of entitlement; otherwise, date of receipt of claim.

(iii) *Deaths on or after May 1, 1957 (in-service waiver cases) (§§ 3.5(b)(3) and 3.702).* Date of receipt of election. (See § 3.114(a)).

(d) [Reserved]

(e) *Apportionment* (§§ *3.450 through 3.461, 3.551*). On original claims, in accordance with the facts found. On other than original claims from the first day of the month following the month in which:

(1) Claim is received for apportionment of a veteran's award, except that where payments to him (her) have been interrupted, apportionment will be effective the day following date of last payment if a claim for apportionment is received within 1 year after that date;

(2) Notice is received that a child included in the surviving spouse's award is not in the surviving spouse's custody, except that where payments to the surviving spouse have been interrupted, apportionment will be effective the day following date of last payment if such notice is received within 1 year after that date.

(f) *Federal employees' compensation cases* (§ *3.708*). Date authorized by applicable law, subject to any payments made by the Office of Workers' Compensation Programs under the Federal Employees' Compensation Act over the same period of time.

(g) *Correction of military records (38 U.S.C. 5110(i); Pub. L. 87–825).* Where entitlement is established because of the correction, change or modification of a military record, or of a discharge or dismissal, by a Board established under 10 U.S.C. 1552 or 1553, or because of other corrective action by competent military naval, or air authority, the award will be effective from the latest of these dates:

(1) Date application for change, correction, or modification was filed with the service department, in either an original or a disallowed claim;

(2) Date of receipt of claim if claim was disallowed; or

(3) One year prior to date of reopening of disallowed claim.

(h) *Difference of opinion (§ 3.105).* (1) As to decisions not finally adjudicated (see § 3.160(d)) prior to timely receipt of an application for higher-level review, or prior to readjudication on VA initiative, the date from which benefits would have been payable if the former decision had been favorable.

(2) As to decisions which have been finally adjudicated (see § 3.160(d)), and notwithstanding other provisions of this section, the date entitlement arose, but not earlier than the date of receipt of the supplemental claim.

(3) As to decisions which have been finally adjudicated (see 3.160(d)) and readjudication is undertaken solely on VA initiative, the date of Central Office approval authorizing a favorable decision or the date of the favorable Board of Veterans' Appeals decision.

(4) Where the initial determination for the purpose of death benefits is favorable, the commencing date will be determined without regard to the fact that the action may reverse, on a difference of opinion, an unfavorable decision for disability purposes by an adjudicative agency other than the Board of Veterans Appeals, which was in effect at the date of the veteran's death.

(i) *Disability or death due to hospitalization, etc.* (38 U.S.C. 5110(c), (d); Public Law 87–825; §§ 3.358, 3.361, and

3.800.) (1) *Disability*. Date injury or aggravation was suffered if claim is received within 1 year after that date; otherwise, date of receipt of claim.

(2) *Death*. First day of month in which the veteran's death occurred if a claim is received within 1 year following the date of death; otherwise, date of receipt of claim.

(j) *Election of Department of Veterans Affairs benefits* (*§ 3.700 series*). (1) Unless otherwise provided, the date of receipt of election, subject to prior payments.

(2) July 1, 1960, as to pension payable under Pub. L. 86–211, where pension is payable for June 30, 1960, under the law in effect on that date, including an award approved after that date, if the election is filed within (generally) 120 days from date of notice of the award. The award will be subject to prior payments over the same period of time.

(3) January 1, 1965, as to pension payable under Pub. L. 86–211 (73 Stat. 432) as amended by Pub. L. 88–664 if there was basic eligibility for pension on June 30, 1960, under the law in effect on that date and an election if filed prior to May 1, 1965.

(4) January 1, 1965, as to pension payable under Pub. L. 86–211 (73 Stat. 432) as amended by Pub. L. 88–664 if there was basic eligibility on that date for pension on the basis of service in the Indian wars or Spanish-American War and an election is filed prior to May 1, 1965.

(5) January 1, 1969, as to pension payable under Pub. L. 86–211 (73 Stat. 432), as amended by Pub. L. 90–275 (82 Stat. 64), if there was basic eligibility for pension on June 30, 1960, under the law in effect on that date and an election is filed prior to May 1, 1969.

(6) August 1, 1972, as to pension payable under Pub. L. (73 Stat. 432) as amended by Pub. L. 92–328 (86 Stat. 393) if there was basic eligibility on that date based on death of a veteran of the Spanish-American War and an election is filed prior to December 1, 1972.

(k) *Error* (*§ 3.105*). Date from which benefits would have been payable if the corrected decision had been made on the date of the reversed decision.

(l) *Foreign residence*. (See § 3.653).

(m) *Forfeiture* (*§§ 3.901, 3.902*). Day following date of last payment on award to payee who forfeited.

(n) *Guardian*. Day following date of last payment to prior payee or fiduciary.

NOTE: Award to guardian shall include amounts withheld for possible apportionments as well as money in Personal Funds of Patients.

(o) *Increases (38 U.S.C. 5110(a) and 5110(b)(2), Pub. L. 94–71, 89 Stat. 395; §§ 3.109, 3.156, 3.157*—(1) *General*. Except as provided in paragraph (o)(2) of this section and § 3.401(b), date of receipt of claim or date entitlement arose, whichever is later. A retroactive increase or additional benefit will not be awarded after basic entitlement has been terminated, such as by severance of service connection.

(2) *Disability compensation*. Earliest date as of which it is factually ascertainable based on all evidence of record that an increase in disability had occurred if a complete claim or intent to file a claim is received within 1 year from such date, otherwise, date of receipt of claim. When medical records indicate an increase in a disability, receipt of such medical records may be used to establish effective date(s) for retroactive benefits based on facts found of an increase in a disability only if a complete claim or intent to file a claim for an increase is received within 1 year of the date of the report of examination, hospitalization, or medical treatment. The provisions of this paragraph apply only when such reports relate to examination or treatment of a disability for which service-connection has previously been established.

(Authority: 38 U.S.C. 501, 5101)

(p) *Liberalizing laws and Department of Veterans Affairs issues*. See § 3.114.

(q) *New and material evidence (§ 3.156) other than service department records*—(1) *Received within appeal period or prior to appellate decision*. The effective date will be as though the former decision had not been rendered. See §§ 20.1103, 20.1104 and 20.1304(b)(1) of this chapter.

(2) *Received after final disallowance*. Date of receipt of new claim or date entitlement arose, whichever is later.

(r) *Reopened claims*. (§§ 3.109, 3.156, 3.157, 3.160(e)) Date of receipt of claim or date entitlement arose, whichever is

later, except as provided in § 20.1304(b)(1) of this chapter.

(Authority: 38 U.S.C. 501)

(s) *Renouncement* (*§ 3.106*). Except as provided in § 3.106(c), date of receipt of new claim.

(t) *Whereabouts now known.* (See § 3.158(c).)

(u) *Void, annulled or terminated marriage of a child* (*38 U.S.C. 5110* (*a*), (*k*), (*l*)*; Pub. L. 93–527, 88 Stat. 1702;* § *3.55*)—(1) *Void.* Date the parties ceased to cohabit or date of receipt of claim, whichever is later.

(2) *Annulled.* Date the decree of annulment became final if claim is filed within 1 year after that date; otherwise date of receipt of claim.

(3) *Death.* Date of death if claim is filed within 1 year after that date; otherwise date of receipt of claim. Benefits are not payable unless the provisions of § 3.55(b) of this part are met.

(4) *Divorce.* Date the decree became final if claim is filed within 1 year of that date; otherwise date of receipt of claim. Benefits are not payable unless the provisions of § 3.55(b) of this part are met.

(v) *Termination of remarriage of surviving spouse (38 U.S.C. 5110(a), (k); 38 U.S.C. 103(d) and 3010(l) effective January 1, 1971; § 3.55)*—(1) *Void.* Date the parties ceased to cohabit or date of receipt of claim, whichever is the later.

(2) *Annulled.* Date the decree of annulment became final if claim is filed within 1 year after that date; otherwise date of receipt of claim.

(3) *Death.* Date of death if claim is filed within 1 year after that date; otherwise date of receipt of claim. Benefits are not payable unless the provisions of § 3.55(a) of this part are met.

(4) *Divorce.* Date the decree became final if claim is filed within 1 year after that date; otherwise date of receipt of claim. Benefits are not payable unless the provisions of § 3.55(a) of this part are met.

(w) *Termination of relationship or conduct resulting in restriction on payment of benefits (38 U.S.C. 5110(m), effective January 1, 1971; §§ 3.50(b)(2) and 3.55).* Date of receipt of application filed after termination of relationship and after December 31, 1970. Benefits are not payable unless the provisions of § 3.55(a), as applicable, are met.

(x) *Effective date of determination of incompetency (§ 3.353).* Date of rating of incompetency. (Not applicable to an incompetency determination made for insurance purposes under 38 U.S.C. 1922).

(y) *Effective date of determination restoring competency (§ 3.353).* Date shown by evidence of record that competency was regained.

(z) *Claims based on service in the Women's Air Forces Service Pilots (WASP), or on service in a similarly situated group (Pub. L. 95–202).* (1) Original claim: Date of receipt of claim or date entitlement arose, whichever is later, or as otherwise provided under this section (e.g., paragraph (b)(1) of this section) except that no benefits shall be awarded for any period prior to November 23, 1977.

(2) Reopened claims received prior to the effective date provided in § 19.2(a) of this chapter: Latest of the following dates:

(i) November 23, 1977.

(ii) Date entitlement arose.

(iii) One year prior to date of receipt of reopened claim.

(3) Supplemental claims received more than one year after notice of decision: Latest of the following dates:

(i) Date entitlement arose.

(ii) One year prior to date of receipt of a supplemental claim.

[26 FR 1593, Feb. 24, 1961]

EDITORIAL NOTE: For FEDERAL REGISTER citations affecting § 3.400, see the List of CFR Sections Affected, which appears in the Finding Aids section of the printed volume and at *www.fdsys.gov.*

§ 3.401 Veterans.

Awards of pension or compensation payable to or for a veteran will be effective as follows:

(a) *Aid and attendance and housebound benefits.* (1) Except as provided in § 3.400(o)(2), the date of receipt of claim or date entitlement arose, whichever is later. However, when an award of pension or compensation based on an original or supplemental claim is effective for a period prior to the date of receipt of the claim, any additional pension or compensation payable by reason of need for aid and attendance or housebound status shall also be awarded for

any part of the award's retroactive period for which entitlement to the additional benefit is established.

(Authority: 38 U.S.C. 501; 5110(b)(1), (3))

(2) Date of departure from hospital, institution, or domiciliary.

(Authority: 38 U.S.C. 501)

(3) Spouse, additional compensation for aid and attendance: Date of receipt of claim or date entitlement arose, whichever is later. However, when an award of disability compensation based on an original or supplemental claim is effective for a period prior to date of receipt of the claim additional disability compensation payable to a veteran by reason of the veteran's spouse's need for aid and attendance shall also be awarded for any part of the award's retroactive period for which the spouse's entitlement to aid and attendance is established.

(Authority: 38 U.S.C. 501; 5110(b)(1), (2))

(b) *Dependent, additional compensation or pension for*. Latest of the following dates:

(1) Date of claim. This term means the following, listed in their order of applicability:

(i) Date of veteran's marriage, or birth of his or her child, or, adoption of a child, if the evidence of the event is received within 1 year of the event; otherwise.

(ii) Date notice is received of the dependent's existence, if evidence is received within 1 year of the Department of Veterans Affairs request.

(2) Date dependency arises.

(3) Effective date of the qualifying disability rating provided evidence of dependency is received within 1 year of notification of such rating action.

(Authority: 38 U.S.C. 5110(f))

(4) Date of commencement of veteran's award. (Other increases, see § 3.400(o). For school attendance see § 3.667.)

(Authority: 38 U.S.C. 5110 (f), (n))

(c) *Divorce of veteran and spouse*. See § 3.501(d).

(d) [Reserved]

(e) *Retirement pay* (*§ 3.750*)—(1) *Election*. Date of entitlement if timely filed. Subject to prior payments of retirement pay.

(2) *Waiver*. Day following date of discontinuance or reduction of retirement pay.

(3) *Reelection*. Day the reelection is received by the Department of Veterans Affairs.

(f) *Service pension (§ 3.3(a))*. Date of receipt of claim.

(g) *Tuberculosis, special compensation for arrested*. As of the date the graduated evaluation of the disability or compensation for that degree of disablement combined with other service-connected disabilities would provide compensation payable at a rate less than $67. See § 3.350(g).

(h) *Temporary increase ''General Policy in Rating,'' 1945 Schedule for Rating Disabilities*—(1) *Section 4.29 of this chapter*. Date of entrance into hospital, after 21 days of continuous hospitalization for treatment.

(2) *Section 4.30 of this chapter*. Date of entrance into hospital, after discharge from hospitalization (regular or release to non-bed care).

(i) *Increased disability pension based on attainment of age 78*. First day of the month during which veteran attains age 78.

[26 FR 1594, Feb. 24, 1961, as amended at 27 FR 11889, Dec. 1, 1962; 36 FR 4599, Mar. 10, 1971; 39 FR 17222, Mar. 14, 1974; 41 FR 36493, Aug. 30, 1976; 41 FR 55874, Dec. 23, 1976; 41 FR 56804, Dec. 30, 1976; 45 FR 34886, May 23, 1980; 54 FR 34981, Aug. 23, 1989; 62 FR 5529, Feb. 6, 1997; 83 FR 32738, July 13, 2018; 84 FR 170, Jan. 18, 2019]

§ 3.402 Surviving spouse.

Awards of pension, compensation, or dependency and indemnity compensation to or for a surviving spouse will be effective as follows:

(a) *Additional allowance of dependency and indemnity compensation for children* *§ 3.5(e)*. Commencing date of surviving spouse's award. See § 3.400(c).

(b) *Legal surviving spouse entitled*. See § 3.657.

(c) *Aid and attendance and housebound benefits*. (1) Date of receipt of claim or date entitlement arose whichever is later. However, when an award of dependency and indemnity compensation (DIC) or pension based on an original

or supplemental claim is effective for a period prior to date of receipt of the claim, any additional DIC or pension payable to the surviving spouse by reason of need for aid and attendance or housebound status shall also be awarded for any part of the award's retroactive period for which entitlement to the additional benefit is established.

(Authority: 38 U.S.C. 501; 5110(d))

(2) Date of departure from hospital, institutional or domiciliary care at Department of Veterans Affairs expense. This is applicable only to aid and attendance benefits. Housebound benefits may be awarded during hospitalization at Department of Veterans Affairs expense.

(Authority: 38 U.S.C. 501)

[45 FR 34887, May 23, 1980, as amended at 84 FR 170, Jan. 18, 2019]

§ 3.403 Children.

(a) Awards of pension, compensation, or dependency and indemnity compensation to or for a child, or to or for a veteran or surviving spouse on behalf of such child, will be effective as follows:

(1) *Permanently incapable of selfsupport (§ 3.57(a)(3))*. In original claims, date fixed by §§ 3.400(b) or (c) or 3.401(b). In claims for continuation of payments, 18th birthday if the condition is claimed prior to or within 1 year after that date; otherwise from date of receipt of claim.

(2) *Majority (§ 13.100)*. Direct payment to child if competent, from date of majority or, date of last payment, whichever is the earlier date.

(3) *Posthumous child*. Date of child's birth if proof of birth is received within 1 year of that date, or if a claim or an intent to file a claim as set forth in § 3.155(b), is received within 1 year after the veteran's death; otherwise, date of claim.

(Authority: 38 U.S.C. 5110(n))

(4) *School attendance*. (See § 3.667.)

(5) *Adopted child*. Date of adoption either interlocutory or final or date of adoptive placement agreement, but not earlier than the date from which benefits are otherwise payable.

(b) *Monetary allowance under 38 U.S.C. 1805 for an individual suffering from spina bifida who is a child of a Vietnam veteran*. Except as provided in § 3.814(e), an award of the monetary allowance under 38 U.S.C. 1805 to or for an individual suffering from spina bifida who is a child of a Vietnam veteran will be effective either date of birth if claim is received within one year of that date, or the later of the date of claim or the date entitlement arose, but not earlier than October 1, 1997.

(Authority: 38 U.S.C. 1805, 1832, 5110)

(c) *Monetary allowance under 38 U.S.C. 1815 for an individual with covered birth defects who is a child of a woman Vietnam veteran*. Except as provided in § 3.114(a) or § 3.815(i), an award of the monetary allowance under 38 U.S.C. 1815 to or for an individual with one or more covered birth defects who is a child of a woman Vietnam veteran will be effective as of the date VA received the claim (or the date of birth if the claim is received within one year of that date), the date entitlement arose, or December 1, 2001, whichever is latest.

(Authority: 38 U.S.C. 1815, 1832, 1834, 5110)

(d) *Monetary allowance under 38 U.S.C. 1821 for an individual suffering from spina bifida who is a child of a veteran with covered service in Korea*. Except as provided in § 3.814(e), an award of the monetary allowance under 38 U.S.C. 1821 based on the existence of an individual suffering from spina bifida who is a child of a veteran with covered service in Korea will be effective from either the date of birth if claim is received within 1 year of that date, or the later of the date of claim or date entitlement arose, but not earlier than December 16, 2003.

(Authority: 38 U.S.C. 1821, 1832, 5110)

[26 FR 1594, Feb. 24, 1961, as amended at 27 FR 11889, Dec. 1, 1962; 36 FR 4599, Mar. 10, 1971; 38 FR 872, Jan. 5, 1973; 39 FR 20204, June 7, 1974; 41 FR 36493, Aug. 30, 1976; 45 FR 34887, May 23, 1980; 62 FR 51279, Sept. 30, 1997; 67 FR 49587, July 31, 2002; 76 FR 4248, Jan. 25, 2011; 79 FR 57697, Sept. 25, 2014; 83 FR 32738, July 13, 2018]

§ 3.404 Parents.

Awards of additional amounts of compensation and dependency and indemnity compensation based on a parent's need for aid and attendance will be effective the date of receipt of claim or date entitlement arose, whichever is later. However, when an award of dependency and indemnity compensation based on an original or supplemental claim is effective for a period prior to date of receipt of claim, any additional dependency and indemnity compensation payable by reason of need for aid and attendance may also be awarded for any part of the award's retroactive period for which entitlement to aid and attendance is established. When the parent is provided hospital, institutional or domiciliary care at Department of Veterans Affairs expense, the effective date will be the date of departure therefrom.

(Authority: 38 U.S.C. 501; 5110(d))

[45 FR 34887, May 23, 1980, as amended at 84 FR 171, Jan. 18, 2019]

§ 3.405 Filipino veterans and their survivors; benefits at the full-dollar rate.

Public Laws 106–377 and 108–183, which provide disability compensation and dependency and indemnity compensation at full-dollar rates to certain Filipino veterans and their survivors, are considered liberalizing laws. As such, the provisions of 38 CFR 3.114(a) apply when determining the effective date of an award. If the requirements of § 3.114(a) are not satisfied, then the effective date of an award of benefits at the full-dollar rate under § 3.42 will be determined as follows:

(a) *Initial entitlement to full-dollar rate.* The latest of the following:

(1) Date entitlement arose;

(2) Date on which the veteran or survivor first met the residency and citizenship or permanent resident alien status requirements in § 3.42, if VA receives evidence of this within one year of that date; or

(3) Effective date of service connection, provided VA receives evidence that the veteran or survivor meets the residency and citizenship or permanent resident alien status requirements in § 3.42 within one year of the date of notification of the decision establishing service connection.

(b) *Resumption of full-dollar rate.* (1) Date the veteran or survivor returned to the United States after an absence of more than 60 consecutive days; or

(2) First day of the calendar year following the year in which the veteran or survivor was absent from the United States for a total of 183 days or more, or the first day after that date that the veteran or survivor returns to the United States.

[71 FR 8221, Feb. 16, 2006]

APPORTIONMENTS

§ 3.450 General.

(a)(1) All or any part of the pension, compensation, or emergency officers' retirement pay payable on account of any veteran may be apportioned.

(i) On behalf of his or her spouse, children, or dependent parents if the veteran is incompetent and is being furnished hospital treatment, institutional, or domiciliary care by the United States, or any political subdivision thereof.

(ii) If the veteran is not residing with his or her spouse, or if the veteran's children are not residing with the veteran and the veteran is not reasonably discharging his or her responsibility for the spouse's or children's support.

(2) Where any of the children of a deceased veteran are not living with the veteran's surviving spouse, the pension, compensation, or dependency and indemnity compensation otherwise payable to the surviving spouse may be apportioned.

(Authority: 38 U.S.C. 5307)

(b) Except as provided in § 3.458(e), no apportionment of disability or death benefits will be made or changed solely because a child has entered active duty with the air, military, or naval services of the United States.

(c) No apportionment will be made where the veteran, the veteran's spouse (when paid ''as wife'' or ''as husband''), surviving spouse, or fiduciary is providing for dependents. The additional benefits for such dependents will be paid to the veteran, spouse, surviving spouse, or fiduciary.

(d) Any amounts payable for children under §§ 3.459, 3.460 and 3.461 will be equally divided among the children.

(e) The amount payable for a child in custody of and residing with the surviving spouse shall be paid to the surviving spouse. Amounts payable to a surviving spouse for a child in the surviving spouse's custody but residing with someone else may be apportioned if the surviving spouse is not reasonably contributing to the child's support.

(f) Prior to release of any amounts the relationship of the claimant and the dependency of a parent will be fully developed, and the necessary evidence secured.

(g) The provisions of § 3.460 are applicable where the surviving spouse is entitled to a higher rate of pension under the circumstances described in that section.

[26 FR 1594, Feb. 24, 1961, as amended at 26 FR 7266, Aug. 11, 1961; 27 FR 6974, July 24, 1962; 32 FR 13226, Sept. 19, 1967; 37 FR 6678, Apr. 1, 1972; 44 FR 45939, Aug. 6, 1979]

§ 3.451 Special apportionments.

Without regard to any other provision regarding apportionment where hardship is shown to exist, pension, compensation, emergency officers' retirement pay, or dependency and indemnity compensation may be specially apportioned between the veteran and his or her dependents or the surviving spouse and children on the basis of the facts in the individual case as long as it does not cause undue hardship to the other persons in interest, except as to those cases covered by § 3.458(b) and (c). In determining the basis for special apportionment, consideration will be given such factors as: Amount of Department of Veterans Affairs benefits payable; other resources and income of the veteran and those dependents in whose behalf apportionment is claimed; and special needs of the veteran, his or her dependents, and the apportionment claimants. The amount apportioned should generally be consistent with the total number of dependents involved. Ordinarily, apportionment of more than 50 percent of the veteran's benefits would constitute undue hardship on him or her while apportionment of less than 20 percent of his or her benefits would not provide a reasonable amount for any apportionee.

[44 FR 45940, Aug. 6, 1979]

§ 3.452 Situations when benefits may be apportioned.

Veterans benefits may be apportioned:

(a) If the veteran is not residing with his or her spouse or his or her children and a claim for apportionment is filed for or on behalf of the spouse or children.

(b) Pending the appointment of a guardian or other fiduciary.

(c)(1) Where an incompetent veteran without a fiduciary is receiving institutional care by the United States or a political subdivision, his or her benefit may be apportioned for a spouse or child, or, except as provided in paragraph (c)(2), for a dependent parent, unless such benefit is paid to a spouse (''as wife'' or ''as husband'') for the use of the veteran and his or her dependents.

(2) Where a married veteran is receiving section 306 or improved pension and the amount payable is reduced under § 3.551(c) because of hospitalization, an apportionment may be paid to the veteran's spouse as provided in § 3.454(b).

(Authority: 38 U.S.C. 501(a); 5307; 5503(a))

(d) Where additional compensation is payable on behalf of a parent and the veteran or his or her guardian neglects or refuses to contribute such an amount to the support of the parent the additional compensation will be paid to the parent upon receipt of a claim.

CROSS REFERENCES: Disappearance of veteran. *See* § 3.656. Reduction because of hospitalization. *See* § 3.551. Penal institutions. *See* § 3.666.

[26 FR 7266, Aug. 11, 1961, as amended at 27 FR 6974, July 24, 1962; 40 FR 21724, May 19, 1975; 44 FR 45940, Aug. 6, 1979; 66 FR 48560, Sept. 21, 2001; 68 FR 34542, June 10, 2003; 83 FR 32738, July 13, 2018]

§ 3.453 Veterans compensation or service pension or retirement pay.

Rates of apportionment of disability compensation, service pension or retirement pay will be determined under § 3.451.

[26 FR 7266, Aug. 11, 1961]

§ 3.454 Veterans disability pension.

Apportionment of disability pension will be as follows:

(a) Where a veteran with spouse, or child is incompetent and without legal fiduciary and is maintained in an institution by the United States or any political subdivision thereof, $25 monthly will be paid as an institutional award to the Director of a Department of Veterans Affairs medical center or chief officer of a non-Department of Veterans Affairs institution for the use of the veteran, and the balance will be paid to the dependent or dependents. If the veteran has no spouse, or child but has a dependent parent, apportionment will be in accordance with § 3.451.

(b)(1) Where the amount of section 306 pension payable to a married veteran under 38 U.S.C. 1521(b), as in effect on December 31, 1978, is reduced to $50 monthly under § 3.551(c), an apportionment may be made to such veteran's spouse upon an affirmative showing of hardship. The amount of the apportionment generally will be the difference between $50 and the total amount of pension payable on December 31, 1978.

(Authority: 38 U.S.C. 5503(a))

(2) Where the amount of improved pension payable to a married veteran under 38 U.S.C. 1521(b) is reduced to $60 monthly under § 3.551(d) or (e)(2), an apportionment may be made to such veteran's spouse upon an affirmative showing of hardship. The amount of the apportionment generally will be the difference between $50 and the rate payable if pension was being paid under 38 U.S.C. 1521(c) including the additional amount payable under 38 U.S.C. 1521(e) if the veteran is so entitled.

(Authority: 38 U.S.C. 5503(a))

(3) Where the amount of improved pension payable to a married veteran under 38 U.S.C. 1521(b) is reduced to $90 monthly under § 3.551(e)(1) an apportionment may be made to such veteran's spouse upon an affirmative showing of hardship. The amount of the apportionment generally will be the difference between $90 and the rate payable if pension was being paid under 38 U.S.C. 1521(c) including the additional amount payable under 38 U.S.C. 1521(e) if the veteran is so entitled.

(Authority: 38 U.S.C. 5503(a))

[40 FR 36329, Aug. 20, 1975, as amended at 44 FR 45940, Aug. 6, 1979; 56 FR 65850, 65851, Dec. 19, 1991; 57 FR 7847, Mar. 4, 1992; 68 FR 34542, June 10, 2003]

§ 3.458 Veteran's benefits not apportionable.

Veteran's benefits will not be apportioned:

(a) Where the total benefit payable to the disabled person does not permit payment of a reasonable amount to any apportionee.

(b) Where the spouse of the disabled person has been found guilty of conjugal infidelity by a court having proper jurisdiction.

(c) For purported or legal spouse of the veteran if it has been determined that he or she has lived with another person and held herself or himself out openly to the public to be the spouse of such other person, except where such relationship was entered into in good faith with a reasonable basis (for example trickery on the part of the veteran) for the spouse believing that the marriage to the veteran was legally terminated. No apportionment to the spouse will thereafter be made unless there has been a reconciliation and later estrangement.

(d) Where the child of the disabled person has been legally adopted by another person.

(e) Where a child enters the active military, air, or naval service, any additional amount will be paid to the veteran unless such child is included in an existing apportionment to an estranged spouse. No adjustment in the apportioned award will be made based on the child's entry into service.

(f)(1) For the spouse, child, father or mother of a disabled veteran, where

forfeiture was declared prior to September 2, 1959, if the dependent is determined by the Department of Veterans Affairs to have been guilty of mutiny, treason, sabotage, or rendering assistance to an enemy of the United States or its allies.

(2) For any dependent of a disabled veteran, or surviving spouse where forfeiture of benefits by a person primarily entitled was declared after September 1, 1959, by reason of fraud, treasonable acts, or subversive activities.

(Authority: 38 U.S.C. 6103(b); 6104(c); 6105(a))

(g) Until the estranged spouse of a veteran files claim for an apportioned share. If there are any children of the veteran not in his or her custody an apportionment will not be authorized unless and until a claim for an apportioned share is filed in their behalf.

CROSS REFERENCES: Child. See §3.57. Child adopted out of family. See §3.58.

[26 FR 7266, Aug. 11, 1961, as amended at 40 FR 21724, May 19, 1975; 44 FR 45940, Aug. 6, 1979; 80 FR 48451, Aug. 13, 2015]

§3.459 Death compensation.

(a) Death compensation will be apportioned if the child or children of the deceased veteran are not in the custody of the surviving spouse.

(b) The surviving spouse may not be paid less than $65 monthly plus the amount of an aid and attendance allowance where applicable.

[40 FR 21725, May 19, 1975, as amended at 44 FR 45940, Aug. 6, 1979]

§3.460 Death pension.

Death pension will be apportioned if the child or children of the deceased veteran are not in the custody of the surviving spouse. Where the surviving spouse's rate is in excess of $70 monthly because of having been the spouse of the veteran during service or because of need for regular aid and attendance, the additional amount will be added to the surviving spouse's share.

(a) *Civil, Indian and Spanish-American wars.* Where pension is payable under 38 U.S.C. 1532, 1534, or 1536 apportionment will be based on the facts in the individual case in accordance with §3.451.

(b) *Section 306 and old-law death pension.* Appointment of benefits provided under these pension programs will be at rates approved by the Under Secretary for Benefits except when the facts and circumstances in a case warrant special apportionment under §3.451.

(Authority: 38 U.S.C. 5307)

(c) *Improved death pension.* Apportionment of the benefits provided under this program shall be made under the special apportionment provision of §3.451.

(Authority: 38 U.S.C. 5307)

[41 FR 21324, May 25, 1976, as amended at 43 FR 14018, Apr. 4, 1978; 44 FR 45940, Aug. 6, 1979; 61 FR 20727, May 8, 1996]

§3.461 Dependency and indemnity compensation.

(a) *Conditions under which apportionment may be made.* The surviving spouse's award of dependency and indemnity compensation will be apportioned where there is a child or children under 18 years of age and not in the custody of the surviving spouse. The surviving spouse's award of dependency and indemnity compensation will not be apportioned under this condition for a child over the age of 18 years.

(b) *Rates payable.* (1) The share for each of the chidren under 18 years of age, including those in the surviving spouse's custody as well as those who are not in such custody, will be at rates approved by the Under Secretary for Benefits except when the facts and circumstances in a case warrant special apportionment under §3.451. The share for the surviving spouse will be the difference between the children's share and the total amount payable. In the application of this rule, however, the surviving spouse's share will not be reduced to an amount less than 50 percent of that to which the surviving spouse would otherwise be entitled.

(2) The additional amount of aid and attendance, where applicable, will be added to the surviving spouse's share and not otherwise included in the computation.

(3) Where the surviving spouse has elected to receive dependency and indemnity compensation instead of death compensation, the share of dependency

and indemnity compensation for a child or children under 18 years of age will be whichever is the greater:

(i) The apportioned share computed under paragraph (b)(1) of this section; or

(ii) The share which would have been payable as death compensation but not in excess of the total dependency and indemnity compensation.

[43 FR 14018, Apr. 4, 1978, as amended at 61 FR 20727, May 8, 1996]

REDUCTIONS AND DISCONTINUANCES

§ 3.500 General.

The effective date of a rating which results in the reduction or discontinuance of an award will be in accordance with the facts found except as provided in § 3.105. The effective date of reduction or discontinuance of an award of pension, compensation, or dependency and indemnity compensation for a payee or dependent will be the earliest of the dates stated in these paragraphs unless otherwise provided. Where an award is reduced, the reduced rate will be effective the day following the date of discontinuance of the greater benefit.

(Authority: 38 U.S.C. 5112(b))

(a) *Except as otherwise provided (38 U.S.C. 5112(a))*. In accordance with the facts found.

(b) *Error; payee's or administrative (38 U.S.C. 5112(b), (9), (10))*. (1) Effective date of award or day preceding act, whichever is later, but not prior to the date entitlement ceased, on an erroneous award based on an act of commission or omission by a payee or with the payee's knowledge.

(2) Except as provided in paragraph (r) of this section, and § 3.501 (e) and (g), date of last payment on an erroneous award based solely on administrative error or error in judgment.

(c) *Annual income*. See § 3.660.

(d) *Apportionment* (§§ *3.450 series; § 3.556*). (1) Except as otherwise provided, date of last payment when reason for apportionment no longer exists.

(2) Where pension was apportioned under § 3.551(c), day preceding date of veteran's release from hospital, unless overpayment would result; date of last payment if necessary to avoid overpayment.

(e) *Federal employees' compensation* (§ *3.708*). The day preceding the date the award of benefits under the Federal Employees' Compensation Act became effective. If children on rolls and surviving spouse has primary title, award to children discontinued same date as surviving spouse's award.

(Authority: 5 U.S.C. 8116)

(f) *Contested claims § 3.402(b) and § subpart F of part 20 of this chapter)*. Date of last payment.

(g) *Death (38 U.S.C. 5112 (a), (b))*—(1) *Payee (includes apportionee)*. Last day of month before death.

(2) *Dependent of payee (includes apportionee):*

(i) Death prior to October 1, 1982: last day of the calendar year in which death occurred.

(ii) Death on or after October 1, 1982: last day of the month in which death occurred, except that section 306 and old-law pension reductions or terminations will continue to be effective the last day of the calendar year in which death occurred.

(3) *Veteran receiving retirement pay*. Date of death.

(h) *Dependency of parent (38 U.S.C. 5112; Pub. L. 90–275;* §§ *3.4(a), (b)(2), 3.250, 3.551(b) and 3.660*). See § 3.660.

(i) *Election of Department of Veterans Affairs benefits* (§ *3.700 series*). Day preceding beginning date of award under other law.

(j) *Foreign residence (38 U.S.C. 5308(a))*. See § 3.653.

(k) *Fraud (38 U.S.C. 6103(a), (d); §§ 3.669 and 3.901)*. Beginning date of award or day preceding date of fraudulent act, whichever is later.

(l)–(m) [Reserved]

(n) *Marriage (or remarriage)* (38 U.S.C. 101(3), 5112 (b))—(1) *Payee* (*includes apportionee*). Last day of month before marriage.

(2) *Dependent of payee (includes apportionee):*

(i) Marriage prior to October 1, 1982: last day of the calendar year in which marriage occurred.

(ii) Marriage on or after October 1, 1982: last day of the month in which marriage occurred, except that section 306 and old-law pension reductions or

terminations will continue to be effective the last day of the calendar year in which marriage occurred.

(3) *Conduct of surviving spouse*. Last day of month before inception of relationship.

(Authority: 38 U.S.C. 101(4), 501)

(o) *Penal institutions*. See § 3.666.

(p) *Philippines (38 U.S.C. 107(a)(3); § 3.40)*. Date of last payment when recognition of service withdrawn.

(q) *Renouncement* (*§ 3.106*). Last day of the month in which the renouncement is received.

(r) *Service connection (38 U.S.C. 5112(b)(6); § 3.105)*. Last day of month following 60 days after notice to payee. Applies to reduced evaluation, and severance of service connection.

(s) *Treasonable acts or subversive activities* (38 U.S.C. 6104 and 6105; §§ 3.902, 3.903). (1) *Treasonable acts*. Date of the forfeiture decision or date of last payment, whichever is earlier.

(2) *Subversive activities*. Beginning date of award or day preceding date of commission of subversive activities for which convicted, whichever is later.

(t) *Whereabouts unknown* (§§ 3.158, 3.656). Date of last payment.

(u) *Change in law or Department of Veterans Affairs issue, or interpretation*. See § 3.114.

(v) *Failure to furnish evidence of continued eligibility*. See § 3.652 (a) and (b).

(w) *Failure to furnish Social Security number*. Last day of the month during which the 60 day period following the date of VA request expires.

(x) *Radiation Exposure Compensation Act of 1990 (§ 3.715)*. (Compensation or dependency and indemnity compensation only.) Last day of the month preceding the month in which payment under the Radiation Exposure Compensation Act of 1990 is issued.

(y) *Compensation for certain disabilities due to undiagnosed illnesses (§§ 3.105; 3.317)*. Last day of the month in which the 60-day period following notice to the payee of the final rating action expires. This applies to both reduced evaluations and severance of service connection.

(Authority: Pub. L. 103–446; 38 U.S.C. 501(a))

(Authority: 38 U.S.C. 8301)

CROSS REFERENCE: Failure to return questionnaire. See § 3.661(b).

[26 FR 1596, Feb. 24, 1961]

EDITORIAL NOTE: For FEDERAL REGISTER citations affecting § 3.500, see the List of CFR Sections Affected, which appears in the Finding Aids section of the printed volume and at *www.fdsys.gov*.

§ 3.501 Veterans.

The effective date of discontinuance of pension or compensation to or for a veteran will be the earliest of the dates stated in this section. Where an award is reduced, the reduced rate will be payable the day following the date of discontinuance of the greater benefit.

(a) *Active service pay (38 U.S.C. 5112(b)(3); Pub. L. 87–825; § 3.700(a))*. Day preceding entrance on active duty. See § 3.654.

(b) *Aid and attendance—(1) Section 3.552(b)(1)*. Last day of calendar month following month in which veteran is hospitalized at Department of Veterans Affairs expense.

(2) *Section 3.552(b)(2)*. Last day of calendar month following month in which veteran hospitalized at United States Government expense.

(3) *Aid and attendance for spouse*. End of month in which award action is taken if need for aid and attendance has ceased.

(c) *Disappearance of veteran*. See § 3.656.

(d) *Divorce or annulment (38 U.S.C. 5112(b)(2)):*

(1) Divorce or annulment prior to October 1, 1982: last day of the calendar year in which divorce or annulment occurred.

(2) Divorce or annulment on or after October 1, 1982: last day of the month in which divorce or annulment occurred, except that section 306 and old-law pension reductions or terminations will continue to be effective the last day of the calendar year in which divorce or annulment occurred.

(e) *Employability regained (38 U.S.C. 5112(b) (5), (6); Pub. L. 87–825; § 3.105)*—(1) *Pension*. Last day of month in which discontinuance is approved.

(2) *Compensation*. Last day of month following 60 days after notice to payee.

(f) *Employment questionnaire, failure to return*. Reduce award to the amount payable for the schedular evaluation

shown in the current rating as of the day following the date of last payment.

(g) *Evaluation reduced (38 U.S.C. 5112(b) (5), (6); Pub. L. 87–825; § 3.105)*—(1) *Pension*. Last day of month in which reduction or discontinuance is approved.

(2) *Compensation*. Last day of month following 60 days after notice to payee.

(h) *Examination; failure to report*. See § 3.655.

(i) *Hospitalization*—(1) *Section 3.551(b)*. Last day of the sixth calendar month following admission if veteran without dependents.

(2) *Section 3.551(c)*. (i) Last day of the second calendar month following admission to domiciliary care if veteran without spouse or child or, though married, is receiving pension at the rate provided for a veteran without dependents. (ii) Last day of the third calendar month following admission for hospital or nursing home care if veteran without spouse or child or, though married, is receiving pension at the rate provided for a veteran without dependents. (iii) Upon readmission to hospital, domiciliary, or nursing home care within 6 months of a period for which pension was reduced under § 3.551(c)(1), the last day of the month of such readmission.

(3) *Section 3.552(b)* Upon readmission to hospital care within 6 months of a period of hospital care for which pension was affected by the provisions of § 3.552(b)(1) and (2) or § 3.552(k) and discharge or release was against medical advice or was the result of disciplinary action, the day preceding the date of such readmission.

(4) *Section 3.551(d)* (i) Last day of the second calendar month following admission to domiciliary care if veteran without spouse or child or, though married, is receiving pension at the rate for a veteran without dependents.

(ii) Last day of the third calendar month following admission for hospitalization or nursing home care if veteran without spouse or child or, though married, is receiving pension at the rate for a veteran without dependents.

(iii) Upon readmission to hospital, domiciliary, or nursing home care within 6 months of a period for which pension was reduced under § 3.551(d)(1) or (2), the last day of the month of such readmission.

(5) *Section 3.551(e)* (i) Last day of the third calendar month following admission to domiciliary or nursing home care if veteran without spouse or child or, though married, is receiving pension at the rate for a veteran without dependents. (ii) Upon readmission to domiciliary or nursing home care within 6 months of a period of domiciliary or nursing home care for which pension was reduced under § 3.551(e)(1), the last day of the month of such readmission.

(6) *Section 3.551(h)*. (i) Last day of the calendar month in which Medicaid payments begin, last day of the month following 60 days after issuance of a prereduction notice required under § 3.103(b)(2), or the earliest date on which payment may be reduced without creating an overpayment, whichever date is later; or

(ii) If the veteran willfully conceals information necessary to make the reduction, the last day of the month in which that willful concealment occurred.

(Authority: 38 U.S.C. 5503)

(j) [Reserved]

(k) *Lump-sum readjustment pay*. See § 3.700(a)(2).

(l) *Retirement pay (38 U.S.C. 5112(b)(3); Pub. L. 87–825; § 3.750)*. Day before effective date of retirement pay.

(m) *Temporary increase (38 U.S.C. 5112(b)(8); § 4.29 of this chapter)*. Last day of month in which hospitalization or treatment terminated, whichever is earlier, where temporary increase in compensation was authorized because of hospitalization for treatment.

(Authority: 38 U.S.C. 5505)

[26 FR 1596, Feb. 24, 1961, as amended at 27 FR 11889, Dec. 1, 1962; 29 FR 12368, Aug. 28, 1964; 29 FR 16329, Dec. 5, 1964; 35 FR 2828, Feb. 11, 1970; 37 FR 6679, Apr. 1, 1972; 38 FR 34115, Dec. 11, 1973; 41 FR 55874, Dec. 23, 1976; 44 FR 45941, Aug. 6, 1979; 48 FR 34473, July 29, 1983; 53 FR 23236, June 21, 1988; 56 FR 25045, June 3, 1991; 56 FR 65849, 65853, Dec. 19, 1991; 66 FR 48560, Sept. 21, 2001; 68 FR 34542, June 10, 2003; 83 FR 32738, July 13, 2018]

§ 3.502 Surviving spouses.

The effective date of discontinuance of pension, compensation, or dependency and indemnity compensation to

or for a surviving spouse will be the earliest of the dates stated in this section. Where an award is reduced, the reduced rate will be payable the day following the date of discontinuance of the greater benefit.

(Authority: 38 U.S.C. 501)

(a) *Additional allowance of dependency and indemnity compensation for children (38 U.S.C. 5112(b) § 3.5(e)(3)).* (1) If marriage occurred prior to October 1, 1982, the day preceding child's 18th birthday or last day of calendar year in which child's marriage occurred (see § 3.500(n) (2) and (3)), whichever is earlier.

(2) If marriage occurred on or after October 1, 1982, the day preceding child's 18th birthday or last day of the month in which marriage occurred (see § 3.500(n) (2) and (3)) whichever is earlier.

(b) *Pay grade; dependency and indemnity compensation (38 U.S.C. 1311(a), 5112(b)(10); Pub. L. 91–96, 83 Stat. 144).* Date of last payment when rate is reduced because of new certification of pay grade.

(c) *Legal surviving spouse entitled.* Date of last payment on award to another person as surviving spouse. See § 3.657.

(Authority: 38 U.S.C. 501)

(d) *Marriage.* See § 3.500(n).

(e) *Aid and attendance (§ 3.351(a)).* (1) Date of last payment, if need for aid and attendance has ceased.

(2) If hospitalized at Department of Veterans Affairs expense as a veteran, the date specified in § 3.552(b) (1) or (3).

(f) *Medicaid-covered nursing home care (§ 3.551(i)).* (1) Last day of the calendar month in which Medicaid payments begin, last day of the month following 60 days after issuance of a prereduction notice required under § 3.103(b)(2), or the earliest date on which payment may be reduced without creating an overpayment, whichever date is later; or

(2) If the surviving spouse willfully conceals information necessary to make the reduction, the last day of the month in which that willful concealment occurred.

(Authority: 38 U.S.C. 5503)

[26 FR 1596, Feb. 24, 1961, as amended at 27 FR 11890, Dec. 1, 1962; 33 FR 2995, Feb. 15, 1968; 35 FR 2828, Feb. 11, 1970; 37 FR 6679, Apr. 1, 1972; 41 FR 55874, Dec. 23, 1976; 48 FR 34473, July 29, 1983; 53 FR 23237, June 21, 1988; 58 FR 32445, June 10, 1993]

§ 3.503 Children.

(a) The effective date of discontinuance of pension, compensation, or dependency and indemnity compensation to or for a child, or to or for a veteran or surviving spouse on behalf of such child, will be the earliest of the dates stated in this section. Where an award is reduced, the reduced rate will be payable the day following the date of discontinuance of the greater benefit.

(Authority: 38 U.S.C. 501)

(1) *Age 18 (or 23) (38 U.S.C. 5112(a); § 3.57).* Day before 18th (or 23d birthday).

(2) *Enters service.* Date of last payment of apportioned disability benefits for child not in custody of estranged spouse. Full rate payable to veteran. No change where payments are being made for the child to the veteran, his (her) estranged spouse, his (her) surviving spouse, or to the fiduciary of a child not in the surviving spouse's custody.

(Authority: 38 U.S.C. 501)

(3) *Permanently incapable of selfsupport (38 U.S.C. 5112(a), (b)(6); Pub. L. 87–825; §§ 3.57, 3.950)*—(i) *Pension.* Date of last payment.

(ii) *Compensation or dependency and indemnity compensation.* Last day of month following 60 days after notice to payee.

(4) *Marriage.* See § 3.500(n).

(5) *School attendance.* See § 3.667.

(6) *Stepchild no longer member of veteran's household* (*§ 3.57*). Last day child was a member of household.

(7) *Two parent cases* (*§ 3.703*). Day preceding beginning date of award based on service of the other parent.

(8) *Dependents' educational assistance* (*§§ 3.707, 3.807, and § 21.3023 of this chapter*). Day preceding beginning date of educational assistance allowance.

(9) *Surviving spouse becomes entitled.* Date of last payment. See § 3.657.

(Authority: 38 U.S.C. 501)

(10) *Interlocutory adoption decree or adoptive placement agreement.* Date child left custody of adopting parent during the interlocutory period or during adoptive placement agreement, or date of rescission of the decree or date of termination of the adoptive placement agreement, whichever first occurs.

(b) *Monetary allowance under 38 U.S.C. chapter 18 for certain individuals who are children of Vietnam veterans or children of veterans with covered service in Korea.* The effective date of discontinuance of the monthly allowance under 38 U.S.C. chapter 18 will be the last day of the month before the month in which the death of the individual occurred.

(c) *Medicaid-covered nursing home care (§ 3.551(i)).* (1) Last day of the calendar month in which Medicaid payments begin, last day of the month following 60 days after issuance of a prereduction notice required under § 3.103(b)(2), or the earliest date on which payment may be reduced without creating an overpayment, whichever date is later; or

(2) If the child or the child's custodian willfully conceals information necessary to make the reduction, the last day of the month in which that willful concealment occurred.

(Authority: 38 U.S.C. 501, 1832, 5112(b))

[26 FR 1597, Feb. 24, 1961, as amended at 27 FR 11890, Dec. 1, 1962; 30 FR 14983, Dec. 3, 1965; 34 FR 839, Jan. 18, 1969; 38 FR 872, Jan. 5, 1973; 41 FR 55875, Dec. 23, 1976; 53 FR 23237, June 21, 1988; 62 FR 51279, Sept. 30, 1997; 67 FR 49587, July 31, 2002; 76 FR 4248, Jan. 25, 2011; 83 FR 47275, Sept. 18, 2018]

§ 3.504 Parents; aid and attendance.

The effective date of discontinuance of an increased award because of the parent's need for aid and attendance will be the day of last payment if need for aid and attendance has ceased. If hospitalized at Department of Veterans Affairs expense as a veteran the date will be specified in § 3.552(b) (1) or (3).

(Authority: Pub. L. 92–197, 85 Stat. 660)

[37 FR 6679, Apr. 1, 1972]

§ 3.505 Filipino veterans and their survivors; benefits at the full-dollar rate.

The effective date of discontinuance of compensation or dependency and indemnity compensation for a Filipino veteran or his or her survivor under § 3.42 will be the earliest of the dates stated in this section. Where an award is reduced, the reduced rate will be payable the day following the date of discontinuance of the greater benefit.

(a) If a veteran or survivor receiving benefits at the full-dollar rate under § 3.42 is physically absent from the U.S. for a total of 183 days or more during any calendar year, VA will reduce benefits to the rate of $0.50 for each dollar authorized under the law, effective on the 183rd day of absence from the U.S.

(b) If a veteran or survivor receiving benefits at the full-dollar rate under § 3.42 is physically absent from the U.S. for more than 60 consecutive days, VA will reduce benefits to the rate of $0.50 for each dollar authorized under the law, effective on the 61st day of the absence.

(c) If a veteran or survivor receiving benefits at the full-dollar rate under § 3.42 loses either U.S. citizenship or status as an alien lawfully admitted for permanent residence in the U.S., VA will reduce benefits to the rate of $0.50 for each dollar authorized under the law, effective on the day he or she no longer satisfies one of these criteria.

(d) If mail to a veteran or survivor receiving benefits at the full-dollar rate under § 3.42 is returned to VA by the U.S. Postal Service, VA will make reasonable efforts to determine the correct mailing address. If VA is unable to determine the veteran's or survivor's correct address through reasonable efforts, VA will reduce benefits to the rate of $0.50 for each dollar authorized under law, effective the first day of the month that follows the month for which VA last paid benefits.

(Authority: 38 U.S.C. 107)

[71 FR 8221, Feb. 16, 2006]

HOSPITALIZATION ADJUSTMENTS

§3.551 Reduction because of hospitalization.

(a) *General.* Pension is subject to reduction as specified below when a veteran who has neither spouse, child nor dependent parent is hospitalized, unless the veteran is hospitalized for Hansen's disease. The provisions of this section apply to initial periods of hospitalization and to readmissions following discharge from a prior period of hospitalization. If the veteran is hospitalized for observation and examination, the date treatment began is considered the date of admission. Special rules governing discontinuance of aid and attendance allowance are contained in §3.552. Except as otherwise indicated the terms ''hospitalized'' and ''hospitalization'' in §§3.551 through 3.556 mean:

(1) Hospital treatment in a Department of Veterans Affairs hospital or in any hospital at Department of Veterans Affairs expense.

(2) Institutional, domiciliary or nursing home care in a Department of Veterans Affairs institution or domiciliary or at Department of Veterans Affairs expense.

(Authority: 38 U.S.C. 5503(a))

(b) *Old-law pension.* (1) Old law pension in excess of $30 monthly for a veteran who has neither spouse, child nor dependent parent shall continue at the full monthly rate until the end of the sixth calendar month following the month of admission for hospitalization. The rate payable will be reduced effective the first of the seventh calendar month to $30 monthly or 50 percent of the amount otherwise payable, whichever is greater. The reduced rate will be effective the first day of the seventh calendar month following admission. Payment of the amount withheld may be made on termination of hospitalization, as provided in §3.556. (Sec. 306(b))

(2) *Readmission following regular discharge.* Where a veteran has been given an approved discharge or release, readmission the next day to the same or any other VA institution begins a new period of hospitalization, unless the veteran was released for purposes of admission to another VA institution.

(3) *Readmission following irregular discharge.* When a veteran whose award is subject to reduction under this paragraph has been discharged or released from a VA institution against medical advice or as a result of disciplinary action, reentry within 6 months from the date of previous admission constitutes a continuation of that period of hospitalization and the award will not be reduced prior to the first day of the seventh calendar month following the month of original admission, exclusive of authorized absences. Reentry 6 months or more after such discharge or release shall be considered a new admission.

(Authority: 38 U.S.C. 5503(a))

(c) *Section 306 pension.* (1) Where any veteran having neither spouse nor child, or any veteran who is married or has a child and is receiving pension as a veteran without dependents, is being furnished hospital, nursing home or domiciliary care by the Department of Veterans Affairs, no pension in excess of $50 monthly shall be paid to or for the veteran for any period after the end of the second full calendar month following the month of admission for such care.

(Authority: 38 U.S.C. 5503(a))

(2) No pension in excess of $50 monthly shall be paid to or for a veteran having neither spouse nor child, or to a veteran who is married or has a child and is receiving pension as a veteran without dependents, for any period after the month in which the veteran is readmitted within 6 months of a period of care for which pension was reduced under paragraph (c) (1) of this section.

(Authority: 38 U.S.C. 5503(a))

(3) Where section 306 pension is being paid to a married veteran at a rate for a veteran without dependents all or any part of the monthly amount of pension withheld in excess of $50 may be apportioned for a spouse as provided in §3.454(b).

(d) *Improved pension prior to February 1, 1990.* (1) Where any veteran having neither spouse nor child, or any veteran who is married or has a child and

is receiving pension as a veteran without dependents, is being furnished domiciliary care by VA, no pension in excess of $60 monthly shall be paid to or for the veteran for any period after the end of the second full calendar month following the month of admission for such care. (38 U.S.C. 5503(a))

(2) Where any veteran having neither spouse nor child, or any veteran who is married or has a child and is receiving pension as a veteran without dependents, is furnished hospital or nursing home care by VA, no pension in excess of $60 monthly shall be paid to or for the veteran for any period after the end of the third full calendar month following the month of admission for such care. (38 U.S.C. 5503(a))

(3) No pension in excess of $60 monthly shall be paid to or for a veteran having neither spouse nor child, or to a veteran who is married or has a child and is receiving pension as a veteran without dependents, for any period after the month in which the veteran is readmitted within 6 months of a period of care for which pension was reduced under paragraph (d)(1) or (2) of this section. (38 U.S.C. 5503(a))

(4) Where improved pension is being paid to a married veteran at the rate prescribed by 38 U.S.C. 1521(b) all or any part of the rate payable under 38 U.S.C. 1521(c) may be apportioned for a spouse as provided in § 3.454(b). (38 U.S.C. 5503(a))

(5) The provisions of paragraphs (d)(1), (2), and (3) of this section are not applicable to any veteran who has a child, but is receiving pension as a veteran without a dependent because it is reasonable that some part of the child's estate be consumed for the child's maintenance under 38 U.S.C. 1522(b).

(6) For the purpose of paragraphs (d)(1), (2), and (3) of this section, if a veteran is furnished hospital or nursing home care by VA and then is transferred to VA-furnished domiciliary care, the period of hospital or nursing home care shall be considered as domiciliary care. Similarly, if a veteran is furnished domiciliary care by VA and then is transferred to VA-furnished hospital or nursing home care, the period of domiciliary care shall be considered hospital or nursing home care.

(e) *Improved pension after January 31, 1990.* (1) Where any veteran having neither spouse nor child, or any veteran who is married or has a child and is receiving pension as a veteran without dependents, is furnished domiciliary or nursing home care by VA, no pension in excess of $90 monthly shall be paid to or for the veteran for any period after the end of the third full calendar month following the month of admission for such care.

(Authority: 38 U.S.C. 5503(a))

(2) No pension in excess of $90 monthly shall be paid to a veteran having neither spouse nor child, or to a veteran who is married or has a child and is receiving pension as a veteran without dependents, for any period after the month in which the veteran is readmitted within six months of a period of domiciliary or nursing home care for which pension was reduced under paragraph (e)(1) of this section.

(3) Where improved pension is being paid to a married veteran at the rate prescribed by 38 U.S.C. 1521(b) all or any part of the rate payable under 38 U.S.C. 1521(c) may be apportioned for a spouse as provided in § 3.454(b).

(Authority: 38 U.S.C. 5503(a))

(4) For the purposes of paragraph (e)(1) of this section, if a veteran is furnished hospital care by VA and then is transferred to VA-furnished nursing home or domiciliary care, the period of hospital care shall not be considered as nursing home or domiciliary care. Transfers from VA-furnished nursing home or domiciliary care to VA-furnished hospital care then back to nursing home or domiciliary care shall be considered as continuous nursing home or domiciliary care provided the period of hospitalization does not exceed six months. Similarly, if a veteran is transferred from domiciliary or nursing home to a VA hospital and dies while so hospitalized, the entire period of VA care shall be considered as domiciliary or nursing home care. Nursing home or domiciliary care shall be considered as terminated effective the date of transfer to a VA hospital if the veteran is completely discharged from

VA care following the period of hospitalization or if the period of hospitalization exceeds six months.

(5) Effective February 1, 1990, reductions of improved pension based on admissions or readmissions to VA hospitals or any hospital at VA expense shall no longer be made except when required under the provisions of 38 CFR 3.552.

(6) The provisions of paragraphs (e)(1) and (2) of this section are not applicable to any veteran who has a child, but is receiving pension as a veteran without a dependent because it is reasonable that some part of the child's estate be consumed for the child's maintenance under 38 U.S.C. 1522(b).

(f) *Computation of period.* For purposes of computing periods of hospitalization in paragraph (c) of this section, authorized absences of 96 hours or less will be included as periods of hospitalization, and those of over 96 hours excluded. Also, for purposes of that paragraph, periods of treatment or care of 60 total days will be considered two calendar months of hospitalization and periods of 90 total days considered three calendar months, exclusive of authorized absences in excess of 96 hours.

(g) *Proof of dependents.* The veteran will be considered to have neither spouse, child nor dependent parent in the absence of satisfactory proof. Statements contained in the claims folder concerning the existence of such dependents will be considered a prima facie showing. If the necessary evidence is not received: (1) Within 60 days after the date of request where the award is subject to reduction under paragraph (b) of this section, or (2) prior to the effective date of reduction under paragraph (c) of this section, the veteran's award will be reduced on the basis of no dependents. The full rate may be authorized from the date of reduction if the necessary evidence is received within 1 year after the date of request.

(h) *Hospitalization*—(1) *General.* The reduction required by paragraphs (d) and (e), except as they refer to domiciliary care, shall not be made for up to three additional calendar months after the last day of the third month referred to in paragraphs (d)(2) or (e)(1) of this section, or after the last day of the month referred to in paragraphs (d)(3) or (e)(2) of this section, under the following conditions:

(i) The Chief Medical Director, or designee, certifies that the primary purpose for furnishing hospital or nursing home care during the additional period is to provide the veteran with a prescribed program of rehabilitation under chapter 17 of title 38, United States Code, designed to restore the veteran's ability to function within the veteran's family and community; and

(ii) The veteran is admitted to a Department of Veterans Affairs hospital or nursing home after October 16, 1981.

(2) *Continued hospitalization for rehabilitation.* The reduction required by paragraph (d) or (e) of this section shall not be made for periods after the expiration of the additional period provided by paragraph (h)(1) of this section under the following conditions:

(i) The veteran remains hospitalized or in a nursing home after the expiration of the additional period provided by paragraph (h)(1) of this section; and

(ii) The Chief Medical Director, or designee, certifies that the primary purpose for furnishing continued hospital or nursing home care after the additional period provided by paragraph (h)(1) of this section is to provide the veteran with a program of rehabilitation under chapter 17 of title 38, United States Code, designed to restore the veteran's ability to function within the veteran's family and community.

(3) *Termination of hospitalization for rehabilitation.* Pension in excess of $60 monthly or $90, if reduction is under paragraph (e)(1) payable to a veteran under this paragraph shall be reduced the end of the calendar month in which the primary purpose of hospitalization or nursing home care is no longer to provide the veteran with a program of rehabilitation under chapter 17 of title 38, United States Code designed to restore the veteran's ability to function within the veteran's family and community.

(Authority: 38 U.S.C. 5503(a))

(i) *Certain beneficiaries receiving Medicaid-covered nursing home care.* This paragraph (i) applies to a veteran without a spouse or child, to a surviving

spouse without a child, and to a surviving child. Effective November 5, 1990, and terminating on the date provided in 38 U.S.C. 5503(d)(7), if such a beneficiary is receiving Medicaid-covered nursing home care, no pension or survivors pension in excess of $90 per month will be paid to or for the beneficiary for any period after the month in which the Medicaid payments begin. A beneficiary is not liable for any pension paid in excess of the $90 per month by reason of the Secretary's inability or failure to reduce payments, unless that inability or failure is the result of willful concealment, by the beneficiary, of information necessary to make that reduction.

(Authority: 38 U.S.C. 5503)

CROSS REFERENCES: Time limits. See § 3.109. Apportionment. See § 3.400(e). Reductions and discontinuances; general. See § 3.500. Incompetents; resumption. See § 3.558.

[27 FR 7677, Aug. 3, 1962]

EDITORIAL NOTE: For FEDERAL REGISTER citations affecting § 3.551, see the List of CFR Sections Affected, which appears in the Finding Aids section of the printed volume and at *www.fdsys.gov*.

§ 3.552 Adjustment of allowance for aid and attendance.

(a)(1) When a veteran who is already entitled to the aid and attendance allowance is hospitalized, the additional compensation or increased pension for aid and attendance shall be discontinued as provided in paragraph (b) of this section except as to disabilities specified in paragraph (a)(2) of this section. (See paragraph (k) of this section for rules applicable to a veteran who establishes entitlement to the aid and attendance allowance on or after date of admission to hospitalization).

(2) The allowance for aid and attendance will be continued during hospitalization where the disability is paraplegia involving paralysis of both lower extremities together with loss of anal and bladder sphincter control, or Hansen's disease, except where discontinuance is required by paragraph (b)(2) of this section. In addition, in pension cases only, the aid and attendance allowance will be continued where the pensionable disability is blindness (visual acuity 5/200 or less) or concentric contraction of visual field to 5 degrees or less. Awards are, however, subject to the provisions of § 3.551 (except where the disabling condition is Hansen's disease) .

(3) Additional compensation for dependents under § 3.4(b)(2) is payable during hospitalization in addition to the rates authorized by this section. The rates specified will also be increased by amounts authorized under 38 U.S.C. 1114(k) based on independently ratable disability, subject to the statutory ceiling on the total amount of compensation payable as set forth in § 3.350(a).

(b)(1) Where a veteran is admitted for hospitalization on or after October 1, 1964, the additional compensation or increased pension for aid and attendance will be discontinued effective the last day of the month following the month in which the veteran is admitted for hospitalization at the expense of the Department of Veterans Affairs.

(2) When a veteran is hospitalized at the expense of the United States Government, the additional aid and attendance allowance authorized by 38 U.S.C. 1114(r)(1) or (2) or 38 U.S.C. 1114(t) will be discontinued effective the last day of the month following the month in which the veteran is admitted for hospitalization.

(3) Where a veteran affected by the provisions of paragraph (b) (1) and (2) or paragraph (k) of this section is discharged or released from the hospital against medical advice or as the result of disciplinary action, and is readmitted to such hospitalization within 6 months after that date, the allowance, additional compensation, or increased pension will be discontinued effective the day preceding the date of readmission. A readmission 6 months or more after such discharge or release will be considered as a new admission.

(c) Reduction will not be made where the same monthly rate of compensation would be payable without consideration of need for regular aid and attendance. This can only be determined after careful review of the current maximum entitlement without regard to any amount for aid and attendance.

(d) Where entitlement by reason of need for regular aid and attendance is the basis of the monthly rate under 38 U.S.C. 1114(1) the award will be reduced

to the rate payable under 38 U.S.C. 1114(s).

(e) Where a veteran is in receipt of section 306 pension, the aid and attendance allowance shall be reduced to the housebound rate of $61 monthly (or $76.25 if the veteran was age 78 or older on December 31, 1978). Where a veteran is in receipt of old-law pension, the total amount payable shall be reduced to $100 monthly. Where a veteran is in receipt of improved pension, the applicable aid and attendance rate shall be reduced to the otherwise applicable rate under 38 U.S.C. 1521(e). No reduction shall be made, however, for any case involving the disabilities specified in paragraph (a)(2) of this section.

(f) Where entitlement to the rate in 38 U.S.C. 1114(o) is based in part on need for regular aid and attendance reduction because of being hospitalized will be to the rate payable for the other conditions shown.

(g) Where a veteran entitled to one of the rates under 38 U.S.C. 1114 (l), (m), or (n) by reason of anatomical losses or losses of use of extremities, blindness (visual acuity 5/200 or less or light perception only), or anatomical loss of both eyes is being paid compensation at the rate under 38 U.S.C. 1114(o) because of entitlement to another rate under section 1114(l) on account of need for aid and attendance, the compensation will be reduced while hospitalized to the following:

(1) If entitlement is under section 1114(l) and in addition there is need for regular aid and attendance for another disability, the award during hospitalization will be at the rate under 38 U.S.C. 1114(m) since the disability requiring aid and attendance is 100 percent disabling.

(Authority: 38 U.S.C. 1114(p))

(2) If entitlement is under section 1114(m), at the rate under 38 U.S.C. 1114(n).

(3) If entitlement is under section 1114(n), the rate under 38 U.S.C. 1114(o) would be continued, since the disability previously causing the need for regular aid and attendance would then be totally disabling entitling the veteran to the maximum rate under 38 U.S.C. 1114(p).

(h) If, because of blindness, a veteran requires regular aid and attendance, but has better vision than ''light perception only'' the award under 38 U.S.C. 1114(m) will be reduced while hospitalized to the rate payable under 38 U.S.C. 1114(1).

(i) If the disability meets the aid and attendance requirements of 38 U.S.C. 1114(l) and the intermediate or next higher rate was assigned for disability independently ratable at 50 percent or 100 percent, the award based on such entitlement will be reduced because of hospitalization to the amount payable under 38 U.S.C. 1114(s).

(j) The section 306 pension aid and attendance allowance authorized by § 3.252(f) is subject to reduction for hospitalization under the provisions of this section in the same manner as the regular section 306 pension aid and attendance allowance. The amount payable shall not be reduced to less than the housebound rate of $61 monthly (or $76.25 monthly if the veteran was age 78 or older on December 31, 1978).

(k)(1) This paragraph is applicable to hospitalized veterans who were not entitled to the aid and attendance allowance prior to hospital admission but who establish entitlement to it on or after the date of hospital admission.

(2) If the effective date of entitlement to the aid and attendance allowance is on or after the date of admission to hospitalization, the aid and attendance allowance shall not be paid until the date of discharge or release from hospitalization, unless the aid and attendance allowance is based on a disability specified in paragraph (a)(2) of this section. If the aid and attendance allowance is based on a disability specified in paragraph (a)(2) of this section, the aid and attendance allowance shall be paid during hospitalization.

(3) If the aid and attendance allowance is not payable to a veteran under paragraph (k)(2) of this section, the veteran shall receive the appropriate reduced rate under paragraphs (d)

through (j) of this section while hospitalized.

(Authority: 38 U.S.C. 5503(c))

[28 FR 1588, Feb. 20, 1963, as amended at 30 FR 14983, Dec. 3, 1965; 32 FR 13226, Sept. 19, 1967; 37 FR 19133, Sept. 19, 1972; 38 FR 34115, Dec. 11, 1973; 41 FR 55875, Dec. 23, 1976; 44 FR 22721, Apr. 17, 1979; 44 FR 45941, Aug. 6, 1979; 46 FR 31011, June 12, 1981; 46 FR 47541, Sept. 29, 1981; 68 FR 34542, June 10, 2003; 83 FR 20737, May 8, 2018]

§§ 3.553–3.555 [Reserved]

§ 3.556 Adjustment on discharge or release.

(a) *Temporary Absence—30 days.* (1) Where a competent veteran whose award was reduced under § 3.551(b) is placed on non-bed care status or other authorized absence of 30 days or more the full monthly rate, excluding any allowance for regular aid and attendance, will be restored effective the date of reduction. The full monthly rate for an incompetent veteran, or for a competent veteran whose pension was reduced under § 3.551(c), will be restored effective the date of departure from the hospital unless it is determined that apportionment for a spouse should be continued. In all instances, any allowance for regular aid and attendance will be restored effective the date of departure from the hospital.

(2) Upon the veteran's return to the hospital, an award which is subject to reduction under § 3.551 (b) or (c) will again be reduced effective the date of the veteran's return to the hospital. In all instances, any allowance for regular aid and attendance will be discontinued, if in order, effective the date of the veteran's return to the hospital.

(b) *Temporary absence—less than 30 days.* A temporary absence of less than 30 days, including the day of departure, will not require adjustment of the award. This applies to any approved absence. Any allowance for regular aid and attendance for such periods will be authorized after the veteran has been discharged from the hospital.

(c) *Adjustment based on need.* Where an award of pension was reduced under § 3.551(c), the full rate covering absences of less than 30 days may be restored, subject to prior payments, prior to discharge from hospitalization at the request of the Director of the hospital, center or domiciliary, where this action is necessary to meet the veteran's financial needs, if the veteran has been hospitalized for more than 6 months and the periods of absence exceed a total of 30 days.

(d) *Irregular discharge.* When a competent veteran is given an irregular discharge, the full rate will be restored effective the date of release from the hospital. Payment of any amount withheld under § 3.551(b) will not be authorized until the expiration of 6 months after termination of hospitalization unless the prior release is changed to a regular release. However, amounts not paid under paragraph (c) of this section covering absence of less than 30 days where the award was reduced under § 3.551(c) will be authorized immediately.

(e) *Regular discharge.* When a veteran, either competent or incompetent, is given a regular discharge or release, the full rate, including any allowance for regular aid and attendance will be restored effective the date of release from the hospital, subject to prior payments. The award will be based on the most recent rating and, where the award was reduced under § 3.551(b), will include, in the case of a competent veteran, any amounts withheld because of hospitalization. The amount withheld for an incompetent veteran will not be authorized until the expiration of 6 months following a rating of competency by VA. Any institutional award will be discontinued effective date of last payment, as provided in § 3.501(j). Where an apportionment made under § 3.551(c) is not continued, the apportionment will be discontinued effective the day preceding the date of the veteran's release from the hospital, or, if adjusted, effective the date of the veteran's release from the hospital, unless an overpayment would result. In the excepted cases, the awards to the veteran and apportionee will be adjusted as of date of last payment.

(Authority: 38 U.S.C. 5503)

(f) *Types of discharges.* A discharge is considered regular if it is granted because of having received maximum

hospital benefits. A discharge for disciplinary reasons or because of the patient's refusal to accept, neglect of or obstruction of treatment; refusal to accept transfer, or failure to return from authorized absence, is considered irregular.

[27 FR 7678, Aug. 3, 1962, as amended at 27 FR 8794, Sept. 1, 1962; 38 FR 34115, Dec. 11, 1973; 39 FR 34532, Sept. 26, 1974; 40 FR 45169, Oct. 1, 1975; 44 FR 22721, Apr. 17, 1979; 44 FR 45942, Aug. 6, 1979; 50 FR 50616, Dec. 11, 1985]

§ 3.557 [Reserved]

§ 3.558 Resumption and payment of withheld benefits; incompetents with estates that equaled or exceeded statutory limit.

(a) Payments for the veteran will be resumed and apportionment awards discontinued under the applicable provisions of § 3.556(a), (d), and (e) upon authorized absence from the hospital for 30 days or more or a regular or irregular discharge or release. Care and maintenance payments to an institution will not be made for any period the veteran is not receiving such care and maintenance.

(b) Any amount not paid because of the provisions of former § 3.557(b) (as in effect prior to December 27, 2001), and any amount of compensation or retirement pay withheld pursuant to the provisions of § 3.551(b) (and/or predecessor regulatory provisions) as it was constituted prior to August 1, 1972, and not previously paid because of the provisions of former § 3.557(b) (as in effect prior to December 27, 2001), will be awarded to the veteran if he or she is subsequently rated competent by VA for a period of not less than six months.

(Authority: 38 U.S.C. 5503)

[27 FR 7679, Aug. 3, 1962, as amended at 36 FR 25225, Dec. 30, 1971; 38 FR 34116, Dec. 11, 1973; 40 FR 45170, Oct. 1, 1975; 41 FR 18412, May 4, 1976; 50 FR 50617, Dec. 11, 1985; 58 FR 34224, June 24, 1993; 66 FR 48560, Sept. 21, 2001; 68 FR 34542, June 10, 2003]

§ 3.559 [Reserved]

ADJUSTMENTS AND RESUMPTIONS

§ 3.650 Rate for additional dependent.

(a) *Running awards.* Except as provided in paragraph (c) of this section where a claim is filed by an additional dependent who has apparent entitlement which, if established, would require reduction of pension, compensation or dependency and indemnity compensation being paid to another dependent, payments to the person or persons on the rolls will be reduced as follows:

(1) Where benefits would be payable from a date prior to the date of filing claim, the reduction will be effective from the date of potential entitlement of the additional dependent.

(2) Where benefits would be payable from the date of filing claim, the reduction will be effective the date of receipt of the claim by the additional dependent, or date of last payment, whichever is later.

If entitlement of the additional dependent is not established, benefits previously being paid will be resumed, if otherwise in order, commencing the day following the effective date of reduction.

(b) *New awards.* If the additional dependent is found to be entitled, the full rate payable will be authorized effective the date of entitlement.

(c) *Retroactive DIC award to a school child*—(1) *General.* If DIC (dependency and indemnity compensation) is being currently paid to a veteran's child or children under 38 U.S.C. 1313(a), and DIC is retroactively awarded to an additional child of the veteran based on school attendance, the full rate payable to the additional child shall be awarded the first of the month following the month in which the award to the additional child is approved. The rate payable under the current award shall be reduced effective the date the full rate is awarded to the additional child. The rate payable to the additional child for periods prior to the date the full rate is awarded shall be the difference between the rate payable for all the children and the rate that was payable before the additional child established entitlement.

(2) *Applicability.* The provisions of paragraph (c)(1) of this section are applicable only when the following conditions are met:

(i) The additional child was receiving DIC under 38 U.S.C. 1313(a) prior to attaining age 18; and

(ii) DIC for the additional child was discontinued on or after attainment of age 18; and

(iii) After DIC has been discontinued, the additional child reestablishes entitlement to DIC under 38 U.S.C. 1313(a) based on attendance at an approved school and the effective date of entitlement is prior to the date the Department of Veterans Affairs receives the additional child's claim to reestablish entitlement.

(Authority: 38 U.S.C. 1313(b))

(3) *Effective date.* This paragraph is applicable to DIC paid after September 30, 1981. If DIC is retroactively awarded for a period prior to October 1, 1981, payment for the period prior to October 1, 1981 shall be made under paragraph (a) of this section and payment for the period after September 30, 1981, shall be made under this paragraph.

[29 FR 9564, July 15, 1964, as amended at 47 FR 24551, June 7, 1982]

§ 3.651 Change in status of dependents.

Except as otherwise provided:

(a) A payee who becomes entitled to pension, compensation, or dependency and indemnity compensation or to a greater rate because payment of that benefit to another payee has been reduced or discontinued will be awarded the benefit or increased benefit without the filing of a new claim.

(b) The commencement or adjustment will be effective the day following the reduction or discontinuance of the award to the other payee if the necessary evidence is received in the Department of Veterans Affairs within 1 year from the date of request therefor; otherwise from the date of receipt of a new claim.

(c) The rate for the persons entitled will be the rate that would have been payable if they had been the only original persons entitled.

[26 FR 1598, Feb. 24, 1961, as amended 27 FR 11890, Dec. 1, 1962; 30 FR 133, Jan. 7, 1965]

§ 3.652 Periodic certification of continued eligibility.

Except as otherwise provided:

(a) Individuals to whom benefits are being paid are required to certify, when requested, that any or all of the eligibility factors which established entitlement to the benefit being paid continue to exist. The beneficiary will be advised at the time of the request that the certification must be furnished within 60 days from the date of the request therefor and that failure to do so will result in the reduction or termination of benefits.

(1) If the certification is not received within 60 days from the date of the request, the eligibility factor(s) for which certification was requested will be considered to have ceased to exist as of the end of the month in which it was last shown by the evidence of record to have existed. For purposes of this paragraph, the effective date of reduction or termination of benefits will be in accordance with §§ 3.500 through 3.504 as in effect on the date the eligibility factor(s) is considered to have ceased to exist. The claimant will be advised of the proposed reduction or termination of benefits and the date the proposed action will be effective. An additional 60 days from the date of notice of the proposed action will be provided for the claimant to respond.

(2) If the certification is not received within the additional 60 day period, the proposed reduction or termination of benefits will be put into effect.

(b) When the required certification is received, benefits will be adjusted, if necessary, in accordance with the facts found.

(Authority: 38 U.S.C. 501)

CROSS REFERENCES: Employment Questionnaire, failure to return. See § 3.501(f). Income and Net Worth Questionnaires. See § 3.661.

[52 FR 43063, Nov. 9, 1987]

§ 3.653 Foreign residence.

(a) *General.* Pension, compensation, or dependency and indemnity compensation is not payable to an alien who is located in the territory of or under the control of an enemy of the United States or of its allies. The benefit may, however, be paid to the dependents of such alien, but not in excess of the amount which would be payable to the dependent if the alien were dead.

(Authority: 38 U.S.C. 5308)

(b) *Retroactive payments.* Any amount not paid to an alien under this section, together with any amounts placed to the alien's credit in the special deposit account in the Treasury or covered into the Treasury as miscellaneous receipts under 31 U.S.C. 123–128 will be paid to him or her on the filing of a new claim. Such claim should be supported with evidence that the alien has not been guilty of mutiny, treason, sabotage or rendering assistance to an enemy, as provided in § 3.902(a).

(Authority: 38 U.S.C. 5309)

(c) *Treasury Department list.* This paragraph is applicable to claims for benefits for aliens residing in countries identified on the list established by the Secretary of the Treasury as countries to which checks could not be delivered with reasonable assurance that the payee would actually receive and be able to negotiate a check for full value.

(1) *Evidence requests.* Requests for evidence to establish either basic or continued entitlement will not be made where such evidence would be obtained from a country on the Treasury Department list unless the claimant requests that checks be sent to him or her in care of a U.S. Foreign Service post in a country which is not on the list.

(2) *Awards.* Payments for a claimant residing in a country included in the Treasury Department list will not be authorized unless the claimant requests that checks be sent to him or her in care of a U.S. Foreign Service post in a country which is not on the list.

(3) *Retroactive payments.* Where award action is authorized under paragraph (c)(2) of this section, or a new claim has been filed after a country has been removed from the Treasury Department list, all benefits to which the payee is otherwise entitled will be paid as provided in paragraph (b) of this section. There is no time limit for filing claim.

(d) *Germany and Japan.* Where payments were discontinued before July 1, 1954, because the payee was a citizen or subject of Germany or Japan, no payments will be made for any period prior to the date of filing a new claim.

(Authority: 38 U.S.C. 5309(b))

[26 FR 1599, Feb. 24, 1961, as amended at 31 FR 13172, Oct. 12, 1966; 47 FR 24551, June 7, 1982]

§ 3.654 Active service pay.

(a) *General.* Pension, compensation, or retirement pay will be discontinued under the circumstances stated in § 3.700(a)(1) for any period for which the veteran received active service pay. For the purposes of this section, active service pay means pay received for active duty, active duty for training or inactive duty training.

(b) *Active duty.* (1) Where the veteran returns to active duty status, the award will be discontinued effective the day preceding reentrance into active duty status. If the exact date is not known, payments will be discontinued effective date of last payment and as of the correct date when the date of reentrance has been ascertained from the service department.

(2) Payments, if otherwise in order, will be resumed effective the day following release from active duty if claim for recommencement of payments is received within 1 year from the date of such release: otherwise payments will be resumed effective 1 year prior to the date of receipt of a new claim. Prior determinations of service connection will not be disturbed except as provided in § 3.105. Compensation will be authorized based on the degree of disability found to exist at the time the award is resumed. Disability will be evaluated on the basis of all facts, including records from the service department relating to the most recent period of active service. If a disability is incurred or aggravated in the second period of service, compensation for that disability cannot be paid unless a claim therefor is filed.

(c) *Training duty.* Prospective adjustment of awards may be made where the veteran waives his or her Department of Veterans Affairs benefit covering anticipated receipt of active service pay because of expected periods of active duty for training or inactive duty training. Where readjustment is in

order because service pay was not received for expected training duty, retroactive payments may be authorized if a claim for readjustment is received within 1 year after the end of the fiscal year for which payments were waived.

[27 FR 11890, Dec. 1, 1962]

§ 3.655 Failure to report for Department of Veterans Affairs examination.

(a) *General.* When entitlement or continued entitlement to a benefit cannot be established or confirmed without a current VA examination or reexamination and a claimant, without good cause, fails to report for such examination, or reexamination, action shall be taken in accordance with paragraph (b) or (c) of this section as appropriate. Examples of good cause include, but are not limited to, the illness or hospitalization of the claimant, death of an immediate family member, etc. For purposes of this section, the terms *examination* and *reexamination* include periods of hospital observation when required by VA.

(b) *Original or supplemental claim, or claim for increase.* When a claimant fails to report for an examination scheduled in conjunction with an original compensation claim, the claim shall be rated based on the evidence of record. When the examination was scheduled in conjunction with any other original claim, a supplemental claim for a benefit which was previously disallowed, or a claim for increase, the claim shall be denied.

(c) *Running award.* (1) When a claimant fails to report for a reexamination and the issue is continuing entitlement, VA shall issue a pretermination notice advising the payee that payment for the disability or disabilities for which the reexamination was scheduled will be discontinued or, if a minimum evaluation is established in part 4 of this title or there is an evaluation protected under § 3.951(b) of this part, reduced to the lower evaluation. Such notice shall also include the prospective date of discontinuance or reduction, the reason therefor and a statement of the claimant's procedural and appellate rights. The claimant shall be allowed 60 days to indicate his or her willingness to report for a reexamination or to present evidence that payment for the disability or disabilities for which the reexamination was scheduled should not be discontinued or reduced.

(2) If there is no response within 60 days, or if the evidence submitted does not establish continued entitlement, payment for such disability or disabilities shall be discontinued or reduced as of the date indicated in the pretermination notice or the date of last payment, whichever is later.

(3) If notice is received that the claimant is willing to report for a reexamination before payment has been discontinued or reduced, action to adjust payment shall be deferred. The reexamination shall be rescheduled and the claimant notified that failure to report for the rescheduled examination shall be cause for immediate discontinuance or reduction of payment. When a claimant fails to report for such rescheduled examination, payment shall be reduced or discontinued as of the date of last payment and shall not be further adjusted until a VA examination has been conducted and the report reviewed.

(4) If within 30 days of a pretermination notice issued under paragraph (c)(1) of this section the claimant requests a hearing, action to adjust payment shall be deferred as set forth in § 3.105(i)(1) of this part. If a hearing is requested more than 30 days after such pretermination notice but before the proposed date of discontinuance or reduction, a hearing shall be scheduled, but payment shall nevertheless be discontinued or reduced as of the date proposed in the pretermination notice or date of last payment, whichever is later, unless information is presented which warrants a different determination. When the claimant has also expressed willingness to report for an examination, however, the provisions of paragraph (c)(3) of this section shall apply.

(Authority: 38 U.S.C. 501)

CROSS REFERENCES: Procedural due process and appellate rights: See § 3.103. Examinations: See § 3.326. Reexaminations: See § 3.327.

Resumption of rating when veteran subsequently reports for VA examination: See § 3.330.

[55 FR 49521, Nov. 29, 1990; 58 FR 46865, Sept. 3, 1993; 80 FR 18117, Apr. 3, 2015; 84 FR 171, Jan. 18, 2019]

§ 3.656 Disappearance of veteran.

(a) When any veteran has disappeared for 90 days or more and his or her whereabouts remain unknown to the members of his or her family and the Department of Veterans Affairs, disability compensation which he or she was receiving or entitled to receive may be paid to or for his or her spouse, children and parents, effective the day following the date of last payment to the veteran if a claim is received within 1 year after that date; otherwise from the date of receipt of a claim. The total amount payable will be the lesser of these amounts:

(1) Dependency and indemnity compensation.

(2) Amount of compensation payable to the veteran at the time of disappearance, subject to authorized insurance deductions.

(b) Where a veteran's whereabouts become known to the Department of Veterans Affairs after an award to dependents has been made as provided in this section, the award to the dependents will be discontinued effective date of last payment, and appropriate action will be taken to adjust the veteran's award in accordance with the facts found.

(Authority: 38 U.S.C. 1158)

(c) Awards to dependents will not be continued under this section in any case where the facts are such as to bring into effect the presumption of death under § 3.212.

(d) When any veteran has disappeared for 90 days or more and the veteran's whereabouts remain unknown to members of the veteran's family and the Department of Veterans Affairs, any improved pension, section 306 or service pension which the veteran was receiving or entitled to receive may be paid to or for the spouse or children. The status of the veteran at the time of disappearance, with respect to permanent and total disability, income and net worth will be presumed to continue unchanged. Payment for the spouse or children will be effective the day following the date of last payment to the veteran if a claim is received within 1 year after that date; otherwise from date of receipt of a claim. The total amount payable will be the lesser of these amounts:

(1) The service death pension rate if the veteran was receiving service pension or the improved death pension rate if the veteran was receiving section 306 or improved pension.

(2) The amount of pension payable to the veteran at the time of disappearance.

(Authority: 38 U.S.C. 1507)

[26 FR 1599, Feb. 24, 1961, as amended at 27 FR 11891, Dec. 1, 1962; 30 FR 6649, May 14, 1965; 40 FR 14313, Mar. 31, 1975; 44 FR 45942, Aug. 6, 1979]

§ 3.657 Surviving spouse becomes entitled, or entitlement terminates.

Where a surviving spouse establishes entitlement to pension, compensation, or dependency and indemnity compensation, an award to another person as surviving spouse, or for a child or children as if there were no surviving spouse will be discontinued or adjusted as provided in this section.

(a) *Surviving spouse's awards.* For periods on or after December 1, 1962, where a legal surviving spouse establishes entitlement after payments have been made to another person as surviving spouse, the full rate payable to the legal surviving spouse will be authorized effective the date of entitlement. Payments to the former payee will be discontinued as follows:

(1) Where benefits are payable to the legal surviving spouse from a date prior to the date of filing claim, the award to the former payee will be terminated the day preceding the effective date of the award to the legal surviving spouse.

(2) Where benefits are payable to the legal surviving spouse from the date of filing claim, the award to the former payee will be terminated effective the date of receipt of the claim or date of last payment, whichever is later.

(b) *Children's awards.* (1) Where a surviving spouse establishes entitlement and:

(i) Payments were being made for a child or children at a lower monthly rate than that provided where there is a surviving spouse, the award to the surviving spouse will be effective the date provided by the applicable law, and will be the difference between the rate paid for the children and the rate payable for the surviving spouse and children. The full rate will be payable for the surviving spouse effective the day following the date of last payment for the children;

(ii) Payments were being made for a child or children at the same or higher monthly rate than that provided where there is a surviving spouse, the award to the surviving spouse will be effective the day following the date of last payment on the awards on behalf of the children.

(2) Where a surviving spouse has received benefits after entitlement was terminated and,

(i) The child or children were entitled to a lower monthly rate, the award to the surviving spouse will be amended to authorize payment at the rate provided for the children as if there were no surviving spouse, covering the period from the date the surviving spouse's entitlement terminated to the date of last payment. The award for the child or children will be made effective the following day.

(ii) The child or children were entitled to a higher monthly rate, the award to the surviving spouse will be discontinued effective date of last payment. The award to the children will be effective the day following the date the surviving spouse's entitlement terminated and will be the difference between the rate payable for the children and the rate paid on the surviving spouse's award. The full rate will be payable for the children effective the day following the date of last payment to the surviving spouse.

[39 FR 20204, June 7, 1974, as amended at 44 FR 45942, Aug. 6, 1979]

§ 3.658 Offsets; dependency and indemnity compensation.

(a) When an award of dependency and indemnity compensation is made covering a period for which death compensation or benefits under the Federal Employee's Compensation Act, based on military service, have been paid to the same payee based on the same death, the award of dependency and indemnity compensation will be made subject to an offset of payments of death compensation or benefits under the Federal Employees' Compensation Act over the same period.

(b) When an award of dependency and indemnity compensation is made covering a period for which death benefits have been paid to the same payee based on the death of another spouse the award will be made subject to an offset of payments of death pension or compensation, or dependency and indemnity compensation over the same period in the case of the other spouse.

(Authority: 38 U.S.C. 103(d)(2), 5304(b)(3))

[41 FR 17387, Apr. 26, 1976]

§ 3.659 Two parents in same parental line.

The provisions of this section are applicable for periods commencing on or after January 1, 1957 in cases involving payments of death compensation or dependency and indemnity compensation, and in addition, for periods commencing on or after June 9, 1960, in cases involving payments of death pension based on death on or after that date.

(a) If death pension, compensation or dependency and indemnity compensation is payable based on the service of one parent, an award of such benefits to or on account of a child will be made subject to any payments of these benefits made to or on account of that child over the same period of time based on the service of another parent in the same parental line.

(b) Any reduction or discontinuance of an award to the child or to a surviving spouse will be effective the day preceding the commencing date of death pension, compensation, or dependency and indemnity compensation or, under the circumstances described in § 3.707, the commencing date of dependents' educational assistance under 38 U.S.C. ch. 35, to or on account of the child based on the service of another parent in the same parental line. Any increase to a surviving spouse or another child will be effective the commencing date of the award to the child.

CROSS REFERENCE: Two-parent cases. See §3.503(a)(7). Two parents in same parental line. See §3.703.

[27 FR 4917, May 25, 1962, as amended at 29 FR 9564, July 15, 1964; 41 FR 17387, Apr. 26, 1976]

§3.660 Dependency, income and estate.

(a) *Reduction or discontinuance*—(1) *General*. A veteran, surviving spouse or child who is receiving pension, or a parent who is receiving compensation or dependency and indemnity compensation must notify the Department of Veterans Affairs of any material change or expected change in his or her income or other circumstances which would affect his or her entitlement to receive, or the rate of, the benefit being paid. Such notice must be furnished when the recipient acquires knowledge that he or she will begin to receive additional income or when his or her marital or dependency status changes. In pension claims subject to §3.252(b) or §3.274 and in compensation claims subject to §3.250(a)(2), notice must be furnished of any material increase in corpus of the estate or net worth.

(2) *Effective dates*. Where reduction or discontinuance of a running award of section 306 pension or old-law pension is required because dependency of another person ceased due to marriage, annulment, divorce or death, or because of an increase in income, which increase could not reasonably have been anticipated based on the amount actually received from that source the year before, the reduction or discontinuance shall be made effective the end of the year in which the increase occurred. Where reduction or discontinuance of a running award of improved pension or dependency and indemnity compensation is required because of an increase in income, the reduction or discontinuance shall be made effective the end of the month in which the increase occurred. Where reduction or discontinuance of a running award of any benefit is required because of an increase in net worth or corpus of estate, because dependency of a parent ceased, or because dependency of another person ceased prior to October 1, 1982, due to marriage, annulment, divorce, or death, the award shall be reduced or discontinued effective the last day of the calendar year in which the increase occurred or dependency ceased. Except as noted in this subparagraph for section 306 or old-law pension, where the dependency of another person ceased on or after October 1, 1982, due to marriage, annulment, divorce or death, the reduction or discontinuance shall be effective the last day of the month in which dependency ceased.

(Authority: 38 U.S.C. 5112(b))

(3) *Overpayments*. Overpayments created by retroactive discontinuance of benefits will be subject to recovery if not waived. Where dependency and indemnity compensation was being paid to two parents living together, an overpayment will be established on the award to each parent.

(b) *Award or increase; income*. Where pension or dependency and indemnity compensation was not paid for a particular 12–month annualization period because the claim was disallowed, an award was deferred under §3.260(b) or §3.271(f), payments were discontinued or made at a lower rate based on anticipated or actual income, benefits otherwise payable may be authorized commencing the first of a 12–month annualization period as provided in this paragraph. In all other cases, benefits may not be authorized for any period prior to the date of receipt of a new claim.

(1) *Anticipated income*. Where payments were not made or were made at a lower rate because of anticipated income, pension or dependency and indemnity compensation may be awarded or increased in accordance with the facts found but not earlier than the beginning of the appropriate 12–month annualization period if satisfactory evidence is received within the same or the next calendar year.

(Authority: 38 U.S.C. 5110(h))

(2) *Actual income*. Where the claimant's actual income did not permit payment, or payment was made at a lower rate, for a given 12–month annualization period, pension or dependency and indemnity compensation may be awarded or increased, effective

the beginning of the next 12–month annualization period, if satisfactory evidence is received within that period.

(c) *Increases; change in status.* Where there is change in the payee's marital status or status of dependents which would permit payment at a higher rate and the change in status is by reason of the claimant's marriage or birth or adoption of a child, the effective date of the increase will be the date of the event if the required evidence is received within 1 year of the event. Where there is a change in dependency status for any reason other than marriage, or the birth or adoption of a child, which would permit payment at a higher rate, the increased rate will be effective the date of receipt of a claim or an intent to file a claim as set forth in § 3.155(b) if the required evidence is received within 1 year of Department of Veterans Affairs request. The rate payable for each period will be determined, as provided in §§ 3.260(f) or 3.273(c). (See § 3.651 as to increase due to termination of payments to another payee. Also see § 3.667 as to increase based on school attendance.)

(d) *Corpus of estate; net worth.* Where a claim has been finally disallowed or terminated because of the corpus of estate and net worth provisions of § 3.263 and entitlement is established on the basis of a reduction in estate or net worth, or a change in circumstances such as health, acquisition of a dependent, or increased rate of depletion of the estate, benefits or increased benefits will not be paid for any period prior to the date of receipt of a new claim.

[30 FR 3354, Mar. 12, 1965, as amended at 44 FR 45942, Aug. 6, 1979; 48 FR 34473, July 29, 1983; 57 FR 59300, Dec. 15, 1992; 79 FR 57697, Sept. 25, 2014; 83 FR 47275, Sept. 18, 2018]

§ 3.661 Eligibility Verification Reports.

(a) *Determination and entitlement.* (1) Where the report shows a change in income, net worth, marital status, status of dependents or change in circumstances affecting the application of the net worth provisions, the award will be adjusted in accordance with § 3.660(a)(2).

(2) Where there is doubt as to the extent of anticipated income payment of pension or dependency and indemnity compensation will be authorized at the lowest appropriate rate or will be withheld, as provided in § 3.260(b) or § 3.271 (f).

(b) *Failure to return report*—(1) *Section 306 and old-law pension*—(i) *Discontinuance.* Discontinuance of old-law or section 306 pension shall be effective the last day of the calendar year for which income (and net worth in a section 306 pension case) was to be reported.

(ii) *Resumption of benefits.* Payment of old-law or section 306 pension may be resumed, if otherwise in order, from the date of last payment if evidence of entitlement is received within the calendar year following the calendar year for which income (and net worth in a section 306 pension case) was to be reported; otherwise pension may not be paid for any period prior to the date of receipt of a new claim.

(2) *Improved pension and dependency and indemnity compensation*—(i) *Discontinuance.* Discontinuance of dependency and indemnity compensation (DIC) or improved pension shall be effective the first day of the 12–month annualization period for which income (and net worth in an improved pension case) was to be reported or the effective date of the award, whichever is the later date.

(ii) *Adjustment of overpayment.* If evidence of entitlement to improved pension or DIC for any period for which payment of improved pension or DIC was discontinued for failure to file an Eligibility Verification Report is received at any time, payment of improved pension or DIC shall be awarded for the period of entitlement for which benefits were discontinued for failure to file an Eligibility Verification Report.

(iii) *Resumption of benefits.* Payment of improved pension and DIC may be resumed, if otherwise in order, from the date of last payment if evidence of entitlement is received within the 12–month annualization period following the 12–month annualization period for which income (and net worth in an improved pension case) was to be reported; otherwise pension or DIC may

not be paid for any period prior to receipt of a new claim.

(Authority: 38 U.S.C. 501)

[30 FR 3355, Mar. 12, 1965, as amended at 44 FR 45942, Aug. 6, 1979; 46 FR 55098, Nov. 6, 1981; 57 FR 59300, Dec. 15, 1992]

§§ 3.662–3.664 [Reserved]

§ 3.665 Incarcerated beneficiaries and fugitive felons—compensation.

(a) *General*. Any person specified in paragraph (c) of this section who is incarcerated in a Federal, State or local penal institution in excess of 60 days for conviction of a felony will not be paid compensation or dependency and indemnity compensation (DIC) in excess of the amount specified in paragraph (d) of this section beginning on the 61st day of incarceration. VA will inform a person whose benefits are subject to this reduction of the rights of the person's dependents to an apportionment while the person is incarcerated, and the conditions under which payments to the person may be resumed upon release from incarceration. In addition, VA will also notify the person's dependents of their right to an apportionment if the VA is aware of their existence and can obtain their addresses. However, no apportionment will be made if the veteran or the dependent is a fugitive felon as defined in paragraph (n) of this section.

(b) *Definitions*. For the purposes of this section the term *compensation* includes disability compensation under 38 U.S.C. 1151. The term *dependency and indemnity compensation* (DIC) includes death compensation payable under 38 U.S.C. 1121 or 1141, death compensation and DIC payable under 38 U.S.C. 1151, and any benefit payable under chapter 13 of title 38, United States Code. The term *release from incarceration* includes participation in a work release or halfway house program, parole, and completion of sentence. For purposes of this section, a felony is any offense punishable by death or imprisonment for a term exceeding 1 year, unless specifically categorized as a misdemeanor under the law of the prosecuting jurisdiction.

(c) *Applicability*. The provisions of paragraph (a) of this section are applicable to the following persons:

(1) A person serving a period of incarceration for conviction of a felony committed after October 7, 1980.

(2) A person serving a period of incarceration after September 30, 1980 (regardless of when the felony was committed) when the following conditions are met:

(i) The person was incarcerated on October 1, 1980; and

(ii) An award of compensation or DIC is approved after September 30, 1980.

(3) A veteran who, on October 7, 1980, was incarcerated in a Federal, State, or local penal institution for a felony committed before that date, and who remains so incarcerated for a conviction of that felony as of December 27, 2001.

(d) *Amount payable during incarceration*—(1) *Veteran rated 20 percent or more*. A veteran to whom the provisions of paragraphs (a) and (c) of this section apply with a service-connected disability evaluation of 20 percent or more shall receive the rate of compensation payable under 38 U.S.C. 1114(a).

(2) *Veteran rated less than 20 percent*. A veteran to whom the provisions of paragraphs (a) and (c) of this section apply with a service-connected disability evaluation of less than 20 percent (even though the rate for 38 U.S.C. 1114 (k) or (q) is paid) shall receive one-half the rate of compensation payable under 38 U.S.C. 1114(a).

(3) *Surviving spouse, parent or child*. A surviving spouse, parent, or child, beneficiary to whom the provisions of paragraphs (a) and (c) of this section apply shall receive one-half the rate of compensation payable under 38 U.S.C. 1114(a).

(e) *Apportionment*—(1) *Compensation*. All or part of the compensation not paid to an incarcerated veteran may be apportioned to the veteran's spouse, child or children and dependent parents on the basis of individual need. In determining individual need consideration shall be given to such factors as the apportionee claimant's income and living expenses, the amount of compensation available to be apportioned, the needs and living expenses of other apportionee claimants as well as any special needs, if any, of all apportionee claimants.

(2) *DIC*. All or part of the DIC not paid to an incarcerated surviving spouse or other children not in the surviving spouse's custody may be apportioned to another child or children. All or part of the DIC not paid to an incarcerated child may be apportioned to the surviving spouse or other children. These apportionments shall be made on the basis of individual need giving consideration to the factors set forth in paragraph (e)(1) of this section.

(f) *Effective dates*. An apportionment under this section shall be effective the date of reduction of payments made to the incarcerated person, subject to payments to the incarcerated person over the same period, if a claim or intent to file a claim as set forth in § 3.155(b) is received within 1 year after notice to the incarcerated person as required by paragraph (a) of this section, and any necessary evidence is received within 1 year from the date of request by the Department of Veterans Affairs; otherwise, payments may not be made for any period prior to the date of receipt of a new claim or intent to file a claim as set forth in § 3.155(b).

(g) *Incarcerated dependent*. No apportionment may be made to or on behalf of any person who is incarcerated in a Federal, State, or local penal institution for conviction of a felony.

(h) *Notice to dependent for whom apportionment granted*. A dependent for whom an apportionment is granted under this section shall be informed that the apportionment is subject to immediate discontinuance upon the incarcerated person's release or participation in a work release or halfway house program. A dependent shall also be informed that if the dependent and the incarcerated person do not live together when the incarcerated person is released (or participates in a work release or halfway house program) the dependent may submit a new claim for apportionment.

(i) *Resumption upon release*—(1) *No apportionment or family reunited*. If there was no apportionment at the time of release from incarceration, or if the released person is reunited with all dependents for whom an apportionment was granted, the released person's award shall be resumed the date of release from incarceration if the Department of Veterans Affairs receives notice of release within 1 year following release; otherwise the award shall be resumed the date of receipt of notice of release. If there was an apportionment award during incarceration, it shall be discontinued date of last payment to the apportionee upon receipt of notice of release of the incarcerated person. Payment to the released person shall then be resumed at the full rate from date of last payment to the apportionee. Payment to the released person from date of release to date of last payment to the apportionee shall be made at the rate which is the difference between the released person's full rate and the sum of (i) the rate that was payable to the apportionee and (ii) the rate payable during incarceration.

(2) *Apportionment granted and family not reunited*. If there was an apportionment granted during incarceration and the released person is not reunited with all dependents for whom an apportionment was granted, the released person's award shall be resumed as stated in paragraph (i)(1) of this section except that when the released person's award is resumed it shall not include any additional amount payable by reason of a dependent(s) not reunited with the released person. The award to this dependent(s) will then be reduced to the additional amount payable for the dependent(s).

(3) *Apportionment to a dependent parent*. An apportionment made to a dependent parent under this section cannot be continued beyond the veteran's release from incarceration unless the veteran is incompetent and the provisions of § 3.452(c) (1) and (2) are for application. When a competent veteran is released from incarceration an apportionment made to a dependent parent shall be discontinued and the veteran's award resumed as provided in paragraph (i)(1) of this section.

(j) *Increased compensation during incarceration*—(1) *General*. The amount of any increased compensation awarded to an incarcerated veteran that results from other than a statutory rate increase may be subject to reduction due to incarceration. This applies to a veteran whose compensation is subject to reduction under paragraphs (a) and (c)

of this section prior to approval of an award of increased compensation as well as to veteran whose compensation is not subject to reduction under paragraphs (a) and (c) of this section prior to approval of an award of increased compensation.

(2) *Veteran subject to reduction under paragraphs (a) and (c) of this section.* If prior to approval of an award of increased compensation the veteran's compensation was reduced under the provisions of paragraphs (a) and (c) of this section, the amount of the increase shall be reduced as follows if the veteran remains incarcerated:

(i) If the veteran's schedular evaluation is increased from 10 percent to 20 percent or greater, the amount payable to the veteran shall be increased from one-half the rate payable under 38 U.S.C. 1114(a) to the rate payable under section 1114(a).

(ii) If the veteran's schedular evaluation was 20 percent or more, none of the increased compensation shall be paid to the veteran while the veteran remains incarcerated.

(3) *Veteran's compensation not subject to reduction under paragraphs (a) and (c) of this section prior to award of increased compensation.* If prior to the approval of an award of increased compensation the veteran is incarcerated in a Federal, State, or local penal institution for conviction of a felony and the veteran's compensation was not reduced under the provisions of paragraphs (a) and (c) of this section, none of the increased compensation shall be paid to the veteran for periods after October 7, 1980, subject to the following conditions:

(i) The veteran remains incarcerated after October 7, 1980 in a Federal, State, or local penal institution for conviction of a felony; and

(ii) The award of increased compensation is approved after October 7, 1980. If the effective date of the increase is prior to October 8, 1980, the amount payable for periods prior to October 8, 1980, shall not be reduced.

(4) *Apportionments.* The amount of any increased compensation reduced under this paragraph may be apportioned as provided in paragraph (e) of this section.

(k) *Retroactive awards.* Whenever compensation or DIC is awarded to an incarcerated person any amounts due for periods prior to date of reduction under this section shall be paid to the incarcerated person.

(l) *DIC parents.* If two parents are both entitled to DIC and were living together prior to the time of the DIC payable to one parent was reduced due to incarceration, they shall be considered as two parents not living together for the purpose of determining entitlement to DIC.

(m) *Conviction overturned on appeal.* If a conviction is overturned on appeal, any compensation or DIC withheld under this section as a result of incarceration for such conviction (less the amount of any apportionment) shall be restored to the beneficiary.

(n) *Fugitive felons.* (1) Compensation is not payable on behalf of a veteran for any period during which he or she is a fugitive felon. Compensation or DIC is not payable on behalf of a dependent of a veteran for any period during which the veteran or the dependent is a fugitive felon.

(2) For purposes of this section, the term *fugitive felon* means a person who is a fugitive by reason of:

(i) Fleeing to avoid prosecution, or custody or confinement after conviction, for an offense, or an attempt to commit an offense, which is a felony under the laws of the place from which the person flees; or

(ii) Violating a condition of probation or parole imposed for commission of a felony under Federal or State law.

(3) For purposes of paragraph (n) of this section, the term *felony* includes a high misdemeanor under the laws of a State which characterizes as high misdemeanors offenses that would be felony offenses under Federal law.

(4) For purposes of paragraph (n) of this section, the term *dependent* means a spouse, surviving spouse, child, or dependent parent of a veteran.

(Authority: 38 U.S.C. 501(a), 5313, 5313B; Sec. 506, Pub. L. 107–103, 115 Stat. 996–997)

[46 FR 47542, Sept. 29, 1981, as amended at 68 FR 34542, June 10, 2003; 79 FR 57697, Sept. 25, 2014]

§ 3.666 Incarcerated beneficiaries and fugitive felons—pension.

If any individual to or for whom pension is being paid under a public or private law administered by the Department of Veterans Affairs is imprisoned in a Federal, State or local penal institution as the result of conviction of a felony or misdemeanor, such pension payments will be discontinued effective on the 61st day of imprisonment following conviction. The payee will be informed of his or her rights and the rights of dependents to payments while he or she is imprisoned as well as the conditions under which payments to him or to her may be resumed on his or her release from imprisonment. However, no apportionment will be made if the veteran or the dependent is a fugitive felon as defined in paragraph (e) of this section. Payments of pension authorized under this section will continue until notice is received by the Department of Veterans Affairs that the imprisonment has terminated.

(a) *Disability pension.* Payment may be made to the spouse, child or children of a veteran disqualified under this section:

(1) If the veteran continues to be eligible except for the provisions of this section, and

(2) If the annual income of the spouse or child is such that death pension would be payable.

(3) At the rate payable under the death pension law or the rate which the veteran was receiving at the time of imprisonment, whichever is less.

(4) From the day following the date of discontinuance of payments to the veteran, subject to payments made to the veteran over the same period, if a claim or intent to file a claim as set forth in § 3.155(b) is received within 1 year after notice to the veteran as required by this section and any necessary evidence is received within 1 year from the date of request; otherwise payments may not be made for any period prior to the date of receipt of a new claim or intent to file a claim as set forth in § 3.155(b).

(b) *Death pension.* Payment may be made to a child or children where a surviving spouse or child is disqualified under this section:

(1) If surviving spouse is disqualified to child or children at the rate of death pension payable if there were no such surviving spouse; or

(2) If a child is disqualified, to a surviving spouse or other child or children at the rate of death pension payable if there were no such child, and

(3) From the day following the date of discontinuance of payments to the disqualified person, subject to payments made to that person over the same period if evidence of income is received within 1 year after date of request; otherwise payments may not be made for any period prior to the date of receipt of a claim or intent to file a claim as set forth in § 3.155(b).

(4) The income limitation applicable to eligible persons will be that which would apply if the imprisoned person did not exist.

(c) *Resumption of pension upon release from incarceration.* Pension will be resumed as of the day of release if notice is received within 1 year following release; otherwise resumption will be effective the date of receipt of such notice. Where an award or increased award was made to any other payee based upon the disqualification of the veteran, surviving spouse, or child while in prison, such award will be reduced or discontinued as of date of last payment and pension will be resumed to the released prisoner at a rate which will be the difference, if any, between the total pension payable and the amount which was paid to the other person or persons through the date of last payment and thereafter the full rate.

(d) *Veteran entitled to compensation.* If an imprisoned veteran is entitled to a lesser rate of disability compensation, it shall be awarded as of the 61st day of imprisonment in lieu of the pension the veteran was receiving if the veteran has neither spouse nor child. If the veteran has a spouse or a child, compensation will be awarded only after the veteran has been furnished an explanation of the effect of electing compensation on the amount available for apportionment. If the veteran then requests compensation, it shall be awarded from the date veteran requests the Department of Veterans Affairs to take such action.

(e) *Fugitive felons.* (1) Pension is not payable on behalf of a veteran for any period during which he or she is a fugitive felon. Pension or death pension is not payable on behalf of a dependent of a veteran for any period during which the veteran or the dependent is a fugitive felon.

(2) For purposes of this section, the term *fugitive felon* means a person who is a fugitive by reason of:

(i) Fleeing to avoid prosecution, or custody or confinement after conviction for an offense, or an attempt to commit an offense, which is a felony under the laws of the place from which the person flees; or

(ii) Violating a condition of probation or parole imposed for commission of a felony under Federal or State law.

(3) For purposes of paragraph (e) of this section, the term *felony* includes a high misdemeanor under the laws of a State which characterizes as high misdemeanors offenses that would be felony offenses under Federal law.

(4) For purposes of paragraph (e) of this section, the term *dependent* means a spouse, surviving spouse, child, or dependent parent of a veteran.

(Authority: 38 U.S.C. 501(a), 5313, 5313B)

[26 FR 1601, Feb. 24, 1961, as amended at 40 FR 6971, Feb. 18, 1975; 40 FR 22254, May 22, 1975; 44 FR 45943, Aug. 6, 1979; 46 FR 47543, Sept. 29, 1981; 62 FR 5529, Feb. 6, 1997; 68 FR 34543, June 10, 2003; 79 FR 57697, Sept. 25, 2014]

§ 3.667 School attendance.

(a) *General.* (1) Pension or compensation may be paid from a child's 18th birthday based upon school attendance if the child was at that time pursing a course of instruction at an approved educational institution and a claim for such benefits is filed within 1 year from the child's 18th birthday.

(2) Pension or compensation based upon a course of instruction at an approved educational institution which was begun after a child's 18th birthday may be paid from the commencement of the course if a claim is filed within 1 year from that date.

(3) An initial award of DIC (dependency and indemnity compensation) to a child in the child's own right is payable from the first day of the month in which the child attains age 18 if the child was pursuing a course of instruction at an approved educational institution on the child's 18th birthday, and if a claim for benefits is filed within 1 year from the child's 18th birthday. In the case of a child who attains age 18 after September 30, 1981, if the child was, immediately before attaining age 18, counted under 38 U.S.C. 1311(b) for the purpose of determining the amount of DIC payable to the surviving spouse, the effective date of an award of DIC to the child shall be the date the child attains age 18 if a claim for DIC is filed within 1 year from that date.

(Authority: 38 U.S.C. 5110(e))

(4) An initial award of dependency and indemnity compensation to a child in its own right based upon a course of instruction at an approved educational institution which was begun after the child's 18th birthday may be paid from the first day of the month in which the course commenced if a claim is filed within 1 year from that date.

(Authority: 38 U.S.C. 5110(e))

(5) Where a child was receiving dependency and indemnity compensation in its own right prior to age 18, payments may be continued from the 18th birthday if the child was then attending an approved educational institution and evidence of such school attendance is received within 1 year from the 18th birthday. Where the child was receiving dependency and indemnity compensation in its own right prior to age 18 and was not attending an approved educational institution on the 18th birthday but commences attendance at an approved educational institution after the 18th birthday, payments may be resumed from the commencing date of the course if evidence of such school attendance is filed within 1 year from that date.

(b) *Vacation periods.* A child is considered to be in school during a vacation or other holiday period if he or she was attending an approved educational institution at the end of the preceding school term and resumes attendance, either in the same or a different approved educational institution, at the beginning of the next term. If an award has been made covering a vacation period, and the child fails to commence or resume school attendance, benefits

will be terminated the date of last payment or the last day of the month preceding the date of failure to pursue the course, whichever is the earlier.

(c) *Ending dates.* Except as provided in paragraph (b) of this section, benefits may be authorized through the last day of the month in which a course was or will be completed.

(Authority: 38 U.S.C. 5112(b)(7))

(d) *Transfers to other schools.* When benefits have been authorized based upon school attendance and it is shown that during a part or all of that period the child was pursuing a different course in the same approved educational institution or a course in a different approved educational institution, payments previously made will not be disturbed.

(e) *Accrued benefits only.* When a claim for accrued benefits is filed by or on behalf of a veteran's child over 18 but under 23 years of age, who was pursuing a course of instruction at the time of the payee's death and payment of accrued benefits only is involved, evidence of school attendance need not be confirmed by the school. When the payee's death occurred during a school vacation period, the requirements will be considered to have been met if the child was carried on the school rolls on the last day of the regular school term immediately preceding the date of the payee's death.

(Authority: 38 U.S.C. 5112(b)(7))

(f) *Nonduplication.* Pension, compensation or dependency and indemnity compensation may not be authorized:

(1) After a child has elected to receive educational assistance under 38 U.S.C. chapter 35 (see § 3.707 and § 21.3023 of this chapter); or

(2) Based on an educational program in a school where the child is wholly supported at the expense of the Federal Government, such as a service academy.

CROSS REFERENCE: Dependents' educational assistance. See § 3.707.

[26 FR 1601, Feb. 24, 1961, as amended at 30 FR 14983, Dec. 3, 1965; 32 FR 12114, Aug. 23, 1967; 34 FR 839, Jan. 18, 1969; 40 FR 22254, May 22, 1975; 47 FR 24552, June 7, 1982; 65 FR 12116, Mar. 8, 2000]

§ 3.668 [Reserved]

§ 3.669 Forfeiture.

(a) *General.* Upon receipt of notice from a Regional Counsel (or in cases under the jurisdiction of the Manila Regional Office, the Veterans Service Center Manager) that a case is being formally submitted for consideration of forfeiture of a payee's rights under § 3.905 of this part or that the payee has been indicted for subversive activities, payments will be suspended effective date of last payment.

(b) *Fraud or treasonable act*—(1) *Fraud.* If forfeiture of rights is not declared, payments shall be resumed from date of last payment, if otherwise in order. If it is determined that rights have been forfeited, benefits shall be discontinued effective the commencing date of the award or the day preceding the commission of the act resulting in the forfeiture, whichever is later.

(2) *Treasonable acts.* If forfeiture of rights is not declared, payments shall be resumed from date of last payment, if otherwise in order. If it is determined that rights have been forfeited, benefits shall be discontinued the date of the forfeiture decision or date of last payment, whichever is earlier.

(c) *Subversive activities.* If the payee is acquitted of the charge, payments will be resumed from date of last payment, if otherwise in order. If the payee is convicted, benefits will be discontinued effective the commencing date of the award or the day preceding the commission of the act resulting in the forfeiture, whichever is later.

(d) *Pardons.* (1) Where the payee's offense has been pardoned by the President of the United States, the award will be resumed, if otherwise in order, effective the date of the pardon if claim is filed within 1 year from that date; otherwise benefits may not be authorized for any period prior to the date of filing claim. The award will be subject to any existing overpayment.

(2) Payments to a dependent of the person whose benefits were declared forfeited before September 2, 1959, will be discontinued effective the day preceding the date of the pardon.

(Authority: 38 U.S.C. 501)

CROSS REFERENCES: Fraud. See § 3.901. Treasonable acts. See § 3.902. Subversive activities. See § 3.903.

[27 FR 8616, Aug. 29, 1962, as amended 28 FR 5618, June 7, 1963; 39 FR 28630, Aug. 9, 1974; 46 FR 34801, July 6, 1981; 71 FR 52290, Sept. 5, 2006]

CONCURRENT BENEFITS AND ELECTIONS

§ 3.700 General.

Not more than one award of pension, compensation, or emergency officers', regular or reserve retirement pay will be made concurrently to any person based on his or her own service except as provided in § 3.803 relating to naval pension and § 3.750(c) relating to waiver of retirement pay. Not more than one award of pension, compensation, or dependency and indemnity compensation may be made concurrently to a dependent on account of more than one period of service of a veteran.

(Authority: 38 U.S.C. 5304(a))

(a) *Veterans*—(1) *Active service pay*. (i) Pension, compensation, or retirement pay on account of his or her own service will not be paid to any person for any period for which he or she receives active service pay.

(Authority: 38 U.S.C. 5304(c))

(ii) Time spent by members of the ROTC in drills as part of their activities as members of the corps is not active service.

(iii) Reservists may waive their pension, compensation, or retirement pay for periods of field training, instruction, other duty or drills. A waiver may include prospective periods and contain a right of recoupment for the days for which the reservists did not receive payment for duty by reason of failure to report for duty.

(2) *Lump-sum readjustment pay*. (i) Where entitlement to disability compensation was established prior to September 15, 1981, a veteran who has received a lump-sum readjustment payment under former 10 U.S.C. 687 (as in effect on September 14, 1981) may receive disability compensation for disability incurred in or aggravated by service prior to the date of receipt of lump-sum readjustment payment subject to deduction of an amount equal to 75 percent of the amount received as readjustment payment.

(Authority: 38 U.S.C. 501)

(ii) Readjustment pay authorized under former 10 U.S.C. 3814(a) is not subject to recoupment through withholding of disability compensation, entitlement to which was established prior to September 15, 1981.

(Authority: 38 U.S.C. 501)

(iii) Where entitlement to disability compensation was established on or after September 15, 1981, a veteran who has received a lump-sum readjustment payment may receive disability compensation for disability incurred in or aggravated by service prior to the date of receipt of the lump-sum readjustment payment, subject to recoupment of the readjustment payment. Where payment of readjustment pay was made on or before September 30, 1996, VA will recoup from disability compensation an amount equal to the total amount of readjustment pay. Where payment of readjustment pay was made after September 30, 1996, VA will recoup from disability compensation an amount equal to the total amount of readjustment pay less the amount of Federal income tax withheld from such pay.

(Authority: 10 U.S.C. 1174(h)(2))

(iv) The receipt of readjustment pay does not affect the payment of disability compensation based on a subsequent period of service. Compensation payable for service-connected disability incurred or aggravated in a subsequent period of service will not be reduced for the purpose of offsetting readjustment pay based on a prior period of service.

(Authority: 10 U.S.C. 1174(h)(2))

(3) *Severance pay*. Where the disability or disabilities found to be service-connected are the same as those

upon which disability severance pay is granted, or where entitlement to disability compensation was established on or after September 15, 1981, an award of compensation will be made subject to recoupment of the disability severance pay. Prior to the initial determination of the degree of disability recoupment will be at the full monthly compensation rate payable for the disability or disabilities for which severance pay was granted. Following initial determination of the degree of disability recoupment shall not be at a monthly rate in excess of the monthly compensation payable for that degree of disability. For this purpose the term ''initial determination of the degree of disability'' means the first regular schedular compensable rating in accordance with the provisions of subpart B, part 4 of this chapter and does not mean a rating based in whole or in part on a need for hospitalization or a period of convalescense. Where entitlement to disability compensation was established prior to September 15, 1981, compensation payable for service-connected disability other than the disability for which disability severance pay was granted will not be reduced for the purpose of recouping disability severance pay. Where entitlement to disability compensation was established on or after September 15, 1981, a veteran may receive disability compensation for disability incurred or aggravated by service prior to the date of receipt of the severance pay, but VA must recoup from that disability compensation an amount equal to the severance pay. Where payment of severance pay was made on or before September 30, 1996, VA will recoup from disability compensation an amount equal to the total amount of the severance pay. Where payment of severance pay was made after September 30, 1996, VA will recoup from disability compensation an amount equal to the total amount of the severance pay less the amount of Federal income tax withheld from such pay. For members of the Armed Forces who separated under Chapter 61 of title 10, United States Code, on or after January 28, 2008, no recoupment of severance pay will be made for disabilities incurred in line of duty in a combat zone or incurred during performance of duty in combat-related operations as designated by the Department of Defense.

(Authority: 10 U.S.C. 1174(h)(2) and 1212(d))

(4) *Improved pension.* If a veteran is entitled to improved pension on the basis of the veteran's own service and is also entitled to pension under any pension program currently or previously in effect on the basis of any other person's service, the Department of Veterans Affairs shall pay the veteran only the greater benefit.

(Authority: 38 U.S.C. 1521(i))

(5) *Separation pay and special separation benefits.* (i) Where entitlement to disability compensation was established on or after September 15, 1981, a veteran who has received separation pay may receive disability compensation for disability incurred in or aggravated by service prior to the date of receipt of separation pay subject to recoupment of the separation pay. Where payment of separation pay was made on or before September 30, 1996, VA will recoup from disability compensation an amount equal to the total amount of separation pay. Where payment of separation pay was made after September 30, 1996, VA will recoup from disability compensation an amount equal to the total amount of separation pay less the amount of Federal income tax withheld from such pay. The Federal income tax withholding amount is the flat withholding rate for Federal income tax withholding.

(ii) The receipt of separation pay does not affect the payment of disability compensation based on a subsequent period of service. Compensation payable for service-connected disability incurred or aggravated in a subsequent period of service will not be reduced for the purpose of offsetting separation pay based on a prior period of service.

(iii) Where payment of special separation benefits under 10 U.S.C. 1174a was made on or after December 5, 1991, VA will recoup from disability compensation an amount equal to the total amount of special separation benefits less the amount of Federal income tax withheld from such pay. The Federal

income tax withholding amount is the flat withholding rate for Federal income tax withholding.

(Authority: 10 U.S.C. 1174 and 1174a)

(b) *Dependents*—(1) *Surviving spouse.* Subject to the provisions of paragraph (a)(4) of this section, the receipt of pension, compensation, or dependency and indemnity compensation by a surviving spouse because of the death of any veteran, or receipt of pension or compensation because of his or her own service, shall not bar the payment to the surviving spouse of pension, compensation, or dependency and indemnity compensation because of the death or disability of any other veteran; however, other than insurance, concurrent benefits under laws administered by the Department of Veterans Affairs may not be authorized to a surviving spouse by reason of the death of more than one veteran to whom the surviving spouse has been married. The surviving spouse may elect to receive benefits based on the death of one such spouse and the election places the right to benefits based on the deaths of other spouses in suspense. The suspension may be lifted at any time by another election based on the death of another spouse. Benefits payable in the elected case will be subject to prior payments for the same period based on the death of the other spouse where, under the provisions of §3.400(c), there is entitlement in the elected case prior to date of receipt of the election.

(Authority: 38 U.S.C. 5304)

(2) *Children.* Except as provided in §3.703 and paragraph (a)(4) of this section, the receipt of pension, compensation, or dependency and indemnity compensation by a child on account of the death of a veteran or the receipt by the child of pension or compensation on account of his or her own service will not bar the payment of pension, compensation, or dependency and indemnity compensation on account of the death or disability of any other veteran.

(3) *Parents.* The receipt of compensation or dependency and indemnity compensation by a parent on account of the death of a veteran or receipt by him or her of pension or compensation on account of his or her own service, will not bar the payment of pension, compensation, or dependency and indemnity compensation on account of the death or disability of any other person.

(Authority: 38 U.S.C. 5304(b))

[26 FR 1601, Feb. 24, 1961, as amended at 29 FR 11359, Aug. 6, 1964; 29 FR 15207, Nov. 11, 1964; 30 FR 11389, Sept. 8, 1965; 35 FR 10648, July 1, 1970; 40 FR 59346, Dec. 23, 1975; 44 FR 45943, Aug. 6, 1979; 52 FR 27340, July 21, 1987; 56 FR 1111, Jan. 11, 1991; 67 FR 60868, Sept. 27, 2002; 74 FR 26957, June 5, 2009; 74 FR 36610, July 24, 2009]

§3.701 Elections of pension or compensation.

(a) *General.* Except as otherwise provided, a person entitled to receive pension or compensation under more than one law or section of a law administered by the Department of Veterans Affairs may elect to receive whichever benefit, regardless of whether it is the greater or lesser benefit, even though the election reduces the benefits payable to his or her dependents. Such person may at any time elect or reelect the other benefit. An election by a veteran controls the rights of all dependents in that case. An election by a surviving spouse controls the claims of all children including children over 18 and children not in the custody of the surviving spouse. The election of improved pension by a surviving spouse, however, shall not prejudice the rights of any child receiving an apportionment on December 31, 1978. Termination of a marriage or marital relationship which had been the reason for terminating an award of section 306 or old-law pension does not restore to the surviving spouse the right to receive section 306 or old-law pension. The claimant's entitlement, if otherwise established, is under the current provisions of 38 U.S.C. 1541.

(Authority: 38 U.S.C. 501)

(b) *Form of election.* An election must be in writing and must specify the benefit the person wishes to receive.

(c) *Change from one law to another.* Except as otherwise provided, where payments of pension or compensation are being made to a person under one law, the right to receive benefits under

another law being in suspension, and a higher rate of pension or compensation becomes payable under the other law, benefits at the higher rate will not be paid for any date prior to the date of receipt of an election.

[26 FR 1602, Feb. 24, 1961, as amended at 36 FR 12618, July 2, 1971; 44 FR 45943, Aug. 6, 1979; 79 FR 57697, Sept. 25, 2014]

§ 3.702 Dependency and indemnity compensation.

(a) *Right to elect.* A person who is eligible for death compensation and who has entitlement to dependency and indemnity compensation pursuant to the provisions of § 3.5(b)(2) or (3) may receive dependency and indemnity compensation upon the filing of a claim. The claim of such a person for service-connected death benefits shall be considered a claim for dependency and indemnity compensation subject to confirmation by the claimant. The effective date of payment is controlled by the provisions of § 3.400(c)(4).

(b) *Effect on child's entitlement.* Where a surviving spouse is entitled to death compensation, the amount of which is based in part on the existence of a child who has attained the age of 18 years, and elects to receive dependency and indemnity compensation, the independent award of dependency and indemnity compensation to which the child is entitled will be awarded to or for the child without separate election by or for the child. Should such a surviving spouse not elect to receive dependency and indemnity compensation, the independent dependency and indemnity compensation to which a child who has attained 18 years of age is entitled, may be awarded upon application by or for the child. The effective date of award in these situations will be in accordance with § 3.400(c)(4)(ii).

(c) *Limitation.* A claim for dependency and indemnity compensation may not be filed or withdrawn after the death of the surviving spouse, child, or parent.

(d) *Finality of election.* (1) Except as noted in paragraph (d)(2), an election to receive dependency and indemnity compensation is final and the claimant may not thereafter reelect death pension or compensation in that case. An election is final when the payee (or the payee's fiduciary) has negotiated one check for this benefit or when the payee dies after filing an election but prior to negotiation of a check.

(2) Notwithstanding the provisions of paragraph (d)(1), effective November 2, 1994, a surviving spouse who is receiving dependency and indemnity compensation may elect to receive death pension instead of such compensation.

(Authority: 38 U.S.C. 1317)

(e) *Surviving spouse becomes entitled.* A surviving spouse who becomes eligible to receive death compensation by reason of liberalizing provisions of any law may receive death compensation or elect dependency and indemnity compensation even though dependency and indemnity compensation has been paid to a child or children of the veteran.

(f) *Death pension rate.* (1) Effective October 1, 1961, where the monthly rate of dependency and indemnity compensation payable to a surviving spouse who has children is less than the monthly rate of death pension which would be payable to such surviving spouse if the veteran's death had not been service connected, dependency and indemnity compensation shall be paid to such surviving spouse in an amount equal to the pension rate for any month (or part thereof) in which this rate is greater.

(2) Effective June 22, 1966, where the monthly rate of dependency and indemnity compensation payable to a surviving spouse who has children is less than the monthly rate of death pension which would be payable for the children if the veteran's death had not been service connected and the surviving spouse were not entitled to such pension, dependency and indemnity compensation shall be payable to the surviving spouse in an amount equal to the monthly rate of death pension which would be payable to the children for any month (or part thereof) in which this rate is greater.

(Authority: 38 U.S.C. 1312(b))

CROSS REFERENCE: Deaths prior to January 1, 1957. See § 3.400(c)(3)(i).

[35 FR 18661, Dec. 9, 1970, as amended at 39 FR 20205, June 7, 1974; 41 FR 17387, Apr. 26, 1976; 44 FR 45943, Aug. 6, 1979; 60 FR 18356, Apr. 11, 1995; 61 FR 20727, May 8, 1996; 62 FR 5529, Feb. 6, 1997]

§ 3.703 Two parents in same parental line.

(a) *General*. Death compensation or dependency and indemnity compensation is not payable for a child if dependency and indemnity compensation is paid to or for a child or to the surviving spouse on account of the child by reason of the death of another parent in the same parental line where both parents died before June 9, 1960. Where the death of one such parent occurred on or after June 9, 1960, gratuitous benefits may not be paid or furnished to or on account of any child by reason of the death of more than one parent in the same parental line.

(b) *Election*. The child or his or her fiduciary may elect to receive benefits based on the service of either veteran. An election of pension, compensation or dependency and indemnity compensation based on the death of one parent places the right to such benefits based on the death of another parent in suspension. The suspension may be lifted at any time by making another election.

(c) *Other payees*. Where a child has elected to receive pension, compensation, dependency and indemnity compensation or dependents' educational assistance under 38 U.S.C. ch. 35 based on the death of a veteran, he (or she) will be excluded from consideration in determining the eligibility or rate payable to a surviving spouse or another child or children in the case of another deceased veteran in the same parental line. See § 3.659(b).

CROSS REFERENCES: Two-parent cases. See § 3.503(a)(7). Two parents in same parental line. See § 3.659.

[27 FR 4993, May 29, 1962, as amended at 39 FR 20205, June 7, 1974]

§ 3.704 Elections within class of dependents.

(a) *Children*. Where children are eligible to receive monthly benefits under more than one law in the same case, the election of benefits under one law by or on behalf of one child will not serve to increase the rate allowable for any other child under another law in that case. The rate payable for each child will not exceed the amount which would be paid if all children were receiving benefits under the same law. Where a child is no longer eligible to receive pension, compensation or dependency and indemnity compensation because of having elected dependents' educational assistance under 38 U.S.C. chapter 35, the child will be excluded from consideration in determining the rate payable for another child or children.

(b) *Parents*. If there are two parents eligible for dependency and indemnity compensation and only one parent files claim for this benefit, the rate of dependency and indemnity compensation for that parent will not exceed the amount which would be paid to him or her if both parents had filed claim for dependency and indemnity compensation. The rate of death compensation for the other parent will not exceed the amount which would be paid if both parents were receiving this benefit.

[26 FR 1602, Feb. 24, 1961, as amended at 27 FR 4993, May 29, 1962; 34 FR 839, Jan. 18, 1969; 39 FR 20205, June 7, 1974; 54 FR 34981, Aug. 23, 1989]

§§ 3.705–3.706 [Reserved]

§ 3.707 Dependents' educational assistance.

(a) *Child*. The conditions applicable to the bar to payment of pension, compensation or dependency and indemnity compensation for a child concurrently with educational assistance allowance under 38 U.S.C. chapter 35 are set forth in § 21.3023 of this chapter.

(b) *Spouse or surviving spouse*. There is no bar to the payment of pension, compensation or dependency and indemnity compensation to a spouse concurrently with educational assistance allowance under 38 U.S.C. ch. 35.

CROSS REFERENCES: Discontinuance. See § 3.503(a)(8). Certification. See § 3.807.

[34 FR 840, Jan. 18, 1969, as amended at 41 FR 29120, July 15, 1976]

§ 3.708 Federal Employees' Compensation.

(a) *Military service*—(1) *Initial election*. Where a person is entitled to compensation from the Office of Workers' Compensation Programs, under the Federal Employees' Compensation Act (FECA) based upon disability or death due to service in the Armed Forces and

is also entitled based upon service in the Armed Forces to pension, compensation or dependency and indemnity compensation under the laws administered by the Department of Veterans Affairs, the claimant will elect which benefit he or she will receive. Pension compensation, or dependency and indemnity compensation may not be paid in such instances by the Department of Veterans Affairs concurrently with compensation from the Office of Workers' Compensation Programs. Benefits are not payable by the Office of Workers' Compensation Programs for disability or death incurred on or after January 1, 1957, based on military service.

(2) *Right of reelection.* Persons receiving compensation from the Office of Workers' Compensation Programs based on death due to military service may elect to receive dependency and indemnity compensation at any time. Once payment of dependency and indemnity compensation has been granted, all further right to FECA benefits is extinguished and only dependency and indemnity compensation is payable thereafter.

(3) *Rights of children.* Where primary title is vested in the surviving spouse, the claimant's election controls the rights of any of the veteran's children, regardless of whether they are in the claimant's custody and regardless of the fact that such children may not be eligible to receive benefits under laws administered by the Office of Workers' Compensation Programs. A child who is eligible for dependency and indemnity compensation or other benefits independent of the surviving spouse's entitlement may receive such benefits concurrently with payment of FECA benefits to the surviving spouse.

(4) *Entitlement based on 38 U.S.C. 1151.* The provisions of this paragraph are applicable also in those cases in which disability or death occurs as a result of having submitted to an examination, medical or surgical treatment, hospitalization or hospital care, training, or compensated work therapy program. See §§ 3.358 and 3.361.

(b) *Civilian employment*—(1) *Same disability or death.* Where a person is entitled to compensation from the Office of Workers' Compensation Programs based upon civilian employment and is also entitled to compensation or dependency and indemnity compensation under laws administered by the Department of Veterans Affairs for the same disability or death, the claimant will elect which benefit he or she will receive. On or after September 13, 1960, an award cannot be approved for payment of compensation or dependency and indemnity compensation concurrently with compensation from the Office of Workers' Compensation Programs in such instances and an election to receive benefits from either agency is final. See § 3.958. There is no right of reelection. (5 U.S.C. 8116(b)) A child who is eligible for dependency and indemnity compensation or other benefits independent of the surviving spouse's entitlement may receive such benefits concurrently with payment of FECA benefits to the surviving spouse.

(2) *Not the same disability or death.* There is no prohibition against payment of benefits under the Federal Employees' Compensation Act concurrently with other benefits administered by the Department of Veterans Affairs when such benefits are not based on the same disability or death.

[39 FR 18099, May 23, 1974, as amended at 41 FR 29120, July 15, 1976; 44 FR 45943, Aug. 6, 1979; 69 FR 46435, Aug. 3, 2004]

§ 3.710 Civil service annuitants.

Department of Veterans Affairs benefits may be paid concurrently with civil service retirement benefits. However, payments will be considered income as provided in § 3.262 (e) and (h).

[29 FR 15208, Nov. 11, 1964]

§ 3.711 Improved pension elections.

Except as otherwise provided by this section and § 3.712, a person entitled to receive section 306 or old-law pension on December 31, 1978, may elect to receive improved pension under the provisions of 38 U.S.C. 1521, 1541, or 1542 as in effect on January 1, 1979. Except as provided by § 3.714, an election of improved pension is final when the payee (or the payee's fiduciary) negotiates one check for this benefit and there is no right to reelection. Any veteran eligible to make an election under this section who is married to a veteran

who is also eligible to make such an election may not receive improved pension unless the veteran's spouse also elects to receive improved pension.

(Authority: Sec. 306(a)(1) of Pub. L. 95–588, 92 Stat. 2497)

[46 FR 11661, Feb. 10, 1981]

§3.712 Improved pension elections; surviving spouses of Spanish-American War veterans.

(a) *General.* A surviving spouse of a Spanish-American War veteran eligible for pension under 38 U.S.C. 1536 may elect to receive improved pension under 38 U.S.C. 1541. Except as provided by §3.714, an election of improved pension is final when the payee (or the payee's fiduciary) negotiates one check for this benefit and there is no right of reelection.

(b) *Aid and attendance.* A surviving spouse of a Spanish-American War veteran who is receiving or entitled to receive pension based on need for regular aid and attendance shall be paid whichever is the greater: The monthly rate authorized by 38 U.S.C. 1536 (a) and (b) and 1544 or the monthly rate authorized by 38 U.S.C. 1541 and 544, as 38 U.S.C. 1541 and 1544 were in effect on December 31, 1978, based on the surviving spouse's current income and net worth. Pension under 38 U.S.C. 1541 and 1544, as in effect on December 31, 1978, is not payable if the current size of the surviving spouse's net worth is a bar to payment under §3.252(b) or if the surviving spouse's income exceeds the applicable limitation as in effect on December 31, 1978. Elections are not required for this purpose. The change in rate shall be effective the first day of the month in which the facts warrant such change.

(Authority: 38 U.S.C. 1536)

[44 FR 45943, Aug. 6, 1979, as amended at 46 FR 11661, Feb. 10, 1981; 61 FR 67950, Dec. 26, 1996]

§3.713 Effective dates of improved pension elections.

(a) *General.* Except as provided in paragraph (b) of this section an election to receive improved pension shall be effective the date of receipt of the election.

(b) *Persons entitled to pension on December 31, 1978.* The effective date of an election to receive improved pension filed before October 1, 1979, by a person entitled to receive either old-law pension or section 306 pension on December 31, 1978, shall be January 1, 1979, or if to the beneficiary's advantage, at any date after January 1, 1979, and before October 1, 1979. The amount of improved pension payable from the effective date of the election shall be reduced by the amount of old-law pension or section 306 pension paid to the beneficiary for such period.

(Authority: Sec. 306(d) of Pub. L. 95–588, 92 Stat. 2497).

[44 FR 45944, Aug. 6, 1979]

§3.714 Improved pension elections—public assistance beneficiaries.

(a) *Definitions.* The following definitions are applicable to this section.

(1) *Pensioner.* This means a person who was entitled to section 306 or old-law pension, or a dependent of such a person for the purposes of chapter 15 of title 38, United States Code as in effect on December 31, 1978.

(2) *Public assistance.* This means payments under the following titles of the Social Security Act:

(i) Title I (Grants to States for Old Age Assistance and Medical Assistance to the Aged).

(ii) Title X (Grants to States for Aid to the Blind).

(iii) Title XIV (Grants to States for Aid to the Permanently and Totally Disabled).

(iv) Part A of title IV (Aid to Families with Dependent Children).

(v) Title XVI (Supplemental Security Income for the Aged, Blind and Disabled).

(3) *Medicaid.* This means a State plan for medical assistance under title XIX of the Social Security Act.

(4) *Informed election.* The term ''informed election'' means an election of improved pension (or a reaffirmation of a previous election of improved pension) after the Department of Veterans Affairs has complied with the requirements of paragraph (e) of this section.

(b) *General.* In some States only a person in receipt of public assistance is eligible for medicaid. When this is the

case the following applies effective January 1, 1979:

(1) A pensioner may not be required to elect improved pension to receive, or to continue to receive, public assistance; or

(2) A pensioner may not be denied (or suffer a reduction in the amount of) public assistance by reason of failure or refusal to elect improved pension.

(c) *Public assistance deemed to continue.* Public assistance (or a supplementary payment under Pub. L. 93–233, sec. 13(c)) payable to a pensioner may have been terminated because the pensioner's income increased as a result of electing improved pension. In this instance public assistance (or a supplementary payment under Pub. L. 93–233, sec. 13(c)) shall be deemed to have remained payable to a pensioner for each month after December 1978 when the following conditons are met:

(1) The pensioner was in receipt of pension for the month of December 1978; and

(2) The pensioner was in receipt of public assistance (or a supplementary payment under Pub. L. 93–233, sec. 13(c)) prior to June 17, 1980, and for the month of December 1978, and

(3) The pensioner's public assistance payments (or a supplementary payment under Pub. L. 93–233, sec. 13(c)) were discontinued because of an increase in income resulting from an election of improved pension.

(d) *End of the deemed period of entitlement to public assistance.* The deemed period of entitlement to public assistance (or a supplementary payment under Pub. L. 93–233, sec. 13(c)) ends the first calendar month that begins more than 10 days after a pensioner makes an informed election of improved pension. (If the pensioner is unable to make an informed election the informed election may be made by a member of the pensioner's family.) A pensioner who fails to disaffirm a previously made election of improved pension within the time limits set forth in paragraph (e) of this section shall be deemed to have reaffirmed the previous election. This will also end the deemed period of entitlement to public assistance.

(e) *Notice of right to make informed election or disaffirm election previously made.* The Department of Veterans Affairs shall send a written notice to each pensioner to whom paragraph (b) of this section applies and who is eligible to elect or who has elected improved pension. The notice shall be in clear and understandable language. It shall include the following:

(1) A description of the consequences to the pensioner (and the pensioner's family if applicable) of losing medicaid eligibility because of an increase in income resulting from electing improved pension; and

(2) A description of the provisions of paragraph (b) of this section; and

(3) In the case of a pensioner who has previously elected improved pension, a form for the purpose of enabling the pensioner to disaffirm the previous election of improved pensions; and

(4) The following provisons of Pub. L. 96–272, sec. 310(b)(2)(B):

(i) That a pensioner has 90 days from the date the notice is mailed to the pensioner to disaffirm a previous election by completing the disaffirmation form and mailing it to the Department of Veterans Affairs.

(ii) That a pensioner who disaffirms a previous election shall receive, beginning the calendar month after the calendar month in which the Department of Veterans Affairs receives the disaffirmation, the amount of pension payable if improved pension had not been elected.

(iii) That a pensioner who disaffirms a previous election may again elect improved pension but without a right to disaffirm the subsequent election.

(iv) That a pensioner who disaffirms an election of improved pension shall not be indebted to the United States for the period in which the pensioner received improved pension.

(Authority: Pub. L. 96–272, sec. 310; 94 Stat. 500)

(f) *Notification to the Social Security Administration.* The Department of Veterans Affairs shall promptly furnish the Social Security Administration the following information:

(1) The name and identifying information of each pensioner who disaffirms his or her election of improved pension.

(2) The name and identifying information of each pensioner who fails to disaffirm and election of improved pension within the 90-day period described in paragraph (e)(4)(i) of this section.

(3) The name and identifying information of each pensioner who after disaffirming his or her election of improved pension, subsequently reelected improved pension.

(Authority: 38 U.S.C. 501)

[46 FR 11661, Feb. 10, 1981, as amended at 71 FR 44919, Aug. 8, 2006]

§ 3.715 Radiation Exposure Compensation Act of 1990, as amended.

(a) *Compensation.* (1) A radiation-exposed veteran, as defined in 38 CFR 3.309(d)(3), who receives a payment under the Radiation Exposure Compensation Act of 1990, as amended (42 U.S.C. 2210 note) (RECA), will not be denied compensation to which the veteran is entitled under 38 CFR 3.309(d) for months beginning after March 26, 2002.

(2) A veteran who is not a ''radiation-exposed veteran,'' as defined in 38 CFR 3.309(d)(3), is not entitled to VA compensation for disability caused by a disease that is attributable to exposure to radiation for which the veteran has received a payment under RECA.

(b) *Dependency and indemnity compensation.* A person who receives a payment under RECA based upon a veteran's death will not be denied dependency and indemnity compensation to which the person is entitled under 38 CFR 3.5 and 3.22 for months beginning after March 26, 2002.

(c) *Offset of RECA payment against VA benefits.* Notwithstanding paragraph (a) or (b) of this section, the amount of a RECA payment will be deducted from the amount of compensation payable pursuant to § 3.309(d) or the amount of dependency and indemnity compensation payable.

(Authority: 38 U.S.C. 1112(c)(4), 1310(c); 42 U.S.C. 2210 note)

[71 FR 44919, Aug. 8, 2006]

RETIREMENT

§ 3.750 Entitlement to concurrent receipt of military retired pay and disability compensation.

(a) *Definition of military retired pay.* For the purposes of this part, military retired pay is payment received by a veteran that is classified as retired pay by the Service Department, including retainer pay, based on the recipient's service as a member of the Armed Forces or as a commissioned officer of the Public Health Service, the Coast and Geodetic Survey, the Environmental Science Services Administration, or the National Oceanic and Atmospheric Administration.

(b) *Payment of both military retired pay and disability compensation or improved pension*—(1) *Compensation.* Subject to paragraphs (b)(2) and (b)(3) of this section, a veteran who is entitled to military retired pay and disability compensation for a service-connected disability rated 50 percent or more, or a combination of service-connected disabilities rated 50 percent or more, under the schedule for rating disabilities (38 CFR part 4, subpart B), is entitled to receive both payments subject to the phase-in period described in paragraph (c) of this section.

(2) *Chapter 61 disability retirees retiring with 20 or more years of service.* Disability retired pay payable under 10 U.S.C. Chapter 61 to a veteran with 20 or more years of creditable service may be paid concurrently with disability compensation to a qualifying veteran subject to the following:

(i) Any waiver required during the phase-in period under paragraph (c)(1)(ii) of this section; and

(ii) If the veteran's disability retired pay exceeds the amount of retired pay the veteran would have received had the veteran retired based on length of service, the veteran must waive that excess amount of disability retired pay in order to receive VA disability compensation.

(3) *Chapter 61 disability retirees retiring with less than 20 years of service.* Veterans who receive disability retired pay under 10 U.S.C. Chapter 61 with less than 20 years of creditable service are not eligible for concurrent receipt.

(4) *Improved Pension*. A veteran may receive improved pension and military retired pay at the same time without having to waive military retired pay. However, in determining entitlement to improved pension, VA will treat military retired pay in the same manner as countable income from other sources.

(c) *Waiver*—(1) *When a waiver is necessary*. (i) A waiver of military retired pay is necessary in order to receive disability compensation when a veteran is eligible for both military retired pay and disability compensation but is not eligible under paragraphs (b)(1) or (b)(2) of this section to receive both benefits at the same time.

(ii) Except as provided in paragraph (c)(2) of this section, all veterans who are eligible to receive both military retired pay and disability compensation at the same time under paragraphs (b)(1) or (b)(2) of this section must file a waiver in order to receive the maximum allowable amount of disability compensation during the phase-in period. The phase-in period ends on December 31, 2013. After the phase-in period, veterans retired under 10 U.S.C. chapter 61 who are eligible for concurrent receipt must still file a waiver under the circumstances described in paragraph (b)(2)(ii) of this section.

(Authority: 10 U.S.C. 1414, 38 U.S.C. 5304, 5305)

(2) *When a waiver is not necessary*. Unless paragraph (b)(2)(ii) of this section applies, veterans who are entitled to receive disability compensation based on a VA determination of individual unemployability as well as veterans rated 100-percent disabled under the VA schedule for rating disabilities need not file waivers of military retired pay. The phase-in period does not apply to this group of veterans.

(3) *How to file a waiver of military retired pay*. A veteran may request a waiver of military retired pay in any written, signed statement, including a VA form, which reflects a desire to waive all or some military retired pay. The statement must be submitted to VA or to the Federal agency that pays the veteran's military retired pay. VA will treat as a waiver an application for VA compensation filed by a veteran who is entitled to military retired pay.

(d) *Elections and the right to reelect either benefit*. (1) A veteran who has filed a waiver of military retired pay under this section has elected to receive disability compensation. A veteran may reelect between benefits covered by this section at any time by submitting a written, signed statement to VA or to the Federal agency that pays the veteran's military retired pay.

(2) An election filed within 1 year from the date of notification of Department of Veterans Affairs entitlement will be considered as ''timely filed'' for effective date purposes. See § 3.401(e)(1). If the veteran is incompetent, the 1-year period will begin on the date that notification is sent to the next friend or fiduciary. In initial determinations, elections may be applied retroactively if the claimant was not advised of his or her right of election and its effect.

(Authority: 38 U.S.C. 5304(a), 5305)

[71 FR 67061, Nov. 20, 2006, as amended at 74 FR 11647, Mar. 19, 2009]

§ 3.751 Statutory awards; retired service personnel.

Retired Regular and Reserve officers and enlisted personnel are not entitled to statutory awards of disability compensation from the Department of Veterans Affairs in addition to their retirement pay. However, under § 3.750(c), eligible persons may waive an amount equal to the basic disability compensation and any statutory award otherwise payable by the Department of Veterans Affairs.

[41 FR 53797, Dec. 9, 1976]

§ 3.752 [Reserved]

§ 3.753 Public Health Service.

Disability compensation may be paid concurrently with retirement pay to an officer of the commissioned corps of the Public Health Service, who was receiving disability compensation on December 31, 1956, as follows:

(a) An officer who incurred a disability before July 29, 1945, but retired for nondisability purposes prior to such date.

(b) An officer who incurred a disability before July 29, 1945, but retired

for nondisability purposes between July 4, 1952, and December 31, 1956.

(c) An officer who incurred a disability between July 29, 1945, and July 3, 1952, but retired for nondisability purposes between July 4, 1952, and December 31, 1956.

[26 FR 1604, Feb. 24, 1961]

§ 3.754 Emergency officers' retirement pay.

A retired emergency officer of World War I has basic eligibility to retirement pay by the Department of Veterans Affairs under Pub. L. 87–875 (sec. 11(b), Pub. L. 85–857) from date of filing application therefor after October 24, 1962, if the following requirements are met:

(a) Emergency officers' retirement pay would have been granted under Pub. L. 506, 70th Congress (Act of May 24, 1928) if application therefor had been filed before May 25, 1929.

(b) Such retirement pay would have continued to be payable under section 10 of Pub. L. 2, 73d Congress, or under section 1 of Pub. L. 743, 76th Congress.

(c) The monthly rate of retirement pay at any time between May 24, 1928 and May 24, 1929, inclusive, would have been lower than the monthly rate of disability compensation payable to the retired emergency officer.

CROSS REFERENCE: Emergency officers' retirement pay. See § 3.953(b).

[28 FR 72, Jan. 3, 1963]

SPECIAL BENEFITS

§ 3.800 Disability or death due to hospitalization, etc.

This section applies to claims received by VA before October 1, 1997. For claims received by VA on or after October 1, 1997, see §§ 3.362 and 3.363.

(a) Where disease, injury, death or the aggravation of an existing disease or injury occurs as a result of having submitted to an examination, medical or surgical treatment, hospitalization or the pursuit of a course of vocational rehabilitation under any law administered by the Department of Veterans Affairs and not the result of his (or her) own willful misconduct, disability or death compensation, or dependency and indemnity compensation will be awarded for such disease, injury, aggravation, or death as if such condition were service connected. The commencing date of benefits is subject to the provisions of § 3.400(i).

(Authority: 38 U.S.C. 1151)

(1) Benefits under paragraph (a) of this section will be in lieu of any benefits the veteran may be entitled to receive under the Federal Employees' Compensation Act inasmuch as concurrent payments are prohibited. (See § 3.708.)

(2) Where any person is awarded a judgment on or after December 1, 1962, against the United States in a civil action brought pursuant to 28 U.S.C. 1346(b), or enters into a settlement or compromise on or after December 1, 1962, under 28 U.S.C. 2672 or 2677, by reason of a disability, aggravation or death within the purview of this section, no compensation or dependency and indemnity compensation shall be paid to such person for any month beginning after the date such judgment, settlement, or compromise on account of such disability, aggravation, or death becomes final until the total amount of benefits which would be paid except for this provision equals the total amount included in such judgment, settlement, or compromise. The provisions of this paragraph do not apply, however, to any portion of such compensation or dependency and indemnity compensation payable for any period preceding the end of the month in which such judgment, settlement or compromise becomes final.

(Authority: 38 U.S.C. 501)

(3) If an administrative award was made or a settlement or compromise became final before December 1, 1962, compensation or dependency and indemnity compensation may not be authorized for any period after such award settlement, or compromise whether before or after December 1, 1962. There is no bar to payment of compensation or dependency and indemnity compensation and no set-off because of a judgment which became final before December 1, 1962, unless specified in the terms of the judgment.

(4) *Offset of award of benefits under 38 U.S.C. chapter 21 or 38 U.S.C. chapter 39.*

(i) If a judgment, settlement, or compromise covered by paragraph (a)(2) of this section becomes final on or after December 10, 2004, and includes an amount that is specifically designated for a purpose for which benefits are provided under 38 U.S.C. chapter 21 (38 CFR 3.809 and 3.809a) or 38 U.S.C. chapter 39 (38 CFR 3.808), and if VA awards 38 U.S.C. chapter 21 or 38 U.S.C. chapter 39 benefits after the date on which the judgment, settlement, or compromise becomes final, the amount of the award will be reduced by the amount received under the judgment, settlement, or compromise for the same purpose.

(ii) If the amount described in paragraph (a)(4)(i) of this section is greater than the amount of an award under 38 U.S.C. chapter 21 or 38 U.S.C. chapter 39, the excess amount received under the judgment, settlement, or compromise will be offset against benefits otherwise payable under 38 U.S.C. chapter 11.

(Authority: 38 U.S.C. 1151(b)(2))

(b)(1) If death occurred prior to January 1, 1957, the benefit payable will be death compensation. See §§ 3.5(b)(2) and 3.702 as to right of election to dependency and indemnity compensation.

(2) If death occurs on or after January 1, 1957, the benefit payable will be dependency and indemnity compensation.

CROSS REFERENCES: Claims; injury due to hospital treatment, etc. See § 3.154. Effective dates; disability or death due to hospitalization, etc. See § 3.400(i).

[26 FR 1604, Feb. 24, 1961, as amended at 27 FR 11892, Dec. 1, 1962; 29 FR 16252, Dec. 4, 1964; 39 FR 34532, Sept. 26, 1974; 53 FR 23237, June 21, 1988; 64 FR 1132, Jan. 8, 1999; 69 FR 46435, Aug. 3, 2004; 71 FR 44919, Aug. 8, 2006; 75 FR 57861, Sept. 23, 2010]

§ 3.801 Special acts.

(a) *General*. A special act is one authorizing the payment of benefits to a particular person or persons. If a beneficiary in a special act has no claim before the Department of Veterans Affairs, a formal application must be filed before benefits may be awarded.

(b) *Limitations*. Where the rate, commencement, and duration are fixed by a special act, they are not subject to be varied by the provisions and limitations of the public laws, but where not fixed, the rate and continuance of the benefit is subject to variance in accordance with the public laws.

(c) *Provisions of act*. (1) When pension or compensation is granted by a special act, which fixes the rate and commencement, the rate thereunder cannot be increased nor can any other pension or compensation be paid in the absence of the payee's election, unless the special act expressly states that the benefit granted thereby is in addition to the benefit which the person is entitled to receive under any public law.

(2) If a special act corrects the nature of separation from military service and does not grant pension or compensation directly, the claimant acquires a status so that he or she may apply for and be allowed benefits. The claimant, then, is placed in the same position he or she would have been if originally released under conditions other than dishonorable.

(d) *Service*. A special act of Congress, reciting that a person is considered to have been mustered into the service on a named date and honorably discharged on a subsequently named date, is sufficient regardless of whether the service department has any record of such service.

(e) *Hospitalization*. Pension payable under special acts is subject to reduction pursuant to § 3.551.

(Authority: 38 U.S.C. 501(a), 5503)

[26 FR 1605, Feb. 24, 1961, as amended at 39 FR 34532, Sept. 26, 1974; 68 FR 34543, June 10, 2003]

§ 3.802 Medal of Honor.

(a) The Secretary of the Department of the Army, the Department of the Navy, the Department of the Air Force, or the Department of Transportation will determine the eligibility of applicants to be entered on the Medal of Honor Roll and will deliver to the Secretary of the Department of Veterans Affairs a certified copy of each certificate issued in which the right of the person named in the certificate to the special pension is set forth. The special

pension will be authorized on the basis of such certification.

(Authority: 38 U.S.C. 1560, 1561)

(b) An award of special pension at the monthly rate specified in 38 U.S.C. 1562 will be made as of the date of filing of the application with the Secretary concerned. The special pension will be paid in addition to all other payments under laws of the United States. However, a person awarded more than one Medal of Honor may not receive more than one special pension.

(Authority: 38 U.S.C. 1562)

(c) VA will pay to each person who is receiving or who in the future receives Medal of Honor pension a retroactive lump sum payment equal to the total amount of Medal of Honor pension that person would have received during the period beginning the first day of the month after the date of the event for which the veteran earned the Medal of Honor and ending on the last day of the month preceding the month in which pension was awarded under paragraph (b) of this section. VA will calculate the lump sum payment using the monthly Medal of Honor pension rates in effect from the first day of the month after the date of the event for which the veteran earned the Medal of Honor, to the last day of the month preceding the month in which the individual was initially awarded the Medal of Honor pension. VA will not make a retroactive lump sum payment under this section before October 1, 2003.

(Authority: 38 U.S.C. 1562(f))

[26 FR 1605, Feb. 24, 1961, as amended at 32 FR 6840, May 4, 1967; 44 FR 22721, Apr. 17, 1979; 52 FR 34909, Sept. 16, 1987; 68 FR 55467, Sept. 26, 2003]

§ 3.803 Naval pension.

(a) Payment of naval pension will be authorized on the basis of a certification by the Secretary of the Navy.

(Authority: 10 U.S.C. 6160)

(b) Awards of naval pension in effect prior to July 14, 1943, or renewed or continued may be paid concurrently with Department of Veterans Affairs pension or compensation; however, naval pension allowance under 10 U.S.C. 6160 may not exceed one-fourth of the rate of disability pension or compensation otherwise payable, exclusive of additional allowances for dependents or specific disabilities.

(c) New awards of naval pension may not be made concurrently with Department of Veterans Affairs pension or compensation.

(Authority: 38 U.S.C. 5304(a))

(d) Naval pension remaining unpaid at the date of the veteran's death is not payable by the Department of Veterans Affairs as an accrued benefit.

[26 FR 1605, Feb. 24, 1961, as amended at 28 FR 2857, Mar. 22, 1963; 44 FR 22721, Apr. 17, 1979]

§ 3.804 Special allowance under 38 U.S.C. 1312.

(a) The provisions of this section are applicable to the payment of a special allowance by the Department of Veterans Affairs to the surviving dependents of a veteran who served after September 15, 1940, and who died on or after January 1, 1957, as a result of such service and who was not a fully and currently insured individual under title II of the Social Security Act.

(b) The special allowance is not payable: (1) Where the veteran's death resulted from Department of Veterans Affairs hospitalization, treatment, examination, or training;

(2) Where the veteran's death was due to service rendered with the Commonwealth Army of the Philippines while such forces were in the service of the Armed Forces pursuant to the military order of the President dated July 26, 1941, or was due to service in the Philippine Scouts under section 14, Pub. L. 190, 79th Congress.

(c) A claim for dependency and indemnity compensation on a form prescribed will be accepted as a claim for the special allowance where it is determined that this benefit is payable or where a specific inquiry concerning entitlement to the special allowance is received.

(d) Payment of this allowance will be authorized on the basis of a certification from the Social Security Administration. Award actions subsequent to the original award, including

adjustment and discontinuance, will be made in accordance with new certifications from the Social Security Administration.

(e)(1) The special allowance will be payable only if the death occurred: (i) While on active duty, active duty for training, or inactive duty training as a member of a uniformed service (line of duty is not a factor); or

(ii) As the result of a disease or injury which was incurred or aggravated in line of duty while on active duty or active duty for training, or an injury which was incurred or aggravated in line of duty while on inactive duty training, as a member of a uniformed service after September 15, 1940, if the veteran was discharged or released from the period of such duty, under conditions other than dishonorable.

(2) Where the veteran died after separation from service: (i) Discharge from service must have been under conditions other than dishonorable as outlined in § 3.12.

(ii) Line of duty and service connection will be determined as outlined in § 3.1(k) and (m) and the § 3.300 series.

[26 FR 1605, Feb. 24, 1961]

§ 3.805 Loan guaranty for surviving spouses; certification.

A certification of loan guaranty benefits may be extended to surviving spouses based on an application filed on or after January 1, 1959, if:

(a) The veteran served in the Armed Forces of the United States (Allied Nations are not included) at any time on or after September 16, 1940; and

(b) The veteran died in service; or

(c) The veteran died after separation from service and such separation was under conditions other than dishonorable provided the veteran's death was the result of injury or disease incurred in or aggravated by service in line of duty rendered on or after September 16, 1940, regardless of the date of entrance into such service (cases where compensation is payable because of death resulting from hospitalization, treatment, examination, or training are not included); and

(d) The surviving spouse meets the requirements of the term ''surviving spouse'' as outlined in § 3.50; and

(e) The veteran's surviving spouse is unmarried; and

(f) The applicant is not an eligible veteran.

CROSS REFERENCES: Wife, widow or spouse. See § 3.50(b). Terminated marital relationships. See § 3.55.

[26 FR 1605, Feb. 24, 1961, as amended at 31 FR 4347, Mar. 12, 1966; 37 FR 24662, Nov. 18, 1972; 40 FR 54245, Nov. 21, 1975, 41 FR 49636, Nov. 10, 1976; 44 FR 22721, Apr. 17, 1979; 62 FR 5529, Feb. 6, 1997]

§ 3.806 Death gratuity; certification.

(a) Where a veteran dies on or after January 1, 1957, and during the 120-day period which begins on the day following the date of his or her discharge or release from active duty, active duty for training, or inactive training duty, the Department of Veterans Affairs will certify that fact to the Secretary concerned if the Department of Veterans Affairs determines on the basis of a claim filed with it that:

(1) Death resulted from:

(i) Disease or injury incurred or aggravated while on such active duty or active duty for training; or

(ii) Injury incurred or aggravated while on such inactive duty training; and

(2) The deceased person was discharged or released from such service under conditions other than dishonorable.

(b) In all cases, other than listed in paragraph (a) of this section, the certification will be furnished at the request of the Secretary concerned.

(c) For the purposes of this section, line of duty is not a factor. The standards, criteria, and procedures for determining incurrence or aggravation of a disease or injury under paragraph (a) of this section are those applicable under disability and death compensation laws administered by the Department of Veterans Affairs.

(Authority: 38 U.S.C. 1323)

[26 FR 1605, Feb. 24, 1961, as amended at 40 FR 54245, Nov. 21, 1975]

§ 3.807 Dependents' educational assistance; certification.

For the purposes of dependents' educational assistance under 38 U.S.C. chapter 35 (see § 21.3020), the child,

spouse or surviving spouse of a veteran or serviceperson will have basic eligibility if the following conditions are met:

(a) *General*. Basic eligibility exists if the veteran:

(1) Was discharged from service under conditions other than dishonorable, or died in service; and

(2) Has a permanent total service-connected disability; or

(3) A permanent total service-connected disability was in existence at the date of the veteran's death; or

(4) Died as a result of a service-connected disability; or (if a serviceperson)

(5) Is on active duty as a member of the Armed Forces and

(i) Now is, and, for a period of more than 90 days, has been listed by the Secretary concerned as missing in action, captured in line of duty by a hostile force, or forcibly detained or interned in line of duty by a foreign Government or power; or

(ii) Has been determined by VA to have a total disability permanent in nature incurred or aggravated in the line of duty during active military, naval, or air service; is hospitalized or receiving outpatient medical care, services, or treatment for such disability; is likely to be discharged or released from such service for such disability; and the pursuit of a course of education by such individual's spouse or child for which benefits under 38 U.S.C. chapter 35 are sought occurred after December 22, 2006.

(b) *Service*. Service-connected disability or death must have been the result of active military, naval, or air service on or after April 21, 1898. (Pub. L. 89–358) Effective September 30, 1966, educational assistance for a child (but not for a spouse or surviving spouse) may be authorized based on service in the Philippine Commonwealth Army or as a Philippine Scout as defined in § 3.40(b), (c), or (d) of this part.

(Authority: 38 U.S.C. 3565)

(c) *Service connection*. For purpose of this section, the term ''service-connected disability'' encompasses combinations of disabilities of paired organs or extremities treated as if service-connected under the provisions of § 3.383(a) of this part. The standards and criteria for determining service connection, either direct or presumptive, are those applicable to the period of service during which the disability was incurred or aggravated (38 U.S.C. 3501(a)). Cases where eligibility for service-connected benefits is established under § 3.358, 3.361, or 3.800 are not included.

(d) *Relationship*—(1) ''Child'' means the son or daughter of a veteran who meets the requirements of § 3.57, except as to age and marital status.

(2) ''Spouse'' means a person whose marriage to the veteran meets the requirements of § 3.50(a) of this part.

(3) ''Surviving spouse'' means a person whose marriage to the veteran meets the requirements of §§ 3.50(b) or 3.52 of this part.

(Authority: 38 U.S.C. 1160, 3501)

CROSS REFERENCES: Discontinuance. See § 3.503(a)(8) Election; concurrent benefits. See § 3.707 Nonduplication. See § 21.3023 of this chapter.

[29 FR 9537, July 14, 1964, as amended at 31 FR 4347, Mar. 12, 1966; 34 FR 840, Jan. 18, 1969; 38 FR 8658, Apr. 5, 1973; 40 FR 54245, Nov. 21, 1975; 53 FR 46607, Nov. 18, 1988; 59 FR 62585, Dec. 6, 1994; 69 FR 46435, Aug. 3, 2004; 73 FR 1076, Jan. 7, 2008]

§ 3.808 Automobiles or other conveyances and adaptive equipment; certification.

(a) *Entitlement*. A certificate of eligibility for financial assistance in the purchase of one automobile or other conveyance in an amount not exceeding the amount specified in 38 U.S.C. 3902 (including all State, local, and other taxes where such are applicable and included in the purchase price) and of basic entitlement to necessary adaptive equipment will be provided to—

(1) A veteran who is entitled to compensation under chapter 11 of title 38, United States Code, for a disability described in paragraph (b) of this section; or

(2) A member of the Armed Forces serving on active duty who has a disability described in paragraph (b) of this section that is the result of an injury or disability incurred or disease contracted in or aggravated by active military, naval, or air service.

(b) *Disability*. One of the following must exist:

(1) Loss or permanent loss of use of one or both feet;

(2) Loss or permanent loss of use of one or both hands;

(3) Permanent impairment of vision of both eyes: Central visual acuity of 20/200 or less in the better eye, with corrective glasses, or 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 the widest diameter of visual field subtends an angular distance no greater than 20° in the better eye.

(4) Severe burn injury: Deep partial thickness or full thickness burns resulting in scar formation that cause contractures and limit motion of one or more extremities or the trunk and preclude effective operation of an automobile.

(5) Amyotrophic lateral sclerosis.

(6) For adaptive equipment eligibility only, ankylosis of one or both knees or one or both hips.

(Authority: 38 U.S.C. 3901, 3902)

(c) *Claim for conveyance and certification for adaptive equipment*. A specific application for financial assistance in purchasing a conveyance is required which must contain a certification by the claimant that the conveyance will be operated only by persons properly licensed. The application will also be considered as an application for the adaptive equipment to insure that the claimant will be able to operate the conveyance in a manner consistent with safety and to satisfy the applicable standards of licensure of the proper licensing authorities. Simultaneously with the certification provided pursuant to the introductory text of this section, a claimant for financial assistance in the purchase of an automobile will be furnished a certificate of eligibility for financial assistance in the purchase of such adaptive equipment as may be appropriate to the claimant's losses unless the need for such equipment is contraindicated by a physical or legal inability to operate the vehicle. There is no time limitation in which to apply. An application by a claimant on active duty will be deemed to have been filed with VA on the date it is shown to have been placed in the hands of military authority for transmittal.

(d) *Additional eligibility criteria for adaptive equipment*. Claimants for adaptive equipment must also satisfy the additional eligibility criteria of §§ 17.156, 17.157, and 17.158 of this chapter.

(e) *Definition*. The term *adaptive equipment*, means generally, that 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 to assist him or her in meeting the applicable standards of licensure of the proper licensing authority.

(1) With regard to automobiles and similar vehicles the term includes a basic automatic transmission as to a claimant who has lost or lost the use of a limb. In addition, the term includes, but is not limited to, power steering, power brakes, power window lifts and power seats. The term also includes air-conditioning equipment when such equipment is necessary to the health and safety of the veteran and to the safety of others, 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.

(2) With regard to automobiles and similar vehicles the term includes such items of equipment as the Chief Medical Director may, by directive, specify as ordinarily necessary for any of the classes of losses specified in paragraph (b) of this section and for any combination of such losses. Such specifications of equipment may include a limit on the financial assistance to be provided based on judgment and experience.

(3) The term also includes other equipment which the Chief Medical Director or designee may deem necessary in an individual case.

(Authority: 38 U.S.C. 501(a), 1151(c)(2), 3902))

[36 FR 7588, Apr. 22, 1971, as amended at 38 FR 14370, June 1, 1973; 40 FR 37037, Aug. 25, 1975; 43 FR 4423, Feb. 2, 1978; 47 FR 24552, June 7, 1982; 53 FR 46607, Nov. 18, 1988; 66 FR 44528, Aug. 24, 2001; 71 FR 44919, Aug. 8, 2006; 78 FR 57487, Sept. 19, 2013; 80 FR 10003, Feb. 25, 2015]

§ 3.809 Specially adapted housing under 38 U.S.C. 2101(a)(2)(A)(i).

In order for a certificate of eligibility for assistance in acquiring specially adapted housing under 38 U.S.C. 2101(a)(2)(A)(i) or 2101A(a) to be extended to a veteran or a member of the Armed Forces serving on active duty, the following requirements must be met:

(a) *General.* A member of the Armed Forces serving on active duty must have a disability rated as permanent and total that was incurred or aggravated in line of duty in active military, naval, or air service. A veteran must be entitled to compensation under chapter 11 of title 38, United States Code, for a disability rated as permanent and total.

(b) *Disability.* The disability must be due to:

(1) The loss or loss of use of both lower extremities, such as to preclude locomotion without the aid of braces, crutches, canes, or a wheelchair,

(2) Blindness in both eyes, having only light perception, plus the anatomical loss or loss of use of one lower extremity,

(3) The loss or loss of use of one lower extremity together with residuals of organic disease or injury which so affect the functions of balance or propulsion as to preclude locomotion without the aid of braces, crutches, canes, or a wheelchair,

(4) The loss or loss of use of one lower extremity together with the loss or loss of use of one upper extremity which so affect the functions of balance or propulsion as to preclude locomotion without the aid of braces, crutches, canes, or a wheelchair,

(5) The loss or loss of use of both upper extremities such as to preclude use of the arms at or above the elbow, or

(6) Full thickness or subdermal burns that have resulted in contractures with limitation of motion of two or more extremities or of at least one extremity and the trunk.

(c) *Preclude locomotion.* This term means the necessity for regular and constant use of a wheelchair, braces, crutches or canes as a normal mode of locomotion although occasional locomotion by other methods may be possible.

(d) *Amyotrophic lateral sclerosis.* VA considers § 3.809(b) satisfied if the veteran or member of the Armed Forces serving on active duty has service-connected amyotrophic lateral sclerosis rated 100 percent disabling under 38 CFR 4.124a, diagnostic code 8017.

(Authority: 38 U.S.C. 501(a), 1151(c)(1), 2101, 2101A)

Cross Reference: Assistance to certain disabled veterans in acquiring specially adapted housing. See §§ 36.4400 through 36.4410 of this chapter.

[78 FR 72576, Dec. 3, 2013]

§ 3.809a Special home adaptation grants under 38 U.S.C. 2101(b).

A certificate of eligibility for assistance in acquiring necessary special home adaptations, or, on or after October 28, 1986, for assistance in acquiring a residence already adapted with necessary special features, under 38 U.S.C. 2101(b) or 2101A(a) may be issued to a veteran who served after April 20, 1898, or to a member of the Armed Forces serving on active duty who is eligible for the benefit under this section on or after December 16, 2003, if the following requirements are met:

(a) The member of the Armed Forces serving on active duty or veteran is not entitled to a certificate of eligibility for assistance in acquiring specially adapted housing under § 3.809 nor had the member of the Armed Forces serving on active duty or veteran previously received assistance in acquiring specially adapted housing under 38 U.S.C. 2101(a). A member of the Armed Forces serving on active duty or veteran who first establishes entitlement

under this section and who later becomes eligible for a certificate of eligibility under § 3.809 may be issued a certificate of eligibility under § 3.809.

(b) A member of the Armed Forces serving on active duty must have a disability that was incurred or aggravated in line of duty in active military, naval, or air service and meets the requirements described in either paragraph (b)(1) or (b)(2) of this section. A veteran must be entitled to compensation under chapter 11 of title 38, United States Code, for a disability that meets the requirements described in either paragraph (b)(1) or (b)(2) of this section.

(1) VA has rated the disability as permanently and totally disabling and it:

(i) Includes the anatomical loss or loss of use of both hands;

(ii) Is due to deep partial thickness burns that have resulted in contracture(s) with limitation of motion of two or more extremities or of at least one extremity and the trunk;

(iii) Is due to full thickness or subdermal burns that have resulted in contracture(s) with limitation of motion of one or more extremities or the trunk; or

(iv) Is due to residuals of an inhalation injury (including, but not limited to, pulmonary fibrosis, asthma, and chronic obstructive pulmonary disease).

(2) The disability is due to blindness in both eyes, having central visual acuity of 20/200 or less in the better eye with the use of a standard correcting lens. For the purposes of this paragraph, an eye with a limitation in the fields of vision such that the widest diameter of the visual field subtends an angle no greater than 20 degrees shall be considered as having a central visual acuity of 20/200 or less. The disability discussed in this paragraph need not be rated as permanently and totally disabling.

(Authority: 38 U.S.C. 1151(c)(1), 2101, 2101A, 2104)

CROSS REFERENCE: Assistance to certain disabled veterans in acquiring specially adapted housing. *See* §§ 36.4400 through 36.4410 of this chapter.

[46 FR 47543, Sept. 29, 1981, as amended at 53 FR 23237, June 21, 1988; 75 FR 57861, Sept. 23, 2010; 79 FR 54609, Sept. 12, 2014]

§ 3.810 Clothing allowance.

(a) Except as provided in paragraph (d) of this section, a veteran who has a service-connected disability, or a disability compensable under 38 U.S.C. 1151 as if it were service connected, is entitled, upon application therefore, to an annual clothing allowance, which is payable in a lump sum, as specified in this paragraph.

(1) *One clothing allowance.* A veteran is entitled to one annual clothing allowance if—

(i) A VA examination or a hospital or examination report from a facility specified in § 3.326(b) establishes that the veteran, because of a service-connected disability or disabilities due to loss or loss of use of a hand or foot compensable at a rate specified in § 3.350(a), (b), (c), (d), or (f), wears or uses one qualifying prosthetic or orthopedic appliance (including, but not limited to, a wheelchair) which tends to wear or tear clothing; or

(ii) The Under Secretary for Health or a designee certifies that—

(A) A veteran, because of a service-connected disability or disabilities, wears or uses one qualifying prosthetic or orthopedic appliance (including, but not limited to, a wheelchair) which tends to wear or tear clothing; or

(B) A veteran uses medication prescribed by a physician for one skin condition, which is due to a service-connected disability, that causes irreparable damage to the veteran's outergarments.

(2) *More than one clothing allowance; multiple types of garments affected.* A veteran is entitled to an annual clothing allowance for each prosthetic or orthopedic appliance (including, but not limited to, a wheelchair) or medication used by the veteran if each appliance or medication—

(i) Satisfies the requirements of paragraph (a)(1) of this section; and

(ii) Affects a distinct type of article of clothing or outergarment.

(3) *Two clothing allowances; single type of garment affected.* A veteran is entitled to two annual clothing allowances if a veteran uses more than one prosthetic or orthopedic appliance, (including, but not limited to, a wheelchair), medication for more than one skin condition, or an appliance and a medication, and the appliance(s) or medication(s)—

(i) Each satisfy the requirements of paragraph (a)(1) of this section; and

(ii) Together tend to wear or tear a single type of article of clothing or irreparably damage a type of outergarment at an increased rate of damage to the clothing or outergarment due to a second appliance or medication.

(b) Effective August 1, 1972, the initial lump sum clothing allowance is due and payable for veterans meeting the eligibility requirements of paragraph (a) of this section as of that date. Subsequent annual payments for those meeting the eligibility requirements of paragraphs (a) of this section will become due on the anniversary date thereafter, both as to initial claims and recurring payments under previously established entitlement.

(c)(1) Except as provided in paragraph (c)(2) of this section, the application for clothing allowance must be filed within 1 year of the anniversary date (August 1) for which entitlement is initially established, otherwise, the application will be acceptable only to effect payment of the clothing allowance becoming due on any succeeding anniversary date for which entitlement is established, provided the application is filed within 1 year of such date. The 1-year period for filing application will include the anniversary date and terminate on July 31 of the following year.

(2) Where the initial determination of service connection for the qualifying disability is made subsequent to an anniversary date for which entitlement is established, the application for clothing allowance may be filed within 1 year from the date of notification to the veteran of such determination.

(Authority: 38 U.S.C. 1162)

(d) If a veteran is incarcerated in a Federal, State, or local penal institution for a period of more than 60 days and is furnished clothing without charge by the institution, VA shall reduce the amount of the annual clothing allowance by 1/365th of the amount otherwise payable for each day the veteran was incarcerated during the 12-month period preceding the anniversary date for which entitlement is established. No reduction shall be made for the first 60 days of incarceration.

(Authority: 38 U.S.C. 5313A)

[37 FR 19134, Sept. 19, 1972, as amended at 39 FR 2362, Jan. 21, 1974; 49 FR 28242, July 11, 1984; 56 FR 5756, Feb. 13, 1991; 62 FR 35422, July 1, 1997; 76 FR 70885, Nov. 16, 2011; 77 FR 34218, June 11, 2012]

§3.811 Minimum income annuity and gratuitous annuity.

(a) *Eligibility for minimum income annuity.* The minimum income annuity authorized by Public Law 92–425 as amended is payable to a person:

(1) Whom the Department of Defense or the Department of Transportation has determined meets the eligibility criteria of section 4(a) of Pub. L. 92–425 as amended other than section 4(a)(1) and (2); and

(2) Who is eligible for pension under subchapter III of chapter 15 of title 38, United States Code, or section 306 of the Veterans' and Survivors' Pension Improvement Act of 1978; and

(3) Whose annual income, as determined in establishing pension eligibility, is less than the maximum annual rate of pension in effect under 38 U.S.C. 1541(b).

(b) *Computation of the minimum income annuity payment*—(1) *Annual income.* VA will determine a beneficiary's annual income for minimum income annuity purposes under the provisions of §§3.271 and 3.272 of this part for beneficiaries receiving improved pension, or under §§3.260 through 3.262 of this part for beneficiaries receiving old law or section 306 pensions, except that the amount of the minimum income annuity will be excluded from the calculation.

(2) VA will determine the minimum income annuity payment for beneficiaries entitled to improved pension by subtracting the annual income for minimum income annuity purposes

from the maximum annual pension rate under 38 U.S.C. 1541(b).

(3) VA will determine the minimum income annuity payment for beneficiaries receiving old law and section 306 pensions by reducing the maximum annual pension rate under 38 U.S.C. 1541(b) by the amount of the Retired Servicemen's Family Protection Plan benefit, if any, that the beneficiary receives and subtracting from that amount the annual income for minimum income annuity purposes.

(4) VA will recompute the monthly minimum income annuity payment whenever there is a change to the maximum annual rate of pension in effect under 38 U.S.C. 1541(b), and whenever there is a change in the beneficiary's income.

(c) An individual otherwise eligible for pension under subchapter III of chapter 15 of title 38, United States Code, or section 306 of the Veterans' and Survivors' Pension Improvement Act of 1978 shall be considered eligible for pension for purposes of determining eligibility for the minimum income annuity even though as a result of adding the amount of the minimum income annuity authorized under Public Law 92–425 as amended to any other countable income, no amount of pension is due.

(d) If the Department of Defense or the Department of Transportation determines that a minimum income annuitant also is entitled to the gratuitous annuity authorized by Pub. L. 100–456 as amended, which is payable to certain surviving spouses of servicemembers who died before November 1, 1953, and were entitled to retired or retainer pay on the date of death, VA will combine the payment of the gratuitous annuity with the minimum income annuity payment.

(e) *Termination*. Other than as provided in paragraph (c) of this section, if a beneficiary receiving the minimum income annuity becomes ineligible for pension, VA will terminate the minimum income annuity effective the same date.

(Authority: Sec. 4, Pub. L. 92–425, 86 Stat. 706, 712, as amended (10 U.S.C. 1448 note))

[63 FR 412, Jan. 6, 1998, as amended at 63 FR 62943, Nov. 10, 1998]

§ 3.812 Special allowance payable under section 156 of Pub. L. 97–377.

The provisions of this section apply to the payment of a special allowance to certain surviving spouses and children of individuals who died on active duty prior to August 13, 1981, or who died as a result of a service-connected disability which was incurred or aggravated prior to August 13, 1981. This special allowance is a replacement for certain social security benefits which were either reduced or terminated by provisions of the Omnibus Budget Reconciliation Act of 1981.

(a) *Eligibility requirements*. (1) A determination must first be made that the person on whose earnings record the claim is based either died on active duty prior to August 13, 1981, or died as a result of a service-connected disability which was incurred or aggravated prior to August 13, 1981. For purposes of this determination, character of discharge is not a factor for consideration, and death on active duty subsequent to August 12, 1981, is qualifying provided that the death resulted from a service-connected disability which was incurred or aggravated prior to August 13, 1981.

(2) Once a favorable determination has been made under paragraph (a)(1) of this section, determinations as to the age, relationship and school attendance requirements contained in paragraphs (a)(1) and (b)(1) of section 156 of Pub. L. 97–377 will be made. In making these eligibility determinations VA shall apply the provisions of the Social Security Act, and any regulations promulgated pursuant thereto, as in effect during the claimant's period of eligibility. Unless otherwise provided in this section, when issues are raised concerning eligibility or entitlement to this special allowance which cannot be appropriately resolved under the provisions of the Social Security Act, or the regulations promulgated pursuant thereto, the provisions of title 38, Code of Federal Regulations, are for application.

(b) *Computation of payment rate*—(1) *Basic entitlement rate*. A basic entitlement rate will be computed for each eligible claimant in accordance with the provisions of subparagraphs (a)(2) and (b)(2) of section 156 of Pub. L. 97–377

using data to be provided by the Social Security Administration. This basic entitlement rate will then be used to compute the monthly payment rate as described in paragraphs (b)(2) to (b)(6) of this section.

(2) *Original or reopened awards to surviving spouses.* The monthly payment rate shall be equal to the basic entitlement rate increased by the overall average percentage (rounded to the nearest tenth of a percent) of each legislative increase in dependency and indemnity compensation rates under 38 U.S.C. 1311 which became effective concurrently with or subsequent to the effective date of the earliest adjustment under section 215(i) of the Social Security Act that was disregarded in computing the basic entitlement rate.

(3) *Original and reopened awards to children.* The monthly payment rate shall be equal to the basic entitlement rate increased by the overall average percentage (rounded to the nearest tenth of a percent) of each legislative increase in the rates of educational assistance allowance under 38 U.S.C. 3531(b) which became effective concurrently with or subsequent to the effective date of the earliest adjustment under section 215(i) of the Social Security Act that was disregarded in computing the basic entitlement rate.

(4) *Subsequent legislative increases in rates.* The monthly rate of special allowance payable to a surviving spouse shall be increased by the same overall average percentage increase (rounded to the nearest tenth of a percent) and on the same effective date as any legislative increase in the rates payable under 38 U.S.C. 1311. The monthly rate of special allowance payable to a child shall be increased by the same overall average percentage increase (rounded to the nearest tenth of a percent) and on the same effective date as any legislative increase in the rates payable under 38 U.S.C. 3531(b).

(5) *Amendment of awards.* Prompt action shall be taken to amend any award of this special allowance to conform with evidence indicating a change in basic eligibility, any basic entitlement rate, or any effective date previously determined. It is the claimant's responsibility to promptly notify VA of any change in their status or employment which affects eligibility or entitlement.

(6) *Rounding of monthly rates.* Any monthly rate computed under the provisions of this paragraph, if not a multiple of $1, shall be rounded to the next lower multiple of $1.

(c) *Claimants not entitled to this special allowance.* The following are not entitled to this special allowance for the reasons indicated.

(1) Claimants eligible for death benefits under 38 U.S.C. 1151. The deaths in such cases are not service-connected.

(2) Claimants eligible for death benefits under 38 U.S.C. 1318. The deaths in such cases are not service connected.

(3) Claimants whose claims are based on an individual's service in:

(i) The Commonwealth Army of the Philippines while such forces were in the service of the Armed Forces pursuant to the military order of the President dated July 26, 1941, including recognized guerrilla forces (see 38 U.S.C. 107).

(ii) The Philippine Scouts under section 14, Pub. L. 190, 79th Congress (see 38 U.S.C. 107).

(iii) The commissioned corps of the Public Health Service (specifically excluded by section 156 of Pub. L. 97–377), or

(iv) The National Oceanic and Atmospheric Administration (specifically excluded by section 156 of Pub. L. 97–377).

(d) *Appellate jurisdiction.* VA shall have appellate jurisdiction of all determinations made in connection with this special allowance.

(e) *Claims.* Claimants must file or submit a complete claim on a paper or electronic form prescribed by the Secretary in order for VA to pay this special allowance. When VA receives an intent to file a claim or inquiries as to eligibility, VA will follow the procedures outlined in §3.155. Otherwise, the date of receipt of the complete claim will be accepted as the date of claim for this special allowance. See §§3.150, 3.151, 3.155, 3.400.

(f) *Retroactivity and effective dates.* There is no time limit for filing a claim for this special allowance. Upon the filing of a complete claim, benefits shall be payable for all periods of eligibility beginning on or after the first

day of the month in which the claimant first became eligible for this special allowance, except that no payment may be made for any period prior to January 1, 1983.

(Authority: Sec. 156, Pub. L. 97–377, 96 Stat. 1830, 1920 (1982))

[49 FR 21709, May 23, 1984, as amended at 54 FR 26030, June 21, 1989; 60 FR 20643, Apr. 27, 1995; 79 FR 57697, Sept. 25, 2014]

§ 3.813 Interim benefits for disability or death due to chloracne or porphyria cutanea tarda.

(a) *Disability benefits.* Except as provided in paragraph (c) of this section, a veteran who served in the active military, naval or air service in the Republic of Vietnam during the Vietnam era, and who suffers from chloracne or porphyria cutanea tarda which became manifest within one year after the date of the veteran's most recent departure from the Republic of Vietnam during such service, shall be paid interim disability benefits under this section in the same manner and to the same extent that compensation would be payable if such disabilities were service-connected.

(b) *Death benefits.* Except as provided in paragraph (c) of this section, if a veteran described in paragraph (a) of this section dies as a result of chloracne or porphyria cutanea tarda, the veteran's survivors shall be paid interim death benefits under this section based upon the same elgibility requirements and at the same rates that dependency and indemnity compensation would be payable if the death were service-connected.

(c) *Exceptions.* Benefits under this section are not payable for any month for which compensation or dependency and indemnity compensation is payable for the same disability or death, nor are benefits payable under this section (1) when there is affirmative evidence that the disease was not incurred by the veteran during service in the Republic of Vietnam during the Vietnam era, (2) when there is affirmative evidence to establish that an intercurrent injury or disease, which is a recognized cause of the disease for which benefits are being claimed, was suffered by the veteran between the date of the veteran's most recent departure from the Republic of Vietnam during active military, naval or air service and the onset of the claimed disease, or (3) if it is determined, based on evidence in the veteran's service records and other records provided by the Secretary of Defense, that the veteran was not exposed to dioxin during active military, naval or air service in the Republic of Vietnam during the Vietnam era.

(d) *Similarity to service-connected benefits.* For purposes of all laws administered by VA (except chapters 11 and 13 of title 38 U.S.C.), a disease establishing eligibility for disability or death benefits under this section shall be treated as if it were service-connected, and the receipt of disability or death benefits shall be treated as if such benefits were compensation or dependency and indemnity compensation, respectively.

(e) *Effective dates.* Benefits under this section may not be paid for any period prior to October 1, 1984, nor for any period after September 30, 1986.

(Authority: Pub. L. 98–542)

[50 FR 34460, Aug. 26, 1985]

§ 3.814 Monetary allowance under 38 U.S.C. chapter 18 for an individual suffering from spina bifida whose biological father or mother is or was a Vietnam veteran or a veteran with covered service in Korea.

(a) *Monthly monetary allowance.* VA will pay a monthly monetary allowance under subchapter I of 38 U.S.C. chapter 18, based upon the level of disability determined under the provisions of paragraph (d) of this section, to or for a person who VA has determined is an individual suffering from spina bifida whose biological mother or father is or was a Vietnam veteran or a veteran with covered service in Korea. Receipt of this allowance will not affect the right of the individual or any related person to receive any other benefit to which he or she may be entitled under any law administered by VA. An individual suffering from spina bifida is entitled to only one monthly allowance under this section, even if the individual's biological father and mother are or were both Vietnam veterans or veterans with covered service in Korea.

(b) [Reserved]

(c) *Definitions*—(1) *Vietnam veteran.* For the purposes of this section, the term ''Vietnam veteran'' means a person who performed active military, naval, or air service in the Republic of Vietnam during the period beginning on January 9, 1962, and ending on May 7, 1975, without regard to the characterization of the person's service. *Service in the Republic of Vietnam* includes service in the waters offshore and service in other locations if the conditions of service involved duty or visitation in the Republic of Vietnam.

(2) *Covered service in Korea.* For the purposes of this section, the term ''veteran with covered service in Korea'' means a person who served in the active military, naval, or air service in or near the Korean DMZ between September 1, 1967, and August 31, 1971, and who is determined by VA, in consultation with the Department of Defense, to have been exposed to an herbicide agent during such service. Exposure to an herbicide agent will be conceded if the veteran served between April 1, 1968, and August 31, 1971, in a unit that, as determined by the Department of Defense, operated in or near the Korean DMZ in an area in which herbicides are known to have been applied during that period, unless there is affirmative evidence to establish that the veteran was not exposed to any such agent during that service.

(3) *Individual.* For the purposes of this section, the term ''individual'' means a person, regardless of age or marital status, whose biological father or mother is or was a Vietnam veteran and who was conceived after the date on which the veteran first served in the Republic of Vietnam during the Vietnam era, or whose biological father or mother is or was a veteran with covered service in Korea and who was conceived after the date on which the veteran first had covered service in Korea as defined in this section. Notwithstanding the provisions of §3.204(a)(1), VA will require the types of evidence specified in §§3.209 and 3.210 sufficient to establish in the judgment of the Secretary that a person is the biological son or daughter of a Vietnam veteran or a veteran with covered service in Korea.

(4) *Spina bifida.* For the purposes of this section, the term ''spina bifida'' means any form and manifestation of spina bifida except spina bifida occulta.

(d) *Disability evaluations.* (1) Except as otherwise specified in this paragraph, VA will determine the level of payment as follows:

(i) *Level I.* The individual walks without braces or other external support as his or her primary means of mobility in the community, has no sensory or motor impairment of the upper extremities, has an IQ of 90 or higher, and is continent of urine and feces without the use of medication or other means to control incontinence.

(ii) *Level II.* Provided that none of the disabilities is severe enough to warrant payment at Level III, and the individual: walks with braces or other external support as his or her primary means of mobility in the community; or, has sensory or motor impairment of the upper extremities, but is able to grasp pen, feed self, and perform self care; or, has an IQ of at least 70 but less than 90; or, requires medication or other means to control the effects of urinary bladder impairment and no more than two times per week is unable to remain dry for at least three hours at a time during waking hours; or, requires bowel management techniques or other treatment to control the effects of bowel impairment but does not have fecal leakage severe or frequent enough to require wearing of absorbent materials at least four days a week; or, has a colostomy that does not require wearing a bag.

(iii) *Level III.* The individual uses a wheelchair as his or her primary means of mobility in the community; or, has sensory or motor impairment of the upper extremities severe enough to prevent grasping a pen, feeding self, and performing self care; or, has an IQ of 69 or less; or, despite the use of medication or other means to control the effects of urinary bladder impairment, at least three times per week is unable to remain dry for three hours at a time during waking hours; or, despite bowel management techniques or other treatment to control the effects of bowel impairment, has fecal leakage severe or frequent enough to require wearing of absorbent materials at least four

days a week; or, regularly requires manual evacuation or digital stimulation to empty the bowel; or, has a colostomy that requires wearing a bag.

(2) If an individual who would otherwise be paid at Level I or II has one or more disabilities, such as blindness, uncontrolled seizures, or renal failure that result either from spina bifida, or from treatment procedures for spina bifida, the Director of the Compensation Service may increase the monthly payment to the level that, in his or her judgment, best represents the extent to which the disabilities resulting from spina bifida limit the individual's ability to engage in ordinary day-to-day activities, including activities outside the home. A Level II or Level III payment will be awarded depending on whether the effects of a disability are of equivalent severity to the effects specified under Level II or Level III.

(3) VA may accept statements from private physicians, or examination reports from government or private institutions, for the purpose of rating spina bifida claims without further examination, provided the statements or reports are adequate for assessing the level of disability due to spina bifida under the provisions of paragraph (d)(1) of this section. In the absence of adequate medical information, VA will schedule an examination for the purpose of assessing the level of disability.

(4) VA will pay an individual eligible for a monetary allowance due to spina bifida at Level I unless or until it receives medical evidence supporting a higher payment. When required to reassess the level of disability under paragraph (d)(5) or (d)(6) of this section, VA will pay an individual eligible for this monetary allowance at Level I in the absence of evidence adequate to support a higher level of disability or if the individual fails to report, without good cause, for a scheduled examination. Examples of good cause include, but are not limited to, the illness or hospitalization of the claimant, death of an immediate family member, etc.

(5) VA will pay individuals under the age of one year at Level I unless a pediatric neurologist or a pediatric neurosurgeon certifies that, in his or her medical judgment, there is a neurological deficit that will prevent the individual from ambulating, grasping a pen, feeding himself or herself, performing self care, or from achieving urinary or fecal continence. If any of those deficits are present, VA will pay the individual at Level III. In either case, VA will reassess the level of disability when the individual reaches the age of one year.

(6) VA will reassess the level of payment whenever it receives medical evidence indicating that a change is warranted. For individuals between the ages of one and twenty-one, however, it must reassess the level of payment at least every five years.

(e) *Effective dates.* Except as otherwise provided, VA will award the monetary allowance for an individual suffering from spina bifida based on an initial claim or supplemental claim as of the date VA received the claim (or the date of birth if the claim is received within 1 year of that date) or the date entitlement arose, whichever is later.

(1) VA will increase benefits as of the earliest date the evidence establishes that the level of severity increased, but only if the beneficiary applies for an increase within one year of that date.

(2) If a claimant reopens a previously disallowed claim based on corrected military records, VA will award the benefit from the latest of the following dates: the date the veteran or beneficiary applied for a correction of the military records; the date the disallowed claim was filed; or, the date one year before the date of receipt of the reopened claim.

(f) *Reductions and discontinuances.* VA will generally reduce or discontinue awards according to the facts found except as provided in §§ 3.105 and 3.114(b).

(1) If benefits were paid erroneously because of beneficiary error, VA will reduce or discontinue benefits as of the effective date of the erroneous award.

(2) If benefits were paid erroneously because of administrative error, VA will reduce or discontinue benefits as of the date of last payment.

(Authority: 38 U.S.C. 501, 1805, 1811, 1812, 1821, 1831, 1832, 1833, 1834, 5101, 5110, 5111, 5112)

CROSS REFERENCE: 38 CFR 3.307(a)(6)(iv).

[62 FR 51279, Sept. 30, 1997, as amended at 65 FR 35282, June 2, 2000; 66 FR 13436, Mar. 6, 2001; 67 FR 49587, July 31, 2002; 76 FR 4249, Jan. 25, 2011; 79 FR 2100, Jan. 13, 2014; 84 FR 171, Jan. 18, 2019]

§3.815 Monetary allowance under 38 U.S.C. chapter 18 for an individual with disability from covered birth defects whose biological mother is or was a Vietnam veteran; identification of covered birth defects.

(a) *Monthly monetary allowance*—(1) *General*. VA will pay a monthly monetary allowance under subchapter II of 38 U.S.C. chapter 18 to or for an individual whose biological mother is or was a Vietnam veteran and who VA has determined to have disability resulting from one or more covered birth defects. Except as provided in paragraph (a)(3) of this section, the amount of the monetary allowance paid will be based upon the level of such disability suffered by the individual, as determined in accordance with the provisions of paragraph (e) of this section.

(2) *Affirmative evidence of cause other than mother's service during Vietnam era*. No monetary allowance will be provided under this section based on a particular birth defect of an individual in any case where affirmative evidence establishes that the birth defect results from a cause other than the active military, naval, or air service of the individual's mother during the Vietnam era and, in determining the level of disability for an individual with more than one birth defect, the particular defect resulting from other causes will be excluded from consideration. This will not prevent VA from paying a monetary allowance under this section for other birth defects.

(3) *Nonduplication; spina bifida*. In the case of an individual whose only covered birth defect is spina bifida, a monetary allowance will be paid under §3.814, and not under this section, nor will the individual be evaluated for disability under this section. In the case of an individual who has spina bifida and one or more additional covered birth defects, a monetary allowance will be paid under this section and the amount of the monetary allowance will be not less than the amount the individual would receive if his or her only covered birth defect were spina bifida. If, but for the individual's one or more additional covered birth defects, the monetary allowance payable to or for the individual would be based on an evaluation at Level I, II, or III, respectively, under §3.814(d), the evaluation of the individual's level of disability under paragraph (e) of this section will be not less than Level II, III, or IV, respectively.

(b) *No effect on other VA benefits*. Receipt of a monetary allowance under 38 U.S.C. chapter 18 will not affect the right of the individual, or the right of any person based on the individual's relationship to that person, to receive any other benefit to which the individual, or that person, may be entitled under any law administered by VA.

(c) *Definitions*—(1) *Vietnam veteran*. For the purposes of this section, the term *Vietnam veteran* means a person who performed active military, naval, or air service in the Republic of Vietnam during the period beginning on February 28, 1961, and ending on May 7, 1975, without regard to the characterization of the person's service. Service in the Republic of Vietnam includes service in the waters offshore and service in other locations if the conditions of service involved duty or visitation in the Republic of Vietnam.

(2) *Individual*. For the purposes of this section, the term individual means a person, regardless of age or marital status, whose biological mother is or was a Vietnam veteran and who was conceived after the date on which the veteran first entered the Republic of Vietnam during the period beginning on February 28, 1961, and ending on May 7, 1975. Notwithstanding the provisions of §3.204(a)(1), VA will require the types of evidence specified in §§3.209 and 3.210 sufficient to establish that a person is the biological son or daughter of a Vietnam veteran.

(3) *Covered birth defect*. For the purposes of this section, the term *covered birth defect* means any birth defect identified by VA as a birth defect that is associated with the service of women Vietnam veterans in the Republic of Vietnam during the period beginning on February 28, 1961, and ending on May 7, 1975, and that has resulted, or may result, in permanent physical or

mental disability. However, the term *covered birth defect* does not include a condition due to a:

(i) Familial disorder;

(ii) Birth-related injury; or

(iii) Fetal or neonatal infirmity with well-established causes.

(d) *Identification of covered birth defects*. All birth defects that are not excluded under the provisions of this paragraph are covered birth defects.

(1) Covered birth defects include, but are not limited to, the following (however, if a birth defect is determined to be familial in a particular family, it will not be a covered birth defect):

(i) Achondroplasia;

(ii) Cleft lip and cleft palate;

(iii) Congenital heart disease;

(iv) Congenital talipes equinovarus (clubfoot);

(v) Esophageal and intestinal atresia;

(vi) Hallerman-Streiff syndrome;

(vii) Hip dysplasia;

(viii) Hirschprung's disease (congenital megacolon);

(ix) Hydrocephalus due to aqueductal stenosis;

(x) Hypospadias;

(xi) Imperforate anus;

(xii) Neural tube defects (including spina bifida, encephalocele, and anencephaly);

(xiii) Poland syndrome;

(xiv) Pyloric stenosis;

(xv) Syndactyly (fused digits);

(xvi) Tracheoesophageal fistula;

(xvii) Undescended testicle; and

(xviii) Williams syndrome.

(2) Birth defects that are familial disorders, including hereditary genetic conditions, are not covered birth defects. Familial disorders include, but are not limited to, the following, unless the birth defect is not familial in a particular family:

(i) Albinism;

(ii) Alpha-antitrypsin deficiency;

(iii) Crouzon syndrome;

(iv) Cystic fibrosis;

(v) Duchenne's muscular dystrophy;

(vi) Galactosemia;

(vii) Hemophilia;

(viii) Huntington's disease;

(ix) Hurler syndrome;

(x) Kartagener's syndrome (Primary Ciliary Dyskinesia);

(xi) Marfan syndrome;

(xii) Neurofibromatosis;

(xiii) Osteogenesis imperfecta;

(xiv) Pectus excavatum;

(xv) Phenylketonuria;

(xvi) Sickle cell disease;

(xvii) Tay-Sachs disease;

(xviii) Thalassemia; and

(xix) Wilson's disease.

(3) Conditions that are congenital malignant neoplasms are not covered birth defects. These include, but are not limited to, the following:

(i) Medulloblastoma;

(ii) Neuroblastoma;

(iii) Retinoblastoma;

(iv) Teratoma; and

(v) Wilm's tumor.

(4) Conditions that are chromosomal disorders are not covered birth defects. These include, but are not limited to, the following:

(i) Down syndrome and other Trisomies;

(ii) Fragile X syndrome;

(iii) Klinefelter's syndrome; and

(iv) Turner's syndrome.

(5) Conditions that are due to birth-related injury are not covered birth defects. These include, but are not limited to, the following:

(i) Brain damage due to anoxia during or around time of birth;

(ii) Cerebral palsy due to birth trauma, (iii) Facial nerve palsy or other peripheral nerve injury;

(iv) Fractured clavicle; and

(v) Horner's syndrome due to forceful manipulation during birth.

(6) Conditions that are due to a fetal or neonatal infirmity with well-established causes or that are miscellaneous pediatric conditions are not covered birth defects. These include, but are not limited to, the following:

(i) Asthma and other allergies;

(ii) Effects of maternal infection during pregnancy, including but not limited to, maternal rubella, toxoplasmosis, or syphilis;

(iii) Fetal alcohol syndrome or fetal effects of maternal drug use;

(iv) Hyaline membrane disease;

(v) Maternal-infant blood incompatibility;

(vi) Neonatal infections;

(vii) Neonatal jaundice;

(viii) Post-infancy deafness/hearing impairment (onset after the age of one year);

(ix) Prematurity; and

(x) Refractive disorders of the eye.

(7) Conditions that are developmental disorders are not covered birth defects. These include, but are not limited to, the following:

(i) Attention deficit disorder;

(ii) Autism;

(iii) Epilepsy diagnosed after infancy (after the age of one year);

(iv) Learning disorders; and

(v) Mental retardation (unless part of a syndrome that is a covered birth defect).

(8) Conditions that do not result in permanent physical or mental disability are not covered birth defects. These include, but are not limited to:

(i) Conditions rendered non-disabling through treatment;

(ii) Congenital heart problems surgically corrected or resolved without disabling residuals;

(iii) Heart murmurs unassociated with a diagnosed cardiac abnormality;

(iv) Hemangiomas that have resolved with or without treatment; and

(v) Scars (other than of the head, face, or neck) as the only residual of corrective surgery for birth defects.

(e) *Disability evaluations.* Whenever VA determines, upon receipt of competent medical evidence, that an individual has one or more covered birth defects, VA will determine the level of disability currently resulting, in combination, from the covered birth defects and associated disabilities. No monetary allowance will be payable under this section if VA determines under this paragraph that an individual has no current disability resulting from the covered birth defects, unless VA determines that the provisions of paragraph (a)(3) of this section are for application. Except as otherwise provided in paragraph (a)(3) of this section, VA will determine the level of disability as follows:

(1) *Levels of disability.*

(i) *Level 0.* The individual has no current disability resulting from covered birth defects.

(ii) *Level I.* The individual meets one or more of the following criteria:

(A) The individual has residual physical or mental effects that only occasionally or intermittently limit or prevent some daily activities; or

(B) The individual has disfigurement or scarring of the head, face, or neck without gross distortion or gross asymmetry of any facial feature (nose, chin, forehead, eyes (including eyelids), ears (auricles), cheeks, or lips).

(iii) *Level II.* The individual meets one or more of the following criteria:

(A) The individual has residual physical or mental effects that frequently or constantly limit or prevent some daily activities, but the individual is able to work or attend school, carry out most household chores, travel, and provide age-appropriate self-care, such as eating, dressing, grooming, and carrying out personal hygiene, and communication, behavior, social interaction, and intellectual functioning are appropriate for age; or

(B) The individual has disfigurement or scarring of the head, face, or neck with either gross distortion or gross asymmetry of one facial feature or one paired set of facial features (nose, chin, forehead, eyes (including eyelids), ears (auricles), cheeks, or lips).

(iv) *Level III.* The individual meets one or more of the following criteria:

(A) The individual has residual physical or mental effects that frequently or constantly limit or prevent most daily activities, but the individual is able to provide age-appropriate self-care, such as eating, dressing, grooming, and carrying out personal hygiene;

(B) The individual is unable to work or attend school, travel, or carry out household chores, or does so intermittently and with difficulty;

(C) The individual's communication, behavior, social interaction, and intellectual functioning are not entirely appropriate for age; or

(D) The individual has disfigurement or scarring of the head, face, or neck with either gross distortion or gross asymmetry of two facial features or two paired sets of facial features (nose, chin, forehead, eyes (including eyelids), ears (auricles), cheeks, or lips).

(v) *Level IV.* The individual meets one or more of the following criteria:

(A) The individual has residual physical or mental effects that prevent age-appropriate self-care, such as eating, dressing, grooming, and carrying out personal hygiene;

(B) The individual's communication, behavior, social interaction, and intellectual functioning are grossly inappropriate for age; or

(C) The individual has disfigurement or scarring of the head, face, or neck with either gross distortion or gross asymmetry of three facial features or three paired sets of facial features (nose, chin, forehead, eyes (including eyelids), ears (auricles), cheeks, or lips).

(2) *Assessing limitation of daily activities.* Physical or mental effects on the following functions are to be considered in assessing limitation of daily activities:

(i) Mobility (ability to stand and walk, including balance and coordination);

(ii) Manual dexterity;

(iii) Stamina;

(iv) Speech;

(v) Hearing;

(vi) Vision (other than correctable refraction errors);

(vii) Memory;

(viii) Ability to concentrate;

(ix) Appropriateness of behavior; and

(x) Urinary and fecal continence.

(f) *Information for determining whether individuals have covered birth defects and rating disability levels.* (1) VA may accept statements from private physicians, or examination reports from government or private institutions, for the purposes of determining whether an individual has a covered birth defect and for rating claims for covered birth defects. If they are adequate for such purposes, VA may make the determination and rating without further examination. In the absence of adequate information, VA may schedule examinations for the purpose of determining whether an individual has a covered birth defect and/or assessing the level of disability.

(2) Except in accordance with paragraph (a)(3) of this section, VA will not pay a monthly monetary allowance unless or until VA is able to obtain medical evidence adequate to determine that an individual has a covered birth defect and adequate to assess the level of disability due to covered birth defects.

(g) *Redeterminations.* VA will reassess a determination under this section whenever it receives evidence indicating that a change is warranted.

(h) *Referrals.* If a regional office is unclear in any case as to whether a condition is a covered birth defect, it may refer the issue to the Director of the Compensation Service for determination.

(i) *Effective dates.* Except as provided in § 3.114(a) or paragraph (i)(1) or (2) of this section, VA will award the monetary allowance under subchapter II of 38 U.S.C. chapter 18, for an individual with disability resulting from one or more covered birth defects, based on an initial claim or supplemental claim, as of the date VA received the claim (or the date of birth if the claim is received within one year of that date), the date entitlement arose, or December 1, 2001, whichever is latest. Subject to the condition that no benefits may be paid for any period prior to December 1, 2001:

(1) VA will increase benefits as of the earliest date the evidence establishes that the level of severity increased, but only if the beneficiary applies for an increase within one year of that date.

(2) If a claimant reopens a previously disallowed claim based on corrected military records, VA will award the benefit from the latest of the following dates: the date the veteran or beneficiary applied for a correction of the military records; the date the disallowed claim was filed; or, the date one year before the date of receipt of the reopened claim.

(j) *Reductions and discontinuances.* VA will generally reduce or discontinue awards under subchapter II of 38 U.S.C. chapter 18 according to the facts found except as provided in §§ 3.105 and 3.114(b).

(1) If benefits were paid erroneously because of beneficiary error, VA will reduce or discontinue benefits as of the effective date of the erroneous award.

(2) If benefits were paid erroneously because of administrative error, VA will reduce or discontinue benefits as of the date of last payment.

(Authority: 38 U.S.C. 501, 1811, 1812, 1813, 1814, 1815, 1816, 1831, 1832, 1833, 1834, 5101, 5110, 5111, 5112)

[67 FR 49588, July 31, 2002, as amended at 76 FR 4249, Jan. 25, 2011; 79 FR 2100, Jan. 13, 2014; 84 FR 171, Jan. 18, 2019]

§3.816 Awards under the Nehmer Court Orders for disability or death caused by a condition presumptively associated with herbicide exposure.

(a) *Purpose.* This section states effective-date rules required by orders of a United States district court in the class-action case of *Nehmer* v. *United States Department of Veterans Affairs,* No. CV–86–6160 TEH (N.D. Cal.).

(b) *Definitions.* For purposes of this section—

(1) *Nehmer class member* means:

(i) A Vietnam veteran who has a covered herbicide disease; or

(ii) A surviving spouse, child, or parent of a deceased Vietnam veteran who died from a covered herbicide disease.

(2) *Covered herbicide disease* means a disease for which the Secretary of Veterans Affairs has established a presumption of service connection pursuant to the Agent Orange Act of 1991, Public Law 102–4, other than chloracne, as provided in §3.309(e).

(c) *Effective date of disability compensation.* If a *Nehmer* class member is entitled to disability compensation for a covered herbicide disease, the effective date of the award will be as follows:

(1) If VA denied compensation for the same covered herbicide disease in a decision issued between September 25, 1985 and May 3, 1989, the effective date of the award will be the later of the date VA received the claim on which the prior denial was based or the date the disability arose, except as otherwise provided in paragraph (c)(3) of this section. A prior decision will be construed as having denied compensation for the same disease if the prior decision denied compensation for a disease that reasonably may be construed as the same covered herbicide disease for which compensation has been awarded. Minor differences in the terminology used in the prior decision will not preclude a finding, based on the record at the time of the prior decision, that the prior decision denied compensation for the same covered herbicide disease.

(2) If the class member's claim for disability compensation for the covered herbicide disease was either pending before VA on May 3, 1989, or was received by VA between that date and the effective date of the statute or regulation establishing a presumption of service connection for the covered disease, the effective date of the award will be the later of the date such claim was received by VA or the date the disability arose, except as otherwise provided in paragraph (c)(3) of this section. A claim will be considered a claim for compensation for a particular covered herbicide disease if:

(i) The claimant's application and other supporting statements and submissions may reasonably be viewed, under the standards ordinarily governing compensation claims, as indicating an intent to apply for compensation for the covered herbicide disability; or

(ii) VA issued a decision on the claim, between May 3, 1989 and the effective date of the statute or regulation establishing a presumption of service connection for the covered disease, in which VA denied compensation for a disease that reasonably may be construed as the same covered herbicide disease for which compensation has been awarded.

(3) If the class member's claim referred to in paragraph (c)(1) or (c)(2) of this section was received within one year from the date of the class member's separation from service, the effective date of the award shall be the day following the date of the class member's separation from active service.

(4) If the requirements of paragraph (c)(1) or (c)(2) of this section are not met, the effective date of the award shall be determined in accordance with §§3.114 and 3.400.

(d) *Effective date of dependency and indemnity compensation (DIC).* If a Nehmer class member is entitled to DIC for a death due to a covered herbicide disease, the effective date of the award will be as follows:

(1) If VA denied DIC for the death in a decision issued between September 25, 1985 and May 3, 1989, the effective date of the award will be the later of the date VA received the claim on which such prior denial was based or the date the death occurred, except as otherwise provided in paragraph (d)(3) of this section.

(2) If the class member's claim for DIC for the death was either pending

before VA on May 3, 1989, or was received by VA between that date and the effective date of the statute or regulation establishing a presumption of service connection for the covered herbicide disease that caused the death, the effective date of the award will be the later of the date such claim was received by VA or the date the death occurred, except as otherwise provided in paragraph (d)(3) of this section. In accordance with § 3.152(b)(1), a claim by a surviving spouse or child for death pension will be considered a claim for DIC. In all other cases, a claim will be considered a claim for DIC if the claimant's application and other supporting statements and submissions may reasonably be viewed, under the standards ordinarily governing DIC claims, as indicating an intent to apply for DIC.

(3) If the class member's claim referred to in paragraph (d)(1) or (d)(2) of this section was received within one year from the date of the veteran's death, the effective date of the award shall be the first day of the month in which the death occurred.

(4) If the requirements of paragraph (d)(1) or (d)(2) of this section are not met, the effective date of the award shall be determined in accordance with §§ 3.114 and 3.400.

(e) *Effect of other provisions affecting retroactive entitlement*—(1) *General*. If the requirements specified in paragraphs (c)(1) or (c)(2) or (d)(1) or (d)(2) of this section are satisfied, the effective date shall be assigned as specified in those paragraphs, without regard to the provisions in 38 U.S.C. 5110(g) or § 3.114 prohibiting payment for periods prior to the effective date of the statute or regulation establishing a presumption of service connection for a covered herbicide disease. However, the provisions of this section will not apply if payment to a *Nehmer* class member based on a claim described in paragraph (c) or (d) of this section is otherwise prohibited by statute or regulation, as, for example, where a class member did not qualify as a surviving spouse at the time of the prior claim or denial.

(2) *Claims Based on Service in the Republic of Vietnam Prior to August 5, 1964.* If a claim referred to in paragraph (c) or (d) of this section was denied by VA prior to January 1, 1997, and the veteran's service in the Republic of Vietnam ended before August 5, 1964, the effective-date rules of this regulation do not apply. The effective date of benefits in such cases shall be determined in accordance with 38 U.S.C. 5110. If a claim referred to in paragraph (c) or (d) of this section was pending before VA on January 1, 1997, or was received by VA after that date, and the veteran's service in the Republic of Vietnam ended before August 5, 1964, the effective date shall be the later of the date provided by paragraph (c) or (d) of this section or January 1, 1997.

(Authority: Public Law 104–275, sec. 505)

(f) *Payment of Benefits to Survivors or Estates of Deceased Beneficiaries*—(1) *General*. If a *Nehmer* class member entitled to retroactive benefits pursuant to paragraphs (c)(1) through (c)(3) or (d)(1) through (d)(3) of this section dies prior to receiving payment of any such benefits, VA shall pay such unpaid retroactive benefits to the first individual or entity listed below that is in existence at the time of payment:

(i) The class member's spouse, regardless of current marital status.

NOTE TO PARAGRAPH (f)(1)(i): For purposes of this paragraph, a spouse is the person who was legally married to the class member at the time of the class member's death.

(ii) The class member's child(ren), regardless of age or marital status (if more than one child exists, payment will be made in equal shares, accompanied by an explanation of the division).

NOTE TO PARAGRAPH (f)(1)(ii): For purposes of this paragraph, the term ''child'' includes natural and adopted children, and also includes any stepchildren who were members of the class member's household at the time of the class member's death.

(iii) The class member's parent(s), regardless of dependency (if both parents are alive, payment will be made in equal shares, accompanied by an explanation of the division).

NOTE TO PARAGRAPH (f)(1)(iii): For purposes of this paragraph, the term ''parent'' includes natural and adoptive parents, but in the event of successive parents, the persons who last stood as parents in relation to the class member will be considered the parents.

(iv) The class member's estate.

(2) *Inapplicability of certain accrued benefit requirements.* The provisions of 38 U.S.C. 5121(c) and §3.1000(c) requiring survivors to file claims for accrued benefits do not apply to payments under this section. When a *Nehmer* class member dies prior to receiving retroactive payments under this section, VA will pay the amount to an identified payee in accordance with paragraph (f)(1) of this section without requiring an application from the payee. Prior to releasing such payment, however, VA may ask the payee to provide further information as specified in paragraph (f)(3) of this section.

(3) *Identifying payees.* VA shall make reasonable efforts to identify the appropriate payee(s) under paragraph (f)(1) of this section based on information in the veteran's claims file. If further information is needed to determine whether any appropriate payee exists or whether there are any persons having equal or higher precedence than a known prospective payee, VA will request such information from a survivor or authorized representative if the claims file provides sufficient contact information. Before releasing payment to an identified payee, VA will ask the payee to state whether there are any other survivors of the class member who may have equal or greater entitlement to payment under this section, unless the circumstances clearly indicate that such a request is unnecessary. If, following such efforts, VA releases the full amount of unpaid benefits to a payee, VA may not thereafter pay any portion of such benefits to any other individual, unless VA is able to recover the payment previously released.

(4) *Bar to accrued benefit claims.* Payment of benefits pursuant to paragraph (f)(1) of this section shall bar a later claim by any individual for payment of all or any part of such benefits as accrued benefits under 38 U.S.C. 5121 and §3.1000.

(g) *Awards covered by this section.* This section applies only to awards of disability compensation or DIC for disability or death caused by a disease listed in paragraph (b)(2) of this section.

(Authority: 38 U.S.C. 501)

[68 FR 50970, Aug. 25, 2003, as amended at 73 FR 61736, Oct. 17, 2008; 78 FR 54766, Sept. 6, 2013]

FORFEITURE

§3.900 General.

(a) Forfeiture of benefits based on one period of service does not affect entitlement to benefits based on a period of service beginning after the offense causing the prior forfeiture.

(b)(1) Except as provided in paragraph (b)(2) of this section, any offense committed prior to January 1, 1959, may cause a forfeiture and any forfeiture in effect prior to January 1, 1959, will continue to be a bar on and after January 1, 1959.

(Authority: Section 3, Pub. L. 85–857)

(2) Effective September 2, 1959, forfeiture of benefits may not be declared except under the circumstances set forth in §3.901(d), §3.902(d), or §3.903. Forfeitures declared before September 2, 1959, will continue to be a bar on and after that date.

(Authority: 38 U.S.C. 6103(d) and 6105)

(c) Pension or compensation payments are not subject to forfeiture because of violation of hospital rules.

(d) When the person primarily entitled has forfeited his or her rights by reason of fraud or a treasonable act determination as to the rights of any dependents of record to benefits under §3.901(c) or §3.902(c) may be made upon receipt of an application.

(Authority: 38 U.S.C. 6103(b) and 38 U.S.C. 6104(b))

[26 FR 1607, Feb. 24, 1961, as amended at 27 FR 8590, Aug. 28, 1962; 53 FR 17934, May 19, 1988]

§3.901 Fraud.

(a) *Definition.* An act committed when a person knowingly makes or causes to be made or conspires, combines, aids, or assists in, agrees to, arranges for, or in any way procures the making or presentation of a false or fraudulent affidavit, declaration, certificate, statement, voucher, or paper,

concerning any claim for benefits under any of the laws administered by the Department of Veterans Affairs (except laws relating to insurance benefits).

(b) *Effect on claim.* For the purposes of paragraph (d) of this section, any person who commits fraud forfeits all rights to benefits under all laws administered by the Department of Veterans Affairs other than laws relating to insurance benefits.

(c) *Forfeiture before September 2, 1959.* Where forfeiture for fraud was declared before September 2, 1959, in the case of a veteran entitled to disability compensation, the compensation payable except for the forfeiture may be paid to the veteran's spouse, children and parents provided the decision to apportion was authorized prior to September 2, 1959. The total amount payable will be the lesser of these amounts:

(Authority: 38 U.S.C. 6103)

(1) Service-connected death benefit payable.

(2) Amount of compensation payable but for the forfeiture.

No benefits are payable to any person who participated in the fraud causing the forfeiture.

(d) *Forfeiture after September 1, 1959.* After September 1, 1959, forfeiture by reason of fraud may be declared only

(1) Where the person was not residing or domiciled in a State as defined in § 3.1(i) at the time of commission of the fraudulent act; or

(2) Where the person ceased to be a resident of or domiciled in a State as defined in § 3.1(i) before expiration of the period during which criminal prosecution could be instituted; or

(3) The fraudulent act was committed in the Philippine Islands.

Where the veteran's rights have been forfeited, no part of his or her benefit may be paid to his or her dependents.

(Authority: 38 U.S.C. 6103)

(e) *Remission of forfeitures imposed prior to September 2, 1959.* Where it is determined that a forfeiture for fraud which was imposed prior to September 2, 1959, would not be imposed under the law and regulation in effect on and after September 2, 1959, the forfeiture shall be remitted effective June 30, 1972. Benefits to which a person becomes eligible by virtue of the remission, upon application therefor, shall be awarded effective as provided by § 3.114.

(Authority: 38 U.S.C. 6103)

[27 FR 8590, Aug. 28, 1962, as amended at 37 FR 19134, Sept. 19, 1972; 53 FR 17934, May 19, 1988]

§ 3.902 Treasonable acts.

(a) *Definition.* An act of mutiny, treason, sabotage or rendering assistance to an enemy of the United States or of its allies.

(b) *Effect on claim.* For the purposes of paragraph (d) of this section, any person determined by the Department of Veterans Affairs to be guilty of a treasonable act forfeits all gratuitous benefits under laws administered by the Department of Veterans Affairs which he or she may be receiving or would have been entitled to receive in the future.

(c) *Forfeiture before September 2, 1959.* Where forfeiture for treasonable acts was declared before September 2, 1959, the Secretary may pay any part of benefits so forfeited to the dependents of the person provided the decision to apportion was authorized prior to September 2, 1959, except that the amount may not be in excess of that which the dependent would be entitled to as a death benefit.

(Authority: 38 U.S.C. 6104(c))

(1) *Compensation.* Whenever a veteran entitled to disability compensation has forfeited his or her right, any part of the compensation payable except for the forfeiture may be paid to the veteran's spouse, children and parents. The total amount payable will be the lesser of these amounts:

(i) Service-connected death benefit payable.

(ii) Amount of compensation payable but for the forfeiture.

No benefits are payable to any person participating in the treasonable act causing the forfeiture.

(2) *Pension.* Whenever a veteran entitled to pension has forfeited his or her right, any part of the pension payable except for the forfeiture provision may

be paid to the veteran's spouse and children. The total amount payable will be the lesser of these amounts:

(i) Nonservice-connected death benefit payable.

(ii) Amount of pension being paid the veteran at the time of forfeiture.

No benefits are payable to any person who participated in the treasonable act causing the forfeiture.

(d) *Forfeiture after September 1, 1959.* After September 1, 1959, forfeiture by reason of a treasonable act may be declared only

(1) Where the person was not residing or domiciled in a State as defined in § 3.1(i) at the time of commission of the act; or

(2) Where the person ceased to be a resident of or domiciled in a State as defined in § 3.1(i) before expiration of the period during which criminal prosecution could be instituted; or

(3) The treasonable act was committed in the Philippine Islands.

No part of the benefits forfeited by the person primarily entitled shall be paid to any dependent.

(Authority: 38 U.S.C. 6104)

(e) *Children.* A treasonable act committed by a child or children, regardless of age, who are in the surviving spouse's custody and included in an award to such person will not affect the award to the surviving spouse.

[27 FR 8590, Aug. 28, 1962; 53 FR 17934, May 19, 1988]

§ 3.903 Subversive activities.

(a) *Definition.* Any offense for which punishment is prescribed: (1) In title 18 U.S.C., sections 792, 793, 794, 798, 2381 through 2385, 2387 through 2390, and chapter 105;

(2) In title 18 U.S.C., sections 175, 229, 831, 1091, 2332a, and 2332b, for claims filed on or after December 17, 2003.

(3) In the Uniform Code of Military Justice, Articles 94, 104 and 106 (10 U.S.C. 894, 904, and 906);

(4) In the following sections of the Atomic Energy Act of 1954: Sections 222 through 226 (42 U.S.C. 2272–2276); and

(5) In section 4 of the Internal Security Act of 1950 (50 U.S.C. 783).

(b) *Effect on claim.* (1) Any person who is convicted after September 1, 1959, of subversive activities shall from and after the date of commission of such offense have no right to gratuitous benefits (including the right to burial in a national cemetery) under laws administered by the Department of Veterans Affairs based on periods of military, naval, or air service commencing before the date of the commission of such offense and no other person shall be entitled to such benefits on account of such person.

(2) The Attorney General will notify the Department of Veterans Affairs in each case in which a person is indicted or convicted of an offense listed in paragraphs (a)(1), (3), and (4) of this section. The Secretary of Defense or the Secretary of the Treasury, as may be appropriate, will notify the Department of Veterans Affairs in each case in which a person is convicted of an offense listed in paragraph (a)(2) of this section.

(c) *Presidential pardon.* Where any person whose right to benefits has been so terminated is granted a pardon of the offense by the President of the United States, the right to such benefits shall be restored as of the date of such pardon, if otherwise eligible.

(Authority: 38 U.S.C. 6105)

[27 FR 8591, Aug. 28, 1962, as amended at 38 FR 4511, Feb. 15, 1973; 38 FR 30106, Nov. 1, 1973; 53 FR 17934, May 19, 1988; 71 FR 44919, Aug. 8, 2006]

§ 3.904 Effect of forfeiture after veteran's death.

(a) *Fraud.* Whenever a veteran has forfeited his or her right by reason of fraud, his or her surviving dependents upon proper application may be paid pension, compensation, or dependency and indemnity compensation, if otherwise eligible. No benefits are payable to any person who participated in the fraud causing the forfeiture.

(Authority: 38 U.S.C. 6103(c))

(b) *Treasonable acts.* Death benefits may be paid as provided in paragraph (a) of this section where forfeiture by reason of a treasonable act was declared before September 2, 1959, and such benefits were authorized prior to that date. Otherwise, no award of gratuitous benefits (including the right to

burial in a national cemetery) may be made to any person based on any period of service commencing before the date of commission of the offense which resulted in the forfeiture.

(Authority: 38 U.S.C. 6104(c))

(c) *Subversive activities.* Where the veteran was convicted of subversive activities after September 1, 1959, no award of gratuitous benefits (including the right to burial in a national cemetery) may be made to any person based on any period of service commencing before the date of commission of the offense which resulted in the forfeiture unless the veteran had been granted a pardon of the offense by the President of the United States. If pardoned, the veteran's surviving dependents upon proper application may be paid pension, compensation or dependency and indemnity compensation, if otherwise eligible, and the right to burial in a national cemetery is restored.

(Authority: 38 U.S.C. 6105(a))

[27 FR 8591, Aug. 28, 1962, as amended at 38 FR 30106, Nov. 1, 1973; 39 FR 13970, Apr. 19, 1974; 53 FR 16924, May 19, 1988]

§ 3.905 Declaration of forfeiture or remission of forfeiture.

(a) *Jurisdiction.* At the regional office level, except in VA Regional Office, Manila, Philippines, the Regional Counsel is authorized to determine whether the evidence warrants formal consideration as to forfeiture. In the Manila Regional Office the Veterans Service Center Manager is authorized to make this determination. Submissions may also be made by the director of a service, the Chairman, Board of Veterans Appeals, and the General Counsel. Jurisdiction to determine whether the claimant or payee has forfeited the right to gratuitous benefits or to remit a prior forfeiture is vested in the Director, Compensation Service, and the Director, Pension and Fiduciary Service, and personnel to whom authority has been delegated under the provisions of § 3.100(c).

(b) *Fraud or treasonable acts.* Forfeiture of benefits under § 3.901 or § 3.902 will not be declared until the person has been notified by the Regional Counsel or, in VA Regional Office, Manila, Philippines, the Veterans Service Center Manager, of the right to present a defense. Such notice shall consist of a written statement sent to the person's latest address of record setting forth the following:

(1) The specific charges against the person;

(2) A detailed statement of the evidence supporting the charges, subject to regulatory limitations on disclosure of information;

(3) Citation and discussion of the applicable statute;

(4) The right to submit a statement or evidence within 60 days, either to rebut the charges or to explain the person's position;

(5) The right to a hearing within 60 days, with representation by counsel of the person's own choosing, that fees for the representation are limited in accordance with 38 U.S.C. 5904(c) and that no expenses incurred by a claimant, counsel or witness will be paid by VA.

(c) *Subversive activities.* Automatic forfeiture of benefits under § 3.903 will be effectuated by an official authorized to declare a forfeiture as provided in paragraph (a) of this section.

(d) *Finality of decisions.* A decision of forfeiture is subject to the provisions of § 3.104(a) and §§ 20.1103 and 20.1104 of this chapter. The officials authorized to file administrative appeals and the time limit for filing such appeals are set forth in § 19.51 of this chapter.

(e) *Remission of forfeiture.* In event of remission of forfeiture under § 3.901(e), any amounts paid as an apportionment(s) during periods of the previously forfeited beneficiary's reentitlement will be offset.

CROSS REFERENCES: Effective dates; forfeiture. See § 3.400(m). Reductions and discontinuances; fraud. See § 3.500(k). Reductions and discontinuances; treasonable acts or subversive activities. See § 3.500(s). Adjustments and resumptions. See § 3.669. Burial benefits. See § 3.1609.

[28 FR 2234, Mar. 7, 1963, as amended at 29 FR 7547, June 12, 1964; 37 FR 19134, Sept. 19, 1972; 39 FR 13970, Apr. 19, 1974; 53 FR 17934, May 19, 1988; 58 FR 32443, June 10, 1993; 79 FR 2100, Jan. 13, 2014]

PROTECTION

§ 3.950 Helpless children; Spanish-American and prior wars.

Marriage is not a bar to the payment of pension or compensation to a helpless child under an award approved prior to April 1, 1944. The presumption, arising from the fact of marriage, that helplessness has ceased may be overcome by positive proof of continuing helplessness. As to awards approved on or after April 1, 1944, pension or compensation may not be paid to a helpless child who has married.

[26 FR 1608, Feb. 24, 1961]

§ 3.951 Preservation of disability ratings.

(a) A readjustment to the Schedule for Rating Disabilities shall not be grounds for reduction of a disability rating in effect on the date of the readjustment unless medical evidence establishes that the disability to be evaluated has actually improved.

(Authority: 38 U.S.C. 1155)

(b) A disability which has been continuously rated at or above any evaluation of disability for 20 or more years for compensation purposes under laws administered by the Department of Veterans Affairs will not be reduced to less than such evaluation except upon a showing that such rating was based on fraud. Likewise, a rating of permanent total disability for pension purposes which has been in force for 20 or more years will not be reduced except upon a showing that the rating was based on fraud. The 20-year period will be computed from the effective date of the evaluation to the effective date of reduction of evaluation.

(Authority: 38 U.S.C. 110)

[34 FR 11970, July 16, 1969, as amended at 57 FR 10426, Mar. 26, 1992]

§ 3.952 Protected ratings.

Ratings under the Schedule of Disability Ratings, 1925, which were the basis of compensation on April 1, 1946, are subject to modification only when a change in physical or mental condition would have required a reduction under the 1925 schedule, or an increased evaluation has been assigned under the Schedule for Rating Disabilities, 1945 (looseleaf edition), after which time all evaluations will be under the 1945 schedule (loose-leaf edition) only. Such increased evaluations must be of an other than temporary nature (due to hospitalization, surgery, etc.). When a temporary evaluation is involved, the 1925 schedule evaluation will be restored after the period of increase has elapsed unless the permanent residuals would have required reduction under that schedule, or unless an increased evualation would be assignable under a 1945 schedule (looseleaf edition) rating. In any instance where the changed condition represents an increased degree of disability under either rating schedule but the evaluation provided by the 1945 schedule (looseleaf edition) is less than the evaluation in effect under the 1925 schedule on April 1, 1946, the 1925 schedule evaluation and award are protected.

[26 FR 12766, Dec. 30, 1961]

§ 3.953 Pub. L. 85–56 and Pub. L. 85–857.

(a) *In receipt of or entitled to receive benefits on December 31, 1958.* Any person receiving or entitled to receive benefits under any public law administered by the Department of Veterans Affairs on December 31, 1958, may, except where there was fraud, clear and unmistakable error of fact or law, or misrepresentation of material facts, continue to receive such benefits as long as the conditions warranting such payment under those laws continue. The greater benefit under the previous law or the corresponding section of title 38 U.S.C., will be paid in the absence of an election to receive the lesser benefit.

(Authority: Section 10, Pub. L. 85–857)

(b) *Emergency officers' retirement pay.* Any person who was receiving, or entitled to receive, emergency officers' retirement pay, or other privileges or benefits as a retired emergency officer of World War I, on December 31, 1958, under the laws in effect on that day, will, except where there was fraud,

clear and unmistakable error as to conclusion of fact or law, or misrepresentation of material facts, continue to receive, or be entitled to receive, emergency officers' retirement pay at the rate otherwise payable on December 31, 1958, and such other privileges and benefits, so long as the conditions warranting such pay, privileges, and benefits under those laws continue.

(Authority: Section 11, Pub. L. 85–857)

(c) *Service connection established under prior laws.* In the absence of fraud, misrepresentation of material facts or clear and unmistakable error, all cases where compensation was payable on December 31, 1957, for disability service connected under prior laws, repealed by Pub. L. 85–56, including those service connected under the second proviso of section 200 of the World War Veterans' Act, 1924, as amended, are protected by section 2316(b), Pub. L. 85–56 and section 10, Pub. L. 85–857 as to both service connection and rate of compensation, so long as the conditions warranting such status and rate continue. Any disability so service connected may be evaluated under the Schedule for Rating Disabilities, 1945 (looseleaf edition) and benefits awarded on the basis thereof, as well as special monthly compensation under 38 U.S.C. 1114, provided such action results in compensation payable at a rate equal to or higher than that payable on December 31, 1957. Where a changed physical condition warrants reevaluation of service-connected disabilities, compensation will be awarded under the provisions of 38 U.S.C. 1114.

[26 FR 1608, Feb. 24, 1961, as amended at 26 FR 8561, Sept. 13, 1961; 26 FR 12766, Dec. 30, 1961]

§§ 3.955–3.956 [Reserved]

§ 3.957 Service connection.

Service connection for any disability or death granted or continued under title 38 U.S.C., which has been in effect for 10 or more years will not be severed except upon a showing that the original grant was based on fraud or it is clearly shown from military records that the person concerned did not have the requisite service or character of discharge. The 10-year period will be computed from the effective date of the Department of Veterans Affairs finding of service connection to the effective date of the rating decision severing service connection, after compliance with § 3.105(d). The protection afforded in this section extends to claims for dependency and indemnity compensation or death compensation.

(Authority: 38 U.S.C. 1159)

[33 FR 15286, Oct. 15, 1968]

§ 3.958 Federal employees' compensation cases.

Any award approved prior to September 13, 1960, authorizing Department of Veterans Affairs benefits concurrently with an award of benefits under the Federal Employees' Compensation Act based on a finding that the same disability or death was due to civilian employment is not affected by the prohibition against concurrent awards contained in 5 U.S.C. 8116(b).

[41 FR 20408, May 18, 1976]

§ 3.959 Tuberculosis.

Any veteran who, on August 19, 1968, was receiving or entitled to receive compensation for active or inactive (arrested) tuberculosis may receive compensation under 38 U.S.C. 1114(q) and 1156 as in effect before August 20, 1968.

(Authority: Pub. L. 90–493; 82 Stat. 809)

[33 FR 16275, Nov. 6, 1968]

§ 3.960 Section 306 and old-law pension protection.

(a) *General.* Except as provided in paragraphs (b) and (c) of this section, any person eligible to elect improved pension under § 3.711 or 3.712 who is in receipt of section 306 or old-law pension on December 31, 1978, shall in the absence of an election to receive improved pension, continue to receive such pension at the monthly rate payable on December 31, 1978.

(b) *Termination.* Pension payable under paragraph (a) of this section shall be terminated for any one of the following reasons:

(1) A veteran pensioner ceases to be permanently and totally disabled.

(2) A surviving spouse pensioner ceases to meet the definition of *surviving spouse* in 38 U.S.C. 101(3).

(3) A child pensioner ceases to meet the definition of *child* in 38 U.S.C. 101(4).

(4) A section 306 pensioner's countable annual income, determined under §§ 3.250 to 3.270, exceeds the applicable amount stated in § 3.26(a).

(5) An old-law pensioner's countable annual income determined under §§ 3.250 to 3.270 exceeds the applicable amount stated in § 3.26(c).

(6) A section 306 pensioner has a net worth of such size that it is reasonable that some part of it be consumed for the pensioner's maintenance. Evaluation of net worth shall be made under § 3.263.

(c) *Reduction.* The pension rate payable under paragraph (a) of this section shall be reduced by the amount of any additional pension payable by reason of a dependent upon the loss of such dependent. A veteran or surviving spouse who no longer has any dependents shall not continue to receive either section 306 pension or old-law pension if countable annual income exceeds the appropriate rate in § 3.26(a), (b), or (c).

(d) *Finality of termination.* Termination of section 306 pension or old-law pension for one of the reasons listed in paragraph (b) of this section precludes a person from thereafter establishing entitlement under any other pension program except the improved pension program.

(Authority: Sec. 306 of Pub. L. 95–588, 92 Stat. 2497)

[44 FR 45944, Aug. 6, 1979, as amended at 56 FR 28824, June 25, 1991]

ACCRUED

§ 3.1000 Entitlement under 38 U.S.C. 5121 to benefits due and unpaid upon death of a beneficiary.

(a) *Basic entitlement.* Except as provided in §§ 3.1001 and 3.1008, where death occurred on or after December 1, 1962, periodic monetary benefits (other than insurance and servicemembers' indemnity) authorized under laws administered by the Department of Veterans Affairs, to which a payee was entitled at his or her death under existing ratings or decisions or those based on evidence in the file at date of death, and due and unpaid will, upon the death of such person, be paid as follows:

(Authority: 38 U.S.C. 5121(a)

(1) Upon the death of a veteran to the living person first listed as follows:

(i) His or her spouse;

(ii) His or her children (in equal shares);

(iii) His or her dependent parents (in equal shares) or the surviving parent.

(2) Upon the death of a surviving spouse or remarried surviving spouse, to the veteran's children.

(3) Upon the death of a child, to the surviving children of the veteran entitled to death pension, compensation, or dependency and indemnity compensation.

(4) Upon the death of a child claiming benefits under chapter 18 of this title, to the surviving parents.

(5) In all other cases, only so much of the accrued benefit may be paid as may be necessary to reimburse the person who bore the expense of last sickness or burial. (See § 3.1002.)

(b) *Apportionments.* (1) Upon the death of a person receiving an apportioned share of benefits payable to a veteran, all or any part of such unpaid amount is payable to the veteran or to any other dependent or dependents of the veteran.

(Authority: 38 U.S.C. 5121(a)(1))

(2) Where at the date of death of the veteran an apportioned share is being paid to or has been withheld on behalf of another person, the apportioned amount remaining unpaid for periods prior to the last day of the month before the veteran's death is payable to the apportionee.

(3) Where the accrued death pension, compensation or dependency and indemnity compensation was payable for a child as an apportioned share of the surviving spouse's benefit, payment will be made under the provisions of paragraph (a)(5) of this section, on the expenses of such deceased child's last sickness or burial.

(c) *Claims and evidence.* Application for accrued benefits must be filed within 1 year after the date of death. A claim for death pension, compensation,

or dependency and indemnity compensation, by an apportionee, surviving spouse, child or parent is deemed to include claim for any accrued benefits. (See § 3.152(b)).

(1) If an application for accrued benefits is incomplete because the claimant has not furnished information necessary to establish that he or she is within the category of eligible persons under the provisions of paragraphs (a)(1) through (a)(5) or paragraph (b) of this section and that circumstances exist which make the claimant the specific person entitled to payment of all or part of any benefits which may have accrued, VA shall notify the claimant:

(i) Of the type of information required to complete the application;

(ii) That VA will take no further action on the claim unless VA receives the required information; and

(iii) That if VA does not receive the required information within 1 year of the date of the original VA notification of information required, no benefits will be awarded on the basis of that application.

(2) Failure to file timely claim, or a waiver of rights, by a preferred dependent will not serve to vest title in a person in a lower class or a claimant for reimbursement; neither will such failure or waiver by a person or persons in a joint class serve to increase the amount payable to another or others in the class.

(Authority: 38 U.S.C. 5121(c); 5112(b))

(d) *Definitions.* (1) *Spouse* means the surviving spouse of the veteran, whose marriage meets the requirements of § 3.1(j) or § 3.52. Where the marriage meets the requirements of § 3.1(j) date of marriage and continuous cohabitation are not factors.

(2) *Child* is as defined in § 3.57 and includes an unmarried child who became permanently incapable of self-support prior to attaining 18 years of age as well as an unmarried child over the age of 18 but not over 23 years of age, who was pursuing a course of instruction within the meaning of § 3.57 at the time of the payee's death. However, upon the death of a child in receipt of death pension, compensation, or dependency and indemnity compensation, any accrued will be payable to the surviving child or children of the veteran entitled to death pension, compensation, or dependency and indemnity compensation. Upon the death of a child, another child who has elected dependents' educational assistance under 38 U.S.C. chapter 35 may receive accrued death pension, compensation, or dependency and indemnity compensation, payable on behalf of the deceased child for periods prior to the commencement of benefits under that chapter.

(3) *Dependent parent* is as defined in § 3.59: *Provided,* That the mother or father was dependent within the meaning of § 3.250 at the date of the veteran's death.

(4) *Evidence in the file at date of death* means evidence in VA's possession on or before the date of the beneficiary's death, even if such evidence was not physically located in the VA claims folder on or before the date of death, in support of a claim for VA benefits pending on the date of death.

(5) *Claim for VA benefits pending on the date of death* means a claim filed with VA that had not been finally adjudicated by VA on or before the date of death. Such a claim includes a deceased beneficiary's claim to reopen a finally disallowed claim based upon new and material evidence or a deceased beneficiary's claim of clear and unmistakable error in a prior rating or decision. Any new and material evidence must have been in VA's possession on or before the date of the beneficiary's death.

(e) *Subsistence allowance.* Subsistence allowance under the provisions of 38 U.S.C. ch. 31 remaining due and unpaid at the date of the veteran's death, is payable under the provisions of this section.

(f) *Dependents' educational assistance.* Educational assistance allowance or special restorative training allowance under 38 U.S.C. ch. 35, remaining due and unpaid at the date of death of an eligible surviving spouse or eligible child is payable to a child or children of the veteran (see paragraphs (a)(2), (a)(3) and (d)(2) of this section), or on the expenses of last sickness and burial (see paragraph (a)(5) of this section.) Benefits due and unpaid at the date of death of an eligible spouse are payable only on the expenses of last sickness

and burial (see paragraph (a)(5) of this section).

(g) *Veterans educational assistance.* Educational assistance allowance under 38 U.S.C chapters 30, 32, or 34, and 10 U.S.C. chapter 1606 remaining due and unpaid at the date of the veteran's death is payable under the provisions of this section.

(Authority: 38 U.S.C. 5121)

(h) *Clothing allowance.* Clothing allowance under 38 U.S.C. 1162 remaining due and unpaid at the date of the veteran's death is payable under the provisions of this section.

(i) *Active service pay.* Benefits awarded under this section do not include compensation or pension benefits for any period for which the veteran received active service pay.

(Authority: 38 U.S.C. 5304(c))

[26 FR 1608, Feb. 24, 1961, as amended at 27 FR 11892, Dec. 1, 1962; 30 FR 11389, Sept. 8, 1965; 31 FR 4790, Mar. 22, 1966; 34 FR 840, Jan. 18, 1969; 39 FR 15126, May 1, 1974; 56 FR 18733, Apr. 24, 1991; 56 FR 24239, May 29, 1991; 61 FR 67950, Dec. 26, 1996; 62 FR 5529, Feb. 6, 1997; 62 FR 35423, July 1, 1997; 67 FR 65708, Oct. 28, 2002; 71 FR 78369, Dec. 29, 2006; 80 FR 18117, Apr. 3, 2015]

§ 3.1001 Hospitalized competent veterans.

The provisions of this section apply only to the payment of amounts actually withheld on a running award under § 3.551(b) which are payable in a lump sum after the veteran's death.

(a) *Basic entitlement.* Where an award of disability pension for a competent veteran without dependents was reduced because of hospital treatment or institutional or domiciliary care by the Department of Veterans Affairs and the veteran dies while receiving such treatment or care or before payment of amounts withheld, the lump sum is payable to the living person first listed as follows:

(1) The veteran's spouse, as defined in § 3.1000(d)(1);

(2) The veteran's children (in equal shares), as defined in § 3.57 but without regard to their age or marital status;

(3) The veteran's dependent parents (in equal shares), or the surviving dependent parent, as defined in § 3.1000(d)(3);

(4) In all other cases, only so much of the lump sum may be paid as may be necessary to reimburse a person who bore the expenses of last sickness or burial. (See § 3.1002.)

(b) *Claim.* Applications must be filed with the Department of Veterans Affairs within 5 years after the death of the veteran. If, however, any person otherwise entitled is under legal disability at the time of the veteran's death, the 5-year period will run from the date of termination or removal of the legal disability.

(1) There is no time limit on the retroactive period of an award or for furnishing evidence.

(2) Failure to file timely claim, or a waiver of rights, by a preferred dependent will not serve to vest title in a person in a lower class or a claimant for reimbursement; neither will such failure or waiver by a person or persons in a joint class serve to increase the amount payable to another or others in the class.

(c) *Lump sum withheld after discharge from institution.* The provisions of paragraphs (a) and (b) of this section will apply in the event of the death of any veteran prior to receiving a lump sum which was withheld because treatment or care was terminated against medical advice or as the result of disciplinary action.

(Authority: 38 U.S.C. 5503)

[26 FR 1609, Feb. 24, 1961, as amended at 27 FR 5539, June 12, 1962; 27 FR 8177, Aug. 16, 1962; 27 FR 11893, Dec. 1, 1962; 39 FR 15126, May 1, 1974]

§ 3.1002 Political subdivisions of United States.

No part of any accrued benefits will be used to reimburse any political subdivision of the United States for expenses incurred in the last sickness or burial of any beneficiary. (See § 3.1(o)).

(Authority: 38 U.S.C. 5121(b) and 5502(d))

[39 FR 15126, May 1, 1974]

§ 3.1003 Returned and canceled checks.

Where the payee of a check for benefits has died prior to negotiating the check, the check shall be returned to the issuing office and canceled.

(a) The amount represented by the returned check, or any amount recovered following improper negotiation of the check, shall be payable to the living person or persons in the order of precedence listed in §3.1000(a)(1) through (5), except that the total amount payable shall not include any payment for the month in which the payee died (see §3.500(g)), and payments to persons described in §3.1000(a)(5) shall be limited to the amount necessary to reimburse such persons for the expenses of last sickness and/or burial.

(1) There is no limit on the retroactive period for which payment of the amount represented by the check may be made, and no time limit for filing a claim to obtain the proceeds of the check or for furnishing evidence to perfect a claim.

(2) Nothing in this section will preclude payment to an otherwise entitled claimant having a lower order of precedence under §3.1000(a)(1) through (5), if it is shown that the person or persons having a higher order of precedence are deceased at the time the claim is adjudicated.

(b) Subject to the limitations in §3.500(g) of this part, any amount not paid in the manner provided in paragraph (a) of this section shall be paid to the estate of the deceased payee, provided that the estate, including the amount paid under this paragraph, will not will not revert to the state because there is no one eligible to inherit it.

(c) The provisions of this section do not apply to checks for lump sums representing amounts withheld under §3.551(b) or §3.557. These amounts are subject to the provisions of §§3.1001 and 3.1007, as applicable.

(Authority: 38 U.S.C. 501(a), 5122)

[59 FR 25329, May 16, 1994, as amended at 64 FR 54207, Oct. 6, 1999; 80 FR 18117, Apr. 3, 2015]

§§3.1004–3.1006 [Reserved]

§3.1007 Hospitalized incompetent veterans.

Where an award of disability pension for an incompetent veteran without dependents was reduced under §3.551(b) because of hospitalization, institutional or domiciliary care by the Department of Veterans Affairs, or an award of disability pension, compensation or emergency officers' retirement pay was discontinued under former §3.557(b) (as applicable prior to December 27, 2001) because the veteran was hospitalized by the United States or a political subdivision and had an estate which equaled or exceeded the statutory maximum, and the veteran dies before payment of amounts withheld or not paid by reason of such care, no part of such amount will be paid to any person. The provisions of this section are applicable to amounts withheld for periods prior to as well as subsequent to the rating of incompetency. The term *dies before payment* includes cases in which a check was issued and the veteran died before negotiating the check.

(Authority: 38 U.S.C. 5503)

[39 FR 30349, Aug. 22, 1974, as amended at 66 FR 48561, Sept. 21, 2001; 68 FR 34543, June 10, 2003]

§3.1008 Accrued benefits payable to foreign beneficiaries.

In case of death of the payee of any check in payment of periodic monetary benefits (other than insurance and servicemembers' indemnity) accruing under laws administered by the Department of Veterans Affairs, while the amount thereof remains in the special deposit account established by Pub. L. 828, 76th Congress, such amount will be payable under section 3 of that act. (31 U.S.C. 125) However, the accrued amount will be payable only if the person on whose behalf checks were issued and the person claiming the accrued amount have not been guilty of mutiny, treason, sabotage, or rendering assistance to an enemy of the United States or of its allies.

[26 FR 1609, Feb. 24, 1961]

§3.1009 Personal funds of patients.

The provisions of this section are applicable to gratuitous benefits deposited by the Department of Veterans Affairs either before, on, or after December 1, 1959, in a personal funds of patients account for an incompetent veteran who was incompetent at the date of death. Where the veteran died after November 30, 1959:

(a) *Eligible persons*. Gratuitous benefits shall be paid to the living person first listed as follows:

(1) His or her spouse, as defined in §3.1000(d)(1);

(2) His or her children (in equal shares), as defined in §3.57 but without regard to their age or marital status;

(3) His or her dependent parents (in equal shares) as defined in §3.59 or the surviving parent, provided that the parent was dependent within the meaning of §3.250 at the date of the veteran's death.

(4) In all other cases, only so much may be paid as may be necessary to reimburse a person who bore the expense of last sickness or burial. (See §3.1002.)

(Authority: 38 U.S.C. 5502(d))

(b) *Claim*. Application must be filed with the Department of Veterans Affairs within 5 years after the death of the veteran. If, however, any person otherwise entitled is under legal disability at the time of the veteran's death, the 5-year period will run from the date of termination or removal of the legal disability.

(1) There is no time limit for the submission of evidence.

(2) Failure to file timely claim, or a waiver of rights, by a preferred dependent will not serve to vest title in a person in a lower class or a claimant for reimbursement; neither will such failure or waiver by a person or persons in a joint class serve to increase the amount payable to another or others in the class.

[27 FR 5539, June 12, 1962, as amended at 28 FR 10487, Sept. 28, 1963; 39 FR 30349, Aug. 22, 1974]

§3.1010 Substitution under 38 U.S.C. 5121A following death of a claimant.

(a) *Eligibility*. If a claimant dies on or after October 10, 2008, a person eligible for accrued benefits under §3.1000(a) listed in 38 CFR 3.1000(a)(1) through (5) may, in priority order, request to substitute for the deceased claimant in a claim for periodic monetary benefits (other than insurance and servicemembers' indemnity) under laws administered by the Secretary, or an appeal of a decision with respect to such a claim, that was pending before the agency of original jurisdiction or the Board of Veterans' Appeals when the claimant died. Upon VA's grant of a request to substitute, the substitute may continue the claim or appeal on behalf of the deceased claimant for purposes of processing the claim or appeal to completion. Any benefits ultimately awarded are payable to the substitute and other members of a joint class, if any, in equal shares.

(b) *Time and place for filing a request*. A person may not substitute for a deceased claimant under this section unless the person files a request to substitute with the agency of original jurisdiction no later than one year after the claimant's death.

(c) *Request format*. (1) A request to substitute must be submitted in writing. At a minimum, a request to substitute must indicate intent to substitute; include the deceased claimant's claim number, Social Security number, or appeal number; and include the names of the deceased claimant and the person requesting to substitute.

(2) In lieu of a specific request to substitute, a claim for accrued benefits, survivors pension, or dependency and indemnity compensation by an eligible person listed in §3.1000(a)(1) through (5) is deemed to include a request to substitute if a claim for periodic monetary benefits (other than insurance and servicemembers' indemnity) under laws administered by the Secretary, or an appeal of a decision with respect to such a claim, was pending before the agency of original jurisdiction or the Board of Veterans' Appeals when the claimant died. A claimant for accrued benefits, survivors pension, or dependency and indemnity compensation may waive the right to substitute in writing over the claimant's signature.

(d) *Evidence of eligibility*. A person filing a request to substitute must provide evidence of eligibility to substitute. Evidence of eligibility to substitute means evidence demonstrating that the person is among those listed in the categories of eligible persons in §3.1000(a)(1) through (5) and first in priority order. If a person's request to substitute does not include evidence of

eligibility when it is originally submitted and the person may be an eligible person, the Secretary will notify the person—

(1) Of the evidence of eligibility required to complete the request to substitute;

(2) That VA will take no further action on the request to substitute unless VA receives the evidence of eligibility; and

(3) That VA must receive the evidence of eligibility no later than 60 days after the date of notification or one year after the claimant's death, whichever is later, or VA will deny the request to substitute.

(e) *Decisions on substitution requests.* Subject to the provisions of § 20.1302 of this chapter, the agency of original jurisdiction will decide in the first instance all requests to substitute, including any request to substitute in an appeal pending before the Board of Veterans' Appeals.

(1) *Notification.* The agency of original jurisdiction will provide written notification of the granting or denial of a request to substitute to the person who filed the request, together with notice in accordance with § 3.103(b)(1).

(2) *Appeals.* The denial of a request to substitute may be appealed to the Board of Veterans' Appeals pursuant to 38 U.S.C. 7104(a) and 7105.

(3) *Joint class representative.* (i) A *joint class* means a group of two or more persons eligible to substitute under the same priority group under § 3.1000(a)(1) through (a)(5), e.g., two or more surviving children.

(ii) In the case of a joint class of potential substitutes, only one person of the joint class may be a substitute at any one time. The first eligible person in the joint class to file a request to substitute will be the substitute representing the joint class.

(f) *Adjudications involving a substitute.* The following provisions apply with respect to a claim or appeal in which a survivor has been substituted for the deceased claimant:

(1) *Notice under § 3.159.* VA will send notice under § 3.159(b), ''Department of Veterans Affairs assistance in developing claims,'' to the substitute only if the required notice was not sent to the deceased claimant or if the notice sent to the deceased claimant was inadequate.

(2) *Expansion of the claim not permitted.* A substitute may not add an issue to or expand the claim. However, a substitute may raise new theories of entitlement in support of the claim.

(3) *Submission of evidence and other rights.* A substitute has the same rights regarding hearings, representation, appeals, and the submission of evidence as would have applied to the claimant had the claimant not died. However, rights that may have applied to the claimant prior to death but which cannot practically apply to a substitute, such as the right to a medical examination, are not available to the substitute. The substitute must complete any action required by law or regulation within the time period remaining for the claimant to take such action on the date of his or her death. The time remaining to take such action will start to run on the date of the mailing of the decision granting the substitution request.

(4) *Board of Veterans' Appeals procedures.* The rules and procedures governing appeals involving substitutes before the Board of Veterans' Appeals are found in parts 19 and 20 of this chapter.

(g) *Limitations on substitution.* The following limitations apply with respect to substitution:

(1) *A claim or appeal must be pending.* (i) A claim is considered to be pending if the claimant had filed the claim with an agency of original jurisdiction but dies before the agency of original jurisdiction makes a decision on the claim. A claim is also considered to be pending if, at the time of the claimant's death, the agency of original jurisdiction has made a decision on the claim, but the claimant has not filed a notice of disagreement, and the period allowed by law for filing a notice of disagreement has not expired.

(ii) An appeal is considered to be pending if a claimant filed a notice of disagreement in response to a notification from an agency of original jurisdiction of its decision on a claim, but

dies before the Board of Veterans' Appeals issues a final decision on the appeal. If the Board issued a final decision on an appeal prior to the claimant's death, the appeal is not pending before VA for purposes of this section, even if the 120-day period for appealing the Board's decision to the Court of Appeals for Veterans Claims has not yet expired.

(2) *Benefits awarded*. Any benefits ultimately awarded are limited to any past-due benefits for the time period between the effective date of the award and what would have been the effective date of discontinuance of the award as a result of the claimant's death.

(3) *Benefits for last sickness and burial only*. When substitution cannot be established under any of the categories listed in § 3.1000(a)(1) through (a)(4), only so much of any benefits ultimately awarded may be paid as may be necessary to reimburse the person who bore the expense of last sickness and burial. No part of any benefits ultimately awarded shall be used to reimburse any political subdivision of the United States for expenses incurred in the last sickness or burial of any claimant.

(4) *Substitution by subordinate members prohibited*. Failure to timely file a request to substitute, or a waiver of the right to request substitution, by a person of a preferred category of eligible person will not serve to vest the right to request substitution in a person in a lower category or a person who bore the expense of last sickness and burial; neither will such failure or waiver by a person or persons in a joint class serve to increase the amount payable to other persons in the class.

(5) *Death of a substitute*. If a substitute dies while a claim or appeal is pending before an agency of original jurisdiction, or an appeal of a decision on a claim is pending before the Board, another member of the same joint class or a member of the next preferred subordinate category listed in § 3.1000(a)(1) through (5) may substitute for the deceased substitute but only if the person requesting the successive substitution files a request to substitute no later than one year after the date of the substitute's death (not the date of the claimant's death).

(Authority: 38 U.S.C. 5121, 5121A)

(The Office of Management and Budget has approved the information collection requirements in this section under control number 2900–0740)

[79 FR 52982, Sept. 5, 2014]

Subpart B—Burial Benefits

SOURCE: 79 FR 32658, June 6, 2014, unless otherwise noted.

AUTHORITY: 105 Stat. 386, 38 U.S.C. 501(a), 2302–2308, unless otherwise noted.

BURIAL BENEFITS: GENERAL

§ 3.1700 Types of VA burial benefits.

(a) *Burial benefits*. VA provides the following types of burial benefits, which are discussed in §§ 3.1700 through 3.1712:

(1) Burial allowance based on service-connected death;

(2) Burial allowance based on non-service-connected death;

(3) Burial allowance for a veteran who died while hospitalized by VA;

(4) Burial plot or interment allowance; and

(5) Reimbursement for transportation of remains.

(b) *Definition*. For purposes of this subpart, *burial* means all the legal methods of disposing of the remains of a deceased person, including, but not limited to, cremation, burial at sea, and medical school donation.

(c) *Cross references*. (1) Other benefits and services related to the memorialization or interment of a deceased veteran and certain survivors include the following:

(i) Burial in a national cemetery (see §§ 38.600 and 38.617 through 38.629 of this chapter);

(ii) Presidential memorial certificates (see 38 U.S.C. 112);

(iii) Burial flags (see § 1.10 of this chapter); and

(iv) Headstones or markers (see §§ 38.630 through 38.633 of this chapter).

(2) The provisions of §§ 3.1702 through 3.1711 do not apply to any of the programs listed in paragraph (c)(1) of this section.

§ 3.1701 Deceased veterans for whom VA may provide burial benefits.

For purposes of providing burial benefits under subpart B of this part, the term ''veteran'' means the same as provided in 38 U.S.C. 101(2). A veteran must be deceased, and burial benefits for that veteran must be authorized by a specific provision of law. For purposes of the non-service-connected burial allowance under 38 U.S.C. 2302, the term ''veteran'' includes a person who died during a period deemed to be active military, naval, or air service under §§ 3.6(b)(7), 3.7(m) and 3.7(o).

(Authority: 38 U.S.C. 101(2), 2302, 2303, 2307, 2308)

§ 3.1702 Persons who may receive burial benefits; priority of payments.

(a) *Automatic payments to surviving spouses of eligible deceased veterans.* (1) On or after July 7, 2014, VA may automatically pay a burial benefit to an eligible veteran's surviving spouse, whether or not previously established as a dependent spouse on the deceased veteran's compensation or pension award, when VA knows of or is informed of the existence of the surviving spouse, can establish the surviving spouse's relationship under § 3.204 (when applicable), and is able to determine burial benefits eligibility based on evidence of record at the time VA updates its computer system to reflect the veteran's date of death.

(2) VA may grant additional burial benefits, including the plot or interment allowance, reimbursement for transportation, and the service-connected burial allowance under § 3.1704, to the surviving spouse or any other eligible person in accordance with paragraph (b) of this section and based on a claim described in § 3.1703.

(b) *Priority of payments—claims received on or after July 7, 2014.* (1) Except for claims a State, or an agency or political subdivision of a State, files under § 3.1707, Plot or interment allowance for burial in a State veterans cemetery or other cemetery, or § 3.1708, Burial of a veteran whose remains are unclaimed, VA will pay, upon the death of a veteran, the first living person to file of those listed below:

(i) His or her surviving spouse;

(ii) The survivor of a legal union between the deceased veteran and the survivor that is not covered by paragraph (b)(1)(i) of this section. For purposes of this paragraph, *legal union* means a formal relationship between the decedent and the survivor that

(A) Existed on the date of the veteran's death,

(B) Was recognized under the law of the State in which the couple formalized the relationship, and

(C) Was evidenced by the State's issuance of documentation memorializing the relationship;

(iii) His or her children, regardless of age;

(iv) His or her parents or the surviving parent; or

(v) The executor or administrator of the estate of the deceased veteran. If no executor or administrator has been appointed, VA may pay burial benefits based on a claim filed by a person acting for such estate who will distribute the burial benefits to the person or persons entitled to such distribution under the laws of the veteran's last State of residence.

(2) In the case of a veteran whose remains are unclaimed, VA will pay the person or entity that provided burial services and transportation subject to the limitations prescribed in §§ 3.1708 and 3.1709.

(3) VA will pay burial benefits to a single representative of the categories in paragraph (b)(1) of this section. VA will not divide applicable burial benefits among claimants; it is the responsibility of the recipient to distribute benefits as may be required.

(c) Priority of payments—claims received before July 7, 2014.

(1) Claims for burial allowance may be executed by:

(i) The funeral director, if entire bill or any balance is unpaid (if unpaid bill or the unpaid balance is less than the applicable statutory burial allowance, only the unpaid amount may be claimed by the funeral director); or

(ii) The individual whose personal funds were used to pay burial, funeral, and transportation expenses; or

(iii) The executor or administrator of the estate of the veteran or the estate of the person who paid the expenses of the veteran's burial or provided such

services. If no executor or administrator has been appointed then by some person acting for such estate who will make distribution of the burial allowance to the person or persons entitled under the laws governing the distribution of interstate estates in the State of the decedent's personal domicile.

(2) Claims for the plot or interment allowance (except for claims filed by a State or an agency or political subdivision thereof), under § 3.1707 may be executed by:

(i) The funeral director, if he or she provided the plot or interment services, or advanced funds to pay for them, and if the entire bill for such or any balance thereof is unpaid (if the unpaid bill or the unpaid balance is less than the statutory plot or interment allowance, only the unpaid amount may be claimed by the funeral director); or

(ii) The person(s) whose personal funds were used to defray the cost of the plot or interment expenses; or

(iii) The person or entity from whom the plot was purchased or who provided interment services if the bill for such is unpaid in whole or in part. An unpaid bill for a plot will take precedence in payment of the plot or interment allowance over an unpaid bill for other interment expenses or a claim for reimbursement for such expenses. Any remaining balance of the plot or interment allowance may then be applied to interment expenses; or

(iv) The executor or administrator of the estate of the veteran or the estate of the person who bore the expense of the plot or interment expenses. If no executor or administrator has been appointed, claim for the plot or interment allowance may be filed as provided in paragraph (c)(1)(iii) of this section for the burial allowance.

(Authority: 38 U.S.C. 2302, 2303, 2307)

Cross Reference: § 3.1(i) for the definition of ''State''.

[79 FR 32658, June 6, 2014, as amended at 83 FR 39888, Aug. 13, 2018]

§ 3.1703 Claims for burial benefits.

(a) *When claims must be filed*—(1) *General rule*. Except as provided in paragraph (a)(2) of this section, VA must receive a claim for the non-service-connected burial allowance no later than 2 years after the burial of the veteran. There are no other time limitations to file claims for burial benefits under subpart B of this part.

(2) *Correction of character of discharge*. If the non-service-connected burial allowance was not payable at the time of the veteran's death or burial because of the character of the veteran's discharge from service, VA may pay the allowance if a competent authority corrects the deceased veteran's discharge to reflect a discharge under conditions other than dishonorable. Claims for the non-service-connected burial allowance must be filed no later than 2 years after the date that the discharge was corrected.

(b) *Supporting evidence*—(1) *General rule*. In order to pay burial benefits, VA must receive all of the following:

(i) A claim, except as provided in § 3.1702(a);

(ii) Proof of the veteran's death in accordance with § 3.211, Death; and

(iii) For persons listed under § 3.1702(b), except as provided in § 3.1702(a), a statement certifying that the claimant incurred burial, plot or interment, or transportation costs of the deceased veteran.

(2) *Reimbursement of transportation expenses*. In order to pay transportation costs, VA must receive a receipt, preferably on letterhead, showing who paid the costs, the name of the deceased veteran, the specific transportation expenses incurred, and the dates of the services rendered.

(3) *Eligibility based on evidence of record*. VA may establish eligibility for benefits in this subpart based upon evidence of service and disability that VA relied upon to grant disability compensation or pension during the veteran's lifetime, unless VA has some other evidence on the date that it receives notice of the veteran's death that creates doubt as to the correctness of that evidence.

(The information collection requirements in this section are approved by the Office of Management and Budget under control number 2900–0003.)

(Authority: 38 U.S.C. 2304, 5107(a))

BURIAL BENEFITS: ALLOWANCES & EXPENSES PAID BY VA

§ 3.1704 Burial allowance based on service-connected death.

(a) *General rule.* VA will pay the maximum burial allowance specified in 38 U.S.C. 2307 for the burial and funeral expenses of a veteran described in paragraph (b) of this section, unless VA has evidence on the date it receives notice of the veteran's death that the expenses incurred were less than that amount. Payment of the service-connected burial allowance is in lieu of other allowances authorized by subpart B of this part, except those allowances listed in paragraph (c) of this section.

(b) *Eligibility.* A burial allowance is payable under this section for a veteran who died as a result of a service-connected disability or disabilities. VA will presume, unless it has evidence to the contrary on the date it receives notice of the veteran's death, that a veteran died as a result of a service-connected disability or disabilities if, at the date of death, the veteran was rated totally disabled for a service-connected disability or disabilities, excluding a total disability rating based on individual unemployability.

(c) *Additional allowances available based on service-connected death.* In addition to the service-connected burial allowance authorized by this section:

(1) VA may reimburse for transportation expenses related to burial in a national cemetery under § 3.1709, Transportation expenses for burial in a national cemetery; and

(2) VA may pay the plot or interment allowance for burial in a State veterans cemetery under § 3.1707(a), Plot or interment allowance.

(Authority: 38 U.S.C. 2303, 2307, 2308)

Cross Reference: § 3.1(i), for the definition of ''State''.

§ 3.1705 Burial allowance based on non-service-connected death.

(a) *General rule.* VA will pay the maximum burial allowance specified in 38 U.S.C. 2302 for the burial and funeral expenses of a veteran described in paragraph (b) of this section, unless VA has evidence on the date it receives notice of the veteran's death that the expenses incurred were less than that amount. Payment of the non-service-connected burial allowance is subject to other applicable regulations in subpart B of this part.

(b) *Eligibility.* A burial allowance is payable under this section for a veteran who, on the date of death:

(1) Was receiving VA pension or disability compensation;

(2) Would have been receiving disability compensation but for the receipt of military retired pay; or

(3) Had pending any of the following claims:

(i) An original claim for pension or disability compensation, and the evidence in the claims file on the date of death and any evidence received under paragraph (d) of this section is sufficient to grant pension or disability compensation effective before the date of death; or

(ii) A claim to reopen a previously denied pension or disability compensation claim, based on new and material evidence, and the evidence in the claims file on the date of the veteran's death and any evidence received under paragraph (d) of this section is sufficient to reopen the claim and grant pension or disability compensation effective before the date of death; or

(iii) A claim for which a person would be eligible to substitute for the deceased veteran under 38 U.S.C. 5121A, Substitution in case of death of claimant, and that claim, once processed to completion by the substitute, results in the grant of pension or disability compensation effective before the date of death.

(c) *Evidence in the claims file on the date of the veteran's death* means evidence in VA's possession on or before the date of the deceased veteran's death, even if such evidence was not part of the VA claims file on or before the date of death.

(d) *Requesting additional evidence.* If the veteran had either an original claim or a claim to reopen pending on the date of death and there is sufficient evidence in VA's possession to support an award of compensation or pension prior to the date of death, but VA determines that additional evidence is needed to confirm that the deceased would have been entitled prior to death, VA will request such evidence. If

VA does not receive such evidence within 1 year after the date of the request, it will deny the claim.

(e) *Additional allowances available based on non-service-connected death.* In addition to the non-service-connected burial allowance authorized by this section:

(1) VA may reimburse for transportation expenses related to burial in a national cemetery under § 3.1709, Transportation expenses for burial in a national cemetery, but only if eligibility under paragraphs (b) of this section is based on a pending claim for, or award of, disability compensation, or eligibility for disability compensation but for receipt of military retired pay, rather than a claim for, or award of, pension; and

(2) VA may pay the plot or interment allowance for burial in a State veterans cemetery under § 3.1707(a), Plot or interment allowance.

(Authority: 38 U.S.C. 2302, 2303, 2304, 2308)

Cross Reference: § 3.1(i), for the definition of ''State''.

§ 3.1706 Burial allowance for a veteran who died while hospitalized by VA.

(a) *General rule.* VA will pay up to the maximum burial allowance specified in 38 U.S.C. 2303(a) for the burial and funeral expenses of a veteran described in paragraph (b) of this section.

(b) *Eligibility.* A burial allowance is payable under this section for a veteran whose death was not service-connected and who died while hospitalized by VA. For purposes of this allowance, a veteran was hospitalized by VA if the veteran:

(1) Was properly admitted to a VA facility (as described in 38 U.S.C. 1701(3)) for hospital, nursing home, or domiciliary care under the authority of 38 U.S.C. 1710 or 1711(a);

(2) Was transferred or admitted to a non-VA facility (as described in 38 U.S.C. 1701(4)) for hospital care under the authority of 38 U.S.C. 1703;

(3) Was transferred or admitted to a nursing home for nursing home care at the expense of the U.S. under the authority of 38 U.S.C. 1720;

(4) Was transferred or admitted to a State nursing home for nursing home care for which payment is authorized under the authority of 38 U.S.C. 1741;

(5) Was traveling under proper prior authorization, and at VA expense, to or from a specified place for purpose of examination, treatment, or care; or

(6) Was hospitalized by VA pursuant to any of paragraphs (b)(1) through (4) of this section but was not at the facility at the time of death and was:

(i) On authorized absence that did not exceed 96 hours at the time of death;

(ii) On unauthorized absence for a period not in excess of 24 hours at the time of death; or

(iii) Absent from the facility for a period not in excess of 24 hours of combined authorized and unauthorized absence at the time of death.

(c) *Hospitalization in the Philippines.* Hospitalization in the Philippines under 38 U.S.C. 1731, 1732, and 1733 does not meet the requirements of this section.

(d) *Additional allowances available based on death while hospitalized by VA.* In addition to the burial allowance authorized by this section:

(1) VA will reimburse for the expense of transporting the remains of a person described in paragraph (b) of this section to the place of burial subject to the limitations of § 3.1709 and where the death occurs within a State and:

(i) The place of burial is in the same State or any other State; or

(ii) The place of burial is in Canada or Mexico. However, reimbursement for transportation of the remains for such burial is authorized only from the place of death within a State to the port of embarkation within a State, or to the border limits of the United States.

(2) VA may pay the plot or interment allowance for burial in a veterans cemetery under § 3.1707, Plot or interment allowance.

(Authority: 38 U.S.C. 2303(a), 2308)

Cross Reference: § 3.1(z) for the definition of ''nursing home'', § 3.1(i) for the definition of ''State''.

§ 3.1707 Plot or interment allowances for burial in a State veterans cemetery or other cemetery.

(a) *General eligibility.* For a veteran who was eligible for burial in a national cemetery under 38 U.S.C. 2402,

but was not buried in a national cemetery or other cemetery under the jurisdiction of the U.S., VA will pay the allowances described below, provided all criteria are met.

(b) *Plot or interment allowance for burial in a State veterans cemetery.* VA will pay the plot or interment allowance in the amount specified in 38 U.S.C. 2303(b)(1) (without regard to whether any other burial benefits were provided for that veteran) to a State, or an agency or political subdivision of a State, that provided a burial plot or interment for the veteran without charge if the State, or agency or political subdivision of the State:

(1) Is claiming the plot or interment allowance for burial of the veteran in a cemetery, or section of a cemetery, owned by the State or agency or subdivision of the State;

(2) Did not charge for the expense of the plot or interment; and

(3) Uses the cemetery or section of a cemetery solely for the interment of:

(i) Persons eligible for burial in a national cemetery; and

(ii) In a claim based on a veteran's death after October 31, 2000, either:

(A) Deceased members of a reserve component of the Armed Forces not otherwise eligible for interment in a national cemetery; or

(B) Deceased former members of a reserve component of the Armed Forces not otherwise eligible for interment in a national cemetery who were discharged or released from service under conditions other than dishonorable.

(c) *Plot or interment allowance payable based on burial in other than a State veterans cemetery.* Unless VA has evidence on the date it receives notice of the veteran's death that the expenses incurred were less, VA will pay the maximum plot or interment allowance specified in 38 U.S.C. 2303(b)(2) to a claimant who incurred plot or interment expenses relating to the purchase of a burial plot for a deceased veteran if the veteran is buried in a cemetery other than a cemetery described in paragraphs (b)(1) and (b)(3) of this section and:

(1) The veteran is eligible for a burial allowance under § 3.1705, Burial allowance based on non-service-connected death;

(2) The veteran is eligible for a burial allowance under § 3.1706, Burial allowance for a veteran who died while hospitalized by VA;

(3) The veteran was discharged from active service for a disability incurred or aggravated in line of duty (VA will accept the official service record of such discharge as proof of eligibility for the plot or interment allowance and VA will disregard any previous VA determination made in connection with a claim for monetary benefits that the disability was not incurred or aggravated in line of duty); or

(4) The veteran, at the time of discharge from active service, had a disability, shown by official service records, which in medical judgment would have justified a discharge for disability.

(d) *Definitions.* For purposes of subpart B of this part, *plot* or *burial plot* means the final disposal site of the remains, whether it is a grave, mausoleum vault, columbarium niche, or other similar place. *Plot or interment expenses* are those expenses associated with the final disposition of the remains and are not confined to the acts done within the burial grounds but may include the removal of remains for burial or interment.

(Authority: 38 U.S.C. 501(a), 2303(b))

Cross Reference: § 3.1(i) for the definition of ''State''.

§ 3.1708 Burial of a veteran whose remains are unclaimed.

(a) *General.* VA will pay the maximum burial allowance specified in 38 U.S.C. 2302 for the burial and funeral expenses of a veteran described in paragraph (b) of this section, unless VA has evidence on the date it receives notice of the veteran's death that the expenses incurred were less than that amount.

(b) *Eligibility.* A burial allowance is payable under this section for a veteran if the Secretary determines that:

(1) There is no next of kin or other person claiming the remains of the deceased veteran; and

(2) There are not sufficient resources available in the veteran's estate to cover the burial and funeral expenses.

(c) *Additional allowance for transportation of unclaimed remains.* VA may reimburse for transportation expenses related to burial in a national cemetery under § 3.1709, Transportation expenses for burial in a national cemetery, for a veteran described in paragraph (b) of this section.

(d) *Burial.* When VA determines that a veteran's remains are unclaimed, the Director of the VA regional office in the area in which the veteran died will immediately complete arrangements for burial in a national cemetery or, at his or her option, in a cemetery or cemetery section meeting the requirements of paragraph (b) of § 3.1707, Plot or interment allowance.

(Authority: 38 U.S.C. 2302(a))

Cross Reference: § 3.1(i) for the definition of ''State''.

§ 3.1709 Transportation expenses for burial in a national cemetery.

(a) *General.* VA will reimburse the costs of transportation, subject to paragraph (d) of this section, of a veteran's remains for burial in a national cemetery for a veteran described in paragraph (b) of this section.

(b) *Eligibility.* VA will reimburse for the expense incurred, subject to paragraph (d) of this section, to transport a veteran's remains for burial in a national cemetery if:

(1) The veteran died as the result of a service-connected disability;

(2) The veteran was receiving service-connected disability compensation on the date of death;

(3) The veteran would have been receiving service-connected disability compensation on the date of death, but for the receipt of military retired pay or non-service-connected disability pension; or

(4) The Secretary determines the veteran is eligible for a burial allowance under § 3.1708.

(c) *Amount payable.* The amount payable under this section will not exceed the cost of transporting the remains to the national cemetery closest to the veteran's last place of residence in which burial space is available, and is subject to the limitations set forth in paragraph (d) of this section.

(d) *Reimbursable transportation expenses.* (1) VA will reimburse reasonable transportation expenses, including but not limited to the costs of shipment via common carrier (*i.e.*, procuring permits for shipment, a shipping case, sealing of the shipping case, and applicable Federal taxes) and costs of transporting the remains to the place of burial.

(2) A reasonable transportation expense is an expense that is usual and customary in the context of burial transportation, with a corresponding charge that is the usual and customary charge made to the general public for the same or similar services.

(Authority: 38 U.S.C. 2303, 2308)

BURIAL BENEFITS: OTHER

§ 3.1710 Escheat (payment of burial benefits to an estate with no heirs).

VA will not pay burial benefits if the payment would escheat (that is, would be turned over to the State because there are no heirs to the estate of the person to whom such benefits would be paid).

(Authority: 38 U.S.C. 501(a))

§ 3.1711 Effect of contributions by government, public, or private organizations.

(a) *Contributions by government or employer.* With respect to claims for a plot or interment allowance under § 3.1707, if VA has evidence that the U.S., a State, any agency or political subdivision of the U.S. or of a State, or the employer of the deceased veteran has paid or contributed payment to the veteran's plot or interment expenses, VA will pay the claimant up to the lesser of:

(1) The allowable statutory amount; or

(2) The amount of the total plot or interment expenses minus the amount of expenses paid by any or all of the organizations described in this paragraph (a).

(b) *Burial expenses paid by other agencies of the U.S.* (1) *Burial allowance when Federal law or regulation also provides for payment.* VA cannot pay the non-service-connected burial allowance when any Federal law or regulation also specifically provides for the payment of the deceased veteran's burial, funeral, or transportation expenses. However, VA will pay the non-service-

connected burial allowance when a Federal law or regulation allows the payment of burial expenses using funds due, or accrued to the credit of, the deceased veteran (such as Social Security benefits), but the law or regulation does not specifically require such payment. In such cases, VA will pay the maximum amount specified in 38 U.S.C. 2302.

(2) *Payment by military service department.* VA will not pay or will recoup the non-service-connected burial allowance for deaths occurring during active service or for other deaths for which the service department pays the burial, funeral, or transportation expenses.

(3) *When a veteran dies while hospitalized.* When a veteran dies while hospitalized at the expense of the U.S. government (including, but not limited to, death in a VA facility) and benefits would be otherwise payable under 10 U.S.C. 1482 and a provision of this subpart B, only one of these benefits is payable. VA will attempt to locate a relative of the veteran or another person entitled to reimbursement under § 3.1702(b) and will ask that person to elect between these benefits.

(Authority: 38 U.S.C. 2302, 2303(b))

§ 3.1712 Effect of forfeiture on payment of burial benefits.

(a) *Forfeiture for fraud.* VA will pay burial benefits, if otherwise in order, based on a deceased veteran who forfeited his or her right to receive benefits due to fraud under § 3.901, Fraud. However, VA will not pay burial benefits to a claimant who participated in fraudulent activity that resulted in forfeiture under § 3.901.

(b) *Forfeiture for treasonable acts or for subversive activity.* VA will not pay burial benefits based on a period of service commencing before the date of commission of the offense if either the veteran or the claimant has forfeited the right to all benefits except insurance payments under § 3.902, Forfeiture for treasonable acts, or § 3.903, Forfeiture for subversive activities, because of a treasonable act or subversive activities, unless the offense was pardoned by the President of the U.S.

(Authority: 38 U.S.C. 6103, 6104, 6105)

Cross Reference: § 3.1(aa), for the definition of ''fraud.''

§ 3.1713 Eligibility based on status before 1958.

When any person dies who had a status under any law in effect on December 31, 1957, that afforded entitlement to burial benefits, burial benefits will be paid, if otherwise in order, even though such status does not meet the service requirements of 38 U.S.C. chapter 23.

(Authority: 38 U.S.C. 2305)

Subpart C [Reserved]

Subpart D—Universal Adjudication Rules That Apply to Benefit Claims Governed by Part 3 of This Title

AUTHORITY: 38 U.S.C. 501(a), unless otherwise noted.

SOURCE: 66 FR 18195, Apr. 6, 2001, unless otherwise noted.

GENERAL

§ 3.2100 Scope of Applicability.

Unless otherwise specified, the provisions of this subpart apply only to claims governed by part 3 of this title.

(Authority: 38 U.S.C. 501(a))

§ 3.2130 Will VA accept a signature by mark or thumbprint?

VA will accept signatures by mark or thumbprint if:

(a) They are witnessed by two people who sign their names and give their addresses, or

(b) They are witnessed by an accredited agent, attorney, or service organization representative, or

(c) They are certified by a notary public or any other person having the authority to administer oaths for general purposes, or

(d) They are certified by a VA employee who has been delegated authority by the Secretary under 38 CFR 2.3.

(Authority: 38 U.S.C. 5101).

§ 3.2400 Applicability of modernized review system.

(a) *Applicability*. The modernized review system defined in 38 CFR 19.2(b) applies to all claims, requests for reopening of finally adjudicated claims, and requests for revision based on clear and unmistakable error:

(1) For which VA issues notice of an initial decision on or after the effective date of the modernized review system as provided in 38 CFR 19.2(a); or

(2) Where a claimant has elected review of a legacy claim under the modernized review system as provided in paragraph (c) of this section.

(b) *Legacy claims*. A legacy claim is a claim, or request for reopening or revision of a finally adjudicated claim, for which VA provided notice of a decision prior to the effective date of the modernized review system and the claimant has not elected to participate in the modernized review system as provided in paragraph (c) of this section.

(c) *Election into the modernized review system*. For claims governed by this part, pursuant to election by a claimant, the modernized review system applies where:

(1) *Rapid appeals modernization program election*. A claimant with a legacy appeal elects to opt-in to the modernized review system on or after November 1, 2017, as part of a program authorized by the Secretary pursuant to section 4 of Public Law 115–55; or

(2) *Election after receiving a statement of the case*. A claimant with a legacy appeal elects to opt-in to the modernized review system, following issuance, on or after the effective date of the modernized system, of a VA Statement of the Case or Supplemental Statement of the Case, by filing for a review option under the new system in accordance with § 3.2500 on a form prescribed by the Secretary within the time allowed for filing a substantive appeal under 38 CFR 19.52(b) and other applicable provisions in part 19 of this chapter.

(d) *Effect of election*. Once an eligible claimant elects the modernized review system with respect to a particular claim, the provisions of 38 CFR parts 3, 19, and 20 applicable only to legacy claims and appeals no longer apply to that claim.

[84 FR 171, Jan. 18, 2019, as amended at 84 FR 4336, Feb. 15, 2019]

§ 3.2500 Review of decisions.

(a) *Reviews available*. (1) Within one year from the date on which the agency of original jurisdiction issues a notice of a decision on a claim or issue as defined in § 3.151(c), except as otherwise provided in paragraphs (c), (e), and (f) of this section, a claimant may elect one of the following administrative review options by timely filing the appropriate form prescribed by the Secretary:

(i) A request for higher-level review under § 3.2601 or

(ii) An appeal to the Board under § 20.202 of this chapter.

(2) At any time after VA issues notice of a decision on an issue within a claim, a claimant may file a supplemental claim under § 3.2501.

(b) *Concurrent election prohibited*. With regard to the adjudication of a claim or an issue as defined in § 3.151(c), a claimant who has filed for review under one of the options available under paragraph (a) of this section may not, while that review is pending final adjudication, file for review under a different available option. While the adjudication of a specific benefit is pending on appeal before a federal court, a claimant may not file for administrative review of the claim under any of options listed in paragraph (a) of this section.

(c) *Continuously pursued issues*. A claimant may continuously pursue a claim or an issue by timely and properly filing one of the following administrative review options, as specified (except as otherwise provided in paragraphs (c), (e), and (f) of this section), after any decision by the agency of original jurisdiction, Board of Veterans' Appeals, or entry of judgment by the U.S. Court of Appeals for Veterans Claims, provided that any appeal to the U.S. Court of Appeals for Veterans Claims is timely filed as determined by the court:

(1) Following notice of a decision on an initial claim or a supplemental claim, the claimant may file a supplemental claim, request a higher-level

review, or appeal to the Board of Veterans' Appeals.

(2) Following notice of a decision on a higher-level review, the claimant may file a supplemental claim or appeal to the Board of Veterans' Appeals. (See appeal to the Board, 38 CFR 20.202).

(3) Following notice of a decision on an appeal to the Board of Veterans' Appeals, the claimant may file a supplemental claim or file a notice of appeal to the Court of Appeals for Veterans Claims.

(4) Following a decision on an appeal to the Court of Appeals for Veterans Claims, the claimant may file a supplemental claim.

(d) *Voluntary withdrawal.* A claimant may withdraw a supplemental claim or a request for a higher-level review at any time before VA renders a decision on the issue. A claimant must submit in writing or through electronic submission in a manner prescribed by the Secretary any notice of withdrawal of an issue under the selected review option to the agency of original jurisdiction. The withdrawal will be effective the date VA receives it. A claimant may withdraw an appeal to the Board of Veteran's Appeals as prescribed in § 20.205.

(e) *Changing review options while a review is pending adjudication*—(1) *Within one year of prior decision notice.* A claimant may change the review option selected by withdrawing the request as prescribed in § 3.2500(d) and filing the appropriate application for the requested review option within one year from the date on which VA issued notice of a decision on an issue.

(2) *More than one year after notice of a decision.* A claimant may change the review option selected to a supplemental claim after expiration of one-year following the date on which VA issued a notice of decision on an issue by following the procedure specified in paragraph (e)(1) of this section. Where VA receives the supplemental claim application after expiration of the one-year period, continuous pursuit of the claim will be broken and VA will apply the effective date provisions under paragraph (h)(2) of this section, unless VA grants an extension of the one-year period for good cause shown under § 3.109(b) and the supplemental claim application is received within the extension period allowed.

(f) *Applicability.* This section applies to claims and requests under the modernized review system as set forth in § 3.2400, with the exception that a supplemental claim may not be filed in connection with a denial of a request to revise a final decision of the agency of original jurisdiction based on clear and unmistakable error.

(g) *Review of simultaneously contested claims.* Notwithstanding other provisions of this part, a party to a simultaneously contested claim may only seek administrative review of a decision by the agency of original jurisdiction on such claim by filing an appeal to the Board as prescribed in § 20.402 of this chapter within 60 days of the date VA issues notice of the decision on the claim. (See contested claims, 38 CFR 20.402).

(h) *Effective dates*—(1) *Continuously pursued claims.* Except as otherwise provided by other provisions of this part, including § 3.400, the effective date will be fixed in accordance with the date of receipt of the initial claim or date entitlement arose, whichever is later, if a claimant continuously pursues an issue by timely filing in succession any of the available review options as specified in paragraph (c) of this section within one year of the issuance of the decision (or the time period specified in paragraph (f) of this section, as applicable to simultaneously contested claims), provided that any appeal to the U.S. Court of Appeals for Veterans Claims must be accepted as timely by that court.

(2) *Supplemental claims received more than one year after notice of decision.* Except as otherwise provided in this section, for supplemental claims received more than one year after the date on which the agency of original jurisdiction issues notice of a decision or the Board of Veterans' Appeals issued notice of a decision, the effective date will be fixed in accordance with the date entitlement arose, but will not be earlier than the date of receipt of the supplemental claim.

[84 FR 171, Jan. 18, 2019, as amended at 84 FR 4336, Feb. 15, 2019]

§ 3.2501 Supplemental claims.

Except as otherwise provided, a claimant or his or her authorized representative, if any, who disagrees with a prior VA decision may file a supplemental claim (see § 3.1(p)(2)) by submitting in writing or electronically a complete application (see § 3.160(a)) on a form prescribed by the Secretary any time after the agency of original jurisdiction issues notice of a decision, regardless of whether the claim is pending (see § 3.160(c)) or has become finally adjudicated (see § 3.160(d)). If new and relevant evidence is presented or secured with respect to the supplemental claim, the agency of original jurisdiction will readjudicate the claim taking into consideration all of the evidence of record. If new and relevant evidence is not presented or secured, the agency of original jurisdiction will issue a decision finding that there was insufficient evidence to readjudicate the claim. In determining whether new and relevant evidence is presented or secured, VA will consider any VA treatment records reasonably identified by the claimant and any evidence received by VA after VA issued notice of a decision on the claim and while the evidentiary record was closed (see 3.103(c)).

(a) *New and relevant evidence.* The new and relevant standard will not impose a higher evidentiary threshold than the previous new and material evidence standard under § 3.156(a).

(1) *Definition.* New evidence is evidence not previously part of the actual record before agency adjudicators. Relevant evidence is information that tends to prove or disprove a matter at issue in a claim. Relevant evidence includes evidence that raises a theory of entitlement that was not previously addressed.

(2) *Receipt prior to notice of a decision.* New and relevant evidence received before VA issues its decision on a supplemental claim will be considered as having been filed in connection with the claim.

(b) *Evidentiary record.* The evidentiary record for a supplemental claim includes all evidence received by VA before VA issues notice of a decision on the supplemental claim. For VA to readjudicate the claim, the evidentiary record must include new and relevant evidence that was not of record as of the date of notice of the prior decision.

(c) *Duty to assist.* Upon receipt of a substantially complete supplemental claim, VA's duty to assist in the gathering of evidence under § 3.159 of this part is triggered and includes any such assistance that may help secure new and relevant evidence as defined in paragraph (a) of this section to complete the supplemental claim application.

(d) *Date of filing.* The filing date of a supplemental claim is determined according to § 3.155, with the exception of the intent to file rule found in § 3.155(b) which applies to initial claims.

(Authority: 38 U.S.C. 501, 5103A(h), 5108)

[83 FR 172, Jan. 18, 2019]

§ 3.2502 Return by higher-level adjudicator or remand by the Board of Veterans' Appeals.

Upon receipt of a returned claim from a higher-level adjudicator or remand by the Board of Veterans' Appeals, the agency of original jurisdiction will expeditiously readjudicate the claim in accordance with 38 U.S.C. 5109B. The agency of original jurisdiction retains jurisdiction of the claim. In readjudicating the claim, the agency of original jurisidction will correct all identified duty to assist errors, complete a new decision and issue notice to the claimant and or his or her legal representative in accordance with 3.103(f). The effective date of any evaluation and award of pension, compensation or dependency and indemnity compensation will be determined in accordance with the date of receipt of the initial claim as prescribed under § 3.2500(g).

[84 FR 172, Jan. 18, 2019]

REVISIONS

§ 3.2600 Legacy review of benefit claims decisions.

This section applies only to legacy claims as defined in § 3.2400 in which a Notice of Disagreement is timely filed on or after June 1, 2001, under regulations applicable at the time of filing.

(a) A claimant who has filed a Notice of Disagreement submitted in accordance with the provisions of § 20.201 of this chapter, and either § 20.302(a) or § 20.501(a) of this chapter, as applicable, with a decision of an agency of original jurisdiction on a benefit claim has a right to a review of that decision under this section. The review will be conducted by a Veterans Service Center Manager, Pension Management Center Manager, or Decision Review Officer, at VA's discretion. An individual who did not participate in the decision being reviewed will conduct this review. Only a decision that has not yet become final (by appellate decision or failure to timely appeal) may be reviewed. Review under this section will encompass only decisions with which the claimant has expressed disagreement in the Notice of Disagreement. The reviewer will consider all evidence of record and applicable law, and will give no deference to the decision being reviewed.

(b) Unless the claimant has requested review under this section with his or her Notice of Disagreement, VA will, upon receipt of the Notice of Disagreement, notify the claimant in writing of his or her right to a review under this section. To obtain such a review, the claimant must request it not later than 60 days after the date VA mails the notice. This 60-day time limit may not be extended. If the claimant fails to request review under this section not later than 60 days after the date VA mails the notice, VA will proceed with the traditional appellate process by issuing a Statement of the Case. A claimant may not have more than one review under this section of the same decision.

(c) The reviewer may conduct whatever development he or she considers necessary to resolve any disagreements in the Notice of Disagreement, consistent with applicable law. This may include an attempt to obtain additional evidence or the holding of an informal conference with the claimant. Upon the request of the claimant, the reviewer will conduct a hearing under the version of § 3.103(c) of this chapter predating Public Law 115–55.

(d) The reviewer may grant a benefit sought in the claim notwithstanding § 3.105(b), but, except as provided in paragraph (e) of this section, may not revise the decision in a manner that is less advantageous to the claimant than the decision under review. A review decision made under this section will include a summary of the evidence, a citation to pertinent laws, a discussion of how those laws affect the decision, and a summary of the reasons for the decision.

(e) Notwithstanding any other provisions of this section, the reviewer may reverse or revise (even if disadvantageous to the claimant) prior decisions of an agency of original jurisdiction (including the decision being reviewed or any prior decision that has become final due to failure to timely appeal) on the grounds of clear and unmistakable error (see § 3.105(a)).

(f) Review under this section does not limit the appeal rights of a claimant. Unless a claimant withdraws his or her Notice of Disagreement as a result of this review process, VA will proceed with the traditional appellate process by issuing a Statement of the Case.

(Authority: 38 U.S.C. 5109A and 7105(d))

[66 FR 21874, May 2, 2001, as amended at 67 FR 46868, July 17, 2002; 74 FR 26959, June 5, 2009; 79 FR 57697, Sept. 25, 2014; 84 FR 172, Jan. 18, 2019; 84 FR 4336, Feb. 15, 2019]

§ 3.2601 Higher-level review.

(a) *Applicability*. This section applies to all claims under the modernized review system, with the exception of simultaneously contested claims.

(b) *Requirements for election*. A claimant who is dissatisfied with a decision by the agency of original jurisdiction may file a request for higher-level review in accordance with § 3.2500, by submitting a complete request for review on a form prescribed by the Secretary.

(c) *Complete request*. A complete request for higher-level review is a submission of a request on a form prescribed by the Secretary, whether paper or electronic, that meets the following requirements:

(1) A complete request must provide the name of the claimant and the relationship to the veteran, if applicable;

(2) A complete request must be signed by the claimant or a person legally authorized to sign for the claimant; and

(3) A complete request must specify the date of the underlying decision for which review is requested and specify the issues for which review is requested.

(d) *Filing period.* A complete request for higher-level review must be received by VA within one year of the date of VA's issuance of the notice of the decision. If VA receives an incomplete request form, VA will notify the claimant and the claimant's representative, if any, of the information necessary to complete the request form prescribed by the Secretary. If a complete request is submitted within 60 days of the date of the VA notification of such incomplete request or prior to the expiration of the one-year filing period, VA will consider it filed as of the date VA received the incomplete application form that did not meet the standards of a complete request.

(e) *Who may conduct a higher-level review.* Higher-level review will be conducted by an experienced adjudicator who did not participate in the prior decision. Selection of a higher-level adjudicator to conduct a higher-level review is at VA's discretion. As a general rule, an adjudicator in an office other than the office that rendered the prior decision will conduct the higher-level review. An exception to this rule applies for claims requiring specialized processing, such as where there is only one office that handles adjudication of a particular type of entitlement. A claimant may request that the office that rendered the prior decision conduct the higher-level review, and VA will grant the request in the absence of good cause to deny such as when processing is centralized at one office within the agency of original jurisdiction or when the office that rendered the prior decision does not have higher-level review personnel available to conduct the review.

(f) *Evidentiary record.* The evidentiary record in a higher-level review is limited to the evidence of record as of the date the agency of original jurisdiction issued notice of the prior decision under review and the higher-level adjudicator may not consider additional evidence. The higher-level adjudicator may not order development of additional evidence that may be relevant to the claim under review, except as provided in paragraph (g) of this section.

(g) *Duty to assist errors.* The higher-level adjudicator will ensure that VA complied with its statutory duty to assist (see § 3.159) in gathering evidence applicable prior to issuance of the decision being reviewed. If the higher-level adjudicator both identifies a duty to assist error that existed at the time of VA's decision on the claim under review and cannot grant the maximum benefit for the claim, the higher-level adjudicator must return the claim for correction of the error and readjudication. Upon receipt, the agency of jurisdiction will expeditiously readjudicate the claim in accordance with 38 U.S.C. 5109B.

(1) For disability evaluations, the *maximum benefit* means the highest schedular evaluation allowed by law and regulation for the issue under review.

(2) For ancillary benefits, the *maximum benefit* means the granting of the benefit sought.

(3) For pension benefits or dependents indemnity compensation, the *maximum benefit* means granting the highest benefit payable.

(h) *Informal conferences.* A claimant or his or her representative may include a request for an informal conference with a request for higher-level review. For purposes of this section, *informal conference* means contact with a claimant's representative or, if not represented, with the claimant, telephonically, or as otherwise determined by VA, for the sole purpose of allowing the claimant or representative to identify any errors of law or fact in a prior decision based on the record at the time the decision was issued. If requested, VA will make reasonable efforts to contact the claimant and/or the authorized representative to conduct one informal conference during a higher-level review, but if such reasonable efforts are not successful, a decision may be issued in the absence of an informal conference. The higher-level adjudicator with determinative authority over the issue will conduct the informal conference, absent exceptional circumstances. VA will not receive any new evidence or introduction of facts

not present at the time of the prior decision or apart of the evidentiary record in support of the higher-level review during the informal conference in accordance with paragraph (d) of this section. Any expenses incurred by the claimant in connection with the informal conference are the responsibility of the claimant.

(i) *De novo review*. The higher-level adjudicator will consider only those decisions and claims for which the claimant has requested higher-level review, and will conduct a de novo review giving no deference to the prior decision, except as provided in § 3.104(c).

(j) *Difference of opinion*. The higher-level adjudicator may grant a benefit sought in the claim under review based on a difference of opinion (see § 3.105(b)). However, any finding favorable to the claimant is binding except as provided in § 3.104(c) of this part. In addition, the higher-level adjudicator will not revise the outcome in a manner that is less advantageous to the claimant based solely on a difference of opinion. The higher-level adjudicator may reverse or revise (even if disadvantageous to the claimant) prior decisions by VA (including the decision being reviewed or any prior decision) on the grounds of clear and unmistakable error under § 3.105(a)(1) or (a)(2), as applicable, depending on whether the prior decision is finally adjudicated.

(k) *Notice requirements*. Notice of a decision made under this section will include all of the elements described in § 3.103(f), a general statement indicating whether evidence submitted while the record was closed was not considered, and notice of the options available to have such evidence considered.

(Authority: 38 U.S.C. 5109A and 7105(d))

[84 FR 173, Jan. 18, 2019]

PART 4—SCHEDULE FOR RATING DISABILITIES

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AUTHORITY: 38 U.S.C. 1155, unless otherwise noted.

SOURCE: 29 FR 6718, May 22, 1964, unless otherwise noted.

Subpart A—General Policy in Rating

§4.1 Essentials of evaluative rating.

This rating schedule is primarily a guide in the evaluation of disability resulting from all types of diseases and injuries encountered as a result of or incident to military service. The percentage ratings represent as far as can practicably be determined the average impairment in earning capacity resulting from such diseases and injuries and

their residual conditions in civil occupations. Generally, the degrees of disability specified are considered adequate to compensate for considerable loss of working time from exacerbations or illnesses proportionate to the severity of the several grades of disability. For the application of this schedule, accurate and fully descriptive medical examinations are required, with emphasis upon the limitation of activity imposed by the disabling condition. Over a period of many years, a veteran's disability claim may require reratings in accordance with changes in laws, medical knowledge and his or her physical or mental condition. It is thus essential, both in the examination and in the evaluation of disability, that each disability be viewed in relation to its history.

[41 FR 11292, Mar. 18, 1976]

§ 4.2 Interpretation of examination reports.

Different examiners, at different times, will not describe the same disability in the same language. Features of the disability which must have persisted unchanged may be overlooked or a change for the better or worse may not be accurately appreciated or described. It is the responsibility of the rating specialist to interpret reports of examination in the light of the whole recorded history, reconciling the various reports into a consistent picture so that the current rating may accurately reflect the elements of disability present. Each disability must be considered from the point of view of the veteran working or seeking work. If a diagnosis is not supported by the findings on the examination report or if the report does not contain sufficient detail, it is incumbent upon the rating board to return the report as inadequate for evaluation purposes.

[41 FR 11292, Mar. 18, 1976]

§ 4.3 Resolution of reasonable doubt.

It is the defined and consistently applied policy of the Department of Veterans Affairs to administer the law under a broad interpretation, consistent, however, with the facts shown in every case. When after careful consideration of all procurable and assembled data, a reasonable doubt arises regarding the degree of disability such doubt will be resolved in favor of the claimant. See § 3.102 of this chapter.

[40 FR 42535, Sept. 15, 1975]

§ 4.6 Evaluation of evidence.

The element of the weight to be accorded the character of the veteran's service is but one factor entering into the considerations of the rating boards in arriving at determinations of the evaluation of disability. Every element in any way affecting the probative value to be assigned to the evidence in each individual claim must be thoroughly and conscientiously studied by each member of the rating board in the light of the established policies of the Department of Veterans Affairs to the end that decisions will be equitable and just as contemplated by the requirements of the law.

§ 4.7 Higher of two evaluations.

Where there is a question as to which of two evaluations shall be applied, the higher evaluation will be assigned if the disability picture more nearly approximates the criteria required for that rating. Otherwise, the lower rating will be assigned.

§ 4.9 Congenital or developmental defects.

Mere congenital or developmental defects, absent, displaced or supernumerary parts, refractive error of the eye, personality disorder and mental deficiency are not diseases or injuries in the meaning of applicable legislation for disability compensation purposes.

[41 FR 11292, Mar. 18, 1976]

§ 4.10 Functional impairment.

The basis of disability evaluations is the ability of the body as a whole, or of the psyche, or of a system or organ of the body to function under the ordinary conditions of daily life including employment. Whether the upper or lower extremities, the back or abdominal wall, the eyes or ears, or the cardiovascular, digestive, or other system, or psyche are affected, evaluations are based upon lack of usefulness, of these

parts or systems, especially in self-support. This imposes upon the medical examiner the responsibility of furnishing, in addition to the etiological, anatomical, pathological, laboratory and prognostic data required for ordinary medical classification, full description of the effects of disability upon the person's ordinary activity. In this connection, it will be remembered that a person may be too disabled to engage in employment although he or she is up and about and fairly comfortable at home or upon limited activity.

[41 FR 11292, Mar. 18, 1976]

§4.13 Effect of change of diagnosis.

The repercussion upon a current rating of service connection when change is made of a previously assigned diagnosis or etiology must be kept in mind. The aim should be the reconciliation and continuance of the diagnosis or etiology upon which service connection for the disability had been granted. The relevant principle enunciated in §4.125, entitled ''Diagnosis of mental disorders,'' should have careful attention in this connection. When any change in evaluation is to be made, the rating agency should assure itself that there has been an actual change in the conditions, for better or worse, and not merely a difference in thoroughness of the examination or in use of descriptive terms. This will not, of course, preclude the correction of erroneous ratings, nor will it preclude assignment of a rating in conformity with §4.7.

[29 FR 6718, May 22, 1964, as amended at 61 FR 52700, Oct. 8, 1996]

§4.14 Avoidance of pyramiding.

The evaluation of the same disability under various diagnoses is to be avoided. Disability from injuries to the muscles, nerves, and joints of an extremity may overlap to a great extent, so that special rules are included in the appropriate bodily system for their evaluation. Dyspnea, tachycardia, nervousness, fatigability, etc., may result from many causes; some may be service connected, others, not. Both the use of manifestations not resulting from service-connected disease or injury in establishing the service-connected evaluation, and the evaluation of the same manifestation under different diagnoses are to be avoided.

§4.15 Total disability ratings.

The ability to overcome the handicap of disability varies widely among individuals. The rating, however, is based primarily upon the average impairment in earning capacity, that is, upon the economic or industrial handicap which must be overcome and not from individual success in overcoming it. However, full consideration must be given to unusual physical or mental effects in individual cases, to peculiar effects of occupational activities, to defects in physical or mental endowment preventing the usual amount of success in overcoming the handicap of disability and to the effect of combinations of disability. Total disability will be considered to exist when there is present any impairment of mind or body which is sufficient to render it impossible for the average person to follow a substantially gainful occupation; *Provided*, That permanent total disability shall be taken to exist when the impairment is reasonably certain to continue throughout the life of the disabled person. The following will be considered to be permanent total disability: the permanent loss of the use of both hands, or of both feet, or of one hand and one foot, or of the sight of both eyes, or becoming permanently helpless or permanently bedridden. Other total disability ratings are scheduled in the various bodily systems of this schedule.

§4.16 Total disability ratings for compensation based on unemployability of the individual.

(a) Total disability ratings for compensation may be assigned, where the schedular rating is less than total, when the disabled person is, in the judgment of the rating agency, unable to secure or follow a substantially gainful occupation as a result of service-connected disabilities: *Provided* That, if there is only one such disability, this disability shall be ratable at 60 percent or more, and that, if there are two or more disabilities, there shall be at least one disability ratable at 40

percent or more, and sufficient additional disability to bring the combined rating to 70 percent or more. For the above purpose of one 60 percent disability, or one 40 percent disability in combination, the following will be considered as one disability: (1) Disabilities of one or both upper extremities, or of one or both lower extremities, including the bilateral factor, if applicable, (2) disabilities resulting from common etiology or a single accident, (3) disabilities affecting a single body system, e.g. orthopedic, digestive, respiratory, cardiovascular-renal, neuropsychiatric, (4) multiple injuries incurred in action, or (5) multiple disabilities incurred as a prisoner of war. It is provided further that the existence or degree of nonservice-connected disabilities or previous unemployability status will be disregarded where the percentages referred to in this paragraph for the service-connected disability or disabilities are met and in the judgment of the rating agency such service-connected disabilities render the veteran unemployable. Marginal employment shall not be considered substantially gainful employment. For purposes of this section, marginal employment generally shall be deemed to exist when a veteran's earned annual income does not exceed the amount established by the U.S. Department of Commerce, Bureau of the Census, as the poverty threshold for one person. Marginal employment may also be held to exist, on a facts found basis (includes but is not limited to employment in a protected environment such as a family business or sheltered workshop), when earned annual income exceeds the poverty threshold. Consideration shall be given in all claims to the nature of the employment and the reason for termination.

(Authority: 38 U.S.C. 501)

(b) It is the established policy of the Department of Veterans Affairs that all veterans who are unable to secure and follow a substantially gainful occupation by reason of service-connected disabilities shall be rated totally disabled. Therefore, rating boards should submit to the Director, Compensation Service, for extra-schedular consideration all cases of veterans who are unemployable by reason of service-connected disabilities, but who fail to meet the percentage standards set forth in paragraph (a) of this section. The rating board will include a full statement as to the veteran's service-connected disabilities, employment history, educational and vocational attainment and all other factors having a bearing on the issue.

[40 FR 42535, Sept. 15, 1975, as amended at 54 FR 4281, Jan. 30, 1989; 55 FR 31580, Aug. 3, 1990; 58 FR 39664, July 26, 1993; 61 FR 52700, Oct. 8, 1996; 79 FR 2100, Jan. 13, 2014]

§ 4.17 Total disability ratings for pension based on unemployability and age of the individual.

All veterans who are basically eligible and who are unable to secure and follow a substantially gainful occupation by reason of disabilities which are likely to be permanent shall be rated as permanently and totally disabled. For the purpose of pension, the permanence of the percentage requirements of § 4.16 is a requisite. When the percentage requirements are met, and the disabilities involved are of a permanent nature, a rating of permanent and total disability will be assigned if the veteran is found to be unable to secure and follow substantially gainful employment by reason of such disability. Prior employment or unemployment status is immaterial if in the judgment of the rating board the veteran's disabilities render him or her unemployable. In making such determinations, the following guidelines will be used:

(a) Marginal employment, for example, as a self-employed farmer or other person, while employed in his or her own business, or at odd jobs or while employed at less than half the usual remuneration will not be considered incompatible with a determination of unemployability, if the restriction, as to securing or retaining better employment, is due to disability.

(b) Claims of all veterans who fail to meet the percentage standards but who meet the basic entitlement criteria and are unemployable, will be referred by the rating board to the Veterans Service Center Manager or the Pension

Management Center Manager under §3.321(b)(2) of this chapter.

(Authority: 38 U.S.C. 1155; 38 U.S.C. 3102)

[43 FR 45348, Oct. 2, 1978, as amended at 56 FR 57985, Nov. 15, 1991; 71 FR 28586, May 17, 2006; 74 FR 26959, June 5, 2009]

§4.17a Misconduct etiology.

A permanent and total disability rating under the provisions of §§4.15, 4.16 and 4.17 will not be precluded by reason of the coexistence of misconduct disability when:

(a) A veteran, regardless of employment status, also has innocently acquired 100 percent disability, or

(b) Where unemployable, the veteran has other disabilities innocently acquired which meet the percentage requirements of §§4.16 and 4.17 and would render, in the judgment of the rating agency, the average person unable to secure or follow a substantially gainful occupation.

[40 FR 42536, Sept. 15, 1975, as amended at 43 FR 45349, Oct. 2, 1978]

§4.18 Unemployability.

A veteran may be considered as unemployable upon termination of employment which was provided on account of disability, or in which special consideration was given on account of the same, when it is satisfactorily shown that he or she is unable to secure further employment. With amputations, sequelae of fractures and other residuals of traumatism shown to be of static character, a showing of continuous unemployability from date of incurrence, or the date the condition reached the stabilized level, is a general requirement in order to establish the fact that present unemployability is the result of the disability. However, consideration is to be given to the circumstances of employment in individual claims, and, if the employment was only occasional, intermittent, tryout or unsuccessful, or eventually terminated on account of the disability, present unemployability may be attributed to the static disability. Where unemployability for pension previously has been established on the basis of combined service-connected and nonservice-connected disabilities and the service-connected disability or disabilities have increased in severity, §4.16 is for consideration.

[40 FR 42536, Sept. 15, 1975, as amended at 43 FR 45349, Oct. 2, 1978]

§4.19 Age in service-connected claims.

Age may not be considered as a factor in evaluating service-connected disability; and unemployability, in service-connected claims, associated with advancing age or intercurrent disability, may not be used as a basis for a total disability rating. Age, as such, is a factor only in evaluations of disability not resulting from service, *i.e.*, for the purposes of pension.

[29 FR 6718, May 22, 1964, as amended at 43 FR 45349, Oct. 2, 1978]

§4.20 Analogous ratings.

When an unlisted condition is encountered it will be permissible to rate under a closely related disease or injury in which not only the functions affected, but the anatomical localization and symptomatology are closely analogous. Conjectural analogies will be avoided, as will the use of analogous ratings for conditions of doubtful diagnosis, or for those not fully supported by clinical and laboratory findings. Nor will ratings assigned to organic diseases and injuries be assigned by analogy to conditions of functional origin.

§4.21 Application of rating schedule.

In view of the number of atypical instances it is not expected, especially with the more fully described grades of disabilities, that all cases will show all the findings specified. Findings sufficiently characteristic to identify the disease and the disability therefrom, and above all, coordination of rating with impairment of function will, however, be expected in all instances.

[41 FR 11293, Mar. 18, 1976]

§4.22 Rating of disabilities aggravated by active service.

In cases involving aggravation by active service, the rating will reflect only the degree of disability over and above the degree existing at the time of entrance into the active service, whether the particular condition was noted at the time of entrance into the active service, or it is determined upon the

evidence of record to have existed at that time. It is necessary therefore, in all cases of this character to deduct from the present degree of disability the degree, if ascertainable, of the disability existing at the time of entrance into active service, in terms of the rating schedule, except that if the disability is total (100 percent) no deduction will be made. The resulting difference will be recorded on the rating sheet. If the degree of disability at the time of entrance into the service is not ascertainable in terms of the schedule, no deduction will be made.

§ 4.23 Attitude of rating officers.

It is to be remembered that the majority of applicants are disabled persons who are seeking benefits of law to which they believe themselves entitled. In the exercise of his or her functions, rating officers must not allow their personal feelings to intrude; an antagonistic, critical, or even abusive attitude on the part of a claimant should not in any instance influence the officers in the handling of the case. Fairness and courtesy must at all times be shown to applicants by all employees whose duties bring them in contact, directly or indirectly, with the Department's claimants.

[41 FR 11292, Mar. 18, 1976]

§ 4.24 Correspondence.

All correspondence relative to the interpretation of the schedule for rating disabilities, requests for advisory opinions, questions regarding lack of clarity or application to individual cases involving unusual difficulties, will be addressed to the Director, Compensation Service. A clear statement will be made of the point or points upon which information is desired, and the complete case file will be simultaneously forwarded to Central Office. Rating agencies will assure themselves that the recent report of physical examination presents an adequate picture of the claimant's condition. Claims in regard to which the schedule evaluations are considered inadequate or excessive, and errors in the schedule will be similarly brought to attention.

[41 FR 11292, Mar. 18, 1976, as amended at 79 FR 2100, Jan. 13, 2014]

§ 4.25 Combined ratings table.

Table I, Combined Ratings Table, results from the consideration of the efficiency of the individual as affected first by the most disabling condition, then by the less disabling condition, then by other less disabling conditions, if any, in the order of severity. Thus, a person having a 60 percent disability is considered 40 percent efficient. Proceeding from this 40 percent efficiency, the effect of a further 30 percent disability is to leave only 70 percent of the efficiency remaining after consideration of the first disability, or 28 percent efficiency altogether. The individual is thus 72 percent disabled, as shown in table I opposite 60 percent and under 30 percent.

(a) To use table I, the disabilities will first be arranged in the exact order of their severity, beginning with the greatest disability and then combined with use of table I as hereinafter indicated. For example, if there are two disabilities, the degree of one disability will be read in the left column and the degree of the other in the top row, whichever is appropriate. The figures appearing in the space where the column and row intersect will represent the combined value of the two. This combined value will then be converted to the nearest number divisible by 10, and combined values ending in 5 will be adjusted upward. Thus, with a 50 percent disability and a 30 percent disability, the combined value will be found to be 65 percent, but the 65 percent must be converted to 70 percent to represent the final degree of disability. Similarly, with a disability of 40 percent, and another disability of 20 percent, the combined value is found to be 52 percent, but the 52 percent must be converted to the nearest degree divisible by 10, which is 50 percent. If there are more than two disabilities, the disabilities will also be arranged in the exact order of their severity and the combined value for the first two will be found as previously described for two disabilities. The combined value, exactly as found in table I, will be combined with the degree of the third disability (in order of severity). The combined value for the three disabilities will be found in the space where the column and row intersect, and if there

are only three disabilities will be converted to the nearest degree divisible by 10, adjusting final 5's upward. Thus, if there are three disabilities ratable at 60 percent, 40 percent, and 20 percent, respectively, the combined value for the first two will be found opposite 60 and under 40 and is 76 percent. This 76 will be combined with 20 and the combined value for the three is 81 percent. This combined value will be converted to the nearest degree divisible by 10 which is 80 percent. The same procedure will be employed when there are four or more disabilities. (See table I).

(b) Except as otherwise provided in this schedule, the disabilities arising from a single disease entity, e.g., arthritis, multiple sclerosis, cerebrovascular accident, etc., are to be rated separately as are all other disabiling conditions, if any. All disabilities are then to be combined as described in paragraph (a) of this section. The conversion to the nearest degree divisible by 10 will be done only once per rating decision, will follow the combining of all disabilities, and will be the last procedure in determining the combined degree of disability.

TABLE I—COMBINED RATINGS TABLE

[10 combined with 10 is 19]

	10	20	30	40	50	60	70	80	90
19	27	35	43	51	60	68	76	84	92
20	28	36	44	52	60	68	76	84	92
21	29	37	45	53	61	68	76	84	92
22	30	38	45	53	61	69	77	84	92
23	31	38	46	54	62	69	77	85	92
24	32	39	47	54	62	70	77	85	92
25	33	40	48	55	63	70	78	85	93
26	33	41	48	56	63	70	78	85	93
27	34	42	49	56	64	71	78	85	93
28	35	42	50	57	64	71	78	86	93
29	36	43	50	57	65	72	79	86	93
30	37	44	51	58	65	72	79	86	93
31	38	45	52	59	66	72	79	86	93
32	39	46	52	59	66	73	80	86	93
33	40	46	53	60	67	73	80	87	93
34	41	47	54	60	67	74	80	87	93
35	42	48	55	61	68	74	81	87	94
36	42	49	55	62	68	74	81	87	94
37	43	50	56	62	69	75	81	87	94
38	44	50	57	63	69	75	81	88	94
39	45	51	57	63	70	76	82	88	94
40	46	52	58	64	70	76	82	88	94
41	47	53	59	65	71	76	82	88	94
42	48	54	59	65	71	77	83	88	94
43	49	54	60	66	72	77	83	89	94
44	50	55	61	66	72	78	83	89	94
45	51	56	62	67	73	78	84	89	95
46	51	57	62	68	73	78	84	89	95
47	52	58	63	68	74	79	84	89	95
48	53	58	64	69	74	79	84	90	95
49	54	59	64	69	75	80	85	90	95
50	55	60	65	70	75	80	85	90	95
51	56	61	66	71	76	80	85	90	95
52	57	62	66	71	76	81	86	90	95
53	58	62	67	72	77	81	86	91	95
54	59	63	68	72	77	82	86	91	95
55	60	64	69	73	78	82	87	91	96
56	60	65	69	74	78	82	87	91	96
57	61	66	70	74	79	83	87	91	96
58	62	66	71	75	79	83	87	92	96
59	63	67	71	75	80	84	88	92	96
60	64	68	72	76	80	84	88	92	96
61	65	69	73	77	81	84	88	92	96
62	66	70	73	77	81	85	89	92	96
63	67	70	74	78	82	85	89	93	96
64	68	71	75	78	82	86	89	93	96
65	69	72	76	79	83	86	90	93	97
66	69	73	76	80	83	86	90	93	97
67	70	74	77	80	84	87	90	93	97
68	71	74	78	81	84	87	90	94	97
69	72	75	78	81	85	88	91	94	97

TABLE I—COMBINED RATINGS TABLE—Continued

[10 combined with 10 is 19]

	10	20	30	40	50	60	70	80	90
70	73	76	79	82	85	88	91	94	97
71	74	77	80	83	86	88	91	94	97
72	75	78	80	83	86	89	92	94	97
73	76	78	81	84	87	89	92	95	97
74	77	79	82	84	87	90	92	95	97
75	78	80	83	85	88	90	93	95	98
76	78	81	83	86	88	90	93	95	98
77	79	82	84	86	89	91	93	95	98
78	80	82	85	87	89	91	93	96	98
79	81	83	85	87	90	92	94	96	98
80	82	84	86	88	90	92	94	96	98
81	83	85	87	89	91	92	94	96	98
82	84	86	87	89	91	93	95	96	98
83	85	86	88	90	92	93	95	97	98
84	86	87	89	90	92	94	95	97	98
85	87	88	90	91	93	94	96	97	99
86	87	89	90	92	93	94	96	97	99
87	88	90	91	92	94	95	96	97	99
88	89	90	92	93	94	95	96	98	99
89	90	91	92	93	95	96	97	98	99
90	91	92	93	94	95	96	97	98	99
91	92	93	94	95	96	96	97	98	99
92	93	94	94	95	96	97	98	98	99
93	94	94	95	96	97	97	98	99	99
94	95	95	96	96	97	98	98	99	99

(Authority: 38 U.S.C. 1155)

[41 FR 11293, Mar. 18, 1976, as amended at 54 FR 27161, June 28, 1989; 54 FR 36029, Aug. 31, 1989; 83 FR 17756, Apr. 24, 2018]

§ 4.26 Bilateral factor.

When a partial disability results from disease or injury of both arms, or of both legs, or of paired skeletal muscles, the ratings for the disabilities of the right and left sides will be combined as usual, and 10 percent of this value will be added (*i.e.*, not combined) before proceeding with further combinations, or converting to degree of disability. The bilateral factor will be applied to such bilateral disabilities before other combinations are carried out and the rating for such disabilities including the bilateral factor in this section will be treated as 1 disability for the purpose of arranging in order of severity and for all further combinations. For example, with disabilities evaluated at 60 percent, 20 percent, 10 percent and 10 percent (the two 10's representing bilateral disabilities), the order of severity would be 60, 21 and 20. The 60 and 21 combine to 68 percent and the 68 and 20 to 74 percent, converted to 70 percent as the final degree of disability.

(a) The use of the terms ''arms'' and ''legs'' is not intended to distinguish between the arm, forearm and hand, or the thigh, leg, and foot, but relates to the upper extremities and lower extremities as a whole. Thus with a compensable disability of the right thigh, for example, amputation, and one of the left foot, for example, pes planus, the bilateral factor applies, and similarly whenever there are compensable disabilities affecting use of paired extremities regardless of location or specified type of impairment.

(b) The correct procedure when applying the bilateral factor to disabilities affecting both upper extremities and both lower extremities is to combine the ratings of the disabilities affecting the 4 extremities in the order of their individual severity and apply the bilateral factor by adding, not combining, 10 percent of the combined value thus attained.

(c) The bilateral factor is not applicable unless there is partial disability of compensable degree in each of 2 paired extremities, or paired skeletal muscles.

§4.27 Use of diagnostic code numbers.

The diagnostic code numbers appearing opposite the listed ratable disabilities are arbitrary numbers for the purpose of showing the basis of the evaluation assigned and for statistical analysis in the Department of Veterans Affairs, and as will be observed, extend from 5000 to a possible 9999. Great care will be exercised in the selection of the applicable code number and in its citation on the rating sheet. No other numbers than these listed or hereafter furnished are to be employed for rating purposes, with an exception as described in this section, as to unlisted conditions. When an unlisted disease, injury, or residual condition is encountered, requiring rating by analogy, the diagnostic code number will be ''built-up'' as follows: The first 2 digits will be selected from that part of the schedule most closely identifying the part, or system, of the body involved; the last 2 digits will be ''99'' for all unlisted conditions. This procedure will facilitate a close check of new and unlisted conditions, rated by analogy. In the selection of code numbers, injuries will generally be represented by the number assigned to the residual condition on the basis of which the rating is determined. With diseases, preference is to be given to the number assigned to the disease itself; if the rating is determined on the basis of residual conditions, the number appropriate to the residual condition will be added, preceded by a hyphen. Thus, rheumatoid (atrophic) arthritis rated as ankylosis of the lumbar spine should be coded ''5002–5240.'' In this way, the exact source of each rating can be easily identified. In the citation of disabilities on rating sheets, the diagnostic terminology will be that of the medical examiner, with no attempt to translate the terms into schedule nomenclature. Residuals of diseases or therapeutic procedures will not be cited without reference to the basic disease.

[41 FR 11293, Mar. 18, 1976, as amended at 70 FR 75399, Dec. 20, 2005]

§4.28 Prestabilization rating from date of discharge from service.

The following ratings may be assigned, in lieu of ratings prescribed elsewhere, under the conditions stated for disability from any disease or injury. The prestabilization rating is not to be assigned in any case in which a total rating is immediately assignable under the regular provisions of the schedule or on the basis of individual unemployability. The prestabilization 50-percent rating is not to be used in any case in which a rating of 50 percent or more is immediately assignable under the regular provisions.

	Rating
Unstabilized condition with severe disability—	
Substantially gainful employment is not feasible or advisable	100
Unhealed or incompletely healed wounds or injuries—	
Material impairment of employability likely	50

NOTE (1): Department of Veterans Affairs examination is not required prior to assignment of prestabilization ratings; however, the fact that examination was accomplished will not preclude assignment of these benefits. Prestabilization ratings are for assignment in the immediate postdischarge period. They will continue for a 12-month period following discharge from service. However, prestabilization ratings may be changed to a regular schedular total rating or one authorizing a greater benefit at any time. In each prestabilization rating an examination will be requested to be accomplished not earlier than 6 months nor more than 12 months following discharge. In those prestabilization ratings in which following examination reduction in evaluation is found to be warranted, the higher evaluation will be continued to the end of the 12th month following discharge or to the end of the period provided under §3.105(e) of this chapter, whichever is later. Special monthly compensation should be assigned concurrently in these cases whenever records are adequate to establish entitlement.

NOTE (2): Diagnosis of disease, injury, or residuals will be cited, with diagnostic code number assigned from this rating schedule for conditions listed therein.

[35 FR 11906, July 24, 1970]

§4.29 Ratings for service-connected disabilities requiring hospital treatment or observation.

A total disability rating (100 percent) will be assigned without regard to other provisions of the rating schedule when it is established that a service-connected disability has required hospital treatment in a Department of

Veterans Affairs or an approved hospital for a period in excess of 21 days or *hospital observation at Department of Veterans Affairs expense* for a service-connected disability for a period in excess of 21 days.

(a) Subject to the provisions of paragraphs (d), (e), and (f) of this section this increased rating will be effective the first day of continuous hospitalization and will be terminated effective the last day of the month of hospital discharge (regular discharge or release to non-bed care) or effective the last day of the month of termination of treatment or observation for the service-connected disability. A temporary release which is approved by an attending Department of Veterans Affairs physician as part of the treatment plan will not be considered an absence.

(1) An authorized absence in excess of 4 days which begins during the first 21 days of hospitalization will be regarded as the equivalent of hospital discharge effective the first day of such authorized absence. An authorized absence of 4 days or less which results in a total of more than 8 days of authorized absence during the first 21 days of hospitalization will be regarded as the equivalent of hospital discharge effective the ninth day of authorized absence.

(2) Following a period of hospitalization in excess of 21 days, an authorized absence in excess of 14 days or a third consecutive authorized absence of 14 days will be regarded as the equivalent of hospital discharge and will interrupt hospitalization effective on the last day of the month in which either the authorized absence in excess of 14 days or the third 14 day period begins, except where there is a finding that convalescence is required as provided by paragraph (e) or (f) of this section. The termination of these total ratings will not be subject to § 3.105(e) of this chapter.

(b) Notwithstanding that hospital admission was for disability not connected with service, if during such hospitalization, hospital treatment for a service-connected disability is instituted and continued for a period in excess of 21 days, the increase to a total rating will be granted from the first day of such treatment. If service connection for the disability under treatment is granted after hospital admission, the rating will be from the first day of hospitalization if otherwise in order.

(c) The assignment of a total disability rating on the basis of hospital treatment or observation will not preclude the assignment of a total disability rating otherwise in order under other provisions of the rating schedule, and consideration will be given to the propriety of such a rating in all instances and to the propriety of its continuance after discharge. Particular attention, with a view to proper rating under the rating schedule, is to be given to the claims of veterans discharged from hospital, regardless of length of hospitalization, with indications on the final summary of expected confinement to bed or house, or to inability to work with requirement of frequent care of physician or nurse at home.

(d) On these total ratings Department of Veterans Affairs regulations governing effective dates for increased benefits will control.

(e) The total hospital rating if convalescence is required may be continued for periods of 1, 2, or 3 months in addition to the period provided in paragraph (a) of this section.

(f) Extension of periods of 1, 2 or 3 months beyond the initial 3 months may be made upon approval of the Veterans Service Center Manager.

(g) Meritorious claims of veterans who are discharged from the hospital with less than the required number of days but need post-hospital care and a prolonged period of convalescence will be referred to the Director, Compensation Service, under § 3.321(b)(1) of this chapter.

[29 FR 6718, May 22, 1964, as amended at 41 FR 11294, Mar. 18, 1976; 41 FR 34256, Aug. 13, 1976; 54 FR 4281, Jan. 30, 1989; 54 FR 34981, Aug. 23, 1989; 71 FR 28586, May 17, 2006; 79 FR 2100, Jan. 13, 2014]

§ 4.30 Convalescent ratings.

A total disability rating (100 percent) will be assigned without regard to other provisions of the rating schedule when it is established by report at hospital discharge (regular discharge or release to non-bed care) or outpatient release that entitlement is warranted

under paragraph (a) (1), (2) or (3) of this section effective the date of hospital admission or outpatient treatment and continuing for a period of 1, 2, or 3 months from the first day of the month following such hospital discharge or outpatient release. The termination of these total ratings will not be subject to §3.105(e) of this chapter. Such total rating will be followed by appropriate schedular evaluations. When the evidence is inadequate to assign a schedular evaluation, a physical examination will be scheduled and considered prior to the termination of a total rating under this section.

(a) Total ratings will be assigned under this section if treatment of a service-connected disability resulted in:

(1) Surgery necessitating at least one month of convalescence (Effective as to outpatient surgery March 1, 1989.)

(2) Surgery with severe postoperative residuals such as incompletely healed surgical wounds, stumps of recent amputations, therapeutic immobilization of one major joint or more, application of a body cast, or the necessity for house confinement, or the necessity for continued use of a wheelchair or crutches (regular weight-bearing prohibited). (Effective as to outpatient surgery March 1, 1989.)

(3) Immobilization by cast, without surgery, of one major joint or more. (Effective as to outpatient treatment March 10, 1976.)

A reduction in the total rating will not be subject to §3.105(e) of this chapter. The total rating will be followed by an open rating reflecting the appropriate schedular evaluation; where the evidence is inadequate to assign the schedular evaluation, a physcial examination will be scheduled prior to the end of the total rating period.

(b) A total rating under this section will require full justification on the rating sheet and may be extended as follows:

(1) Extensions of 1, 2 or 3 months beyond the initial 3 months may be made under paragraph (a) (1), (2) or (3) of this section.

(2) Extensions of 1 or more months up to 6 months beyond the initial 6 months period may be made under paragraph (a) (2) or (3) of this section upon approval of the Veterans Service Center Manager.

[41 FR 34256, Aug. 13, 1976, as amended at 54 FR 4281, Jan. 30, 1989; 71 FR 28586, May 17, 2006]

§4.31 Zero percent evaluations.

In every instance where the schedule does not provide a zero percent evaluation for a diagnostic code, a zero percent evaluation shall be assigned when the requirements for a compensable evaluation are not met.

[58 FR 52018, Oct. 6, 1993]

Subpart B—Disability Ratings

THE MUSCULOSKELETAL SYSTEM

§4.40 Functional loss.

Disability of the musculoskeletal system is primarily the inability, due to damage or infection in parts of the system, to perform the normal working movements of the body with normal excursion, strength, speed, coordination and endurance. It is essential that the examination on which ratings are based adequately portray the anatomical damage, and the functional loss, with respect to all these elements. The functional loss may be due to absence of part, or all, of the necessary bones, joints and muscles, or associated structures, or to deformity, adhesions, defective innervation, or other pathology, or it may be due to pain, supported by adequate pathology and evidenced by the visible behavior of the claimant undertaking the motion. Weakness is as important as limitation of motion, and a part which becomes painful on use must be regarded as seriously disabled. A little used part of the musculoskeletal system may be expected to show evidence of disuse, either through atrophy, the condition of the skin, absence of normal callosity or the like.

§4.41 History of injury.

In considering the residuals of injury, it is essential to trace the medical-industrial history of the disabled person from the original injury, considering

the nature of the injury and the attendant circumstances, and the requirements for, and the effect of, treatment over past periods, and the course of the recovery to date. The duration of the initial, and any subsequent, period of total incapacity, especially periods reflecting delayed union, inflammation, swelling, drainage, or operative intervention, should be given close attention. This consideration, or the absence of clear cut evidence of injury, may result in classifying the disability as not of traumatic origin, either reflecting congenital or developmental etiology, or the effects of healed disease.

§ 4.42 Complete medical examination of injury cases.

The importance of complete medical examination of injury cases at the time of first medical examination by the Department of Veterans Affairs cannot be overemphasized. When possible, this should include complete neurological and psychiatric examination, and other special examinations indicated by the physical condition, in addition to the required general and orthopedic or surgical examinations. When complete examinations are not conducted covering all systems of the body affected by disease or injury, it is impossible to visualize the nature and extent of the service connected disability. Incomplete examination is a common cause of incorrect diagnosis, especially in the neurological and psychiatric fields, and frequently leaves the Department of Veterans Affairs in doubt as to the presence or absence of disabling conditions at the time of the examination.

§ 4.43 Osteomyelitis.

Chronic, or recurring, suppurative osteomyelitis, once clinically identified, including chronic inflammation of bone marrow, cortex, or periosteum, should be considered as a continuously disabling process, whether or not an actively discharging sinus or other obvious evidence of infection is manifest from time to time, and unless the focus is entirely removed by amputation will entitle to a permanent rating to be combined with other ratings for residual conditions, however, not exceeding amputation ratings at the site of election.

§ 4.44 The bones.

The osseous abnormalities incident to trauma or disease, such as malunion with deformity throwing abnormal stress upon, and causing malalignment of joint surfaces, should be depicted from study and observation of all available data, beginning with inception of injury or disease, its nature, degree of prostration, treatment and duration of convalescence, and progress of recovery with development of permanent residuals. With shortening of a long bone, some degree of angulation is to be expected; the extent and direction should be brought out by X-ray and observation. The direction of angulation and extent of deformity should be carefully related to strain on the neighboring joints, especially those connected with weight-bearing.

§ 4.45 The joints.

As regards the joints the factors of disability reside in reductions of their normal excursion of movements in different planes. Inquiry will be directed to these considerations:

(a) Less movement than normal (due to ankylosis, limitation or blocking, adhesions, tendon-tie-up, contracted scars, etc.).

(b) More movement than normal (from flail joint, resections, nonunion of fracture, relaxation of ligaments, etc.).

(c) Weakened movement (due to muscle injury, disease or injury of peripheral nerves, divided or lengthened tendons, etc.).

(d) Excess fatigability.

(e) Incoordination, impaired ability to execute skilled movements smoothly.

(f) Pain on movement, swelling, deformity or atrophy of disuse. Instability of station, disturbance of locomotion, interference with sitting, standing and weight-bearing are related considerations. For the purpose of rating disability from arthritis, the shoulder, elbow, wrist, hip, knee, and ankle are considered major joints; multiple involvements of the interphalangeal, metacarpal and carpal joints of

the upper extremities, the interphalangeal, metatarsal and tarsal joints of the lower extremities, the cervical vertebrae, the dorsal vertebrae, and the lumbar vertebrae, are considered groups of minor joints, ratable on a parity with major joints. The lumbosacral articulation and both sacroiliac joints are considered to be a group of minor joints, ratable on disturbance of lumbar spine functions.

§4.46 Accurate measurement.

Accurate measurement of the length of stumps, excursion of joints, dimensions and location of scars with respect to landmarks, should be insisted on. The use of a goniometer in the measurement of limitation of motion is indispensable in examinations conducted within the Department of Veterans Affairs. Muscle atrophy must also be accurately measured and reported.

[41 FR 11294, Mar. 18, 1976]

§§4.47–4.54 [Reserved]

§4.55 Principles of combined ratings for muscle injuries.

(a) A muscle injury rating will not be combined with a peripheral nerve paralysis rating of the same body part, unless the injuries affect entirely different functions.

(b) For rating purposes, the skeletal muscles of the body are divided into 23 muscle groups in 5 anatomical regions: 6 muscle groups for the shoulder girdle and arm (diagnostic codes 5301 through 5306); 3 muscle groups for the forearm and hand (diagnostic codes 5307 through 5309); 3 muscle groups for the foot and leg (diagnostic codes 5310 through 5312); 6 muscle groups for the pelvic girdle and thigh (diagnostic codes 5313 through 5318); and 5 muscle groups for the torso and neck (diagnostic codes 5319 through 5323).

(c) There will be no rating assigned for muscle groups which act upon an ankylosed joint, with the following exceptions:

(1) In the case of an ankylosed knee, if muscle group XIII is disabled, it will be rated, but at the next lower level than that which would otherwise be assigned.

(2) In the case of an ankylosed shoulder, if muscle groups I and II are severely disabled, the evaluation of the shoulder joint under diagnostic code 5200 will be elevated to the level for unfavorable ankylosis, if not already assigned, but the muscle groups themselves will not be rated.

(d) The combined evaluation of muscle groups acting upon a single unankylosed joint must be lower than the evaluation for unfavorable ankylosis of that joint, except in the case of muscle groups I and II acting upon the shoulder.

(e) For compensable muscle group injuries which are in the same anatomical region but do not act on the same joint, the evaluation for the most severely injured muscle group will be increased by one level and used as the combined evaluation for the affected muscle groups.

(f) For muscle group injuries in different anatomical regions which do not act upon ankylosed joints, each muscle group injury shall be separately rated and the ratings combined under the provisions of §4.25.

(Authority: 38 U.S.C. 1155)

[62 FR 30237, June 3, 1997]

§4.56 Evaluation of muscle disabilities.

(a) An open comminuted fracture with muscle or tendon damage will be rated as a severe injury of the muscle group involved unless, for locations such as in the wrist or over the tibia, evidence establishes that the muscle damage is minimal.

(b) A through-and-through injury with muscle damage shall be evaluated as no less than a moderate injury for each group of muscles damaged.

(c) For VA rating purposes, the cardinal signs and symptoms of muscle disability are loss of power, weakness, lowered threshold of fatigue, fatigue-pain, impairment of coordination and uncertainty of movement.

(d) Under diagnostic codes 5301 through 5323, disabilities resulting from muscle injuries shall be classified as slight, moderate, moderately severe or severe as follows:

(1) *Slight disability of muscles*—(i) *Type of injury*. Simple wound of muscle without debridement or infection.

(ii) *History and complaint.* Service department record of superficial wound with brief treatment and return to duty. Healing with good functional results. No cardinal signs or symptoms of muscle disability as defined in paragraph (c) of this section.

(iii) *Objective findings.* Minimal scar. No evidence of fascial defect, atrophy, or impaired tonus. No impairment of function or metallic fragments retained in muscle tissue.

(2) *Moderate disability of muscles*—(i) *Type of injury.* Through and through or deep penetrating wound of short track from a single bullet, small shell or shrapnel fragment, without explosive effect of high velocity missile, residuals of debridement, or prolonged infection.

(ii) *History and complaint.* Service department record or other evidence of in-service treatment for the wound. Record of consistent complaint of one or more of the cardinal signs and symptoms of muscle disability as defined in paragraph (c) of this section, particularly lowered threshold of fatigue after average use, affecting the particular functions controlled by the injured muscles.

(iii) *Objective findings.* Entrance and (if present) exit scars, small or linear, indicating short track of missile through muscle tissue. Some loss of deep fascia or muscle substance or impairment of muscle tonus and loss of power or lowered threshold of fatigue when compared to the sound side.

(3) *Moderately severe disability of muscles*—(i) *Type of injury.* Through and through or deep penetrating wound by small high velocity missile or large low-velocity missile, with debridement, prolonged infection, or sloughing of soft parts, and intermuscular scarring.

(ii) *History and complaint.* Service department record or other evidence showing hospitalization for a prolonged period for treatment of wound. Record of consistent complaint of cardinal signs and symptoms of muscle disability as defined in paragraph (c) of this section and, if present, evidence of inability to keep up with work requirements.

(iii) *Objective findings.* Entrance and (if present) exit scars indicating track of missile through one or more muscle groups. Indications on palpation of loss of deep fascia, muscle substance, or normal firm resistance of muscles compared with sound side. Tests of strength and endurance compared with sound side demonstrate positive evidence of impairment.

(4) *Severe disability of muscles*—(i) *Type of injury.* Through and through or deep penetrating wound due to high-velocity missile, or large or multiple low velocity missiles, or with shattering bone fracture or open comminuted fracture with extensive debridement, prolonged infection, or sloughing of soft parts, intermuscular binding and scarring.

(ii) *History and complaint.* Service department record or other evidence showing hospitalization for a prolonged period for treatment of wound. Record of consistent complaint of cardinal signs and symptoms of muscle disability as defined in paragraph (c) of this section, worse than those shown for moderately severe muscle injuries, and, if present, evidence of inability to keep up with work requirements.

(iii) *Objective findings.* Ragged, depressed and adherent scars indicating wide damage to muscle groups in missile track. Palpation shows loss of deep fascia or muscle substance, or soft flabby muscles in wound area. Muscles swell and harden abnormally in contraction. Tests of strength, endurance, or coordinated movements compared with the corresponding muscles of the uninjured side indicate severe impairment of function. If present, the following are also signs of severe muscle disability:

(A) X-ray evidence of minute multiple scattered foreign bodies indicating intermuscular trauma and explosive effect of the missile.

(B) Adhesion of scar to one of the long bones, scapula, pelvic bones, sacrum or vertebrae, with epithelial sealing over the bone rather than true skin covering in an area where bone is normally protected by muscle.

(C) Diminished muscle excitability to pulsed electrical current in electrodiagnostic tests.

(D) Visible or measurable atrophy.

(E) Adaptive contraction of an opposing group of muscles.

(F) Atrophy of muscle groups not in the track of the missile, particularly of

the trapezius and serratus in wounds of the shoulder girdle.

(G) Induration or atrophy of an entire muscle following simple piercing by a projectile.

(Authority: 38 U.S.C. 1155

[62 FR 30238, June 3, 1997]

§4.57 Static foot deformities.

It is essential to make an initial distinction between bilateral flatfoot as a congenital or as an acquired condition. The congenital condition, with depression of the arch, but no evidence of abnormal callosities, areas of pressure, strain or demonstrable tenderness, is a congenital abnormality which is not compensable or pensionable. In the acquired condition, it is to be remembered that depression of the longitudinal arch, or the degree of depression, is not the essential feature. The attention should be given to anatomical changes, as compared to normal, in the relationship of the foot and leg, particularly to the inward rotation of the superior portion of the os calcis, medial deviation of the insertion of the Achilles tendon, the medial tilting of the upper border of the astragalus. This is an unfavorable mechanical relationship of the parts. A plumb line dropped from the middle of the patella falls inside of the normal point. The forepart of the foot is abducted, and the foot everted. The plantar surface of the foot is painful and shows demonstrable tenderness, and manipulation of the foot produces spasm of the Achilles tendon, peroneal spasm due to adhesion about the peroneal sheaths, and other evidence of pain and limited motion. The symptoms should be apparent without regard to exercise. In severe cases there is gaping of bones on the inner border of the foot, and rigid valgus position with loss of the power of inversion and adduction. Exercise with undeveloped or unbalanced musculature, producing chronic irritation, can be an aggravating factor. In the absence of trauma or other definite evidence of aggravation, service connection is not in order for pes cavus which is a typically congenital or juvenile disease.

§4.58 Arthritis due to strain.

With service incurred lower extremity amputation or shortening, a disabling arthritis, developing in the same extremity, or in both lower extremities, with indications of earlier, or more severe, arthritis in the injured extremity, including also arthritis of the lumbosacral joints and lumbar spine, if associated with the leg amputation or shortening, will be considered as service incurred, provided, however, that arthritis affecting joints not directly subject to strain as a result of the service incurred amputation will not be granted service connection. This will generally require separate evaluation of the arthritis in the joints directly subject to strain. Amputation, or injury to an upper extremity, is not considered as a causative factor with subsequently developing arthritis, except in joints subject to direct strain or actually injured.

§4.59 Painful motion.

With any form of arthritis, painful motion is an important factor of disability, the facial expression, wincing, etc., on pressure or manipulation, should be carefully noted and definitely related to affected joints. Muscle spasm will greatly assist the identification. Sciatic neuritis is not uncommonly caused by arthritis of the spine. The intent of the schedule is to recognize painful motion with joint or periarticular pathology as productive of disability. It is the intention to recognize actually painful, unstable, or malaligned joints, due to healed injury, as entitled to at least the minimum compensable rating for the joint. Crepitation either in the soft tissues such as the tendons or ligaments, or crepitation within the joint structures should be noted carefully as points of contact which are diseased. Flexion elicits such manifestations. The joints involved should be tested for pain on both active and passive motion, in weight-bearing and nonweight-bearing and, if possible, with the range of the opposite undamaged joint.

§ 4.60 [Reserved]

§ 4.61 Examination.

With any form of arthritis (except traumatic arthritis) it is essential that the examination for rating purposes cover all major joints, with especial reference to Heberden's or Haygarth's nodes.

§ 4.62 Circulatory disturbances.

The circulatory disturbances, especially of the lower extremity following injury in the popliteal space, must not be overlooked, and require rating generally as phlebitis.

§ 4.63 Loss of use of hand or foot.

Loss of use of a hand or a foot, for the purpose of special monthly compensation, will be held to exist when no effective function remains other than that which would be equally well served by an amputation stump at the site of election below elbow or knee with use of a suitable prosthetic appliance. The determination will be made on the basis of the actual remaining function of the hand or foot, whether the acts of grasping, manipulation, etc., in the case of the hand, or of balance and propulsion, etc., in the case of the foot, could be accomplished equally well by an amputation stump with prosthesis.

(a) Extremely unfavorable complete ankylosis of the knee, or complete ankylosis of 2 major joints of an extremity, or shortening of the lower extremity of 3½ inches (8.9 cms.) or more, will be taken as loss of use of the hand or foot involved.

(b) Complete paralysis of the external popliteal nerve (common peroneal) and consequent, footdrop, accompanied by characteristic organic changes including trophic and circulatory disturbances and other concomitants confirmatory of complete paralysis of this nerve, will be taken as loss of use of the foot.

[29 FR 6718, May 22, 1964, as amended at 43 FR 45349, Oct. 2, 1978]

§ 4.64 Loss of use of both buttocks.

Loss of use of both buttocks shall be deemed to exist when there is severe damage to muscle Group XVII, bilateral (diagnostic code number 5317) and additional disability rendering it impossible for the disabled person, without assistance, to rise from a seated position and from a stooped position (fingers to toes position) and to maintain postural stability (the pelvis upon head of femur). The assistance may be rendered by the person's own hands or arms, and, in the matter of postural stability, by a special appliance.

§ 4.65 [Reserved]

§ 4.66 Sacroiliac joint.

The common cause of disability in this region is arthritis, to be identified in the usual manner. The lumbosacral and sacroiliac joints should be considered as one anatomical segment for rating purposes. X-ray changes from arthritis in this location are decrease or obliteration of the joint space, with the appearance of increased bone density of the sacrum and ilium and sharpening of the margins of the joint. Disability is manifest from erector spinae spasm (not accounted for by other pathology), tenderness on deep palpation and percussion over these joints, loss of normal quickness of motion and resiliency, and postural defects often accompanied by limitation of flexion and extension of the hip. Traumatism is a rare cause of disability in this connection, except when superimposed upon congenital defect or upon an existent arthritis; to permit assumption of pure traumatic origin, objective evidence of damage to the joint, and history of trauma sufficiently severe to injure this extremely strong and practically immovable joint is required. There should be careful consideration of lumbosacral sprain, and the various symptoms of pain and paralysis attributable to disease affecting the lumbar vertebrae and the intervertebral disc.

§ 4.67 Pelvic bones.

The variability of residuals following these fractures necessitates rating on specific residuals, faulty posture, limitation of motion, muscle injury, painful motion of the lumbar spine, manifest by muscle spasm, mild to moderate sciatic neuritis, peripheral nerve injury, or limitation of hip motion.

§4.68 Amputation rule.

The combined rating for disabilities of an extremity shall not exceed the rating for the amputation at the elective level, were amputation to be performed. For example, the combined evaluations for disabilities below the knee shall not exceed the 40 percent evaluation, diagnostic code 5165. This 40 percent rating may be further combined with evaluation for disabilities above the knee but not to exceed the above the knee amputation elective level. Painful neuroma of a stump after amputation shall be assigned the evaluation for the elective site of reamputation.

§4.69 Dominant hand.

Handedness for the purpose of a dominant rating will be determined by the evidence of record, or by testing on VA examination. Only one hand shall be considered dominant. The injured hand, or the most severely injured hand, of an ambidextrous individual will be considered the dominant hand for rating purposes.

(Authority: 38 U.S.C. 1155)

[62 FR 30239, June 3, 1997]

§4.70 Inadequate examinations.

If the report of examination is inadequate as a basis for the required consideration of service connection and evaluation, the rating agency may request a supplementary report from the examiner giving further details as to the limitations of the disabled person's ordinary activity imposed by the disease, injury, or residual condition, the prognosis for return to, or continuance of, useful work. When the best interests of the service will be advanced by personal conference with the examiner, such conference may be arranged through channels.

§4.71 Measurement of ankylosis and joint motion.

Plates I and II provide a standardized description of ankylosis and joint motion measurement. The anatomical position is considered as 0°, with two major exceptions: (a) Shoulder rotation—arm abducted to 90°, elbow flexed to 90° with the position of the forearm reflecting the midpoint 0° between internal and external rotation of the shoulder; and (b) supination and pronation—the arm next to the body, elbow flexed to 90°, and the forearm in midposition 0° between supination and pronation. Motion of the thumb and fingers should be described by appropriate reference to the joints (See Plate III) whose movement is limited, with a statement as to how near, in centimeters, the tip of the thumb can approximate the fingers, or how near the tips of the fingers can approximate the proximal transverse crease of palm.

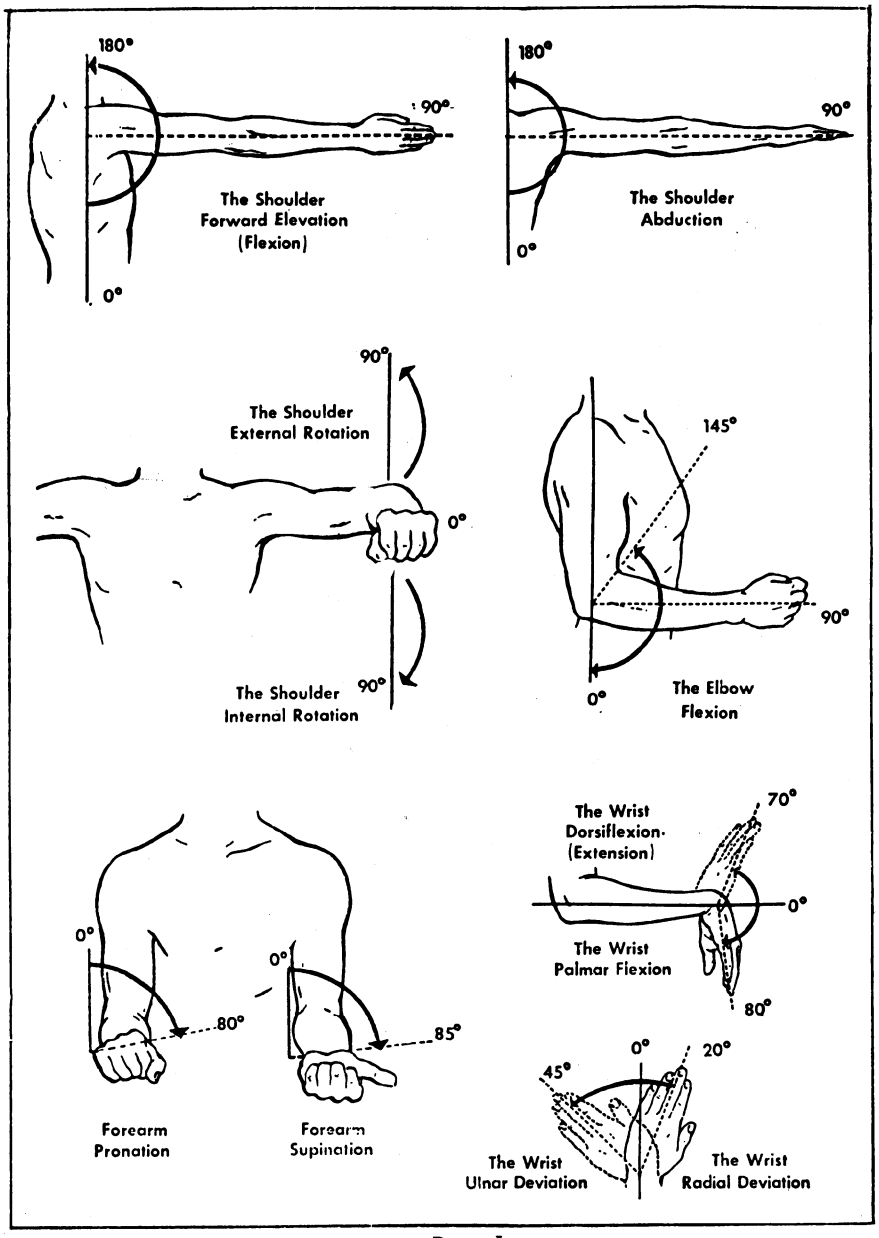

180°
90°
0°
The Shoulder
Forward Elevation
(Flexion)
180°
90°
0°
The Shoulder
Abduction
90°
0°
90°
The Shoulder
External Rotation
The Shoulder
Internal Rotation
145°
90°
0°
The Elbow
Flexion
The Wrist
Dorsiflexion
(Extension)
70°
0°
The Wrist
Palmar Flexion
80°
0°
80°
Forearm
Pronation
0°
85°
Forearm
Supination
0°
20°
45°
The Wrist
Ulnar Deviation
The Wrist
Radial Deviation

PLATE I

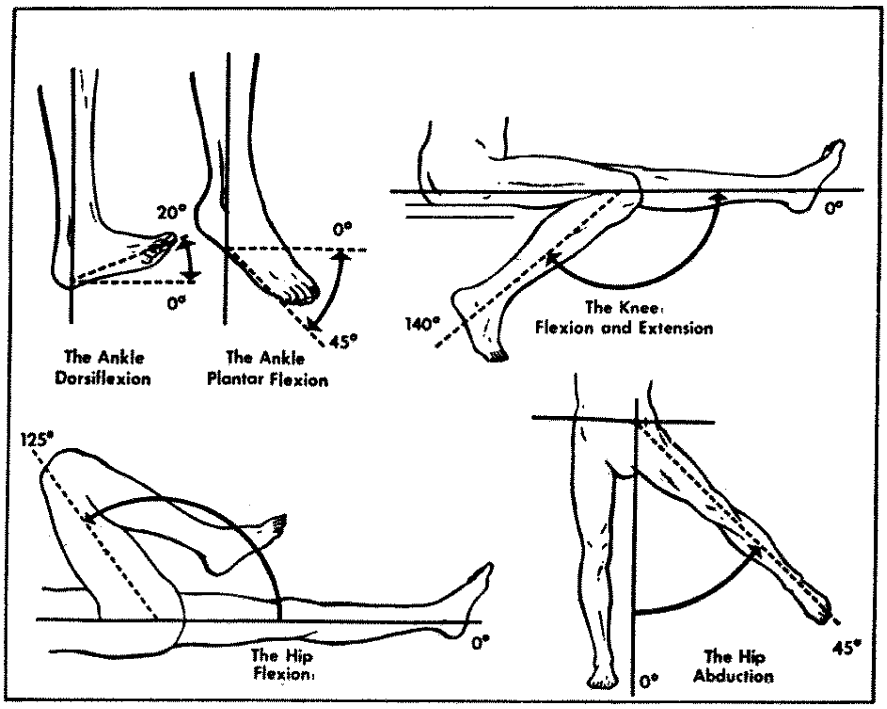


PLATE II

[29 FR 6718, May 22, 1964, as amended at 43 FR 45349, Oct. 2, 1978; 67 FR 48785, July 26, 2002]

§4.71a Schedule of ratings—musculoskeletal system.

ACUTE, SUBACUTE, OR CHRONIC DISEASES

	Rating
5000 Osteomyelitis, acute, subacute, or chronic:	
Of the pelvis, vertebrae, or extending into major joints, or with multiple localization or with long history of intractability and debility, anemia, amyloid liver changes, or other continuous constitutional symptoms	100
Frequent episodes, with constitutional symptoms	60
With definite involucrum or sequestrum, with or without discharging sinus	30
With discharging sinus or other evidence of active infection within the past 5 years	20
Inactive, following repeated episodes, without evidence of active infection in past 5 years	10

ACUTE, SUBACUTE, OR CHRONIC DISEASES—Continued

	Rating
NOTE (1): A rating of 10 percent, as an exception to the amputation rule, is to be assigned in any case of active osteomyelitis where the amputation rating for the affected part is no percent. This 10 percent rating and the other partial ratings of 30 percent or less are to be combined with ratings for ankylosis, limited motion, nonunion or malunion, shortening, etc., subject, of course, to the amputation rule. The 60 percent rating, as it is based on constitutional symptoms, is not subject to the amputation rule. A rating for osteomyelitis will not be applied following cure by removal or radical resection of the affected bone.	

ACUTE, SUBACUTE, OR CHRONIC DISEASES—Continued

	Rating
NOTE (2): The 20 percent rating on the basis of activity within the past 5 years is not assignable following the initial infection of active osteomyelitis with no subsequent reactivation. The prerequisite for this historical rating is an established recurrent osteomyelitis. To qualify for the 10 percent rating, 2 or more episodes following the initial infection are required. This 20 percent rating or the 10 percent rating, when applicable, will be assigned once only to cover disability at all sites of previously active infection with a future ending date in the case of the 20 percent rating.	
5001 Bones and joints, tuberculosis of, active or inactive:	
Active	100
Inactive: See §§ 4.88b and 4.89.	
5002 Arthritis rheumatoid (atrophic) *As an active process:*	
With constitutional manifestations associated with active joint involvement, totally incapacitating	100
Less than criteria for 100% but with weight loss and anemia productive of severe impairment of health or severely incapacitating exacerbations occurring 4 or more times a year or a lesser number over prolonged periods	60
Symptom combinations productive of definite impairment of health objectively supported by examination findings or incapacitating exacerbations occurring 3 or more times a year	40
One or two exacerbations a year in a well-established diagnosis	20
For chronic residuals:	
For residuals such as limitation of motion or ankylosis, favorable or unfavorable, rate under the appropriate diagnostic codes for the specific joints involved. Where, however, the limitation of motion of the specific joint or joints involved is noncompensable under the codes a rating of 10 percent is for application for each such major joint or group of minor joints affected by limitation of motion, to be combined, not added under diagnostic code 5002. Limitation of motion must be objectively confirmed by findings such as swelling, muscle spasm, or satisfactory evidence of painful motion.	
NOTE: The ratings for the active process will not be combined with the residual ratings for limitation of motion or ankylosis. Assign the higher evaluation.	
5003 Arthritis, degenerative (hypertrophic or osteoarthritis):	
Degenerative arthritis established by X-ray findings will be rated on the basis of limitation of motion under the appropriate diagnostic codes for the specific joint or joints involved (DC 5200 etc.). When however, the limitation of motion of the specific joint or joints involved is noncompensable under the appropriate diagnostic codes, a rating of 10 pct is for application for each such major joint or group of minor joints affected by limitation of motion, to be combined, not added under diagnostic code 5003. Limitation of motion must be objectively confirmed by findings such as swelling, muscle spasm, or satisfactory evidence of painful motion. In the absence of limitation of motion, rate as below:	
With X-ray evidence of involvement of 2 or more major joints or 2 or more minor joint groups, with occasional incapacitating exacerbations	20
With X-ray evidence of involvement of 2 or more major joints or 2 or more minor joint groups	10
NOTE (1): The 20 pct and 10 pct ratings based on X-ray findings, above, will not be combined with ratings based on limitation of motion.	
NOTE (2): The 20 pct and 10 pct ratings based on X-ray findings, above, will not be utilized in rating conditions listed under diagnostic codes 5013 to 5024, inclusive.	
5004 Arthritis, gonorrheal.	
5005 Arthritis, pneumococcic.	
5006 Arthritis, typhoid.	
5007 Arthritis, syphilitic.	
5008 Arthritis, streptococcic.	
5009 Arthritis, other types (specify).	
With the types of arthritis, diagnostic codes 5004 through 5009, rate the disability as rheumatoid arthritis.	
5010 Arthritis, due to trauma, substantiated by X-ray findings: Rate as arthritis, degenerative.	
5011 Bones, caisson disease of: Rate as arthritis, cord involvement, or deafness, depending on the severity of disabling manifestations.	
5012 Bones, new growths of, malignant	100
NOTE: The 100 percent rating will be continued for 1 year following the cessation of surgical, X-ray, antineoplastic chemotherapy or other therapeutic procedure. At this point, if there has been no local recurrence or metastases, the rating will be made on residuals.	
5013 Osteoporosis, with joint manifestations.	
5014 Osteomalacia.	
5015 Bones, new growths of, benign.	
5016 Osteitis deformans.	
5017 Gout.	
5018 Hydrarthrosis, intermittent.	
5019 Bursitis.	
5020 Synovitis.	
5021 Myositis.	
5022 Periostitis.	
5023 Myositis ossificans.	
5024 Tenosynovitis.	
The diseases under diagnostic codes 5013 through 5024 will be rated on limitation of motion of affected parts, as arthritis, degenerative, except gout which will be rated under diagnostic code 5002.	
5025 Fibromyalgia (fibrositis, primary fibromyalgia syndrome)	
With widespread musculoskeletal pain and tender points, with or without associated fatigue, sleep disturbance, stiffness, paresthesias, headache, irritable bowel symptoms, depression, anxiety, or Raynaud's-like symptoms:	
That are constant, or nearly so, and refractory to therapy	40
That are episodic, with exacerbations often precipitated by environmental or emotional stress or by overexertion, but that are present more than one-third of the time	20
That require continuous medication for control	10

ACUTE, SUBACUTE, OR CHRONIC DISEASES—Continued

	Rating
NOTE: Widespread pain means pain in both the left and right sides of the body, that is both above and below the waist, and that affects both the axial skeleton (*i.e.*, cervical spine, anterior chest, thoracic spine, or low back) and the extremities.	

PROSTHETIC IMPLANTS

	Rating	
	Major	Minor
5051 Shoulder replacement (prosthesis).		
Prosthetic replacement of the shoulder joint:		
For 1 year following implantation of prosthesis	100	100
With chronic residuals consisting of severe, painful motion or weakness in the affected extremity	60	50
With intermediate degrees of residual weakness, pain or limitation of motion, rate by analogy to diagnostic codes 5200 and 5203.		
Minimum rating	30	20
5052 Elbow replacement (prosthesis).		
Prosthetic replacement of the elbow joint:		
For 1 year following implantation of prosthesis	100	100
With chronic residuals consisting of severe painful motion or weakness in the affected extremity	50	40
With intermediate degrees of residual weakness, pain or limitation of motion rate by analogy to diagnostic codes 5205 through 5208.		
Minimum evaluation	30	20
5053 Wrist replacement (prosthesis).		
Prosthetic replacement of wrist joint:		
For 1 year following implantation of prosthesis	100	100
With chronic residuals consisting of severe, painful motion or weakness in the affected extremity	40	30
With intermediate degrees of residual weakness, pain or limitation of motion, rate by analogy to diagnostic code 5214.		
Minimum rating	20	20
NOTE: The 100 pct rating for 1 year following implantation of prosthesis will commence after initial grant of the 1-month total rating assigned under §4.30 following hospital discharge.		
5054 Hip replacement (prosthesis).		
Prosthetic replacement of the head of the femur or of the acetabulum:		
For 1 year following implantation of prosthesis		100
Following implantation of prosthesis with painful motion or weakness such as to require the use of crutches		[1] 90

PROSTHETIC IMPLANTS—Continued

	Rating	
	Major	Minor
Markedly severe residual weakness, pain or limitation of motion following implantation of prosthesis		70
Moderately severe residuals of weakness, pain or limitation of motion		50
Minimum rating		30
5055 Knee replacement (prosthesis).		
Prosthetic replacement of knee joint:		
For 1 year following implantation of prosthesis		100
With chronic residuals consisting of severe painful motion or weakness in the affected extremity		60
With intermediate degrees of residual weakness, pain or limitation of motion rate by analogy to diagnostic codes 5256, 5261, or 5262.		
Minimum rating		30
5056 Ankle replacement (prosthesis).		
Prosthetic replacement of ankle joint:		
For 1 year following implantation of prosthesis		100
With chronic residuals consisting of severe painful motion or weakness		40
With intermediate degrees of residual weakness, pain or limitation of motion rate by analogy to 5270 or 5271.		
Minimum rating		20
NOTE (1): The 100 pct rating for 1 year following implantation of prosthesis will commence after initial grant of the 1-month total rating assigned under §4.30 following hospital discharge.		
NOTE (2): Special monthly compensation is assignable during the 100 pct rating period the earliest date permanent use of crutches is established.		

COMBINATIONS OF DISABILITIES

5104 Anatomical loss of one hand and loss of use of one foot		[1] 100
5105 Anatomical loss of one foot and loss of use of one hand		[1] 100
5106 Anatomical loss of both hands		[1] 100
5107 Anatomical loss of both feet		[1] 100
5108 Anatomical loss of one hand and one foot		[1] 100
5109 Loss of use of both hands		[1] 100
5110 Loss of use of both feet		[1] 100
5111 Loss of use of one hand and one foot		[1] 100

NOTE: The term ''prosthetic replacement'' in diagnostic codes 5051 through 5056 means a total replacement of the named joint. However, in DC 5054, ''prosthetic replacement'' means a total replacement of the head of the femur or of the acetabulum.

[1] Also entitled to special monthly compensation.

TABLE II—RATINGS FOR MULTIPLE LOSSES OF EXTREMITIES WITH DICTATOR'S RATING CODE AND 38 CFR CITATION

Impairment of one extremity	Impairment of other extremity					
	Anatomical loss or loss of use below elbow	Anatomical loss or loss of use below knee	Anatomical loss or loss of use above elbow (preventing use of prosthesis)	Anatomical loss or loss of use above knee (preventing use of prosthesis)	Anatomical loss near shoulder (preventing use of prosthesis)	Anatomical loss near hip (preventing use of prosthesis)
Anatomical loss or loss of use below elbow.	M Codes M–1 a, b, or c, 38 CFR 3.350 (c)(1)(i).	L Codes L–1 d, e, f, or g, 38 CFR 3.350(b).	M½ Code M–5, 38 CFR 3.350 (f)(1)(x).	L½ Code L–2 c, 38 CFR 3.350 (f)(1)(vi).	N Code N–3, 38 CFR 3.350 (f)(1)(xi).	M Code M–3 c, 38 CFR 3.350 (f)(1)(viii)
Anatomical loss or loss of use below knee.	.....	L Codes L–1 a, b, or c, 38 CFR 3.350(b).	L½ Code L–2 b, 38 CFR 3.350 (f)(1)(iii).	L½ Code L–2 a, 38 CFR 3.350 (f)(1)(i).	M Code M–3 b, 38 CFR 3.350 (f)(1)(iv).	M Code M–3 a, 38 CFR 3.350 (f)(1)(ii)
Anatomical loss or loss of use above elbow (preventing use of prosthesis).	.....	.....	N Code N–1, 38 CFR 3.350 (d)(1).	M Code M–2 a, 38 CFR 3.350 (c)(1)(iii).	N½ Code N–4, 38 CFR 3.350 (f)(1)(ix).	M½ Code M–4 c, 38 CFR 3.350 (f)(1)(xi)
Anatomical loss or loss of use above knee (preventing use of prosthesis).	.....	.....	.....	M Code M–2 a, 38 CFR 3.350 (c)(1)(ii).	M½ Code M–4 b, 38 CFR 3.350 (f)(1)(vii).	M½ Code M–4 a, 38 CFR 3.350 (f)(1)(v)
Anatomical loss near shoulder (preventing use of prosthesis).	.....	.....	.....	.....	O Code O–1, 38 CFR 3.350 (e)(1)(i).	N Code N–2 b, 38 CFR 3.350 (d)(3)
Anatomical loss near hip (preventing use of prosthesis).	.....	.....	.....	.....	.....	N Code N–2 a, 38 CFR 3.350 (d)(2)

NOTE.—Need for aid attendance or permanently bedridden qualifies for subpar. L. Code L–1 h, i (38 CFR 3.350(b)). Paraplegia with loss of use of both lower extremities and loss of anal and bladder sphincter control qualifies for subpar. O. Code O–2 (38 CFR 3.350(e)(2)). Where there are additional disabilities rated 50% or 100%, or anatomical or loss of use of a third extremity see 38 CFR 3.350(f) (3), (4) or (5).

(Authority: 38 U.S.C. 1115)

AMPUTATIONS: UPPER EXTREMITY

	Rating	
	Major	Minor
Arm, amputation of:		
5120 Disarticulation	[1] 90	[1] 90
5121 Above insertion of deltoid	[1] 90	[1] 80
5122 Below insertion of deltoid	[1] 80	[1] 70
Forearm, amputation of:		
5123 Above insertion of pronator teres	[1] 80	[1] 70
5124 Below insertion of pronator teres	[1] 70	[1] 60
5125 Hand, loss of use of	[1] 70	[1] 60
MULTIPLE FINGER AMPUTATIONS		
5126 Five digits of one hand, amputation of	[1] 70	[1] 60
Four digits of one hand, amputation of:		
5127 Thumb, index, long and ring	[1] 70	[1] 60
5128 Thumb, index, long and little	[1] 70	[1] 60
5129 Thumb, index, ring and little	[1] 70	[1] 60
5130 Thumb, long, ring and little	[1] 70	[1] 60
5131 Index, long, ring and little	60	50
Three digits of one hand, amputation of:		
5132 Thumb, index and long	60	50
5133 Thumb, index and ring	60	50
5134 Thumb, index and little	60	50
5135 Thumb, long and ring	60	50
5136 Thumb, long and little	60	50

AMPUTATIONS: UPPER EXTREMITY—Continued

	Rating	
	Major	Minor
5137 Thumb, ring and little	60	50
5138 Index, long and ring	50	40
5139 Index, long and little	50	40
5140 Index, ring and little	50	40
5141 Long, ring and little	40	30
Two digits of one hand, amputation of:		
5142 Thumb and index	50	40
5143 Thumb and long	50	40
5144 Thumb and ring	50	40
5145 Thumb and little	50	40
5146 Index and long	40	30
5147 Index and ring	40	30
5148 Index and little	40	30
5149 Long and ring	30	20
5150 Long and little	30	20
5151 Ring and little	30	20
(a) The ratings for multiple finger amputations apply to amputations at the proximal interphalangeal joints or through proximal phalanges..		
(b) Amputation through middle phalanges will be rated as prescribed for unfavorable ankylosis of the fingers..		

AMPUTATIONS: UPPER EXTREMITY—Continued

	Rating	
	Major	Minor
(c) Amputations at distal joints, or through distal phalanges, other than negligible losses, will be rated as prescribed for favorable ankylosis of the fingers..		
(d) Amputation or resection of metacarpal bones (more than one-half the bone lost) in multiple fingers injuries will require a rating of 10 percent added to (not combined with) the ratings, multiple finger amputations, subject to the amputation rule applied to the forearm.		
(e) Combinations of finger amputations at various levels, or finger amputations with ankylosis or limitation of motion of the fingers will be rated on the basis of the grade of disability; *i.e.*, amputation, unfavorable ankylosis, most representative of the levels or combinations. With an even number of fingers involved, and adjacent grades of disability, select the higher of the two grades.		
(f) Loss of use of the hand will be held to exist when no effective function remains other than that which would be equally well served by an amputation stump with a suitable prosthetic appliance.		
SINGLE FINGER AMPUTATIONS		
5152 Thumb, amputation of:		

AMPUTATIONS: UPPER EXTREMITY—Continued

	Rating	
	Major	Minor
With metacarpal resection	40	30
At metacarpophalangeal joint or through proximal phalanx	30	20
At distal joint or through distal phalanx	20	20
5153 Index finger, amputation of		
With metacarpal resection (more than one-half the bone lost)	30	20
Without metacarpal resection, at proximal interphalangeal joint or proximal thereto	20	20
Through middle phalanx or at distal joint	10	10
5154 Long finger, amputation of:		
With metacarpal resection (more than one-half the bone lost)	20	20
Without metacarpal resection, at proximal interphalangeal joint or proximal thereto	10	10
5155 Ring finger, amputation of:		
With metacarpal resection (more than one-half the bone lost)	20	20
Without metacarpal resection, at proximal interphalangeal joint or proximal thereto	10	10
5156 Little finger, amputation of:		
With metacarpal resection (more than one-half the bone lost)	20	20
Without metacarpal resection, at proximal interphalangeal joint or proximal thereto	10	10
NOTE: The single finger amputation ratings are the only applicable ratings for amputations of whole or part of single fingers.		

[1] Entitled to special monthly compensation.

SINGLE FINGER AMPUTATIONS

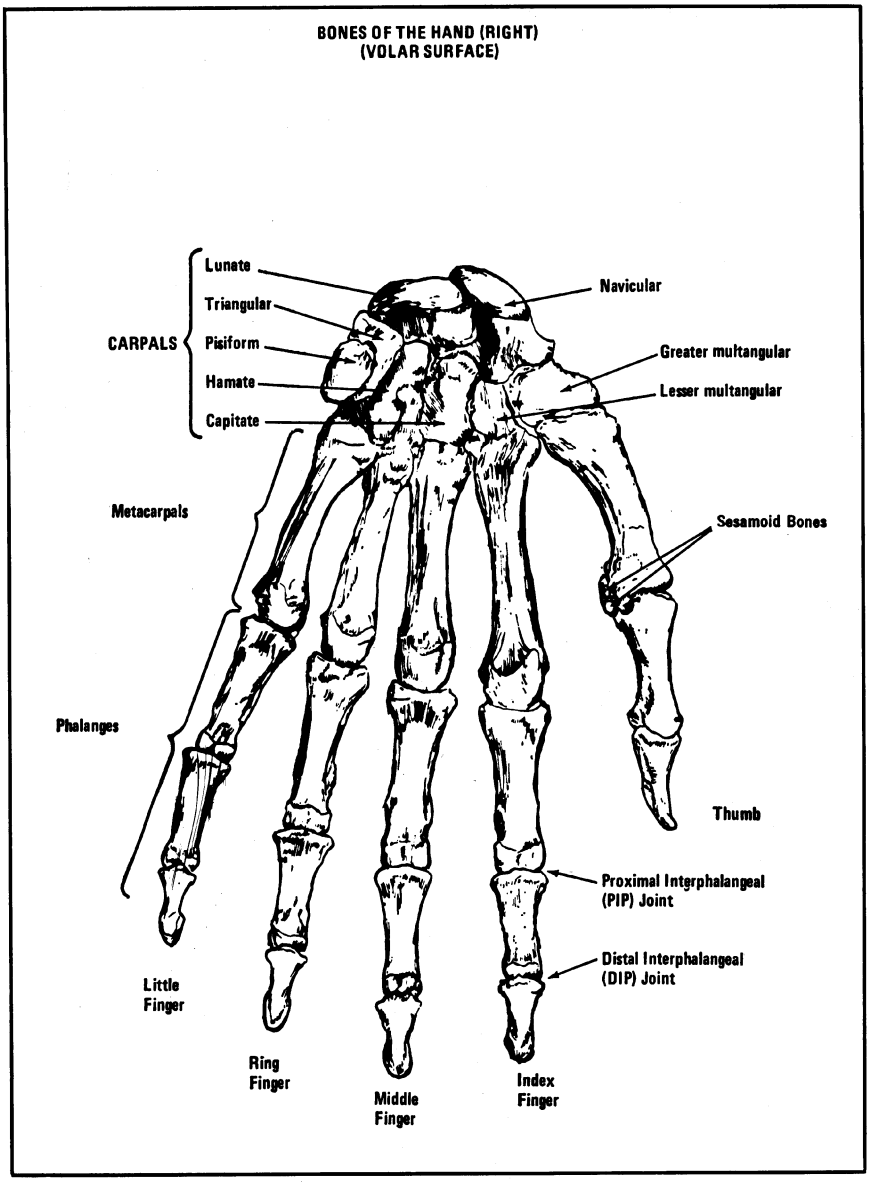


PLATE III

AMPUTATIONS: LOWER EXTREMITY

	Rating
Thigh, amputation of:	
5160 Disarticulation, with loss of extrinsic pelvic girdle muscles	[2] 90
5161 Upper third, one-third of the distance from perineum to knee joint measured from perineum	[2] 80
5162 Middle or lower thirds	[2] 60
Leg, amputation of:	
5163 With defective stump, thigh amputation recommended	[2] 60
5164 Amputation not improvable by prosthesis controlled by natural knee action	[2] 60
5165 At a lower level, permitting prosthesis	[2] 40
5166 Forefoot, amputation proximal to metatarsal bones (more than one-half of metatarsal loss)	[2] 40
5167 Foot, loss of use of	[2] 40

AMPUTATIONS: LOWER EXTREMITY—Continued

	Rating
5170 Toes, all, amputation of, without metatarsal loss	30
5171 Toe, great, amputation of:	
With removal of metatarsal head	30
Without metatarsal involvement	10
5172 Toes, other than great, amputation of, with removal of metatarsal head:	
One or two	20
Without metatarsal involvement	0
5173 Toes, three or four, amputation of, without metatarsal involvement:	
Including great toe	20
Not including great toe	10

[2] Also entitled to special monthly compensation.

AMPUTATIONS: LOWER EXTREMITY

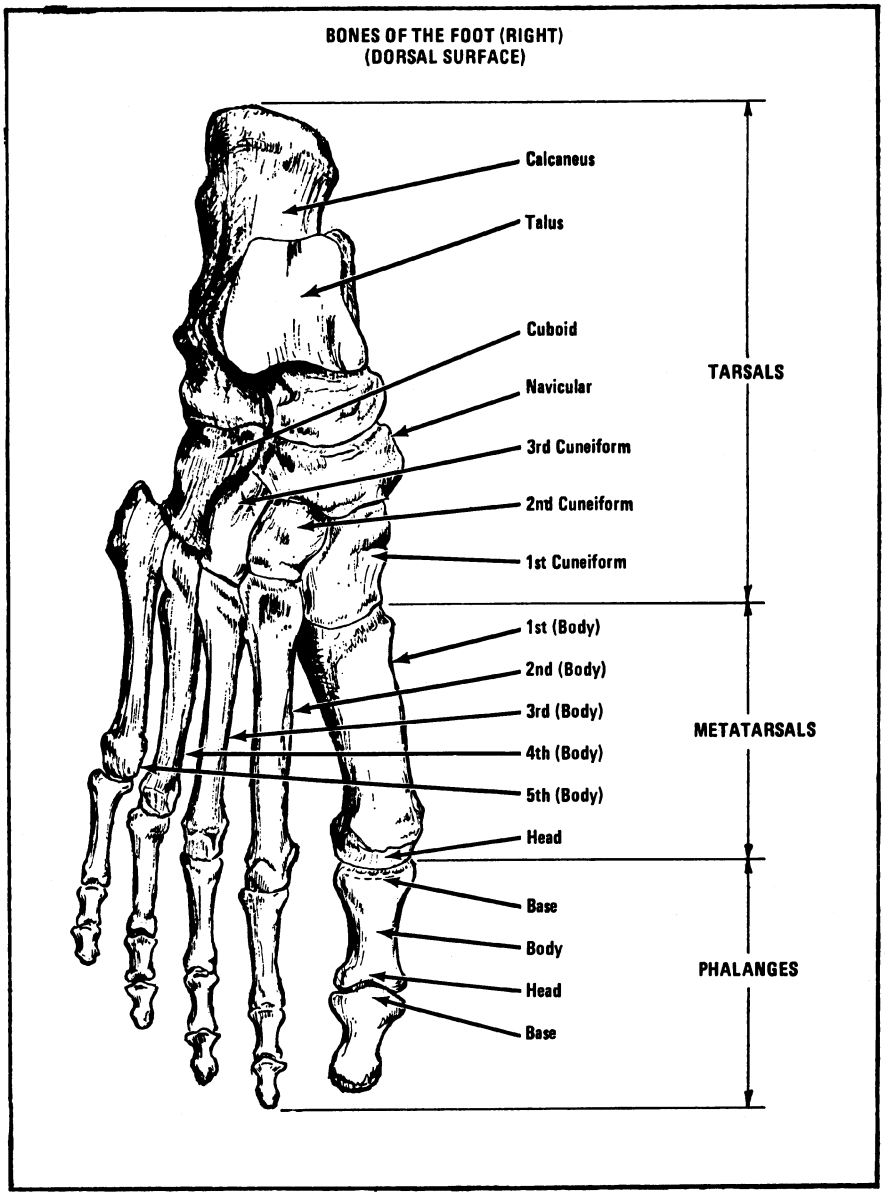


PLATE IV

THE SHOULDER AND ARM

	Rating	
	Major	Minor
5200 Scapulohumeral articulation, ankylosis of:		
NOTE: The scapula and humerus move as one piece.		
Unfavorable, abduction limited to 25° from side	50	40
Intermediate between favorable and unfavorable	40	30
Favorable, abduction to 60°, can reach mouth and head	30	20
5201 Arm, limitation of motion of:		
To 25° from side	40	30
Midway between side and shoulder level	30	20
At shoulder level	20	20
5202 Humerus, other impairment of:		
Loss of head of (flail shoulder)	80	70
Nonunion of (false flail joint)	60	50
Fibrous union of	50	40
Recurrent dislocation of at scapulohumeral joint.		
With frequent episodes and guarding of all arm movements	30	20
With infrequent episodes, and guarding of movement only at shoulder level	20	20
Malunion of:		
Marked deformity	30	20
Moderate deformity	20	20
5203 Clavicle or scapula, impairment of:		
Dislocation of	20	20
Nonunion of:		
With loose movement	20	20
Without loose movement	10	10
Malunion of	10	10
Or rate on impairment of function of contiguous joint.		

THE ELBOW AND FOREARM

	Rating	
	Major	Minor
5205 Elbow, ankylosis of:		
Unfavorable, at an angle of less than 50° or with complete loss of supination or pronation	60	50
Intermediate, at an angle of more than 90°, or between 70° and 50°	50	40
Favorable, at an angle between 90° and 70°	40	30
5206 Forearm, limitation of flexion of:		
Flexion limited to 45°	50	40
Flexion limited to 55°	40	30
Flexion limited to 70°	30	20
Flexion limited to 90°	20	20
Flexion limited to 100°	10	10
Flexion limited to 110°	0	0
5207 Forearm, limitation of extension of:		
Extension limited to 110°	50	40
Extension limited to 100°	40	30
Extension limited to 90°	30	20
Extension limited to 75°	20	20
Extension limited to 60°	10	10
Extension limited to 45°	10	10
5208 Forearm, flexion limited to 100° and extension to 45°	20	20
5209 Elbow, other impairment of Flail joint	60	50

THE ELBOW AND FOREARM—Continued

	Rating	
	Major	Minor
Joint fracture, with marked cubitus varus or cubitus valgus deformity or with ununited fracture of head of radius	20	20
5210 Radius and ulna, nonunion of, with flail false joint	50	40
5211 Ulna, impairment of:		
Nonunion in upper half, with false movement:		
With loss of bone substance (1 inch (2.5 cms.) or more) and marked deformity	40	30
Without loss of bone substance or deformity	30	20
Nonunion in lower half	20	20
Malunion of, with bad alignment	10	10
5212 Radius, impairment of:		
Nonunion in lower half, with false movement:		
With loss of bone substance (1 inch (2.5 cms.) or more) and marked deformity	40	30
Without loss of bone substance or deformity	30	20
Nonunion in upper half	20	20
Malunion of, with bad alignment	10	10
5213 Supination and pronation, impairment of:		
Loss of (bone fusion):		
The hand fixed in supination or hyperpronation	40	30
The hand fixed in full pronation	30	20
The hand fixed near the middle of the arc or moderate pronation	20	20
Limitation of pronation:		
Motion lost beyond middle of arc	30	20
Motion lost beyond last quarter of arc, the hand does not approach full pronation	20	20
Limitation of supination:		
To 30° or less	10	10
NOTE: In all the forearm and wrist injuries, codes 5205 through 5213, multiple impaired finger movements due to tendon tie-up, muscle or nerve injury, are to be separately rated and combined not to exceed rating for loss of use of hand.		

THE WRIST

	Rating	
	Major	Minor
5214 Wrist, ankylosis of:		
Unfavorable, in any degree of palmar flexion, or with ulnar or radial deviation	50	40
Any other position, except favorable	40	30
Favorable in 20° to 30° dorsiflexion	30	20
NOTE: Extremely unfavorable ankylosis will be rated as loss of use of hands under diagnostic code 5125.		
5215 Wrist, limitation of motion of:		
Dorsiflexion less than 15°	10	10
Palmar flexion limited in line with forearm	10	10

EVALUATION OF ANKYLOSIS OR LIMITATION OF MOTION OF SINGLE OR MULTIPLE DIGITS OF THE HAND

	Rating	
	Major	Minor
(1) For the index, long, ring, and little fingers (digits II, III, IV, and V), zero degrees of flexion represents the fingers fully extended, making a straight line with the rest of the hand. The position of function of the hand is with the wrist dorsiflexed 20 to 30 degrees, the metacarpophalangeal and proximal interphalangeal joints flexed to 30 degrees, and the thumb (digit I) abducted and rotated so that the thumb pad faces the finger pads. Only joints in these positions are considered to be in favorable position. For digits II through V, the metacarpophalangeal joint has a range of zero to 90 degrees of flexion, the proximal interphalangeal joint has a range of zero to 100 degrees of flexion, and the distal (terminal) interphalangeal joint has a range of zero to 70 or 80 degrees of flexion	.....	.....
(2) When two or more digits of the same hand are affected by any combination of amputation, ankylosis, or limitation of motion that is not otherwise specified in the rating schedule, the evaluation level assigned will be that which best represents the overall disability (*i.e.*, amputation, unfavorable or favorable ankylosis, or limitation of motion), assigning the higher level of evaluation when the level of disability is equally balanced between one level and the next higher level	.....	.....
(3) Evaluation of ankylosis of the index, long, ring, and little fingers:		
(i) If both the metacarpophalangeal and proximal interphalangeal joints of a digit are ankylosed, and either is in extension or full flexion, or there is rotation or angulation of a bone, evaluate as amputation without metacarpal resection, at proximal interphalangeal joint or proximal thereto	.....	.....
(ii) If both the metacarpophalangeal and proximal interphalangeal joints of a digit are ankylosed, evaluate as unfavorable ankylosis, even if each joint is individually fixed in a favorable position.		
(iii) If only the metacarpophalangeal or proximal interphalangeal joint is ankylosed, and there is a gap of more than two inches (5.1 cm.) between the fingertip(s) and the proximal transverse crease of the palm, with the finger(s) flexed to the extent possible, evaluate as unfavorable ankylosis	.....	.....

EVALUATION OF ANKYLOSIS OR LIMITATION OF MOTION OF SINGLE OR MULTIPLE DIGITS OF THE HAND—Continued

	Rating	
	Major	Minor
(iv) If only the metacarpophalangeal or proximal interphalangeal joint is ankylosed, and there is a gap of two inches (5.1 cm.) or less between the fingertip(s) and the proximal transverse crease of the palm, with the finger(s) flexed to the extent possible, evaluate as favorable ankylosis	.....	.....
(4) Evaluation of ankylosis of the thumb:		
(i) If both the carpometacarpal and interphalangeal joints are ankylosed, and either is in extension or full flexion, or there is rotation or angulation of a bone, evaluate as amputation at metacarpophalangeal joint or through proximal phalanx	.....	.....
(ii) If both the carpometacarpal and interphalangeal joints are ankylosed, evaluate as unfavorable ankylosis, even if each joint is individually fixed in a favorable position	.....	.....
(iii) If only the carpometacarpal or interphalangeal joint is ankylosed, and there is a gap of more than two inches (5.1 cm.) between the thumb pad and the fingers, with the thumb attempting to oppose the fingers, evaluate as unfavorable ankylosis	.....	.....
(iv) If only the carpometacarpal or interphalangeal joint is ankylosed, and there is a gap of two inches (5.1 cm.) or less between the thumb pad and the fingers, with the thumb attempting to oppose the fingers, evaluate as favorable ankylosis	.....	.....
(5) If there is limitation of motion of two or more digits, evaluate each digit separately and combine the evaluations	.....	.....
I. Multiple Digits: Unfavorable Ankylosis		
5216 Five digits of one hand, unfavorable ankylosis of	60	50
Note: Also consider whether evaluation as amputation is warranted.		
5217 Four digits of one hand, unfavorable ankylosis of:		
Thumb and any three fingers	60	50
Index, long, ring, and little fingers	50	40
Note: Also consider whether evaluation as amputation is warranted.		
5218 Three digits of one hand, unfavorable ankylosis of:		
Thumb and any two fingers	50	40
Index, long, and ring; index, long, and little; or index, ring, and little fingers	40	30
Long, ring, and little fingers	30	20
Note: Also consider whether evaluation as amputation is warranted.		
5219 Two digits of one hand, unfavorable ankylosis of:		
Thumb and any finger	40	30

EVALUATION OF ANKYLOSIS OR LIMITATION OF MOTION OF SINGLE OR MULTIPLE DIGITS OF THE HAND—Continued

	Rating	
	Major	Minor
Index and long; index and ring; or index and little fingers	30	20
Long and ring; long and little; or ring and little fingers	20	20
Note: Also consider whether evaluation as amputation is warranted.		
II. Multiple Digits: Favorable Ankylosis		
5220 Five digits of one hand, favorable ankylosis of	50	40
5221 Four digits of one hand, favorable ankylosis of:		
Thumb and any three fingers	50	40
Index, long, ring, and little fingers	40	30
5222 Three digits of one hand, favorable ankylosis of:		
Thumb and any two fingers	40	30
Index, long, and ring; index, long, and little; or index, ring, and little fingers	30	20
Long, ring and little fingers	20	20
5223 Two digits of one hand, favorable ankylosis of:		
Thumb and any finger	30	20
Index and long; index and ring; or index and little fingers	20	20
Long and ring; long and little; or ring and little fingers	10	10
III. Ankylosis of Individual Digits		
5224 Thumb, ankylosis of:		
Unfavorable	20	20
Favorable	10	10
Note: Also consider whether evaluation as amputation is warranted and whether an additional evaluation is warranted for resulting limitation of motion of other digits or interference with overall function of the hand.		
5225 Index finger, ankylosis of:		
Unfavorable or favorable	10	10
Note: Also consider whether evaluation as amputation is warranted and whether an additional evaluation is warranted for resulting limitation of motion of other digits or interference with overall function of the hand.		
5226 Long finger, ankylosis of:		
Unfavorable or favorable	10	10
Note: Also consider whether evaluation as amputation is warranted and whether an additional evaluation is warranted for resulting limitation of motion of other digits or interference with overall function of the hand.		
5227 Ring or little finger, ankylosis of:		
Unfavorable or favorable	0	0

EVALUATION OF ANKYLOSIS OR LIMITATION OF MOTION OF SINGLE OR MULTIPLE DIGITS OF THE HAND—Continued

	Rating	
	Major	Minor
Note: Also consider whether evaluation as amputation is warranted and whether an additional evaluation is warranted for resulting limitation of motion of other digits or interference with overall function of the hand.		
IV. Limitation of Motion of Individual Digits		
5228 Thumb, limitation of motion:		
With a gap of more than two inches (5.1 cm.) between the thumb pad and the fingers, with the thumb attempting to oppose the fingers	20	20
With a gap of one to two inches (2.5 to 5.1 cm.) between the thumb pad and the fingers, with the thumb attempting to oppose the fingers	10	10
With a gap of less than one inch (2.5 cm.) between the thumb pad and the fingers, with the thumb attempting to oppose the fingers	0	0
5229 Index or long finger, limitation of motion:		
With a gap of one inch (2.5 cm.) or more between the fingertip and the proximal transverse crease of the palm, with the finger flexed to the extent possible, or; with extension limited by more than 30 degrees	10	10
With a gap of less than one inch (2.5 cm.) between the fingertip and the proximal transverse crease of the palm, with the finger flexed to the extent possible, and; extension is limited by no more than 30 degrees	0	0
5230 Ring or little finger, limitation of motion:		
Any limitation of motion	0	0

THE SPINE

	Rating
General Rating Formula for Diseases and Injuries of the Spine	
(For diagnostic codes 5235 to 5243 unless 5243 is evaluated under the Formula for Rating Intervertebral Disc Syndrome Based on Incapacitating Episodes):	
With or without symptoms such as pain (whther or not it radiates), stiffness, or aching in the area of the spine affected by residuals of injury or disease	
Unfavorable ankylosis of the entire spine	100
Unfavorable ankylosis of the entire thoracolumbar spine	50

THE SPINE—Continued

	Rating
Unfavorable ankylosis of the entire cervical spine; or, forward flexion of the thoracolumbar spine 30 degrees or less; or, favorable ankylosis of the entire thoracolumbar spine	40
Forward flexion of the cervical spine 15 degrees or less; or, favorable ankylosis of the entire cervical spine	30
Forward flexion of the thoracolumbar spine greater than 30 degrees but not greater than 60 degrees; or, forward flexion of the cervical spine greater than 15 degrees but not greater than 30 degrees; or, the combined range of motion of the thoracolumbar spine not greater than 120 degrees; or, the combined range of motion of the cervical spine not greater than 170 degrees; or, muscle spasm or guarding severe enough to result in an abnormal gait or abnormal spinal contour such as scoliosis, reversed lordosis, or abnormal kyphosis	20
Forward flexion of the thoracolumbar spine greater than 60 degrees but not greater than 85 degrees; or, forward flexion of the cervical spine greater than 30 degrees but not greater than 40 degrees; or, combined range of motion of the thoracolumbar spine greater than 120 degrees but not greater than 235 degrees; or, combined range of motion of the cervical spine greater than 170 degrees but not greater than 335 degrees; or, muscle spasm, guarding, or localized tenderness not resulting in abnormal gait or abnormal spinal contour; or, vertebral body fracture with loss of 50 percent or more of the height	10

Note (1): Evaluate any associated objective neurologic abnormalities, including, but not limited to, bowel or bladder impairment, separately, under an appropriate diagnostic code.

THE SPINE—Continued

	Rating

Note (2): (See also Plate V.) For VA compensation purposes, normal forward flexion of the cervical spine is zero to 45 degrees, extension is zero to 45 degrees, left and right lateral flexion are zero to 45 degrees, and left and right lateral rotation are zero to 80 degrees. Normal forward flexion of the thoracolumbar spine is zero to 90 degrees, extension is zero to 30 degrees, left and right lateral flexion are zero to 30 degrees, and left and right lateral rotation are zero to 30 degrees. The combined range of motion refers to the sum of the range of forward flexion, extension, left and right lateral flexion, and left and right rotation. The normal combined range of motion of the cervical spine is 340 degrees and of the thoracolumbar spine is 240 degrees. The normal ranges of motion for each component of spinal motion provided in this note are the maximum that can be used for calculation of the combined range of motion.

Note (3): In exceptional cases, an examiner may state that because of age, body habitus, neurologic disease, or other factors not the result of disease or injury of the spine, the range of motion of the spine in a particular individual should be considered normal for that individual, even though it does not conform to the normal range of motion stated in Note (2). Provided that the examiner supplies an explanation, the examiner's assessment that the range of motion is normal for that individual will be accepted.

Note (4): Round each range of motion measurement to the nearest five degrees.

Note (5): For VA compensation purposes, unfavorable ankylosis is a condition in which the entire cervical spine, the entire thoracolumbar spine, or the entire spine is fixed in flexion or extension, and the ankylosis results in one or more of the following: difficulty walking because of a limited line of vision; restricted opening of the mouth and chewing; breathing limited to diaphragmatic respiration; gastrointestinal symptoms due to pressure of the costal margin on the abdomen; dyspnea or dysphagia; atlantoaxial or cervical subluxation or dislocation; or neurologic symptoms due to nerve root stretching. Fixation of a spinal segment in neutral position (zero degrees) always represents favorable ankylosis.

Note (6): Separately evaluate disability of the thoracolumbar and cervical spine segments, except when there is unfavorable ankylosis of both segments, which will be rated as a single disability.

5235 Vertebral fracture or dislocation
5236 Sacroiliac injury and weakness
5237 Lumbosacral or cervical strain
5238 Spinal stenosis
5239 Spondylolisthesis or segmental instability
5240 Ankylosing spondylitis
5241 Spinal fusion
5242 Degenerative arthritis of the spine (see also diagnostic code 5003)
5243 Intervertebral disc syndrome

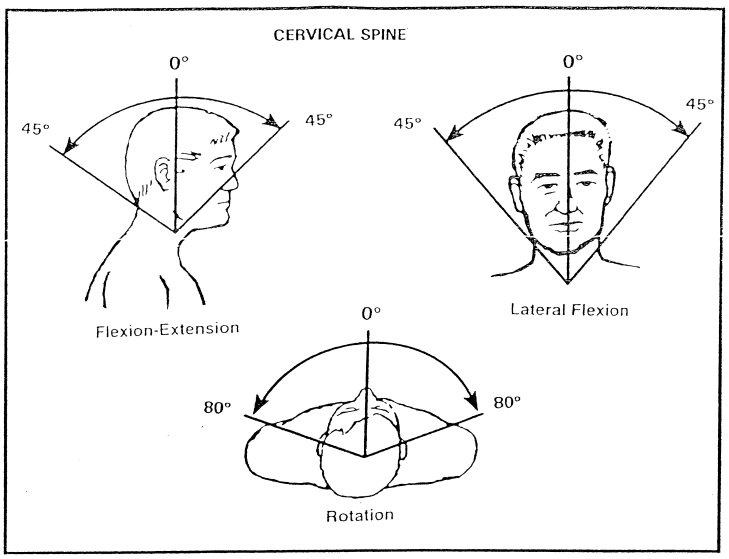
Evaluate intervertebral disc syndrome (preoperatively or postoperatively) either under the General Rating Formula for Diseases and Injuries of the Spine or under the Formula for Rating Intervertebral Disc Syndrome Based on Incapacitating Episodes, whichever method results in the higher evaluation when all disabilities are combined under § 4.25.

THE SPINE—Continued

	Rating
Formula for Rating Intervertebral Disc Syndrome Based on Incapacitating Episodes	
With incapacitating episodes having a total duration of at least 6 weeks during the past 12 months	60
With incapacitating episodes having a total duration of at least 4 weeks but less than 6 weeks during the past 12 months	40
With incapacitating episodes having a total duration of at least 2 weeks but less than 4 weeks during the past 12 months	20
With incapacitating episodes having a total duration of at least one week but less than 2 weeks during the past 12 months	10

THE SPINE—Continued

	Rating
Note (1): For purposes of evaluations under diagnostic code 5243, an incapacitating episode is a period of acute signs and symptoms due to intervertebral disc syndrome that requires bed rest prescribed by a physician and treatment by a physician.	
Note (2): If intervertebral disc syndrome is present in more than one spinal segment, provided that the effects in each spinal segment are clearly distinct, evaluate each segment on the basis of incapacitating episodes or under the General Rating Formula for Diseases and Injuries of the Spine, whichever method results in a higher evaluation for that segment.	



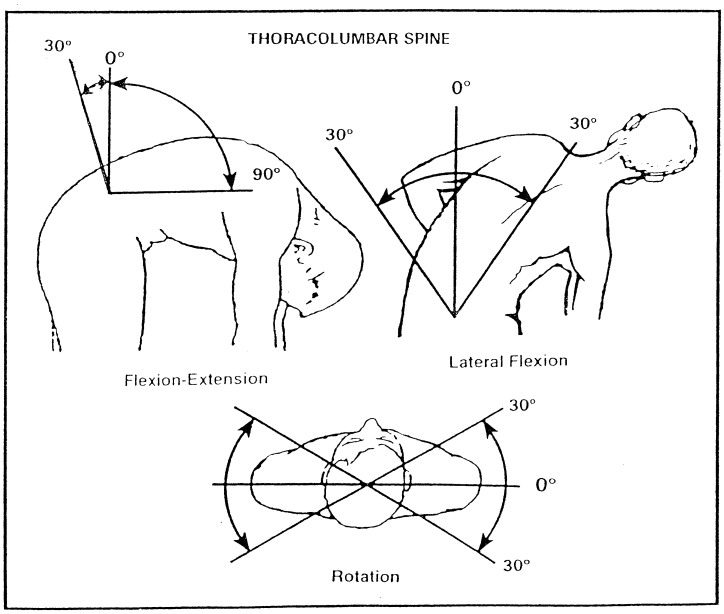


PLATE V
RANGE OF MOTION OF CERVICAL AND THORACOLUMBAR SPINE

THE HIP AND THIGH

	Rating
5250 Hip, ankylosis of:	
Unfavorable, extremely unfavorable ankylosis, the foot not reaching ground, crutches necessitated	[3] 90
Intermediate	70
Favorable, in flexion at an angle between 20° and 40°, and slight adduction or abduction	60
5251 Thigh, limitation of extension of:	
Extension limited to 5°	10
5252 Thigh, limitation of flexion of:	
Flexion limited to 10°	40
Flexion limited to 20°	30
Flexion limited to 30°	20
Flexion limited to 45°	10
5253 Thigh, impairment of:	
Limitation of abduction of, motion lost beyond 10°	20
Limitation of adduction of, cannot cross legs	10
Limitation of rotation of, cannot toe-out more than 15°, affected leg	10
5254 Hip, flail joint	80
5255 Femur, impairment of:	
Fracture of shaft or anatomical neck of:	
With nonunion, with loose motion (spiral or oblique fracture)	80
With nonunion, without loose motion, weightbearing preserved with aid of brace	60
Fracture of surgical neck of, with false joint	60
Malunion of:	
With marked knee or hip disability	30
With moderate knee or hip disability	20
With slight knee or hip disability	10

[3] Entitled to special monthly compensation.

THE KNEE AND LEG

	Rating
5256 Knee, ankylosis of:	
Extremely unfavorable, in flexion at an angle of 45° or more	60
In flexion between 20° and 45°	50
In flexion between 10° and 20°	40
Favorable angle in full extension, or in slight flexion between 0° and 10°	30
5257 Knee, other impairment of:	
Recurrent subluxation or lateral instability:	
Severe	30
Moderate	20
Slight	10
5258 Cartilage, semilunar, dislocated, with frequent episodes of "locking," pain, and effusion into the joint	20
5259 Cartilage, semilunar, removal of, symptomatic	10
5260 Leg, limitation of flexion of:	
Flexion limited to 15°	30
Flexion limited to 30°	20
Flexion limited to 45°	10
Flexion limited to 60°	0
5261 Leg, limitation of extension of:	
Extension limited to 45°	50
Extension limited to 30°	40
Extension limited to 20°	30
Extension limited to 15°	20
Extension limited to 10°	10
Extension limited to 5°	0
5262 Tibia and fibula, impairment of:	
Nonunion of, with loose motion, requiring brace	40
Malunion of:	
With marked knee or ankle disability	30

THE KNEE AND LEG—Continued

	Rating
With moderate knee or ankle disability	20
With slight knee or ankle disability	10
5263 Genu recurvatum (acquired, traumatic, with weakness and insecurity in weight-bearing objectively demonstrated)	10

THE ANKLE

	Rating
5270 Ankle, ankylosis of:	
In plantar flexion at more than 40°, or in dorsiflexion at more than 10° or with abduction, adduction, inversion or eversion deformity	40
In plantar flexion, between 30° and 40°, or in dorsiflexion, between 0° and 10°	30
In plantar flexion, less than 30°	20
5271 Ankle, limited motion of:	
Marked	20
Moderate	10
5272 Subastragalar or tarsal joint, ankylosis of:	
In poor weight-bearing position	20
In good weight-bearing position	10
5273 Os calcis or astragalus, malunion of:	
Marked deformity	20
Moderate deformity	10
5274 Astragalectomy	20

SHORTENING OF THE LOWER EXTREMITY

	Rating
5275 Bones, of the lower extremity, shortening of:	
Over 4 inches (10.2 cms.)	[3] 60
3½ to 4 inches (8.9 cms. to 10.2 cms.)	[3] 50
3 to 3½ inches (7.6 cms. to 8.9 cms.)	40
2½ to 3 inches (6.4 cms. to 7.6 cms.)	30
2 to 2½ inches (5.1 cms. to 6.4 cms.)	20
1¼ to 2 inches (3.2 cms. to 5.1 cms.)	10
NOTE: Measure both lower extremities from anterior superior spine of the ilium to the internal malleolus of the tibia. Not to be combined with other ratings for fracture or faulty union in the same extremity.	

[3] Also entitled to special monthly compensation.

THE FOOT

	Rating
5276 Flatfoot, acquired:	
Pronounced; marked pronation, extreme tenderness of plantar surfaces of the feet, marked inward displacement and severe spasm of the tendo achillis on manipulation, not improved by orthopedic shoes or appliances.	
Bilateral	50
Unilateral	30
Severe; objective evidence of marked deformity (pronation, abduction, etc.), pain on manipulation and use accentuated, indication of swelling on use, characteristic callosities:	
Bilateral	30
Unilateral	20
Moderate; weight-bearing line over or medial to great toe, inward bowing of the tendo achillis, pain on manipulation and use of the feet, bilateral or unilateral	10

THE FOOT—Continued

	Rating
Mild; symptoms relieved by built-up shoe or arch support	0
5277 Weak foot, bilateral:	
A symptomatic condition secondary to many constitutional conditions, characterized by atrophy of the musculature, disturbed circulation, and weakness:	
Rate the underlying condition, minimum rating	10
5278 Claw foot (pes cavus), acquired:	
Marked contraction of plantar fascia with dropped forefoot, all toes hammer toes, very painful callosities, marked varus deformity:	
Bilateral	50
Unilateral	30
All toes tending to dorsiflexion, limitation of dorsiflexion at ankle to right angle, shortened plantar fascia, and marked tenderness under metatarsal heads:	
Bilateral	30
Unilateral	20
Great toe dorsiflexed, some limitation of dorsiflexion at ankle, definite tenderness under metatarsal heads:	
Bilateral	10
Unilateral	10
Slight	0
5279 Metatarsalgia, anterior (Morton's disease), unilateral, or bilateral	10
5280 Hallux valgus, unilateral:	
Operated with resection of metatarsal head	10
Severe, if equivalent to amputation of great toe	10
5281 Hallux rigidus, unilateral, severe:	
Rate as hallux valgus, severe.	
Note: Not to be combined with claw foot ratings.	
5282 Hammer toe:	
All toes, unilateral without claw foot	10
Single toes	0
5283 Tarsal, or metatarsal bones, malunion of, or nonunion of:	
Severe	30
Moderately severe	20
Moderate	10
NOTE: With actual loss of use of the foot, rate 40 percent.	
5284 Foot injuries, other:	
Severe	30
Moderately severe	20
Moderate	10
NOTE: With actual loss of use of the foot, rate 40 percent.	

THE SKULL

	Rating
5296 Skull, loss of part of, both inner and outer tables:	
With brain hernia	80
Without brain hernia:	
Area larger than size of a 50-cent piece or 1.140 in^2 (7.355 cm^2)	50
Area intermediate	30
Area smaller than the size of a 25-cent piece or 0.716 in^2 (4.619 cm^2)	10
NOTE: Rate separately for intracranial complications.	

THE RIBS

	Rating
5297 Ribs, removal of:	
More than six	50
Five or six	40
Three or four	30
Two	20
One or resection of two or more ribs without regeneration	10
NOTE (1): The rating for rib resection or removal is not to be applied with ratings for purrulent pleurisy, lobectomy, pneumonectomy or injuries of pleural cavity.	
NOTE (2): However, rib resection will be considered as rib removal in thoracoplasty performed for collapse therapy or to accomplish obliteration of space and will be combined with the rating for lung collapse, or with the rating for lobectomy, pneumonectomy or the graduated ratings for pulmonary tuberculosis.	

THE COCCYX

	Rating
5298 Coccyx, removal of:	
Partial or complete, with painful residuals	10
Without painful residuals	0

(Authority: 38 U.S.C. 1155)

[29 FR 6718, May 22, 1964, as amended at 34 FR 5062, Mar. 11, 1969; 40 FR 42536, Sept. 15, 1975; 41 FR 11294, Mar. 18, 1976; 43 FR 45350, Oct. 2, 1978; 51 FR 6411, Feb. 24, 1986; 61 FR 20439, May 7, 1996; 67 FR 48785, July 26, 2002; 67 FR 54349, Aug. 22, 2002; 68 FR 51456, Aug. 27, 2003; 69 FR 32450, June 10, 2004; 80 FR 42041, July 16, 2015]

§ 4.72 [Reserved]

§ 4.73 Schedule of ratings—muscle injuries.

NOTE: When evaluating any claim involving muscle injuries resulting in loss of use of any extremity or loss of use of both buttocks (diagnostic code 5317, Muscle Group XVII), refer to § 3.350 of this chapter to determine whether the veteran may be entitled to special monthly compensation.

THE SHOULDER GIRDLE AND ARM

	Rating	
	Dominant	Nondominant
5301 Group I. *Function:* Upward rotation of scapula; elevation of arm above shoulder level. *Extrinsic muscles of shoulder girdle:* (1) Trapezius; (2) levator scapulae; (3) serratus magnus.		
Severe	40	30
Moderately Severe	30	20
Moderate	10	10
Slight	0	0

THE SHOULDER GIRDLE AND ARM—Continued

	Rating	
	Dominant	Nondominant
5302 Group II. *Function:* Depression of arm from vertical overhead to hanging at side (1, 2); downward rotation of scapula (3, 4); 1 and 2 act with Group III in forward and backward swing of arm. *Extrinsic muscles of shoulder girdle: (1) Pectoralis major II (costosternal); (2) latissimus dorsi and teres major (teres major, although technically an intrinsic muscle, is included with latissimus dorsi); (3) pectoralis minor; (4) rhomboid.*		
Severe	40	30
Moderately Severe	30	20
Moderate	20	20
Slight	0	0
5303 Group III. *Function:* Elevation and abduction of arm to level of shoulder; act with 1 and 2 of Group II in forward and backward swing of arm. *Intrinsic muscles of shoulder girdle: (1) Pectoralis major I (clavicular); (2) deltoid.*		
Severe	40	30
Moderately Severe	30	20
Moderate	20	20
Slight	0	0
5304 Group IV. *Function:* Stabilization of shoulder against injury in strong movements, holding head of humerus in socket; abduction; outward rotation and inward rotation of arm. *Intrinsic muscles of shoulder girdle: (1) Supraspinatus; (2) infraspinatus and teres minor; (3) subscapularis; (4) coracobrachialis.*		
Severe	30	20
Moderately Severe	20	20
Moderate	10	10
Slight	0	0
5305 Group V. *Function:* Elbow supination (1) (long head of biceps is stabilizer of shoulder joint); flexion of elbow (1, 2, 3). *Flexor muscles of elbow: (1) Biceps; (2) brachialis; (3) brachioradialis.*		
Severe	40	30
Moderately Severe	30	20
Moderate	10	10
Slight	0	0
5306 Group VI. *Function:* Extension of elbow (long head of triceps is stabilizer of shoulder joint). *Extensor muscles of the elbow:* (1) Triceps; (2) anconeus..		
Severe	40	30
Moderately Severe	30	20
Moderate	10	10
Slight	0	0

THE FOREARM AND HAND

	Rating	
	Dominant	Nondominant
5307 Group VII. *Function:* Flexion of wrist and fingers. *Muscles arising from internal condyle of humerus:* Flexors of the carpus and long flexors of fingers and thumb; pronator.		

THE FOREARM AND HAND—Continued

	Rating	
	Dominant	Nondominant
Severe	40	30
Moderately Severe	30	20
Moderate	10	10
Slight	0	0
5308 Group VIII. *Function:* Extension of wrist, fingers, and thumb; abduction of thumb. *Muscles arising mainly from external condyle of humerus:* Extensors of carpus, fingers, and thumb; supinator.		
Severe	30	20
Moderately Severe	20	20
Moderate	10	10
Slight	0	0
5309 Group IX. *Function:* The forearm muscles act in strong grasping movements and are supplemented by the intrinsic muscles in delicate manipulative movements. *Intrinsic muscles of hand:* Thenar eminence; short flexor, opponens, abductor and adductor of thumb; hypothenar eminence; short flexor, opponens and abductor of little finger; 4 lumbricales; 4 dorsal and 3 palmar interossei.		
NOTE: The hand is so compact a structure that isolated muscle injuries are rare, being nearly always complicated with injuries of bones, joints, tendons, etc. Rate on limitation of motion, minimum 10 percent.		

THE FOOT AND LEG

	Rating
5310 Group X. *Function:* Movements of forefoot and toes; propulsion thrust in walking. *Intrinsic muscles of the foot: Plantar:* (1) Flexor digitorum brevis; (2) abductor hallucis; (3) abductor digiti minimi; (4) quadratus plantae; (5) lumbricales; (6) flexor hallucis brevis; (7) adductor hallucis; (8) flexor digiti minimi brevis; (9) dorsal and plantar interossei. Other important plantar structures: Plantar aponeurosis, long plantar and calcaneonavicular ligament, tendons of posterior tibial, peroneus longus, and long flexors of great and little toes.	
Severe	30
Moderately Severe	20
Moderate	10
Slight	0
Dorsal: (1) Extensor hallucis brevis; (2) extensor digitorum brevis. Other important dorsal structures: cruciate, crural, deltoid, and other ligaments; tendons of long extensors of toes and peronei muscles.	
Severe	20
Moderately Severe	10
Moderate	10
Slight	0

THE FOOT AND LEG—Continued

	Rating
NOTE: Minimum rating for through-and-through wounds of the foot—10.	
5311 Group XI. *Function:* Propulsion, plantar flexion of foot (1); stabilization of arch (2, 3); flexion of toes (4, 5); Flexion of knee (6). *Posterior and lateral crural muscles, and muscles of the calf:* (1) Triceps surae (gastrocnemius and soleus); (2) tibialis posterior; (3) peroneus longus; (4) peroneus brevis; (5) flexor hallucis longus; (6) flexor digitorum longus; (7) popliteus; (8) plantaris.	
Severe	30
Moderately Severe	20
Moderate	10
Slight	0
5312 Group XII. *Function:* Dorsiflexion (1); extension of toes (2); stabilization of arch (3). *Anterior muscles of the leg:* (1) Tibialis anterior; (2) extensor digitorum longus; (3) extensor hallucis longus; (4) peroneus tertius.	
Severe	30
Moderately Severe	20
Moderate	10
Slight	0

THE PELVIC GIRDLE AND THIGH

	Rating
5313 Group XIII. *Function:* Extension of hip and flexion of knee; outward and inward rotation of flexed knee; acting with rectus femoris and sartorius (see XIV, 1, 2) synchronizing simultaneous flexion of hip and knee and extension of hip and knee by belt-over-pulley action at knee joint. *Posterior thigh group, Hamstring complex of 2-joint muscles:* (1) Biceps femoris; (2) semimembranosus; (3) semitendinosus.	
Severe	40
Moderately Severe	30
Moderate	10
Slight	0
5314 Group XIV. *Function:* Extension of knee (2, 3, 4, 5); simultaneous flexion of hip and flexion of knee (1); tension of fascia lata and iliotibial (Maissiat's) band, acting with XVII (1) in postural support of body (6); acting with hamstrings in synchronizing hip and knee (1, 2). *Anterior thigh group:* (1) Sartorius; (2) rectus femoris; (3) vastus externus; (4) vastus intermedius; (5) vastus internus; (6) tensor vaginae femoris.	
Severe	40
Moderately Severe	30
Moderate	10
Slight	0
5315 Group XV. *Function:* Adduction of hip (1, 2, 3, 4); flexion of hip (1, 2); flexion of knee (4). *Mesial thigh group:* (1) Adductor longus; (2) adductor brevis; (3) adductor magnus; (4) gracilis.	
Severe	30
Moderately Severe	20
Moderate	10
Slight	0
5316 Group XVI. *Function:* Flexion of hip (1, 2, 3). *Pelvic girdle group 1:* (1) Psoas; (2) iliacus; (3) pectineus.	
Severe	40
Moderately Severe	30
Moderate	10
Slight	0

THE PELVIC GIRDLE AND THIGH—Continued

	Rating
5317 Group XVII. *Function:* Extension of hip (1); abduction of thigh; elevation of opposite side of pelvis (2, 3); tension of fascia lata and iliotibial (Maissiat's) band, acting with XIV (6) in postural support of body steadying pelvis upon head of femur and condyles of femur on tibia (1). *Pelvic girdle group 2:* (1) Gluteus maximus; (2) gluteus medius; (3) gluteus minimus.	
Severe	*50
Moderately Severe	40
Moderate	20
Slight	0
5318 Group XVIII. *Function:* Outward rotation of thigh and stabilization of hip joint. *Pelvic girdle group 3:* (1) Pyriformis; (2) gemellus (superior or inferior); (3) obturator (external or internal); (4) quadratus femoris.	
Severe	30
Moderately Severe	20
Moderate	10
Slight	0

* If bilateral, see § 3.350(a)(3) of this chapter to determine whether the veteran may be entitled to special monthly compensation.

THE TORSO AND NECK

	Rating
5319 Group XIX. *Function:* Support and compression of abdominal wall and lower thorax; flexion and lateral motions of spine; synergists in strong downward movements of arm (1). *Muscles of the abdominal wall:* (1) Rectus abdominis; (2) external oblique; (3) internal oblique; (4) transversalis; (5) quadratus lumborum.	
Severe	50
Moderately Severe	30
Moderate	10
Slight	0
5320 Group XX. *Function:* Postural support of body; extension and lateral movements of spine. *Spinal muscles:* Sacrospinalis (erector spinae and its prolongations in thoracic and cervical regions).	
Cervical and thoracic region:.	
Severe	40
Moderately Severe	20
Moderate	10
Slight	0
Lumbar region:.	
Severe	60
Moderately Severe	40
Moderate	20
Slight	0
5321 Group XXI. *Function:* Respiration. *Muscles of respiration:* Thoracic muscle group.	
Severe or Moderately Severe	20
Moderate	10
Slight	0
5322 Group XXII. *Function:* Rotary and forward movements of the head; respiration; deglutition. *Muscles of the front of the neck:* (Lateral, supra-, and infrahyoid group.) (1) Trapezius I (clavicular insertion); (2) sternocleidomastoid; (3) the ''hyoid'' muscles; (4) sternothyroid; (5) digastric.	
Severe	30
Moderately Severe	20
Moderate	10
Slight	0

THE TORSO AND NECK—Continued

	Rating
5323 Group XXIII. *Function:* Movements of the head; fixation of shoulder movements. *Muscles of the side and back of the neck:* Suboccipital; lateral vertebral and anterior vertebral muscles.	
Severe	30
Moderately Severe	20
Moderate	10
Slight	0

MISCELLANEOUS

	Rating
5324 Diaphragm, rupture of, with herniation. Rate under diagnostic code 7346.	
5325 Muscle injury, facial muscles. Evaluate functional impairment as seventh (facial) cranial nerve neuropathy (diagnostic code 8207), disfiguring scar (diagnostic code 7800), etc. Minimum, if interfering to any extent with mastication—10.	
5326 Muscle hernia, extensive. Without other injury to the muscle—10.	
5327 Muscle, neoplasm of, malignant (excluding soft tissue sarcoma)—100.	
NOTE: A rating of 100 percent shall continue beyond the cessation of any surgery, radiation treatment, antineoplastic chemotherapy or other therapeutic procedures. Six months after discontinuance of such treatment, the appropriate disability rating shall be determined by mandatory VA examination. Any change in evaluation based upon that or any subsequent examination shall be subject to the provisions of §3.105(e) of this chapter. If there has been no local recurrence or metastasis, rate on residual impairment of function.	
5328 Muscle, neoplasm of, benign, postoperative. Rate on impairment of function, *i.e.*, limitation of motion, or scars, diagnostic code 7805, etc.	
5329 Sarcoma, soft tissue (of muscle, fat, or fibrous connective tissue)—100.	
NOTE: A rating of 100 percent shall continue beyond the cessation of any surgery, radiation treatment, antineoplastic chemotherapy or other therapeutic procedures. Six months after discontinuance of such treatment, the appropriate disability rating shall be determined by mandatory VA examination. Any change in evaluation based upon that or any subsequent examination shall be subject to the provisions of §3.105(e) of this chapter. If there has been no local recurrence or metastasis, rate on residual impairment of function.	

(Authority: 38 U.S.C. 1155)

[62 FR 30239, June 3, 1997]

THE ORGANS OF SPECIAL SENSE

§4.75 General considerations for evaluating visual impairment.

(a) *Visual impairment*. The evaluation of visual impairment is based on impairment of visual acuity (excluding developmental errors of refraction), visual field, and muscle function.

(b) *Examination for visual impairment*. The examination must be conducted by a licensed optometrist or by a licensed ophthalmologist. The examiner must identify the disease, injury, or other pathologic process responsible for any visual impairment found. Examinations of visual fields or muscle function will be conducted only when there is a medical indication of disease or injury that may be associated with visual field defect or impaired muscle function. Unless medically contraindicated, the fundus must be examined with the claimant's pupils dilated.

(c) *Service-connected visual impairment of only one eye*. Subject to the provisions of 38 CFR 3.383(a), if visual impairment of only one eye is service-connected, the visual acuity of the other eye will be considered to be 20/40 for purposes of evaluating the service-connected visual impairment.

(d) *Maximum evaluation for visual impairment of one eye*. The evaluation for visual impairment of one eye must not exceed 30 percent unless there is anatomical loss of the eye. Combine the evaluation for visual impairment of one eye with evaluations for other disabilities of the same eye that are not based on visual impairment (e.g., disfigurement under diagnostic code 7800).

(e) *Anatomical loss of one eye with inability to wear a prosthesis*. When the claimant has anatomical loss of one eye and is unable to wear a prosthesis, increase the evaluation for visual acuity under diagnostic code 6063 by 10 percent, but the maximum evaluation for visual impairment of both eyes must not exceed 100 percent. A 10-percent increase under this paragraph precludes an evaluation under diagnostic code 7800 based on gross distortion or asymmetry of the eye but not an evaluation under diagnostic code 7800 based on other characteristics of disfigurement.

(f) *Special monthly compensation*. When evaluating visual impairment, refer to 38 CFR 3.350 to determine whether the claimant may be entitled to special monthly compensation. Footnotes in the schedule indicate levels of visual impairment that potentially establish entitlement to special monthly compensation; however, other levels of visual impairment combined

with disabilities of other body systems may also establish entitlement.

(Authority: 38 U.S.C. 1114 and 1155)

[73 FR 66549, Nov. 10, 2008]

§ 4.76 Visual acuity.

(a) *Examination of visual acuity*. Examination of visual acuity must include the central *uncorrected* and *corrected* visual acuity for *distance* and *near* vision using Snellen's test type or its equivalent.

(b) *Evaluation of visual acuity*. (1) Evaluate central visual acuity on the basis of corrected distance vision with central fixation, even if a central scotoma is present. However, when the lens required to correct distance vision in the poorer eye differs by more than three diopters from the lens required to correct distance vision in the better eye (and the difference is not due to congenital or developmental refractive error), and either the poorer eye or both eyes are service connected, evaluate the visual acuity of the poorer eye using either its uncorrected or corrected visual acuity, whichever results in better combined visual acuity.

(2) Provided that he or she customarily wears contact lenses, evaluate the visual acuity of any individual affected by a corneal disorder that results in severe irregular astigmatism that can be improved more by contact lenses than by eyeglass lenses, as corrected by contact lenses.

(3) In any case where the examiner reports that there is a difference equal to two or more scheduled steps between near and distance corrected vision, with the near vision being worse, the examination report must include at least two recordings of near and distance corrected vision and an explanation of the reason for the difference. In these cases, evaluate based on corrected distance vision adjusted to one step poorer than measured.

(4) To evaluate the impairment of visual acuity where a claimant has a reported visual acuity that is between two sequentially listed visual acuities, use the visual acuity which permits the higher evaluation.

(Authority: 38 U.S.C. 1155)

[73 FR 66549, Nov. 10, 2008]

§ 4.76a Computation of average concentric contraction of visual fields.

TABLE III—NORMAL VISUAL FIELD EXTENT AT 8 PRINCIPAL MERIDIANS

Meridian	Normal degrees
Temporally	85
Down temporally	85
Down	65
Down nasally	50
Nasally	60
Up nasally	55
Up	45
Up temporally	55
Total	500

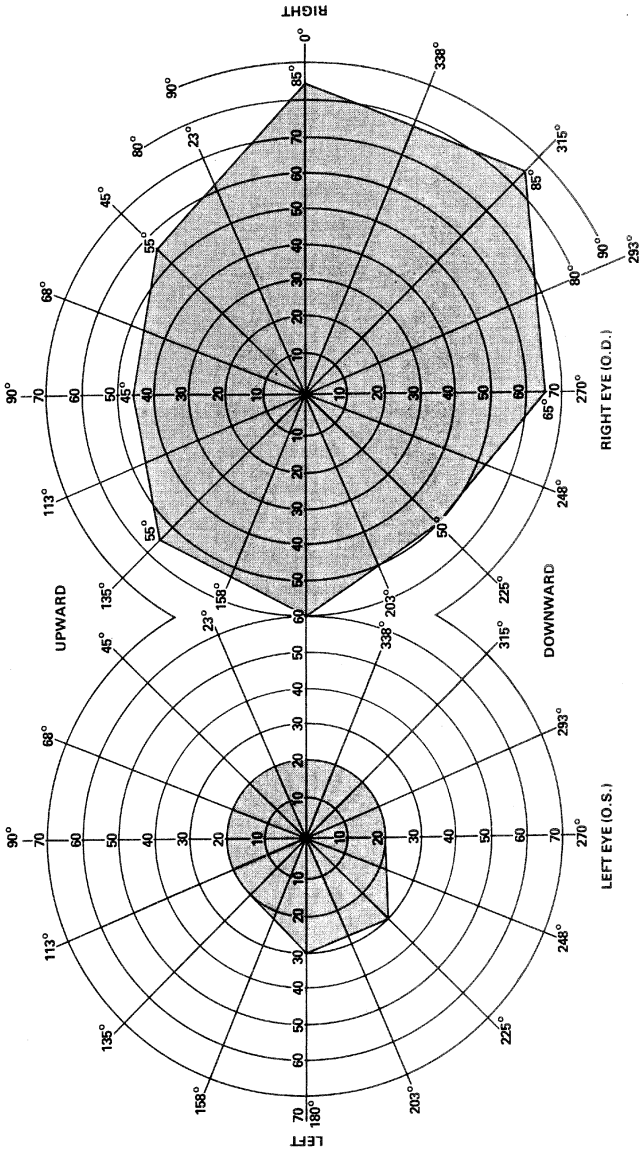


Figure 1. Chart of visual field showing normal field right eye and abnormal contraction visual field left eye.

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52a

Example of computation of concentric contraction under the schedule with abnormal findings taken from Figure 1.

Loss	Degrees
Temporally	55
Down temporally	55
Down	45

Loss	Degrees
Down nasally	30
Nasally	40
Up nasally	35
Up	25
Up temporally	35
Total loss	320

Remaining field 500° minus 320° = 180°. 180° ÷ 8 = 22½° average concentric contraction.

(Authority: 38 U.S.C. 1155)

[43 FR 45352, Oct. 2, 1978, as amended at 73 FR 66549, Nov. 10, 2008]

§ 4.77 Visual fields.

(a) *Examination of visual fields.* Examiners must use either Goldmann kinetic perimetry or automated perimetry using Humphrey Model 750, Octopus Model 101, or later versions of these perimetric devices with simulated kinetic Goldmann testing capability. For phakic (normal) individuals, as well as for pseudophakic or aphakic individuals who are well adapted to intraocular lens implant or contact lens correction, visual field examinations must be conducted using a standard target size and luminance, which is Goldmann's equivalent III/4e. For aphakic individuals not well adapted to contact lens correction or pseudophakic individuals not well adapted to intraocular lens implant, visual field examinations must be conducted using Goldmann's equivalent IV/4e. The examiner must document the results for at least 16 meridians 22½ degrees apart for each eye and indicate the Goldmann equivalent used. See Table III for the normal extent (in degrees) of the visual fields at the 8 principal meridians (45 degrees apart). When the examiner indicates that additional testing is necessary to evaluate visual fields, the additional testing must be conducted using either a tangent screen or a 30-degree threshold visual field with the Goldmann III stimulus size. The examination report must document the results of either the tangent screen or of the 30-degree threshold visual field with the Goldmann III stimulus size.

(b) *Evaluation of visual fields.* Determine the average concentric contraction of the visual field of each eye by measuring the remaining visual field (in degrees) at each of eight principal meridians 45 degrees apart, adding them, and dividing the sum by eight.

(c) *Combination of visual field defect and decreased visual acuity.* To determine the evaluation for visual impairment when both decreased visual acuity and visual field defect are present in one or both eyes and are service connected, separately evaluate the visual acuity and visual field defect (expressed as a level of visual acuity), and combine them under the provisions of § 4.25.

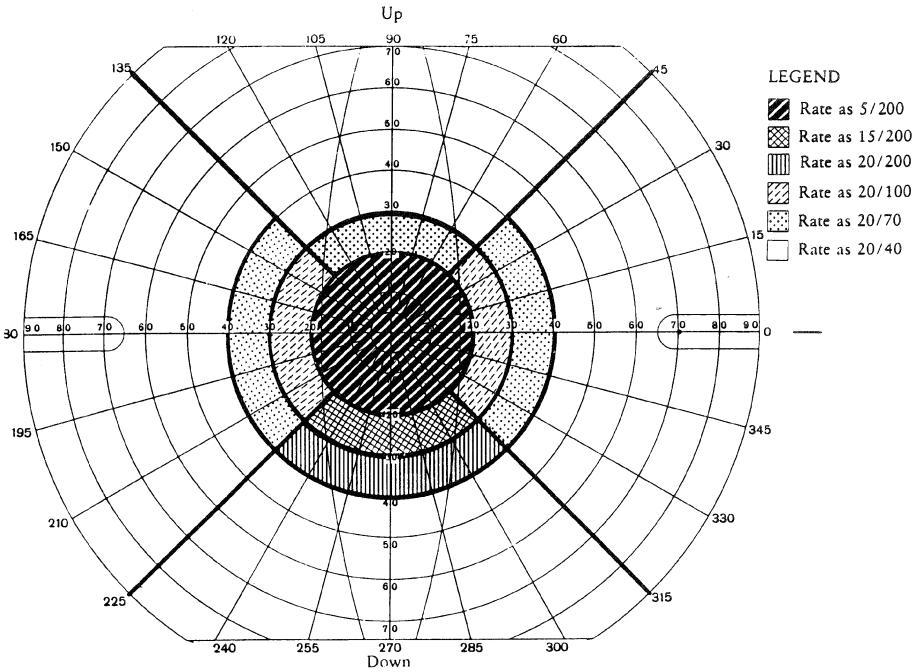

Figure 2. Goldmann Perimeter Chart

52c

(Authority: 38 U.S.C. 1155)

[53 FR 30262, Aug. 11, 1988, as amended at 73 FR 66549, Nov. 10, 2008; 74 FR 7648, Feb. 19, 2009; 83 FR 15320, Apr. 10, 2018]

§4.78 Muscle function.

(a) *Examination of muscle function.* The examiner must use a Goldmann perimeter chart or the Tangent Screen method that identifies the four major quadrants (upward, downward, left, and right lateral) and the central field (20 degrees or less) (see Figure 2). The examiner must document the results of muscle function testing by identifying the quadrant(s) and range(s) of degrees in which diplopia exists.

(b) *Evaluation of muscle function.* (1) An evaluation for diplopia will be assigned to only one eye. When a claimant has both diplopia and decreased visual acuity or visual field defect, assign a level of corrected visual acuity for the poorer eye (or the affected eye, if disability of only one eye is service-connected) that is: one step poorer than it would otherwise warrant if the evaluation for diplopia under diagnostic code 6090 is 20/70 or 20/100; two steps poorer if the evaluation under diagnostic code 6090 is 20/200 or 15/200; or three steps poorer if the evaluation under diagnostic code 6090 is 5/200. This adjusted level of corrected visual acuity, however, must not exceed a level of 5/200. Use the adjusted visual acuity for the poorer eye (or the affected eye, if

disability of only one eye is service-connected), and the corrected visual acuity for the better eye (or visual acuity of 20/40 for the other eye, if only one eye is service-connected) to determine the percentage evaluation for visual impairment under diagnostic codes 6065 through 6066.

(2) When diplopia extends beyond more than one quadrant or range of degrees, evaluate diplopia based on the quadrant and degree range that provides the highest evaluation.

(3) When diplopia exists in two separate areas of the same eye, increase the equivalent visual acuity under diagnostic code 6090 to the next poorer level of visual acuity, not to exceed 5/200.

(Authority: 38 U.S.C. 1155)

[73 FR 66550, Nov. 10, 2008, as amended at 83 FR 15321, Apr. 10, 2018]

§ 4.79 Schedule of ratings—eye.

DISEASES OF THE EYE

	Rating
General Rating Formula for Diseases of the Eye:	
Evaluate on the basis of either visual impairment due to the particular condition or on incapacitating episodes, whichever results in a higher evaluation	
With documented incapacitating episodes requiring 7 or more treatment visits for an eye condition during the past 12 months	60
With documented incapacitating episodes requiring at least 5 but less than 7 treatment visits for an eye condition during the past 12 months	40
With documented incapacitating episodes requiring at least 3 but less than 5 treatment visits for an eye condition during the past 12 months	20
With documented incapacitating episodes requiring at least 1 but less than 3 treatment visits for an eye condition during the past 12 months	10
Note (1): For the purposes of evaluation under 38 CFR 4.79, an incapacitating episode is an eye condition severe enough to require a clinic visit to a provider specifically for treatment purposes.	
Note (2): Examples of treatment may include but are not limited to: Systemic immunosuppressants or biologic agents; intravitreal or periocular injections; laser treatments; or other surgical interventions.	
Note (3): For the purposes of evaluating visual impairment due to the particular condition, refer to 38 CFR 4.75–4.78 and to § 4.79, diagnostic codes 6061–6091.	
6000 Choroidopathy, including uveitis, iritis, cyclitis, or choroiditis.	
6001 Keratopathy.	
6002 Scleritis.	
6006 Retinopathy or maculopathy not otherwise specified	
6007 Intraocular hemorrhage.	
6008 Detachment of retina.	
6009 Unhealed eye injury.	
Note: This code includes orbital trauma, as well as penetrating or non-penetrating eye injury	
6010 Tuberculosis of eye:	
Active	100
Inactive: Evaluate under § 4.88c or § 4.89 of this part, whichever is appropriate.	
6011 Retinal scars, atrophy, or irregularities:	
Localized scars, atrophy, or irregularities of the retina, unilateral or bilateral, that are centrally located and that result in an irregular, duplicated, enlarged, or diminished image	10
Alternatively, evaluate based on the General Rating Formula for Diseases of the Eye, if this would result in a higher evaluation	
6012 Angle-closure glaucoma	
Evaluate under the General Rating Formula for Diseases of the Eye. Minimum evaluation if continuous medication is required	10
6013 Open-angle glaucoma	
Evaluate under the General Rating Formula for Diseases of the Eye. Minimum evaluation if continuous medication is required	10
6014 Malignant neoplasms of the eye, orbit, and adnexa (excluding skin):	
Malignant neoplasms of the eye, orbit, and adnexa (excluding skin) that require therapy that is comparable to those used for systemic malignancies, i.e., systemic chemotherapy, X-ray therapy more extensive than to the area of the eye, or surgery more extensive than enucleation	100
Note: Continue the 100 percent rating beyond the cessation of any surgical, X-ray, antineoplastic chemotherapy, or other therapeutic procedure. Six months after discontinuance of such treatment, the appropriate disability rating will be determined by mandatory VA examination. Any change in evaluation based upon that or any subsequent examination will be subject to the provisions of § 3.105(e) of this chapter. If there has been no local recurrence or metastasis, evaluate based on residuals	
Malignant neoplasms of the eye, orbit, and adnexa (excluding skin) that do not require therapy comparable to that for systemic malignancies:	
Separately evaluate visual and nonvisual impairment, e.g., disfigurement (diagnostic code 7800), and combine the evaluations.	
6015 Benign neoplasms of the eye, orbit, and adnexa (excluding skin):	

DISEASES OF THE EYE—Continued

	Rating
Separately evaluate visual and nonvisual impairment, e.g., disfigurement (diagnostic code 7800), and combine the evaluations	
6016 Nystagmus, central	10
6017 Trachomatous conjunctivitis:	
Active: Evaluate under the General Rating Formula for Diseases of the Eye, minimum rating	30
Inactive: Evaluate based on residuals, such as visual impairment and disfigurement (diagnostic code 7800)	
6018 Chronic conjunctivitis (nontrachomatous):	
Active: Evaluate under the General Rating Formula for Diseases of the Eye, minimum rating	10
Inactive: Evaluate based on residuals, such as visual impairment and disfigurement (diagnostic code 7800)	
6019 Ptosis, unilateral or bilateral:	
Evaluate based on visual impairment or, in the absence of visual impairment, on disfigurement (diagnostic code 7800).	
6020 Ectropion:	
Bilateral	20
Unilateral	10
6021 Entropion:	
Bilateral	20
Unilateral	10
6022 Lagophthalmos:	
Bilateral	20
Unilateral	10
6023 Loss of eyebrows, complete, unilateral or bilateral	10
6024 Loss of eyelashes, complete, unilateral or bilateral	10
6025 Disorders of the lacrimal apparatus (epiphora, dacryocystitis, etc.):	
Bilateral	20
Unilateral	10
6026 Optic neuropathy	
6027 Cataract:	
Preoperative: Evaluate under the General Rating Formula for Diseases of the Eye	
Postoperative: If a replacement lens is present (pseudophakia), evaluate under the General Rating Formula for Diseases of the Eye. If there is no replacement lens, evaluate based on aphakia (diagnostic code 6029)	
6029 Aphakia or dislocation of crystalline lens:	
Evaluate based on visual impairment, and elevate the resulting level of visual impairment one step.	
Minimum (unilateral or bilateral)	30
6030 Paralysis of accommodation (due to neuropathy of the Oculomotor Nerve (cranial nerve III)).	20
6032 Loss of eyelids, partial or complete:	
Separately evaluate both visual impairment due to eyelid loss and nonvisual impairment, e.g., disfigurement (diagnostic code 7800), and combine the evaluations.	
6034 Pterygium:	
Evaluate under the General Rating Formula for Diseases of the Eye, disfigurement (diagnostic code 7800), conjunctivitis (diagnostic code 6018), etc., depending on the particular findings, and combine in accordance with §4.25	
6035 Keratoconus	
6036 Status post corneal transplant:	
Evaluate under the General Rating Formula for Diseases of the Eye. Minimum, if there is pain, photophobia, and glare sensitivity	10
6037 Pinguecula:	
Evaluate based on disfigurement (diagnostic code 7800).	
6040 Diabetic retinopathy	
6042 Retinal dystrophy (including retinitis pigmentosa, wet or dry macular degeneration, early-onset macular degeneration, rod and/or cone dystrophy)	
6046 Post-chiasmal disorders	
Impairment of Central Visual Acuity	
6061 Anatomical loss of both eyes [1]	100
6062 No more than light perception in both eyes [1]	100
6063 Anatomical loss of one eye: [1]	
In the other eye 5/200 (1.5/60)	100
In the other eye 10/200 (3/60)	90
In the other eye 15/200 (4.5/60)	80
In the other eye 20/200 (6/60)	70
In the other eye 20/100 (6/30)	60
In the other eye 20/70 (6/21)	60
In the other eye 20/50 (6/15)	50
In the other eye 20/40 (6/12)	40
6064 No more than light perception in one eye: [1]	
In the other eye 5/200 (1.5/60)	100
In the other eye 10/200 (3/60)	90
In the other eye 15/200 (4.5/60)	80

DISEASES OF THE EYE—Continued

	Rating
In the other eye 20/200 (6/60)	70
In the other eye 20/100 (6/30)	60
In the other eye 20/70 (6/21)	50
In the other eye 20/50 (6/15)	40
In the other eye 20/40 (6/12)	30
6065 Vision in one eye 5/200 (1.5/60):	
In the other eye 5/200 (1.5/60)	[1]100
In the other eye 10/200 (3/60)	90
In the other eye 15/200 (4.5/60)	80
In the other eye 20/200 (6/60)	70
In the other eye 20/100 (6/30)	60
In the other eye 20/70 (6/21)	50
In the other eye 20/50 (6/15)	40
In the other eye 20/40 (6/12)	30
6066 Visual acuity in one eye 10/200 (3/60) or better:	
Vision in one eye 10/200 (3/60):	
In the other eye 10/200 (3/60)	90
In the other eye 15/200 (4.5/60)	80
In the other eye 20/200 (6/60)	70
In the other eye 20/100 (6/30)	60
In the other eye 20/70 (6/21)	50
In the other eye 20/50 (6/15)	40
In the other eye 20/40 (6/12)	30
Vision in one eye 15/200 (4.5/60):	
In the other eye 15/200 (4.5/60)	80
In the other eye 20/200 (6/60)	70
In the other eye 20/100 (6/30)	60
In the other eye 20/70 (6/21)	40
In the other eye 20/50 (6/15)	30
In the other eye 20/40 (6/12)	20
Vision in one eye 20/200 (6/60):	
In the other eye 20/200 (6/60)	70
In the other eye 20/100 (6/30)	60
In the other eye 20/70 (6/21)	40
In the other eye 20/50 (6/15)	30
In the other eye 20/40 (6/12)	20
Vision in one eye 20/100 (6/30):	
In the other eye 20/100 (6/30)	50
In the other eye 20/70 (6/21)	30
In the other eye 20/50 (6/15)	20
In the other eye 20/40 (6/12)	10
Vision in one eye 20/70 (6/21):	
In the other eye 20/70 (6/21)	30
In the other eye 20/50 (6/15)	20
In the other eye 20/40 (6/12)	10
Vision in one eye 20/50 (6/15):	
In the other eye 20/50 (6/15)	10
In the other eye 20/40 (6/12)	10
Vision in one eye 20/40 (6/12):	
In the other eye 20/40 (6/12)	0

[1] Review for entitlement to special monthly compensation under 38 CFR 3.350.

RATINGS FOR IMPAIRMENT OF VISUAL FIELDS

	Rating
6080 Visual field defects:	
Homonymous hemianopsia	30
Loss of temporal half of visual field:	
Bilateral	30
Unilateral	10
Or evaluate each affected eye as 20/70 (6/21).	
Loss of nasal half of visual field:	
Bilateral	10
Unilateral	10
Or evaluate each affected eye as 20/50 (6/15).	
Loss of inferior half of visual field:	
Bilateral	30
Unilateral	10
Or evaluate each affected eye as 20/70 (6/21).	
Loss of superior half of visual field:	

RATINGS FOR IMPAIRMENT OF VISUAL FIELDS—Continued

	Rating
Bilateral	10
Unilateral	10
Or evaluate each affected eye as 20/50 (6/15).	
Concentric contraction of visual field:	
With remaining field of 5 degrees: [1]	
Bilateral	100
Unilateral	30
Or evaluate each affected eye as 5/200 (1.5/60).	
With remaining field of 6 to 15 degrees:	
Bilateral	70
Unilateral	20
Or evaluate each affected eye as 20/200 (6/60).	
With remaining field of 16 to 30 degrees:	
Bilateral	50
Unilateral	10
Or evaluate each affected eye as 20/100 (6/30).	
With remaining field of 31 to 45 degrees:	
Bilateral	30
Unilateral	10
Or evaluate each affected eye as 20/70 (6/21).	
With remaining field of 46 to 60 degrees:	
Bilateral	10
Unilateral	10
Or evaluate each affected eye as 20/50 (6/15).	
6081 Scotoma, unilateral:	
Minimum, with scotoma affecting at least one-quarter of the visual field (quadrantanopsia) or with centrally located scotoma of any size	10
Alternatively, evaluate based on visual impairment due to scotoma, if that would result in a higher evaluation.	

[1] Review for entitlement to special monthly compensation under 38 CFR 3.350.

RATINGS FOR IMPAIRMENT OF MUSCLE FUNCTION

Degree of diplopia	Equivalent visual acuity
6090 Diplopia (double vision):	
(a) Central 20 degrees	5/200 (1.5/60)
(b) 21 degrees to 30 degrees	
(1) Down	15/200 (4.5/60)
(2) Lateral	20/100 (6/30)
(3) Up	20/70 (6/21)
(c) 31 degrees to 40 degrees	
(1) Down	20/200 (6/60)
(2) Lateral	20/70 (6/21)
(3) Up	20/40 (6/12)
Note: In accordance with 38 CFR 4.31, diplopia that is occasional or that is correctable with spectacles is evaluated at 0 percent.	
6091 Symblepharon:	
Evaluate under the General Rating Formula for Diseases of the Eye, lagophthalmos (diagnostic code 6022), disfigurement (diagnostic code 7800), etc., depending on the particular findings, and combine in accordance with §4.25	

(Authority: 38 U.S.C. 1155)

[73 FR 66550, Nov. 10, 2008, as amended at 83 FR 15321, Apr. 10, 2018]

§§4.80–4.84 [Reserved]

IMPAIRMENT OF AUDITORY ACUITY

§4.85 Evaluation of hearing impairment.

(a) An examination for hearing impairment for VA purposes must be conducted by a state-licensed audiologist and must include a controlled speech discrimination test (Maryland CNC) and a puretone audiometry test. Examinations will be conducted without the use of hearing aids.

(b) Table VI, ''Numeric Designation of Hearing Impairment Based on Puretone Threshold Average and

Speech Discrimination,'' is used to determine a Roman numeral designation (I through XI) for hearing impairment based on a combination of the percent of speech discrimination (horizontal rows) and the puretone threshold average (vertical columns). The Roman numeral designation is located at the point where the percentage of speech discrimination and puretone threshold average intersect.

(c) Table VIa, ''Numeric Designation of Hearing Impairment Based Only on Puretone Threshold Average,'' is used to determine a Roman numeral designation (I through XI) for hearing impairment based only on the puretone threshold average. Table VIa will be used when the examiner certifies that use of the speech discrimination test is not appropriate because of language difficulties, inconsistent speech discrimination scores, etc., or when indicated under the provisions of § 4.86.

(d) ''Puretone threshold average,'' as used in Tables VI and VIa, is the sum of the puretone thresholds at 1000, 2000, 3000 and 4000 Hertz, divided by four. This average is used in all cases (including those in § 4.86) to determine the Roman numeral designation for hearing impairment from Table VI or VIa.

(e) Table VII, ''Percentage Evaluations for Hearing Impairment,'' is used to determine the percentage evaluation by combining the Roman numeral designations for hearing impairment of each ear. The horizontal rows represent the ear having the better hearing and the vertical columns the ear having the poorer hearing. The percentage evaluation is located at the point where the row and column intersect.

(f) If impaired hearing is service-connected in only one ear, in order to determine the percentage evaluation from Table VII, the non-service-connected ear will be assigned a Roman Numeral designation for hearing impairment of I, subject to the provisions of § 3.383 of this chapter.

(g) When evaluating any claim for impaired hearing, refer to § 3.350 of this chapter to determine whether the veteran may be entitled to special monthly compensation due either to deafness, or to deafness in combination with other specified disabilities.

(h) *Numeric tables VI, VIA*, and VII.*

TABLE VI

NUMERIC DESIGNATION OF HEARING IMPAIRMENT BASED ON PURETONE THRESHOLD AVERAGE AND SPEECH DISCRIMINATION

Puretone Threshold Average

% of discrim-ination	0-41	42-49	50-57	58-65	66-73	74-81	82-89	90-97	98+
92-100	I	I	I	II	II	II	III	III	IV
84-90	II	II	II	III	III	III	IV	IV	IV
76-82	III	III	IV	IV	IV	V	V	V	V
68-74	IV	IV	V	V	VI	VI	VII	VII	VII
60-66	V	V	VI	VI	VII	VII	VIII	VIII	VIII
52-58	VI	VI	VII	VII	VIII	VIII	VIII	VIII	IX
44-50	VII	VII	VIII	VIII	VIII	IX	IX	IX	X
36-42	VIII	VIII	VIII	IX	IX	IX	X	X	X
0-34	IX	X	XI	XI	XI	XI	XI	XI	XI

TABLE VIA*

NUMERIC DESIGNATION OF HEARING IMPAIRMENT BASED ONLY ON PURETONE THRESHOLD AVERAGE

Puretone Threshold Average

0-41	42-48	49-55	56-62	63-69	70-76	77-83	84-90	91-97	98-104	105+
I	II	III	IV	V	VI	VII	VIII	IX	X	XI

* This table is for use only as specified in §§ 4.85 and 4.86.

TABLE VII

PERCENTAGE EVALUATION FOR HEARING IMPAIRMENT (DIAGNOSTIC CODE 6100)

Poorer Ear

Better Ear											
XI	100*										
X	90	80									
IX	80	70	60								
VIII	70	60	50	50							
VII	60	60	50	40	40						
VI	50	50	40	40	30	30					
V	40	40	40	30	30	20	20				
IV	30	30	30	20	20	20	10	10			
III	20	20	20	20	20	10	10	10	0		
II	10	10	10	10	10	10	10	0	0	0	
I	10	10	0	0	0	0	0	0	0	0	0
	XI	**X**	**IX**	**VIII**	**VII**	**VI**	**V**	**IV**	**III**	**II**	**I**

* Review for entitlement to special monthly compensation under §3.350 of this chapter.

[64 FR 25206, May 11, 1999]

§ 4.86 Exceptional patterns of hearing impairment.

(a) When the puretone threshold at each of the four specified frequencies (1000, 2000, 3000, and 4000 Hertz) is 55 decibels or more, the rating specialist will determine the Roman numeral designation for hearing impairment from either Table VI or Table VIa, whichever results in the higher numeral. Each ear will be evaluated separately.

(b) When the puretone threshold is 30 decibels or less at 1000 Hertz, and 70 decibels or more at 2000 Hertz, the rating specialist will determine the Roman numeral designation for hearing impairment from either Table VI or Table VIa, whichever results in the higher numeral. That numeral will then be elevated to the next higher

Roman numeral. Each ear will be evaluated separately.

(Authority: 38 U.S.C. 1155)

[64 FR 25209, May 11, 1999]

§4.87 Schedule of ratings—ear.

DISEASES OF THE EAR

	Rating
6200 Chronic suppurative otitis media, mastoiditis, or cholesteatoma (or any combination):	
During suppuration, or with aural polyps	10
NOTE: Evaluate hearing impairment, and complications such as labyrinthitis, tinnitus, facial nerve paralysis, or bone loss of skull, separately.	
6201 Chronic nonsuppurative otitis media with effusion (serous otitis media):	
Rate hearing impairment	
6202 Otosclerosis:	
Rate hearing impairment	
6204 Peripheral vestibular disorders:	
Dizziness and occasional staggering	30
Occasional dizziness	10
NOTE: Objective findings supporting the diagnosis of vestibular disequilibrium are required before a compensable evaluation can be assigned under this code. Hearing impairment or suppuration shall be separately rated and combined.	
6205 Meniere's syndrome (endolymphatic hydrops):	
Hearing impairment with attacks of vertigo and cerebellar gait occurring more than once weekly, with or without tinnitus	100
Hearing impairment with attacks of vertigo and cerebellar gait occurring from one to four times a month, with or without tinnitus	60
Hearing impairment with vertigo less than once a month, with or without tinnitus	30
NOTE: Evaluate Meniere's syndrome either under these criteria or by separately evaluating vertigo (as a peripheral vestibular disorder), hearing impairment, and tinnitus, whichever method results in a higher overall evaluation. But do not combine an evaluation for hearing impairment, tinnitus, or vertigo with an evaluation under diagnostic code 6205.	
6207 Loss of auricle:	
Complete loss of both	50
Complete loss of one	30
Deformity of one, with loss of one-third or more of the substance	10
6208 Malignant neoplasm of the ear (other than skin only)	100
NOTE: A rating of 100 percent shall continue beyond the cessation of any surgical, radiation treatment, antineoplastic chemotherapy or other therapeutic procedure. Six months after discontinuance of such treatment, the appropriate disability rating shall be determined by mandatory VA examination. Any change in evaluation based on that or any subsequent examination shall be subject to the provisions of §3.105(e) of this chapter. If there has been no local recurrence or metastasis, rate on residuals.	
6209 Benign neoplasms of the ear (other than skin only):	
Rate on impairment of function.	
6210 Chronic otitis externa:	

DISEASES OF THE EAR—Continued

	Rating
Swelling, dry and scaly or serous discharge, and itching requiring frequent and prolonged treatment	10
6211 Tympanic membrane, perforation of	0
6260 Tinnitus, recurrent	10
NOTE (1): A separate evaluation for tinnitus may be combined with an evaluation under diagnostic codes 6100, 6200, 6204, or other diagnostic code, except when tinnitus supports an evaluation under one of those diagnostic codes.	
NOTE (2): Assign only a single evaluation for recurrent tinnitus, whether the sound is perceived in one ear, both ears, or in the head.	
NOTE (3): Do not evaluate objective tinnitus (in which the sound is audible to other people and has a definable cause that may or may not be pathologic) under this diagnostic code, but evaluate it as part of any underlying condition causing it.	

(Authority: 38 U.S.C. 1155)

[64 FR 25210, May 11, 1999, as amended at 68 FR 25823, May 14, 2003]

§4.87a Schedule of ratings—other sense organs.

	Rating
6275 Sense of smell, complete loss	10
6276 Sense of taste, complete loss	10
NOTE: Evaluation will be assigned under diagnostic codes 6275 or 6276 only if there is an anatomical or pathological basis for the condition.	

(Authority: 38 U.S.C. 1155)

[64 FR 25210, May 11, 1999]

INFECTIOUS DISEASES, IMMUNE DISORDERS AND NUTRITIONAL DEFICIENCIES

§4.88 [Reserved]

§4.88a Chronic fatigue syndrome.

(a) For VA purposes, the diagnosis of chronic fatigue syndrome requires:

(1) new onset of debilitating fatigue severe enough to reduce daily activity to less than 50 percent of the usual level for at least six months; and

(2) the exclusion, by history, physical examination, and laboratory tests, of all other clinical conditions that may produce similar symptoms; and

(3) six or more of the following:

(i) acute onset of the condition,

(ii) low grade fever,

(iii) nonexudative pharyngitis,

(iv) palpable or tender cervical or axillary lymph nodes,

(v) generalized muscle aches or weakness,

(vi) fatigue lasting 24 hours or longer after exercise,

(vii) headaches (of a type, severity, or pattern that is different from headaches in the pre-morbid state),

(viii) migratory joint pains,

(ix) neuropsychologic symptoms,

(x) sleep disturbance.

(b) [Reserved]

[59 FR 60902, Nov. 29, 1994]

§ 4.88b Schedule of ratings—infectious diseases, immune disorders and nutritional deficiencies.

		Rating
6300	Cholera, Asiatic:	
	As active disease, and for 3 months convalescence	100
	Thereafter rate residuals such as renal necrosis under the appropriate system	
6301	Visceral Leishmaniasis:	
	During treatment for active disease	100
	NOTE: A 100 percent evaluation shall continue beyond the cessation of treatment for active disease. Six months after discontinuance of such treatment, the appropriate disability rating shall be determined by mandatory VA examination. Any change in evaluation based upon that or any subsequent examination shall be subject to the provisions of § 3.105(e) of this chapter. Rate residuals such as liver damage or lymphadenopathy under the appropriate system.	
6302	Leprosy (Hansen's Disease):	
	As active disease	100
	NOTE: A 100 percent evaluation shall continue beyond the date that an examining physician has determined that this has become inactive. Six months after the date of inactivity, the appropriate disability rating shall be determined by mandatory VA examination. Any change in evaluation based upon that or any subsequent examination shall be subject to the provisions of § 3.105(e) of this chapter. Rate residuals such as skin lesions or peripheral neuropathy under the appropriate system.	
6304	Malaria:	
	As active disease	100
	NOTE: The diagnosis of malaria depends on the identification of the malarial parasites in blood smears. If the veteran served in an endemic area and presents signs and symptoms compatible with malaria, the diagnosis may be based on clinical grounds alone. Relapses must be confirmed by the presence of malarial parasites in blood smears.	
	Thereafter rate residuals such as liver or spleen damage under the appropriate system	
6305	Lymphatic Filariasis:	
	As active disease	100
	Thereafter rate residuals such as epididymitis or lymphangitis under the appropriate system	
6306	Bartonellosis:	
	As active disease, and for 3 months convalescence	100
	Thereafter rate residuals such as skin lesions under the appropriate system	
6307	Plague:	
	As active disease	100
	Thereafter rate residuals such as lymphadenopathy under the appropriate system	
6308	Relapsing Fever:	
	As active disease	100
	Thereafter rate residuals such as liver or spleen damage or central nervous system involvement under the appropriate system	
6309	Rheumatic fever:	
	As active disease	100
	Thereafter rate residuals such as heart damage under the appropriate system	
6310	Syphilis, and other treponemal infections:	
	Rate the complications of nervous system, vascular system, eyes or ears. (See DC 7004, syphilitic heart disease, DC 8013, cerebrospinal syphilis, DC 8014, meningovascular syphilis, DC 8015, tabes dorsalis, and DC 9301, dementia associated with central nervous system syphilis)	
6311	Tuberculosis, miliary:	
	As active disease	100
	Inactive: See §§ 4.88c and 4.89.	
6313	Avitaminosis:	
	Marked mental changes, moist dermatitis, inability to retain adequate nourishment, exhaustion, and cachexia	100
	With all of the symptoms listed below, plus mental symptoms and impaired bodily vigor	60
	With stomatitis, diarrhea, and symmetrical dermatitis	40
	With stomatitis, or achlorhydria, or diarrhea	20
	Confirmed diagnosis with nonspecific symptoms such as: decreased appetite, weight loss, abdominal discomfort, weakness, inability to concentrate and irritability	10

	Rating
6314 Beriberi:	
As active disease:	
With congestive heart failure, anasarca, or Wernicke-Korsakoff syndrome	100
With cardiomegaly, or; with peripheral neuropathy with footdrop or atrophy of thigh or calf muscles	60
With peripheral neuropathy with absent knee or ankle jerks and loss of sensation, or; with symptoms such as weakness, fatigue, anorexia, dizziness, heaviness and stiffness of legs, headache or sleep disturbance	30
Thereafter rate residuals under the appropriate body system.	
6315 Pellagra:	
Marked mental changes, moist dermatitis, inability to retain adequate nourishment, exhaustion, and cachexia	100
With all of the symptoms listed below, plus mental symptoms and impaired bodily vigor	60
With stomatitis, diarrhea, and symmetrical dermatitis	40
With stomatitis, or achlorhydria, or diarrhea	20
Confirmed diagnosis with nonspecific symptoms such as: decreased appetite, weight loss, abdominal discomfort, weakness, inability to concentrate and irritability	10
6316 Brucellosis:	
As active disease	100
Thereafter rate residuals such as liver or spleen damage or meningitis under the appropriate system	
6317 Typhus, scrub:	
As active disease, and for 3 months convalescence	100
Thereafter rate residuals such as spleen damage or skin conditions under the appropriate system	
6318 Melioidosis:	
As active disease	100
Thereafter rate residuals such as arthritis, lung lesions or meningitis under the appropriate system	
6319 Lyme Disease:	
As active disease	100
Thereafter rate residuals such as arthritis under the appropriate system	
6320 Parasitic diseases otherwise not specified:	
As active disease	100
Thereafter rate residuals such as spleen or liver damage under the appropriate system	
6350 Lupus erythematosus, systemic (disseminated):	
Not to be combined with ratings under DC 7809 Acute, with frequent exacerbations, producing severe impairment of health	100
Exacerbations lasting a week or more, 2 or 3 times per year	60
Exacerbations once or twice a year or symptomatic during the past 2 years	10
NOTE: Evaluate this condition either by combining the evaluations for residuals under the appropriate system, or by evaluating DC 6350, whichever method results in a higher evaluation.	
6351 HIV-Related Illness:	
AIDS with recurrent opportunistic infections or with secondary diseases afflicting multiple body systems; HIV-related illness with debility and progressive weight loss, without remission, or few or brief remissions	100
Refractory constitutional symptoms, diarrhea, and pathological weight loss, or; minimum rating following development of AIDS-related opportunistic infection or neoplasm	60
Recurrent constitutional symptoms, intermittent diarrhea, and on approved medication(s), or; minimum rating with T4 cell count less than 200, or Hairy Cell Leukoplakia, or Oral Candidiasis	30
Following development of definite medical symptoms, T4 cell of 200 or more and less than 500, and on approved medication(s), or; with evidence of depression or memory loss with employment limitations	10
Asymptomatic, following initial diagnosis of HIV infection, with or without lymphadenopathy or decreased T4 cell count	0
NOTE (1): The term ''approved medication(s)'' includes medications prescribed as part of a research protocol at an accredited medical institution.	
NOTE (2): Psychiatric or central nervous system manifestations, opportunistic infections, and neoplasms may be rated separately under appropriate codes if higher overall evaluation results, but not in combination with percentages otherwise assignable above.	
6354 Chronic Fatigue Syndrome (CFS):	
Debilitating fatigue, cognitive impairments (such as inability to concentrate, forgetfulness, confusion), or a combination of other signs and symptoms:	
Which are nearly constant and so severe as to restrict routine daily activities almost completely and which may occasionally preclude self-care	100
Which are nearly constant and restrict routine daily activities to less than 50 percent of the pre-illness level, or; which wax and wane, resulting in periods of incapacitation of at least six weeks total duration per year	60
Which are nearly constant and restrict routine daily activities to 50 to 75 percent of the pre-illness level, or; which wax and wane, resulting in periods of incapacitation of at least four but less than six weeks total duration per year	40
Which are nearly constant and restrict routine daily activities by less than 25 percent of the pre-illness level, or; which wax and wane, resulting in periods of incapacitation of at least two but less than four weeks total duration per year	20
Which wax and wane but result in periods of incapacitation of at least one but less than two weeks total duration per year, or; symptoms controlled by continuous medication	10
NOTE: For the purpose of evaluating this disability, the condition will be considered incapacitating only while it requires bed rest and treatment by a physician.	

[61 FR 39875, July 31, 1996]

EFFECTIVE DATE NOTE: At 84 FR 28230, June 18, 2019, § 4.88b was amended by adding introductory text, adding the entry ''General Rating Formula for Infectious Diseases:'' before the entry for diagnostic code 6300, revising the entries for diagnostic codes 6300 through 6302 and 6304 through 6311, adding in numerical order an entry for diagnostic code 6312, revising the entries for diagnostic codes 6316 through 6320, adding in numerical order entries for diagnostic codes 6325, 6326, 6329 through 6331, and 6333 through 6335 and revising the entries for diagnostic codes 6351 and 6354, effective Aug. 11, 2019. For the convenience of the user, the added and revised text is set forth as follows:

§ 4.88b Schedule of ratings-infectious diseases, immune disorders, and nutritional deficiencies.

NOTE: Rate any residual disability of infection within the appropriate body system as indicated by the notes in the evaluation criteria. As applicable, consider the long-term health effects potentially associated with infectious diseases as listed in § 3.317(d) of this chapter, specifically Brucellosis, Campylobacter jejuni, Coxiella burnetii (Q fever), Malaria, Mycobacterium Tuberculosis, Nontyphoid Salmonella, Shigella, Visceral Leishmaniasis, and West Nile virus.

		Rating
	General Rating Formula for Infectious Diseases:	
	For active disease	100
	After active disease has resolved, rate at 0 percent for infection. Rate any residual disability of infection within the appropriate body system.	
6300	Vibriosis (Cholera, Non-cholera):	
	Evaluate under the General Rating Formula.	
	Note: Rate residuals of cholera and non-cholera vibrio infections, such as renal failure, skin, and musculoskeletal conditions, within the appropriate body system.	
6301	Visceral leishmaniasis:	
	As active disease	100
	Note 1: Continue a 100 percent evaluation beyond the cessation of treatment for active disease. Six months after discontinuance of such treatment, determine the appropriate disability rating by mandatory VA examination. Any change in evaluation based upon that or any subsequent examination shall be subject to the provisions of § 3.105(e) of this chapter. Thereafter, rate under the appropriate body system any residual disability of infection, which includes, but is not limited to liver damage and bone marrow disease.	
	Note 2: Confirm the recurrence of active infection by culture, histopathology, or other diagnostic laboratory testing.	
6302	Leprosy (Hansen's disease):	
	As active disease	100
	Note: Continue a 100 percent evaluation beyond the cessation of treatment for active disease. Six months after discontinuance of such treatment, determine the appropriate disability rating by mandatory VA examination. Any change in evaluation based upon that or any subsequent examination shall be subject to the provisions of § 3.105(e) of this chapter. Thereafter, rate under the appropriate body system any residual disability of infection, which includes, but is not limited to, skin lesions, peripheral neuropathy, or amputations.	
6304	Malaria:	
	Evaluate under the General Rating Formula.	
	Note 1: The diagnosis of malaria, both initially and during relapse, depends on the identification of the malarial parasites in blood smears or other specific diagnostic laboratory tests such as antigen detection, immunologic (immunochromatographic) tests, and molecular testing such as polymerase chain reaction tests.	
	Note 2: Rate under the appropriate body system any residual disability of infection, which includes, but is not limited to, liver or splenic damage, and central nervous system conditions.	
6305	Lymphatic filariasis, to include elephantiasis:	
	Evaluate under the General Rating Formula.	
	Note: Rate under the appropriate body system any residual disability of infection, which includes, but is not limited to, epididymitis, lymphangitis, lymphatic obstruction, or lymphedema affecting extremities, genitals, and/or breasts.	
6306	Bartonellosis:	
	Evaluate under the General Rating Formula.	
	Note: Rate under the appropriate body system any residual disability of infection, which includes, but is not limited to, endocarditis or skin lesions.	
6307	Plague:	
	Evaluate under the General Rating Formula.	
	Note: Rate under the appropriate body system any residual disability of infection.	
6308	Relapsing Fever:	
	Evaluate under the General Rating Formula.	
	Note: Rate under the appropriate body system any residual disability of infection, which includes, but is not limited to, liver or spleen damage, iritis, uveitis, or central nervous system involvement.	
6309	Rheumatic fever:	
	Evaluate under the General Rating Formula.	
	Note: Rate under the appropriate body system any residual disability of infection, which includes, but is not limited to, heart damage.	

		Rating
6310	Syphilis, and other treponema infections:	
	Note: Rate under the appropriate body system any residual disability of infection, which includes, but is not limited to, diseases of the nervous system, vascular system, eyes, or ears (*see* DC 7004, DC 8013, DC 8014, DC 8015, and DC 9301).	
6311	Tuberculosis, miliary:	
	As active disease	100
	Inactive disease: *See* §§4.88c and 4.89.	
	Note 1: Confirm the recurrence of active infection by culture, histopathology, or other diagnostic laboratory testing.	
	Note 2: Rate under the appropriate body system any residual disability of infection which includes, but is not limited to, skin conditions and conditions of the respiratory, central nervous, musculoskeletal, ocular, gastrointestinal, and genitourinary systems and those residuals listed in §4.88c.	
6312	Nontuberculosis mycobacterium infection:	
	As active disease	100
	Note 1: Continue the rating of 100 percent for the duration of treatment for active disease followed by a mandatory VA exam. If there is no relapse, rate on residuals. Any change in evaluation based upon that or any subsequent examination shall be subject to the provisions of §3.105(e) of this chapter.	
	Note 2: Confirm the recurrence of active infection by culture, histopathology, or other diagnostic laboratory testing.	
	Note 3: Rate under the appropriate body system any residual disability of infection which includes, but is not limited to, skin conditions and conditions of the respiratory, central nervous, musculoskeletal, ocular, gastrointestinal, and genitourinary systems and those residuals listed in §4.88c.	
*	* * * * * *	*
6316	Brucellosis:	
	Evaluate under the General Rating Formula.	
	Note 1: Culture, serologic testing, or both must confirm the initial diagnosis and recurrence of active infection.	
	Note 2: Rate under the appropriate body system any residual disability of infection, which includes, but is not limited to, meningitis, liver, spleen and musculoskeletal conditions.	
6317	Rickettsial, ehrlichia, and anaplasma infections:	
	Evaluate under the General Rating Formula.	
	Note 1: Rate under the appropriate body system any residual disability of infection, which includes, but is not limited to, bone marrow, spleen, central nervous system, and skin conditions.	
	Note 2: This diagnostic code includes, but is not limited to, scrub typhus, Rickettsial pox, African tick-borne fever, Rocky Mountain spotted fever, ehrlichiosis, or anaplasmosis.	
6318	Melioidosis:	
	Evaluate under the General Rating Formula.	
	Note 1: Confirm by culture or other specific diagnostic laboratory tests the initial diagnosis and any relapse or chronic activity of infection.	
	Note 2: Rate under the appropriate body system any residual disability of infection, which includes, but is not limited to, arthritis, lung lesions, or meningitis.	
6319	Lyme disease:	
	Evaluate under the General Rating Formula.	
	Note: Rate under the appropriate body system any residual disability of infection, which includes, but is not limited to, arthritis, Bell's palsy, radiculopathy, ocular, or cognitive dysfunction.	
6320	Parasitic diseases otherwise not specified:	
	Evaluate under the General Rating Formula.	
	Note: Rate under the appropriate body system any residual disability of infection.	
6325	Hyperinfection syndrome or disseminated strongyloidiasis:	
	As active disease	100
	Note: Continue the rating of 100 percent through active disease followed by a mandatory VA exam. If there is no relapse, rate on residual disability. Any change in evaluation based upon that or any subsequent examination shall be subject to the provisions of §3.105(e) of this chapter.	
6326	Schistosomiasis:	
	As acute or asymptomatic chronic disease	0
	Note: Rate under the appropriate body system any residual disability of infection, which includes, but is not limited to, conditions of the liver, intestinal system, female genital tract, genitourinary tract, or central nervous system.	
6329	Hemorrhagic fevers, including dengue, yellow fever, and others:	
	Evaluate under the General Rating Formula.	
	Note: Rate under the appropriate body system any residual disability of infection, which includes, but is not limited to, conditions of the central nervous system, liver, or kidney.	
6330	Campylobacter jejuni infection:	
	Evaluate under the General Rating Formula.	
	Note: Rate under the appropriate body system any residual disability of infection, which includes, but is not limited to, Guillain-Barre syndrome, reactive arthritis, or uveitis.	
6331	Coxiella burnetii infection (Q fever):	
	Evaluate under the General Rating Formula.	
	Note: Rate under the appropriate body system any residual disability of infection, which includes, but is not limited to, chronic hepatitis, endocarditis, osteomyelitis, post Q-fever chronic fatigue syndrome, or vascular infections.	
6333	Nontyphoid salmonella infections:	
	Evaluate under the General Rating Formula.	

		Rating
	Note: Rate under the appropriate body system any residual disability of infection, which includes, but is not limited to, reactive arthritis.	
6334	Shigella infections:	
	Evaluate under the General Rating Formula.	
	Note: Rate under the appropriate body system any residual disability of infection, which includes, but is not limited to, hemolytic-uremic syndrome or reactive arthritis.	
6335	West Nile virus infection:	
	Evaluate under the General Rating Formula.	
	Note: Rate under the appropriate body system any residual disability of infection, which includes, but is not limited to, variable physical, functional, or cognitive disabilities.	
*	* * * * * *	*
6351	HIV-related illness:	
	AIDS with recurrent opportunistic infections (see Note 3) or with secondary diseases afflicting multiple body systems; HIV-related illness with debility and progressive weight loss	100
	Refractory constitutional symptoms, diarrhea, and pathological weight loss; or minimum rating following development of AIDS-related opportunistic infection or neoplasm	60
	Recurrent constitutional symptoms, intermittent diarrhea, and use of approved medication(s); or minimum rating with T4 cell count less than 200	30
	Following development of HIV-related constitutional symptoms; T4 cell count between 200 and 500; use of approved medication(s); or with evidence of depression or memory loss with employment limitations	10
	Asymptomatic, following initial diagnosis of HIV infection, with or without lymphadenopathy or decreased T4 cell count	0
	Note 1: In addition to standard therapies and regimens, the term ''approved medication(s)'' includes treatment regimens and medications prescribed as part of a research protocol at an accredited medical institution.	
	Note 2: Diagnosed psychiatric illness, central nervous system manifestations, opportunistic infections, and neoplasms may be rated separately under the appropriate diagnostic codes if a higher overall evaluation results, provided the disability symptoms do not overlap with evaluations otherwise assignable above.	
	Note 3: The following list of opportunistic infections are considered AIDS-defining conditions, that is, a diagnosis of AIDS follows if a person has HIV and one more of these infections, regardless of the CD4 count—candidiasis of the bronchi, trachea, esophagus, or lungs; invasive cervical cancer; coccidioidomycosis; cryptococcosis; cryptosporidiosis; cytomegalovirus (particularly CMV retinitis); HIV-related encephalopathy; herpes simplex-chronic ulcers for greater than one month, or bronchitis, pneumonia, or esophagitis; histoplasmosis; isosporiasis (chronic intestinal); Kaposi's sarcoma; lymphoma; mycobacterium avium complex; tuberculosis; pneumocystis jirovecii (carinii) pneumonia; pneumonia, recurrent; progressive multifocal leukoencephalopathy; salmonella septicemia, recurrent; toxoplasmosis of the brain; and wasting syndrome due to HIV.	
6354	Chronic fatigue syndrome (CFS):	
	Debilitating fatigue, cognitive impairments (such as inability to concentrate, forgetfulness, or confusion), or a combination of other signs and symptoms:	
	Which are nearly constant and so severe as to restrict routine daily activities almost completely and which may occasionally preclude self-care	100
	Which are nearly constant and restrict routine daily activities to less than 50 percent of the pre-illness level; or which wax and wane, resulting in periods of incapacitation of at least six weeks total duration per year	60
	Which are nearly constant and restrict routine daily activities from 50 to 75 percent of the pre-illness level; or which wax and wane, resulting in periods of incapacitation of at least four but less than six weeks total duration per year	40
	Which are nearly constant and restrict routine daily activities by less than 25 percent of the pre-illness level; or which wax and wane, resulting in periods of incapacitation of at least two but less than four weeks total duration per year	20
	Which wax and wane but result in periods of incapacitation of at least one but less than two weeks total duration per year; or symptoms controlled by continuous medication	10
	Note: For the purpose of evaluating this disability, incapacitation exists only when a licensed physician prescribes bed rest and treatment.	

§4.88c Ratings for inactive nonpulmonary tuberculosis initially entitled after August 19, 1968.

	Rating
For 1 year after date of inactivity, following active tuberculosis	100
Thereafter: Rate residuals under the specific body system or systems affected.	
Following the total rating for the 1 year period after date of inactivity, the schedular evaluation for residuals of nonpulmonary tuberculosis, *i.e.*, ankylosis, surgical removal of a part, etc., will be assigned under the appropriate diagnostic code for the residual preceded by the diagnostic code for tuberculosis of the body part affected. For example, tuberculosis of the hip joint with residual ankylosis would be coded 5001–5250. Where there are existing residuals of pulmonary and nonpulmonary conditions, the evaluations for residual separate functional impairment may be combined.	
Where there are existing pulmonary and nonpulmonary conditions, the total rating for the 1 year, after attainment of inactivity, may not be applied to both conditions during the same period. However, the total rating during the 1-year period for the pulmonary or for the nonpulmonary condition will be utilized, combined with evaluation for residuals of the condition not covered by the 1-year total evaluation, so as to allow any additional benefit provided during such period.	

[34 FR 5062, Mar. 11, 1969. Redesignated at 59 FR 60902, Nov. 29, 1994]

§4.89 Ratings for inactive nonpulmonary tuberculosis in effect on August 19, 1968.

Public Law 90–493 repealed section 356 of title 38, United States Code which provided graduated ratings for inactive tuberculosis. The repealed section, however, still applies to the case of any veteran who on August 19, 1968, was receiving or entitled to receive compensation for tuberculosis. The use of the protective provisions of Pub. L. 90–493 should be mentioned in the discussion portion of all ratings in which these provisions are applied. For use in rating cases in which the protective provisions of Pub. L. 90–493 apply, the former evaluations are retained in this section.

	Rating
For 2 years after date of inactivity, following active tuberculosis, which was clinically identified during service or subsequently	100
Thereafter, for 4 years, or in any event, to 6 years after date of inactivity	50
Thereafter, for 5 years, or to 11 years after date of inactivity	30
Thereafter, in the absence of a schedular compensable permanent residual	0
Following the total rating for the 2-year period after date of inactivity, the schedular evaluation for residuals of nonpulmonary tuberculosis, *i.e.*, ankylosis, surgical removal of a part, etc., if in excess of 50 percent or 30 percent will be assigned under the appropriate diagnostic code for the specific residual preceded by the diagnostic code for tuberculosis of the body part affected. For example, tuberculosis of the hipjoint with residual ankylosis would be coded 5001–5250.	
The graduated ratings for nonpulmonary tuberculosis will not be combined with residuals of nonpulmonary tuberculosis unless the graduated rating and the rating for residual disability cover separate functional losses, e.g., graduated ratings for tuberculosis of the kidney and residuals of tuberculosis of the spine. Where there are existing pulmonary and nonpulmonary conditions, the graduated evaluation for the pulmonary, or for the nonpulmonary, condition will be utilized, combined with evaluations for residuals of the condition not covered by the graduated evaluation utilized, so as to provide the higher evaluation over such period.	
The ending dates of all graduated ratings of nonpulmonary tuberculosis will be controlled by the date of attainment of inactivity.	
These ratings are applicable only to veterans with nonpulmonary tuberculosis active on or after October 10, 1949.	

[29 FR 6718, May 22, 1964, as amended at 34 FR 5062, Mar. 11, 1969; 43 FR 45361, Oct. 2, 1978]

THE RESPIRATORY SYSTEM

§4.96 Special provisions regarding evaluation of respiratory conditions.

(a) *Rating coexisting respiratory conditions.* Ratings under diagnostic codes 6600 through 6817 and 6822 through 6847 will not be combined with each other. Where there is lung or pleural involvement, ratings under diagnostic codes 6819 and 6820 will not be combined with each other or with diagnostic codes 6600 through 6817 or 6822 through 6847. A single rating will be assigned under the diagnostic code which reflects the predominant disability with elevation to the next higher evaluation where the severity of the overall disability warrants such elevation. However, in cases protected by the provisions of Pub. L. 90–493, the graduated ratings of 50 and 30 percent for inactive tuberculosis will not be elevated.

(b) *Rating ''protected'' tuberculosis cases.* Public Law 90–493 repealed section 356 of title 38, United States Code which had provided graduated ratings for inactive tuberculosis. The repealed

section, however, still applies to the case of any veteran who on August 19, 1968, was receiving or entitled to receive compensation for tuberculosis. The use of the protective provisions of Pub. L. 90–493 should be mentioned in the discussion portion of all ratings in which these provisions are applied. For application in rating cases in which the protective provisions of Pub. L. 90–493 apply the former evaluations pertaining to pulmonary tuberculosis are retained in § 4.97.

(c) *Special monthly compensation.* When evaluating any claim involving complete organic aphonia, refer to § 3.350 of this chapter to determine whether the veteran may be entitled to special monthly compensation. Footnotes in the schedule indicate conditions which potentially establish entitlement to special monthly compensation; however, there are other conditions in this section which under certain circumstances also establish entitlement to special monthly compensation.

(d) *Special provisions for the application of evaluation criteria for diagnostic codes 6600, 6603, 6604, 6825–6833, and 6840–6845.* (1) Pulmonary function tests (PFT's) are required to evaluate these conditions except:

(i) When the results of a maximum exercise capacity test are of record and are 20 ml/kg/min or less. If a maximum exercise capacity test is not of record, evaluate based on alternative criteria.

(ii) When pulmonary hypertension (documented by an echocardiogram or cardiac catheterization), cor pulmonale, or right ventricular hypertrophy has been diagnosed.

(iii) When there have been one or more episodes of acute respiratory failure.

(iv) When outpatient oxygen therapy is required.

(2) If the DLCO (SB) (Diffusion Capacity of the Lung for Carbon Monoxide by the Single Breath Method) test is not of record, evaluate based on alternative criteria as long as the examiner states why the test would not be useful or valid in a particular case.

(3) When the PFT's are not consistent with clinical findings, evaluate based on the PFT's unless the examiner states why they are not a valid indication of respiratory functional impairment in a particular case.

(4) Post-bronchodilator studies are required when PFT's are done for disability evaluation purposes except when the results of pre-bronchodilator pulmonary function tests are normal or when the examiner determines that post-bronchodilator studies should not be done and states why.

(5) When evaluating based on PFT's, use post-bronchodilator results in applying the evaluation criteria in the rating schedule unless the post-bronchodilator results were poorer than the pre-bronchodilator results. In those cases, use the pre-bronchodilator values for rating purposes.

(6) When there is a disparity between the results of different PFT's (FEV–1 (Forced Expiratory Volume in one second), FVC (Forced Vital Capacity), etc.), so that the level of evaluation would differ depending on which test result is used, use the test result that the examiner states most accurately reflects the level of disability.

(7) If the FEV–1 and the FVC are both greater than 100 percent, do not assign a compensable evaluation based on a decreased FEV–1/FVC ratio.

(Authority: 38 U.S.C. 1155)

[34 FR 5062, Mar. 11, 1969, as amended at 61 FR 46727, Sept. 5, 1996; 71 FR 52459, Sept. 6, 2006]

§ 4.97 Schedule of ratings—respiratory system.

	Rating
DISEASES OF THE NOSE AND THROAT	
6502 Septum, nasal, deviation of:	
Traumatic only,	
With 50-percent obstruction of the nasal passage on both sides or complete obstruction on one side	10
6504 Nose, loss of part of, or scars:	
Exposing both nasal passages	30
Loss of part of one ala, or other obvious disfigurement	10

	Rating
Note: Or evaluate as DC 7800, scars, disfiguring, head, face, or neck.	
6510 Sinusitis, pansinusitis, chronic.	
6511 Sinusitis, ethmoid, chronic.	
6512 Sinusitis, frontal, chronic.	
6513 Sinusitis, maxillary, chronic.	
6514 Sinusitis, sphenoid, chronic.	
General Rating Formula for Sinusitis (DC's 6510 through 6514):	
Following radical surgery with chronic osteomyelitis, or; near constant sinusitis characterized by headaches, pain and tenderness of affected sinus, and purulent discharge or crusting after repeated surgeries	50
Three or more incapacitating episodes per year of sinusitis requiring prolonged (lasting four to six weeks) antibiotic treatment, or; more than six non-incapacitating episodes per year of sinusitis characterized by headaches, pain, and purulent discharge or crusting	30
One or two incapacitating episodes per year of sinusitis requiring prolonged (lasting four to six weeks) antibiotic treatment, or; three to six non-incapacitating episodes per year of sinusitis characterized by headaches, pain, and purulent discharge or crusting	10
Detected by X-ray only	0
Note: An incapacitating episode of sinusitis means one that requires bed rest and treatment by a physician.	
6515 Laryngitis, tuberculous, active or inactive.	
Rate under §§4.88c or 4.89, whichever is appropriate.	
6516 Laryngitis, chronic:	
Hoarseness, with thickening or nodules of cords, polyps, submucous infiltration, or pre-malignant changes on biopsy	30
Hoarseness, with inflammation of cords or mucous membrane	10
6518 Laryngectomy, total.	[1] 100
Rate the residuals of partial laryngectomy as laryngitis (DC 6516), aphonia (DC 6519), or stenosis of larynx (DC 6520).	
6519 Aphonia, complete organic:	
Constant inability to communicate by speech	[1] 100
Constant inability to speak above a whisper	60
Note: Evaluate incomplete aphonia as laryngitis, chronic (DC 6516).	
6520 Larynx, stenosis of, including residuals of laryngeal trauma (unilateral or bilateral):	
Forced expiratory volume in one second (FEV–1) less than 40 percent of predicted value, with Flow-Volume Loop compatible with upper airway obstruction, or; permanent tracheostomy	100
FEV–1 of 40- to 55-percent predicted, with Flow-Volume Loop compatible with upper airway obstruction	60
FEV–1 of 56- to 70-percent predicted, with Flow-Volume Loop compatible with upper airway obstruction	30
FEV–1 of 71- to 80-percent predicted, with Flow-Volume Loop compatible with upper airway obstruction	10
Note: Or evaluate as aphonia (DC 6519).	
6521 Pharynx, injuries to:	
Stricture or obstruction of pharynx or nasopharynx, or; absence of soft palate secondary to trauma, chemical burn, or granulomatous disease, or; paralysis of soft palate with swallowing difficulty (nasal regurgitation) and speech impairment	50
6522 Allergic or vasomotor rhinitis:	
With polyps	30
Without polyps, but with greater than 50-percent obstruction of nasal passage on both sides or complete obstruction on one side	10
6523 Bacterial rhinitis:	
Rhinoscleroma	50
With permanent hypertrophy of turbinates and with greater than 50-percent obstruction of nasal passage on both sides or complete obstruction on one side	10
6524 Granulomatous rhinitis:	
Wegener's granulomatosis, lethal midline granuloma	100
Other types of granulomatous infection	20
DISEASES OF THE TRACHEA AND BRONCHI	
6600 Bronchitis, chronic:	
FEV–1 less than 40 percent of predicted value, or; the ratio of Forced Expiratory Volume in one second to Forced Vital Capacity (FEV–1/FVC) less than 40 percent, or; Diffusion Capacity of the Lung for Carbon Monoxide by the Single Breath Method (DLCO (SB)) less than 40-percent predicted, or; maximum exercise capacity less than 15 ml/kg/min oxygen consumption (with cardiac or respiratory limitation), or; cor pulmonale (right heart failure), or; right ventricular hypertrophy, or; pulmonary hypertension (shown by Echo or cardiac catheterization), or; episode(s) of acute respiratory failure, or; requires outpatient oxygen therapy	100
FEV–1 of 40- to 55-percent predicted, or; FEV–1/FVC of 40 to 55 percent, or; DLCO (SB) of 40- to 55-percent predicted, or; maximum oxygen consumption of 15 to 20 ml/kg/min (with cardiorespiratory limit)	60
FEV–1 of 56- to 70-percent predicted, or; FEV–1/FVC of 56 to 70 percent, or; DLCO (SB) 56- to 65-percent predicted	30
FEV–1 of 71- to 80-percent predicted, or; FEV–1/FVC of 71 to 80 percent, or; DLCO (SB) 66- to 80-percent predicted	10
6601 Bronchiectasis:	
With incapacitating episodes of infection of at least six weeks total duration per year	100

	Rating
With incapacitating episodes of infection of four to six weeks total duration per year, or; near constant findings of cough with purulent sputum associated with anorexia, weight loss, and frank hemoptysis and requiring antibiotic usage almost continuously	60
With incapacitating episodes of infection of two to four weeks total duration per year, or; daily productive cough with sputum that is at times purulent or blood-tinged and that requires prolonged (lasting four to six weeks) antibiotic usage more than twice a year	30
Intermittent productive cough with acute infection requiring a course of antibiotics at least twice a year	10
Or rate according to pulmonary impairment as for chronic bronchitis (DC 6600).	
Note: An incapacitating episode is one that requires bedrest and treatment by a physician.	
6602 Asthma, bronchial:	
FEV–1 less than 40-percent predicted, or; FEV–1/FVC less than 40 percent, or; more than one attack per week with episodes of respiratory failure, or; requires daily use of systemic (oral or parenteral) high dose corticosteroids or immuno-suppressive medications	100
FEV–1 of 40- to 55-percent predicted, or; FEV–1/FVC of 40 to 55 percent, or; at least monthly visits to a physician for required care of exacerbations, or; intermittent (at least three per year) courses of systemic (oral or parenteral) corticosteroids	60
FEV–1 of 56- to 70-percent predicted, or; FEV–1/FVC of 56 to 70 percent, or; daily inhalational or oral bronchodilator therapy, or; inhalational anti-inflammatory medication	30
FEV–1 of 71- to 80-percent predicted, or; FEV–1/FVC of 71 to 80 percent, or; intermittent inhalational or oral bronchodilator therapy	10
Note: In the absence of clinical findings of asthma at time of examination, a verified history of asthmatic attacks must be of record.	
6603 Emphysema, pulmonary:	
FEV–1 less than 40 percent of predicted value, or; the ratio of Forced Expiratory Volume in one second to Forced Vital Capacity (FEV–1/FVC) less than 40 percent, or; Diffusion Capacity of the Lung for Carbon Monoxide by the Single Breath Method (DLCO (SB)) less than 40-percent predicted, or; maximum exercise capacity less than 15 ml/kg/min oxygen consumption (with cardiac or respiratory limitation), or; cor pulmonale (right heart failure), or; right ventricular hypertrophy, or; pulmonary hypertension (shown by Echo or cardiac catheterization), or; episode(s) of acute respiratory failure, or; requires outpatient oxygen therapy.	100
FEV–1 of 40- to 55-percent predicted, or; FEV–1/FVC of 40 to 55 percent, or; DLCO (SB) of 40- to 55-percent predicted, or; maximum oxygen consumption of 15 to 20 ml/kg/min (with cardiorespiratory limit)	60
FEV–1 of 56- to 70-percent predicted, or; FEV–1/FVC of 56 to 70 percent, or; DLCO (SB) 56- to 65-percent predicted	30
FEV–1 of 71- to 80-percent predicted, or; FEV–1/FVC of 71 to 80 percent, or; DLCO (SB) 66- to 80-percent predicted	10
6604 Chronic obstructive pulmonary disease:	
FEV–1 less than 40 percent of predicted value, or; the ratio of Forced Expiratory Volume in one second to Forced Vital Capacity (FEV–1/FVC) less than 40 percent, or; Diffusion Capacity of the Lung for Carbon Monoxide by the Single Breath Method (DLCO (SB)) less than 40-percent predicted, or; maximum exercise capacity less than 15 ml/kg/min oxygen consumption (with cardiac or respiratory limitation), or; cor pulmonale (right heart failure), or; right ventricular hypertrophy, or; pulmonary hypertension (shown by Echo or cardiac catheterization), or; episode(s) of acute respiratory failure, or; requires outpatient oxygen therapy.	100
FEV–1 of 40- to 55-percent predicted, or; FEV–1/FVC of 40 to 55 percent, or; DLCO (SB) of 40- to 55-percent predicted, or; maximum oxygen consumption of 15 to 20 ml/kg/min (with cardiorespiratory limit)	60
FEV–1 of 56- to 70-percent predicted, or; FEV–1/FVC of 56 to 70 percent, or; DLCO (SB) 56- to 65-percent predicted	30
FEV–1 of 71- to 80-percent predicted, or; FEV–1/FVC of 71 to 80 percent, or; DLCO (SB) 66- to 80-percent predicted	10

DISEASES OF THE LUNGS AND PLEURA—TUBERCULOSIS
Ratings for Pulmonary Tuberculosis Entitled on August 19, 1968

6701 Tuberculosis, pulmonary, chronic, far advanced, active	100
6702 Tuberculosis, pulmonary, chronic, moderately advanced, active	100
6703 Tuberculosis, pulmonary, chronic, minimal, active	100
6704 Tuberculosis, pulmonary, chronic, active, advancement unspecified	100
6721 Tuberculosis, pulmonary, chronic, far advanced, inactive.	
6722 Tuberculosis, pulmonary, chronic, moderately advanced, inactive.	
6723 Tuberculosis, pulmonary, chronic, minimal, inactive.	
6724 Tuberculosis, pulmonary, chronic, inactive, advancement unspecified.	
General Rating Formula for Inactive Pulmonary Tuberculosis: For two years after date of inactivity, following active tuberculosis, which was clinically identified during service or subsequently	100
Thereafter for four years, or in any event, to six years after date of inactivity	50
Thereafter, for five years, or to eleven years after date of inactivity	30
Following far advanced lesions diagnosed at any time while the disease process was active, minimum	30
Following moderately advanced lesions, provided there is continued disability, emphysema, dyspnea on exertion, impairment of health, etc	20
Otherwise	0

	Rating
Note (1): The 100-percent rating under codes 6701 through 6724 is not subject to a requirement of precedent hospital treatment. It will be reduced to 50 percent for failure to submit to examination or to follow prescribed treatment upon report to that effect from the medical authorities. When a veteran is placed on the 100-percent rating for inactive tuberculosis, the medical authorities will be appropriately notified of the fact, and of the necessity, as given in footnote 1 to 38 U.S.C. 1156 (and formerly in 38 U.S.C. 356, which has been repealed by Public Law 90–493), to notify the Veterans Service Center in the event of failure to submit to examination or to follow treatment.	
Note (2): The graduated 50-percent and 30-percent ratings and the permanent 30 percent and 20 percent ratings for inactive pulmonary tuberculosis are not to be combined with ratings for other respiratory disabilities. Following thoracoplasty the rating will be for removal of ribs combined with the rating for collapsed lung. Resection of the ribs incident to thoracoplasty will be rated as removal.	
Ratings for Pulmonary Tuberculosis Initially Evaluated After August 19, 1968	
6730 Tuberculosis, pulmonary, chronic, active	100
Note: Active pulmonary tuberculosis will be considered permanently and totally disabling for non-service-connected pension purposes in the following circumstances: (a) Associated with active tuberculosis involving other than the respiratory system. (b) With severe associated symptoms or with extensive cavity formation. (c) Reactivated cases, generally. (d) With advancement of lesions on successive examinations or while under treatment. (e) Without retrogression of lesions or other evidence of material improvement at the end of six months hospitalization or without change of diagnosis from ''active'' at the end of 12 months hospitalization. Material improvement means lessening or absence of clinical symptoms, and X-ray findings of a stationary or retrogressive lesion.	
6731 Tuberculosis, pulmonary, chronic, inactive: Depending on the specific findings, rate residuals as interstitial lung disease, restrictive lung disease, or, when obstructive lung disease is the major residual, as chronic bronchitis (DC 6600). Rate thoracoplasty as removal of ribs under DC 5297.	
Note: A mandatory examination will be requested immediately following notification that active tuberculosis evaluated under DC 6730 has become inactive. Any change in evaluation will be carried out under the provisions of §3.105(e).	
6732 Pleurisy, tuberculous, active or inactive: Rate under §§4.88c or 4.89, whichever is appropriate.	
NONTUBERCULOUS DISEASES	
6817 Pulmonary Vascular Disease:	
Primary pulmonary hypertension, or; chronic pulmonary thromboembolism with evidence of pulmonary hypertension, right ventricular hypertrophy, or cor pulmonale, or; pulmonary hypertension secondary to other obstructive disease of pulmonary arteries or veins with evidence of right ventricular hypertrophy or cor pulmonale	100
Chronic pulmonary thromboembolism requiring anticoagulant therapy, or; following inferior vena cava surgery without evidence of pulmonary hypertension or right ventricular dysfunction	60
Symptomatic, following resolution of acute pulmonary embolism	30
Asymptomatic, following resolution of pulmonary thromboembolism	0
Note: Evaluate other residuals following pulmonary embolism under the most appropriate diagnostic code, such as chronic bronchitis (DC 6600) or chronic pleural effusion or fibrosis (DC 6844), but do not combine that evaluation with any of the above evaluations.	
6819 Neoplasms, malignant, any specified part of respiratory system exclusive of skin growths	100
Note: A rating of 100 percent shall continue beyond the cessation of any surgical, X-ray, antineoplastic chemotherapy or other therapeutic procedure. Six months after discontinuance of such treatment, the appropriate disability rating shall be determined by mandatory VA examination. Any change in evaluation based upon that or any subsequent examination shall be subject to the provisions of §3.105(e) of this chapter. If there has been no local recurrence or metastasis, rate on residuals.	
6820 Neoplasms, benign, any specified part of respiratory system. Evaluate using an appropriate respiratory analogy.	
Bacterial Infections of the Lung	
6822 Actinomycosis.	
6823 Nocardiosis.	
6824 Chronic lung abscess.	
General Rating Formula for Bacterial Infections of the Lung (diagnostic codes 6822 through 6824):	
Active infection with systemic symptoms such as fever, night sweats, weight loss, or hemoptysis	100
Depending on the specific findings, rate residuals as interstitial lung disease, restrictive lung disease, or, when obstructive lung disease is the major residual, as chronic bronchitis (DC 6600).	
Interstitial Lung Disease	
6825 Diffuse interstitial fibrosis (interstitial pneumonitis, fibrosing alveolitis).	
6826 Desquamative interstitial pneumonitis.	
6827 Pulmonary alveolar proteinosis.	
6828 Eosinophilic granuloma of lung.	

	Rating
6829 Drug-induced pulmonary pneumonitis and fibrosis.	
6830 Radiation-induced pulmonary pneumonitis and fibrosis.	
6831 Hypersensitivity pneumonitis (extrinsic allergic alveolitis).	
6832 Pneumoconiosis (silicosis, anthracosis, etc.).	
6833 Asbestosis.	
General Rating Formula for Interstitial Lung Disease (diagnostic codes 6825 through 6833):	
Forced Vital Capacity (FVC) less than 50-percent predicted, or; Diffusion Capacity of the Lung for Carbon Monoxide by the Single Breath Method (DLCO (SB)) less than 40-percent predicted, or; maximum exercise capacity less than 15 ml/kg/min oxygen consumption with cardiorespiratory limitation, or; cor pulmonale or pulmonary hypertension, or; requires outpatient oxygen therapy	100
FVC of 50- to 64-percent predicted, or; DLCO (SB) of 40- to 55-percent predicted, or; maximum exercise capacity of 15 to 20 ml/kg/min oxygen consumption with cardiorespiratory limitation	60
FVC of 65- to 74-percent predicted, or; DLCO (SB) of 56- to 65-percent predicted	30
FVC of 75- to 80-percent predicted, or; DLCO (SB) of 66- to 80-percent predicted	10
Mycotic Lung Disease	
6834 Histoplasmosis of lung.	
6835 Coccidioidomycosis.	
6836 Blastomycosis.	
6837 Cryptococcosis.	
6838 Aspergillosis.	
6839 Mucormycosis.	
General Rating Formula for Mycotic Lung Disease (diagnostic codes 6834 through 6839):	
Chronic pulmonary mycosis with persistent fever, weight loss, night sweats, or massive hemoptysis	100
Chronic pulmonary mycosis requiring suppressive therapy with no more than minimal symptoms such as occasional minor hemoptysis or productive cough	50
Chronic pulmonary mycosis with minimal symptoms such as occasional minor hemoptysis or productive cough	30
Healed and inactive mycotic lesions, asymptomatic	0
Note: Coccidioidomycosis has an incubation period up to 21 days, and the disseminated phase is ordinarily manifest within six months of the primary phase. However, there are instances of dissemination delayed up to many years after the initial infection which may have been unrecognized. Accordingly, when service connection is under consideration in the absence of record or other evidence of the disease in service, service in southwestern United States where the disease is endemic and absence of prolonged residence in this locality before or after service will be the deciding factor.	
Restrictive Lung Disease	
6840 Diaphragm paralysis or paresis.	
6841 Spinal cord injury with respiratory insufficiency.	
6842 Kyphoscoliosis, pectus excavatum, pectus carinatum.	
6843 Traumatic chest wall defect, pneumothorax, hernia, etc.	
6844 Post-surgical residual (lobectomy, pneumonectomy, etc.).	
6845 Chronic pleural effusion or fibrosis.	
General Rating Formula for Restrictive Lung Disease (diagnostic codes 6840 through 6845):	
FEV–1 less than 40 percent of predicted value, or; the ratio of Forced Expiratory Volume in one second to Forced Vital Capacity (FEV–1/FVC) less than 40 percent, or; Diffusion Capacity of the Lung for Carbon Monoxide by the Single Breath Method (DLCO (SB)) less than 40-percent predicted, or; maximum exercise capacity less than 15 ml/kg/min oxygen consumption (with cardiac or respiratory limitation), or; cor pulmonale (right heart failure), or; right ventricular hypertrophy, or; pulmonary hypertension (shown by Echo or cardiac catheterization), or; episode(s) of acute respiratory failure, or; requires outpatient oxygen therapy	100
FEV–1 of 40- to 55-percent predicted, or; FEV–1/FVC of 40 to 55 percent, or; DLCO (SB) of 40- to 55-percent predicted, or; maximum oxygen consumption of 15 to 20 ml/kg/min (with cardiorespiratory limit)	60
FEV–1 of 56- to 70-percent predicted, or; FEV–1/FVC of 56 to 70 percent, or; DLCO (SB) 56- to 65-percent predicted	30
FEV–1 of 71- to 80-percent predicted, or; FEV–1/FVC of 71 to 80 percent, or; DLCO (SB) 66- to 80-percent predicted	10
Or rate primary disorder.	
Note (1): A 100-percent rating shall be assigned for pleurisy with empyema, with or without pleurocutaneous fistula, until resolved.	
Note (2): Following episodes of total spontaneous pneumothorax, a rating of 100 percent shall be assigned as of the date of hospital admission and shall continue for three months from the first day of the month after hospital discharge.	
Note (3): Gunshot wounds of the pleural cavity with bullet or missile retained in lung, pain or discomfort on exertion, or with scattered rales or some limitation of excursion of diaphragm or of lower chest expansion shall be rated at least 20-percent disabling. Disabling injuries of shoulder girdle muscles (Groups I to IV) shall be separately rated and combined with ratings for respiratory involvement. Involvement of Muscle Group XXI (DC 5321), however, will not be separately rated.	
6846 Sarcoidosis:	

	Rating
Cor pulmonale, or; cardiac involvement with congestive heart failure, or; progressive pulmonary disease with fever, night sweats, and weight loss despite treatment	100
Pulmonary involvement requiring systemic high dose (therapeutic) corticosteroids for control	60
Pulmonary involvement with persistent symptoms requiring chronic low dose (maintenance) or intermittent corticosteroids	30
Chronic hilar adenopathy or stable lung infiltrates without symptoms or physiologic impairment	0
Or rate active disease or residuals as chronic bronchitis (DC 6600) and extra-pulmonary involvement under specific body system involved.	
6847 Sleep Apnea Syndromes (Obstructive, Central, Mixed):	
Chronic respiratory failure with carbon dioxide retention or cor pulmonale, or; requires tracheostomy	100
Requires use of breathing assistance device such as continuous airway pressure (CPAP) machine	50
Persistent day-time hypersomnolence	30
Asymptomatic but with documented sleep disorder breathing	0

[1] Review for entitlement to special monthly compensation under §3.350 of this chapter.

[61 FR 46728, Sept. 5, 1996, as amended at 71 FR 28586, May 17, 2006]

THE CARDIOVASCULAR SYSTEM

§4.100 Application of the evaluation criteria for diagnostic codes 7000–7007, 7011, and 7015–7020.

(a) Whether or not cardiac hypertrophy or dilatation (documented by electrocardiogram, echocardiogram, or X-ray) is present and whether or not there is a need for continuous medication must be ascertained in all cases.

(b) Even if the requirement for a 10% (based on the need for continuous medication) or 30% (based on the presence of cardiac hypertrophy or dilatation) evaluation is met, METs testing is required in all cases except:

(1) When there is a medical contraindication.

(2) When the left ventricular ejection fraction has been measured and is 50% or less.

(3) When chronic congestive heart failure is present or there has been more than one episode of congestive heart failure within the past year.

(4) When a 100% evaluation can be assigned on another basis.

(c) If left ventricular ejection fraction (LVEF) testing is not of record, evaluate based on the alternative criteria unless the examiner states that the LVEF test is needed in a particular case because the available medical information does not sufficiently reflect the severity of the veteran's cardiovascular disability.

[71 FR 52460, Sept. 6, 2006]

§§4.101–4.103 [Reserved]

§4.104 Schedule of ratings—cardiovascular system.

DISEASES OF THE HEART

	Rating
NOTE (1): Evaluate cor pulmonale, which is a form of secondary heart disease, as part of the pulmonary condition that causes it.	
NOTE (2): One MET (metabolic equivalent) is the energy cost of standing quietly at rest and represents an oxygen uptake of 3.5 milliliters per kilogram of body weight per minute. When the level of METs at which dyspnea, fatigue, angina, dizziness, or syncope develops is required for evaluation, and a laboratory determination of METs by exercise testing cannot be done for medical reasons, an estimation by a medical examiner of the level of activity (expressed in METs and supported by specific examples, such as slow stair climbing or shoveling snow) that results in dyspnea, fatigue, angina, dizziness, or syncope may be used.	
7000 Valvular heart disease (including rheumatic heart disease):	
During active infection with valvular heart damage and for three months following cessation of therapy for the active infection	100
Thereafter, with valvular heart disease (documented by findings on physical examination and either echocardiogram, Doppler echocardiogram, or cardiac catheterization) resulting in:	
Chronic congestive heart failure, or; workload of 3 METs or less results in dyspnea, fatigue, angina, dizziness, or syncope, or; left ventricular dysfunction with an ejection fraction of less than 30 percent	100
More than one episode of acute congestive heart failure in the past year, or; workload of greater than 3 METs but not greater than 5 METs results in dyspnea, fatigue, angina, dizziness, or syncope, or; left ventricular dysfunction with an ejection fraction of 30 to 50 percent	60

DISEASES OF THE HEART—Continued

	Rating
Workload of greater than 5 METs but not greater than 7 METs results in dyspnea, fatigue, angina, dizziness, or syncope, or; evidence of cardiac hypertrophy or dilatation on electro-cardiogram, echocardiogram, or X-ray	30
Workload of greater than 7 METs but not greater than 10 METs results in dyspnea, fatigue, angina, dizziness, or syncope, or; continuous medication required	10
7001 Endocarditis:	
For three months following cessation of therapy for active infection with cardiac involvement	100
Thereafter, with endocarditis (documented by findings on physical examination and either echocardiogram, Doppler echocardiogram, or cardiac catheterization) resulting in:	
Chronic congestive heart failure, or; workload of 3 METs or less results in dyspnea, fatigue, angina, dizziness, or syncope, or; left ventricular dysfunction with an ejection fraction of less than 30 percent	100
More than one episode of acute congestive heart failure in the past year, or; workload of greater than 3 METs but not greater than 5 METs results in dyspnea, fatigue, angina, dizziness, or syncope, or; left ventricular dysfunction with an ejection fraction of 30 to 50 percent	60
Workload of greater than 5 METs but not greater than 7 METs results in dyspnea, fatigue, angina, dizziness, or syncope, or; evidence of cardiac hypertrophy or dilatation on electrocardiogram, echocardiogram, or X-ray	30
Workload of greater than 7 METs but not greater than 10 METs results in dyspnea, fatigue, angina, dizziness, or syncope, or; continuous medication required	10
7002 Pericarditis:	
For three months following cessation of therapy for active infection with cardiac involvement	100
Thereafter, with documented pericarditis resulting in:	
Chronic congestive heart failure, or; workload of 3 METs or less results in dyspnea, fatigue, angina, dizziness, or syncope, or; left ventricular dysfunction with an ejection fraction of less than 30 percent.	100
More than one episode of acute congestive heart failure in the past year, or; workload of greater than 3 METs but not greater than 5 METs results in dyspnea, fatigue, angina, dizziness, or syncope, or; left ventricular dysfunction with an ejection fraction of 30 to 50 percent	60
Workload of greater than 5 METs but not greater than 7 METs results in dyspnea, fatigue, angina, dizziness, or syncope, or; evidence of cardiac hypertrophy or dilatation on electro-cardiogram, echocardiogram, or X-ray	30
Workload of greater than 7 METs but not greater than 10 METs results in dyspnea, fatigue, angina, dizziness, or syncope, or; continuous medication required	10
7003 Pericardial adhesions:	

DISEASES OF THE HEART—Continued

	Rating
Chronic congestive heart failure, or; workload of 3 METs or less results in dyspnea, fatigue, angina, dizziness, or syncope, or; left ventricular dysfunction with an ejection fraction of less than 30 percent	100
More than one episode of acute congestive heart failure in the past year, or; workload of greater than 3 METs but not greater than 5 METs results in dyspnea, fatigue, angina, dizziness, or syncope, or; left ventricular dysfunction with an ejection fraction of 30 to 50 percent	60
Workload of greater than 5 METs but not greater than 7 METs results in dyspnea, fatigue, angina, dizziness, or syncope, or; evidence of cardiac hypertrophy or dilatation on electro-cardiogram, echocardiogram, or X-ray	30
Workload of greater than 7 METs but not greater than 10 METs results in dyspnea, fatigue, angina, dizziness, or syncope, or; continuous medication required	10
7004 Syphilitic heart disease:	
Chronic congestive heart failure, or; workload of 3 METs or less results in dyspnea, fatigue, angina, dizziness, or syncope, or; left ventricular dysfunction with an ejection fraction of less than 30 percent	100
More than one episode of acute congestive heart failure in the past year, or; workload of greater than 3 METs but not greater than 5 METs results in dyspnea, fatigue, angina, dizziness, or syncope, or; left ventricular dysfunction with an ejection fraction of 30 to 50 percent	60
Workload of greater than 5 METs but not greater than 7 METs results in dyspnea, fatigue, angina, dizziness, or syncope, or; evidence of cardiac hypertrophy or dilatation on electrocardiogram, echocardiogram, or X-ray	30
Workload of greater than 7 METs but not greater than 10 METs results in dyspnea, fatigue, angina, dizziness, or syncope, or; continuous medication required	10
NOTE: Evaluate syphilitic aortic aneurysms under DC 7110 (aortic aneurysm).	
7005 Arteriosclerotic heart disease (Coronary artery disease):	
With documented coronary artery disease resulting in:	
Chronic congestive heart failure, or; workload of 3 METs or less results in dyspnea, fatigue, angina, dizziness, or syncope, or; left ventricular dysfunction with an ejection fraction of less than 30 percent	100
More than one episode of acute congestive heart failure in the past year, or; workload of greater than 3 METs but not greater than 5 METs results in dyspnea, fatigue, angina, dizziness, or syncope, or; left ventricular dysfunction with an ejection fraction of 30 to 50 percent	60

DISEASES OF THE HEART—Continued

	Rating
Workload of greater than 5 METs but not greater than 7 METs results in dyspnea, fatigue, angina, dizziness, or syncope, or; evidence of cardiac hypertrophy or dilatation on electrocardiogram, echocardiogram, or X-ray	30
Workload of greater than 7 METs but not greater than 10 METs results in dyspnea, fatigue, angina, dizziness, or syncope, or; continuous medication required	10
NOTE: If nonservice-connected arteriosclerotic heart disease is superimposed on service-connected valvular or other non-arteriosclerotic heart disease, request a medical opinion as to which condition is causing the current signs and symptoms.	
7006 Myocardial infarction:	
During and for three months following myocardial infarction, documented by laboratory tests	100
Thereafter:	
With history of documented myocardial infarction, resulting in:	
Chronic congestive heart failure, or; workload of 3 METs or less results in dyspnea, fatigue, angina, dizziness, or syncope, or; left ventricular dysfunction with an ejection fraction of less than 30 percent	100
More than one episode of acute congestive heart failure in the past year, or; workload of greater than 3 METs but not greater than 5 METs results in dyspnea, fatigue, angina, dizziness, or syncope, or; left ventricular dysfunction with an ejection fraction of 30 to 50 percent	60
Workload of greater than 5 METs but not greater than 7 METs results in dyspnea, fatigue, angina, dizziness, or syncope, or; evidence of cardiac hypertrophy or dilatation on electrocardiogram, echocardiogram, or X-ray	30
Workload of greater than 7 METs but not greater than 10 METs results in dyspnea, fatigue, angina, dizziness, or syncope, or; continuous medication required	10
7007 Hypertensive heart disease:	
Chronic congestive heart failure, or; workload of 3 METs or less results in dyspnea, fatigue, angina, dizziness, or syncope, or; left ventricular dysfunction with an ejection fraction of less than 30 percent	100
More than one episode of acute congestive heart failure in the past year, or; workload of greater than 3 METs but not greater than 5 METs results in dyspnea, fatigue, angina, dizziness, or syncope, or; left ventricular dysfunction with an ejection fraction of 30 to 50 percent	60
Workload of greater than 5 METs but not greater than 7 METs results in dyspnea, fatigue, angina, dizziness, or syncope, or; evidence of cardiac hypertrophy or dilatation on electrocardiogram, echocardiogram, or X-ray	30
Workload of greater than 7 METs but not greater than 10 METs results in dyspnea, fatigue, angina, dizziness, or syncope, or; continuous medication required	10
7008 Hyperthyroid heart disease.	

DISEASES OF THE HEART—Continued

	Rating
Rate under the appropriate cardiovascular diagnostic code, depending on particular findings.	
7010 Supraventricular arrhythmias:	
Paroxysmal atrial fibrillation or other supraventricular tachycardia, with more than four episodes per year documented by ECG or Holter monitor	30
Permanent atrial fibrillation (lone atrial fibrillation), or; one to four episodes per year of paroxysmal atrial fibrillation or other supraventricular tachycardia documented by ECG or Holter monitor	10
7011 Ventricular arrhythmias (sustained):	
For indefinite period from date of hospital admission for initial evaluation and medical therapy for a sustained ventricular arrhythmia, or; for indefinite period from date of hospital admission for ventricular aneurysmectomy, or; with an automatic implantable Cardioverter-Defibrillator (AICD) in place	100
Chronic congestive heart failure, or; workload of 3 METs or less results in dyspnea, fatigue, angina, dizziness, or syncope, or; left ventricular dysfunction with an ejection fraction of less than 30 percent	100
More than one episode of acute congestive heart failure in the past year, or; workload of greater than 3 METs but not greater than 5 METs results in dyspnea, fatigue, angina, dizziness, or syncope, or; left ventricular dysfunction with an ejection fraction of 30 to 50 percent	60
Workload of greater than 5 METs but not greater than 7 METs results in dyspnea, fatigue, angina, dizziness, or syncope, or; evidence of cardiac hypertrophy or dilatation on electrocardiogram, echocardiogram, or X-ray	30
Workload of greater than 7 METs but not greater than 10 METs results in dyspnea, fatigue, angina, dizziness, or syncope, or; continuous medication required	10
NOTE: A rating of 100 percent shall be assigned from the date of hospital admission for initial evaluation and medical therapy for a sustained ventricular arrhythmia or for ventricular aneurysmectomy. Six months following discharge, the appropriate disability rating shall be determined by mandatory VA examination. Any change in evaluation based upon that or any subsequent examination shall be subject to the provisions of §3.105(e) of this chapter.	
7015 Atrioventricular block:	
Chronic congestive heart failure, or; workload of 3 METs or less results in dyspnea, fatigue, angina, dizziness, or syncope, or; left ventricular dysfunction with an ejection fraction of less than 30 percent	100
More than one episode of acute congestive heart failure in the past year, or; workload of greater than 3 METs but not greater than 5 METs results in dyspnea, fatigue, angina, dizziness, or syncope, or; left ventricular dysfunction with an ejection fraction of 30 to 50 percent	60

DISEASES OF THE HEART—Continued

	Rating
Workload of greater than 5 METs but not greater than 7 METs results in dyspnea, fatigue, angina, dizziness, or syncope, or; evidence of cardiac hypertrophy or dilatation on electrocardiogram, echocardiogram, or X-ray	30
Workload of greater than 7 METs but not greater than 10 METs results in dyspnea, fatigue, angina, dizziness, or syncope, or; continuous medication or a pacemaker required	10
NOTE: Unusual cases of arrhythmia such as atrioventricular block associated with a supraventricular arrhythmia or pathological bradycardia should be submitted to the Director, Compensation Service. Simple delayed P-R conduction time, in the absence of other evidence of cardiac disease, is not a disability.	
7016 Heart valve replacement (prosthesis):	
For indefinite period following date of hospital admission for valve replacement	100
Thereafter:	
Chronic congestive heart failure, or; workload of 3 METs or less results in dyspnea, fatigue, angina, dizziness, or syncope, or; left ventricular dysfunction with an ejection fraction of less than 30 percent	100
More than one episode of acute congestive heart failure in the past year, or; workload of greater than 3 METs but not greater than 5 METs results in dyspnea, fatigue, angina, dizziness, or syncope, or; left ventricular dysfunction with an ejection fraction of 30 to 50 percent	60
Workload of greater than 5 METs but not greater than 7 METs results in dyspnea, fatigue, angina, dizziness, or syncope, or; evidence of cardiac hypertrophy or dilatation on electrocardiogram, echocardiogram, or X-ray	30
Workload of greater than 7 METs but not greater than 10 METs results in dyspnea, fatigue, angina, dizziness, or syncope, or; continuous medication required	10
NOTE: A rating of 100 percent shall be assigned as of the date of hospital admission for valve replacement. Six months following discharge, the appropriate disability rating shall be determined by mandatory VA examination. Any change in evaluation based upon that or any subsequent examination shall be subject to the provisions of § 3.105(e) of this chapter.	
7017 Coronary bypass surgery:	
For three months following hospital admission for surgery	100
Thereafter:	
Chronic congestive heart failure, or; workload of 3 METs or less results in dyspnea, fatigue, angina, dizziness, or syncope, or; left ventricular dysfunction with an ejection fraction of less than 30 percent	100
More than one episode of acute congestive heart failure in the past year, or; workload of greater than 3 METs but not greater than 5 METs results in dyspnea, fatigue, angina, dizziness, or syncope, or; left ventricular dysfunction with an ejection fraction of 30 to 50 percent	60

DISEASES OF THE HEART—Continued

	Rating
Workload of greater than 5 METs but not greater than 7 METs results in dyspnea, fatigue, angina, dizziness, or syncope, or; evidence of cardiac hypertrophy or dilatation on electrocardiogram, echocardiogram, or X-ray	30
Workload greater than 7 METs but not greater than 10 METs results in dyspnea, fatigue, angina, dizziness, or syncope, or; continuous medication required	10
7018 Implantable cardiac pacemakers:	
For two months following hospital admission for implantation or reimplantation	100
Thereafter:	
Evaluate as supraventricular arrhythmias (DC 7010), ventricular arrhythmias (DC 7011), or atrioventricular block (DC 7015). Minimum	10
NOTE: Evaluate implantable Cardioverter-Defibrillators (AICD's) under DC 7011.	
7019 Cardiac transplantation:	
For an indefinite period from date of hospital admission for cardiac transplantation	100
Thereafter:	
Chronic congestive heart failure, or; workload of 3 METs or less results in dyspnea, fatigue, angina, dizziness, or syncope, or; left ventricular dysfunction with an ejection fraction of less than 30 percent	100
More than one episode of acute congestive heart failure in the past year, or; workload of greater than 3 METs but not greater than 5 METs results in dyspnea, fatigue, angina, dizziness, or syncope, or; left ventricular dysfunction with an ejection fraction of 30 to 50 percent	60
Minimum	30
NOTE: A rating of 100 percent shall be assigned as of the date of hospital admission for cardiac transplantation. One year following discharge, the appropriate disability rating shall be determined by mandatory VA examination. Any change in evaluation based upon that or any subsequent examination shall be subject to the provisions of § 3.105(e) of this chapter.	
7020 Cardiomyopathy:	
Chronic congestive heart failure, or; workload of 3 METs or less results in dyspnea, fatigue, angina, dizziness, or syncope, or; left ventricular dysfunction with an ejection fraction of less than 30 percent	100
More than one episode of acute congestive heart failure in the past year, or; workload of greater than 3 METs but not greater than 5 METs results in dyspnea, fatigue, angina, dizziness, or syncope, or; left ventricular dysfunction with an ejection fraction of 30 to 50 percent	60
Workload of greater than 5 METs but not greater than 7 METs results in dyspnea, fatigue, angina, dizziness, or syncope, or; evidence of cardiac hypertrophy or dilatation on electrocardiogram, echocardiogram, or X-ray	30
Workload of greater than 7 METs but not greater than 10 METs results in dyspnea, fatigue, angina, dizziness, or syncope, or; continuous medication required	10

DISEASES OF THE HEART—Continued

	Rating
Diseases of the Arteries and Veins	
7101 Hypertensive vascular disease (hypertension and isolated systolic hypertension):	
Diastolic pressure predominantly 130 or more	60
Diastolic pressure predominantly 120 or more	40
Diastolic pressure predominantly 110 or more, or; systolic pressure predominantly 200 or more	20
Diastolic pressure predominantly 100 or more, or; systolic pressure predominantly 160 or more, or; minimum evaluation for an individual with a history of diastolic pressure predominantly 100 or more who requires continuous medication for control	10
NOTE (1): Hypertension or isolated systolic hypertension must be confirmed by readings taken two or more times on at least three different days. For purposes of this section, the term hypertension means that the diastolic blood pressure is predominantly 90mm. or greater, and isolated systolic hypertension means that the systolic blood pressure is predominantly 160mm. or greater with a diastolic blood pressure of less than 90mm.	
NOTE (2): Evaluate hypertension due to aortic insufficiency or hyperthyroidism, which is usually the isolated systolic type, as part of the condition causing it rather than by a separate evaluation.	
NOTE (3): Evaluate hypertension separately from hypertensive heart disease and other types of heart disease.	
7110 Aortic aneurysm:	
If five centimeters or larger in diameter, or; if symptomatic, or; for indefinite period from date of hospital admission for surgical correction (including any type of graft insertion)	100
Precluding exertion	60
Evaluate residuals of surgical correction according to organ systems affected.	
NOTE: A rating of 100 percent shall be assigned as of the date of admission for surgical correction. Six months following discharge, the appropriate disability rating shall be determined by mandatory VA examination. Any change in evaluation based upon that or any subsequent examination shall be subject to the provisions of §3.105(e) of this chapter.	
7111 Aneurysm, any large artery:	
If symptomatic, or; for indefinite period from date of hospital admission for surgical correction	100
Following surgery:	
Ischemic limb pain at rest, and; either deep ischemic ulcers or ankle/brachial index of 0.4 or less	100
Claudication on walking less than 25 yards on a level grade at 2 miles per hour, and; persistent coldness of the extremity, one or more deep ischemic ulcers, or ankle/brachial index of 0.5 or less	60
Claudication on walking between 25 and 100 yards on a level grade at 2 miles per hour, and; trophic changes (thin skin, absence of hair, dystrophic nails) or ankle/brachial index of 0.7 or less	40
Claudication on walking more than 100 yards, and; diminished peripheral pulses or ankle/brachial index of 0.9 or less	20

DISEASES OF THE HEART—Continued

	Rating
NOTE (1): The ankle/brachial index is the ratio of the systolic blood pressure at the ankle (determined by Doppler study) divided by the simultaneous brachial artery systolic blood pressure. The normal index is 1.0 or greater.	
NOTE (2): These evaluations are for involvement of a single extremity. If more than one extremity is affected, evaluate each extremity separately and combine (under §4.25), using the bilateral factor, if applicable.	
NOTE (3): A rating of 100 percent shall be assigned as of the date of hospital admission for surgical correction. Six months following discharge, the appropriate disability rating shall be determined by mandatory VA examination. Any change in evaluation based upon that or any subsequent examination shall be subject to the provisions of §3.105(e) of this chapter.	
7112 Aneurysm, any small artery:	
Asymptomatic	0
NOTE: If symptomatic, evaluate according to body system affected. Following surgery, evaluate residuals under the body system affected.	
7113 Arteriovenous fistula, traumatic:	
With high output heart failure	100
Without heart failure but with enlarged heart, wide pulse pressure, and tachycardia	60
Without cardiac involvement but with edema, stasis dermatitis, and either ulceration or cellulitis:	
Lower extremity	50
Upper extremity	40
With edema or stasis dermatitis:	
Lower extremity	30
Upper extremity	20
7114 Arteriosclerosis obliterans:	
Ischemic limb pain at rest, and; either deep ischemic ulcers or ankle/brachial index of 0.4 or less	100
Claudication on walking less than 25 yards on a level grade at 2 miles per hour, and; either persistent coldness of the extremity or ankle/brachial index of 0.5 or less	60
Claudication on walking between 25 and 100 yards on a level grade at 2 miles per hour, and; trophic changes (thin skin, absence of hair, dystrophic nails) or ankle/brachial index of 0.7 or less	40
Claudication on walking more than 100 yards, and; diminished peripheral pulses or ankle/brachial index of 0.9 or less	20
NOTE (1): The ankle/brachial index is the ratio of the systolic blood pressure at the ankle (determined by Doppler study) divided by the simultaneous brachial artery systolic blood pressure. The normal index is 1.0 or greater.	
NOTE (2): Evaluate residuals of aortic and large arterial bypass surgery or arterial graft as arteriosclerosis obliterans.	
NOTE (3): These evaluations are for involvement of a single extremity. If more than one extremity is affected, evaluate each extremity separately and combine (under §4.25), using the bilateral factor (§4.26), if applicable.	
7115 Thrombo-angiitis obliterans (Buerger's Disease):	

DISEASES OF THE HEART—Continued

	Rating
Ischemic limb pain at rest, and; either deep ischemic ulcers or ankle/brachial index of 0.4 or less	100
Claudication on walking less than 25 yards on a level grade at 2 miles per hour, and; either persistent coldness of the extremity or ankle/brachial index of 0.5 or less	60
Claudication on walking between 25 and 100 yards on a level grade at 2 miles per hour, and; trophic changes (thin skin, absence of hair, dystrophic nails) or ankle/brachial index of 0.7 or less	40
Claudication on walking more than 100 yards, and; diminished peripheral pulses or ankle/brachial index of 0.9 or less	20
NOTE (1): The ankle/brachial index is the ratio of the systolic blood pressure at the ankle (determined by Doppler study) divided by the simultaneous brachial artery systolic blood pressure. The normal index is 1.0 or greater.	
NOTE (2): These evaluations are for involvement of a single extremity. If more than one extremity is affected, evaluate each extremity separately and combine (under § 4.25), using the bilateral factor (§ 4.26), if applicable.	
7117 Raynaud's syndrome:	
With two or more digital ulcers plus autoamputation of one or more digits and history of characteristic attacks	100
With two or more digital ulcers and history of characteristic attacks	60
Characteristic attacks occurring at least daily	40
Characteristic attacks occurring four to six times a week	20
Characteristic attacks occurring one to three times a week	10
NOTE: For purposes of this section, characteristic attacks consist of sequential color changes of the digits of one or more extremities lasting minutes to hours, sometimes with pain and paresthesias, and precipitated by exposure to cold or by emotional upsets. These evaluations are for the disease as a whole, regardless of the number of extremities involved or whether the nose and ears are involved.	
7118 Angioneurotic edema:	
Attacks without laryngeal involvement lasting one to seven days or longer and occurring more than eight times a year, or; attacks with laryngeal involvement of any duration occurring more than twice a year	40
Attacks without laryngeal involvement lasting one to seven days and occurring five to eight times a year, or; attacks with laryngeal involvement of any duration occurring once or twice a year	20
Attacks without laryngeal involvement lasting one to seven days and occurring two to four times a year	10
7119 Erythromelalgia:	
Characteristic attacks that occur more than once a day, last an average of more than two hours each, respond poorly to treatment, and that restrict most routine daily activities	100

DISEASES OF THE HEART—Continued

	Rating
Characteristic attacks that occur more than once a day, last an average of more than two hours each, and respond poorly to treatment, but that do not restrict most routine daily activities	60
Characteristic attacks that occur daily or more often but that respond to treatment	30
Characteristic attacks that occur less than daily but at least three times a week and that respond to treatment	10
NOTE: For purposes of this section, a characteristic attack of erythromelalgia consists of burning pain in the hands, feet, or both, usually bilateral and symmetrical, with increased skin temperature and redness, occurring at warm ambient temperatures. These evaluations are for the disease as a whole, regardless of the number of extremities involved.	
7120 Varicose veins:	
With the following findings attributed to the effects of varicose veins: Massive board-like edema with constant pain at rest	100
Persistent edema or subcutaneous induration, stasis pigmentation or eczema, and persistent ulceration	60
Persistent edema and stasis pigmentation or eczema, with or without intermittent ulceration	40
Persistent edema, incompletely relieved by elevation of extremity, with or without beginning stasis pigmentation or eczema	20
Intermittent edema of extremity or aching and fatigue in leg after prolonged standing or walking, with symptoms relieved by elevation of extremity or compression hosiery	10
Asymptomatic palpable or visible varicose veins	0
NOTE: These evaluations are for involvement of a single extremity. If more than one extremity is involved, evaluate each extremity separately and combine (under § 4.25), using the bilateral factor (§ 4.26), if applicable.	
7121 Post-phlebitic syndrome of any etiology:	
With the following findings attributed to venous disease:	
Massive board-like edema with constant pain at rest	100
Persistent edema or subcutaneous induration, stasis pigmentation or eczema, and persistent ulceration	60
Persistent edema and stasis pigmentation or eczema, with or without intermittent ulceration	40
Persistent edema, incompletely relieved by elevation of extremity, with or without beginning stasis pigmentation or eczema	20
Intermittent edema of extremity or aching and fatigue in leg after prolonged standing or walking, with symptoms relieved by elevation of extremity or compression hosiery	10
Asymptomatic palpable or visible varicose veins	0

DISEASES OF THE HEART—Continued

	Rating
NOTE: These evaluations are for involvement of a single extremity. If more than one extremity is involved, evaluate each extremity separately and combine (under §4.25), using the bilateral factor (§4.26), if applicable.	
7122 Cold injury residuals:	
With the following in affected parts:	
Arthralgia or other pain, numbness, or cold sensitivity plus two or more of the following: tissue loss, nail abnormalities, color changes, locally impaired sensation, hyperhidrosis, X-ray abnormalities (osteoporosis, subarticular punched out lesions, or osteoarthritis)	30
Arthralgia or other pain, numbness, or cold sensitivity plus tissue loss, nail abnormalities, color changes, locally impaired sensation, hyperhidrosis, or X-ray abnormalities (osteoporosis, subarticular punched out lesions, or osteoarthritis)	20
Arthralgia or other pain, numbness, or cold sensitivity	10
NOTE (1): Separately evaluate amputations of fingers or toes, and complications such as squamous cell carcinoma at the site of a cold injury scar or peripheral neuropathy, under other diagnostic codes. Separately evaluate other disabilities that have been diagnosed as the residual effects of cold injury, such as Raynaud's phenomenon, muscle atrophy, etc., unless they are used to support an evaluation under diagnostic code 7122.	
NOTE (2): Evaluate each affected part (e.g., hand, foot, ear, nose) separately and combine the ratings in accordance with §§4.25 and 4.26.	
7123 Soft tissue sarcoma (of vascular origin)	100
NOTE: A rating of 100 percent shall continue beyond the cessation of any surgical, X-ray, antineoplastic chemotherapy or other therapeutic procedure. Six months after discontinuance of such treatment, the appropriate disability rating shall be determined by mandatory VA examination. Any change in evaluation based upon that or any subsequent examination shall be subject to the provisions of §3.105(e) of this chapter. If there has been no local recurrence or metastasis, rate on residuals.	

(Authority: 38 U.S.C. 1155)

[62 FR 65219, Dec. 11, 1997, as amended at 63 FR 37779, July 14, 1998; 71 FR 52460, Sept. 6, 2006; 79 FR 2100, Jan. 13, 2014; 82 FR 50804, Nov. 2, 2017]

THE DIGESTIVE SYSTEM

§4.110 Ulcers.

Experience has shown that the term ''peptic ulcer'' is not sufficiently specific for rating purposes. Manifest differences in ulcers of the stomach or duodenum in comparison with those at an anastomotic stoma are sufficiently recognized as to warrant two separate graduated descriptions. In evaluating the ulcer, care should be taken that the findings adequately identify the particular location.

§4.111 Postgastrectomy syndromes.

There are various postgastrectomy symptoms which may occur following anastomotic operations of the stomach. When present, those occurring during or immediately after eating and known as the ''dumping syndrome'' are characterized by gastrointestinal complaints and generalized symptoms simulating hypoglycemia; those occurring from 1 to 3 hours after eating usually present definite manifestations of hypoglycemia.

§4.112 Weight loss.

For purposes of evaluating conditions in §4.114, the term ''substantial weight loss'' means a loss of greater than 20 percent of the individual's baseline weight, sustained for three months or longer; and the term ''minor weight loss'' means a weight loss of 10 to 20 percent of the individual's baseline weight, sustained for three months or longer. The term ''inability to gain weight'' means that there has been substantial weight loss with inability to regain it despite appropriate therapy. ''Baseline weight'' means the average weight for the two-year-period preceding onset of the disease.

(Authority: 38 U.S.C. 1155)

[66 FR 29488, May 31, 2001]

§4.113 Coexisting abdominal conditions.

There are diseases of the digestive system, particularly within the abdomen, which, while differing in the site of pathology, produce a common disability picture characterized in the main by varying degrees of abdominal distress or pain, anemia and disturbances in nutrition. Consequently, certain coexisting diseases in this area, as indicated in the instruction under the

title ''Diseases of the Digestive System,'' do not lend themselves to distinct and separate disability evaluations without violating the fundamental principle relating to pyramiding as outlined in § 4.14.

§ 4.114 Schedule of ratings—digestive system.

Ratings under diagnostic codes 7301 to 7329, inclusive, 7331, 7342, and 7345 to 7348 inclusive will not be combined with each other. A single evaluation will be assigned under the diagnostic code which reflects the predominant disability picture, with elevation to the next higher evaluation where the severity of the overall disability warrants such elevation.

	Rating
7200 Mouth, injuries of.	
Rate as for disfigurement and impairment of function of mastication.	
7201 Lips, injuries of.	
Rate as for disfigurement of face.	
7202 Tongue, loss of whole or part:	
With inability to communicate by speech	100
One-half or more	60
With marked speech impairment	30
7203 Esophagus, stricture of:	
Permitting passage of liquids only, with marked impairment of general health	80
Severe, permitting liquids only	50
Moderate	30
7204 Esophagus, spasm of (cardiospasm).	
If not amenable to dilation, rate as for the degree of obstruction (stricture).	
7205 Esophagus, diverticulum of, acquired.	
Rate as for obstruction (stricture).	
7301 Peritoneum, adhesions of:	
Severe; definite partial obstruction shown by X-ray, with frequent and prolonged episodes of severe colic distension, nausea or vomiting, following severe peritonitis, ruptured appendix, perforated ulcer, or operation with drainage	50
Moderately severe; partial obstruction manifested by delayed motility of barium meal and less frequent and less prolonged episodes of pain	30
Moderate; pulling pain on attempting work or aggravated by movements of the body, or occasional episodes of colic pain, nausea, constipation (perhaps alternating with diarrhea) or abdominal distension	10
Mild	0
NOTE: Ratings for adhesions will be considered when there is history of operative or other traumatic or infectious (intraabdominal) process, and at least two of the following: disturbance of motility, actual partial obstruction, reflex disturbances, presence of pain.	
7304 Ulcer, gastric.	
7305 Ulcer, duodenal:	
Severe; pain only partially relieved by standard ulcer therapy, periodic vomiting, recurrent hematemesis or melena, with manifestations of anemia and weight loss productive of definite impairment of health	60
Moderately severe; less than severe but with impairment of health manifested by anemia and weight loss; or recurrent incapacitating episodes averaging 10 days or more in duration at least four or more times a year	40
Moderate; recurring episodes of severe symptoms two or three times a year averaging 10 days in duration; or with continuous moderate manifestations	20
Mild; with recurring symptoms once or twice yearly	10
7306 Ulcer, marginal (gastrojejunal):	
Pronounced; periodic or continuous pain unrelieved by standard ulcer therapy with periodic vomiting, recurring melena or hematemesis, and weight loss. Totally incapacitating	100
Severe; same as pronounced with less pronounced and less continuous symptoms with definite impairment of health	60
Moderately severe; intercurrent episodes of abdominal pain at least once a month partially or completely relieved by ulcer therapy, mild and transient episodes of vomiting or melena	40
Moderate; with episodes of recurring symptoms several times a year	20
Mild; with brief episodes of recurring symptoms once or twice yearly	10
7307 Gastritis, hypertrophic (identified by gastroscope):	
Chronic; with severe hemorrhages, or large ulcerated or eroded areas	60
Chronic; with multiple small eroded or ulcerated areas, and symptoms	30
Chronic; with small nodular lesions, and symptoms	10
Gastritis, atrophic.	
A complication of a number of diseases, including pernicious anemia.	
Rate the underlying condition.	
7308 Postgastrectomy syndromes:	
Severe; associated with nausea, sweating, circulatory disturbance after meals, diarrhea, hypoglycemic symptoms, and weight loss with malnutrition and anemia	60
Moderate; less frequent episodes of epigastric disorders with characteristic mild circulatory symptoms after meals but with diarrhea and weight loss	40
Mild; infrequent episodes of epigastric distress with characteristic mild circulatory symptoms or continuous mild manifestations	20
7309 Stomach, stenosis of.	
Rate as for gastric ulcer.	
7310 Stomach, injury of, residuals.	
Rate as peritoneal adhesions.	
7311 Residuals of injury of the liver:	
Depending on the specific residuals, separately evaluate as adhesions of peritoneum (diagnostic code 7301), cirrhosis of liver (diagnostic code 7312), and chronic liver disease without cirrhosis (diagnostic code 7345).	
7312 Cirrhosis of the liver, primary biliary cirrhosis, or cirrhotic phase of sclerosing cholangitis:	
Generalized weakness, substantial weight loss, and persistent jaundice, or; with one of the following refractory to treatment: ascites, hepatic encephalopathy, hemorrhage from varices or portal gastropathy (erosive gastritis)	100

	Rating
History of two or more episodes of ascites, hepatic encephalopathy, or hemorrhage from varices or portal gastropathy (erosive gastritis), but with periods of remission between attacks	70
History of one episode of ascites, hepatic encephalopathy, or hemorrhage from varices or portal gastropathy (erosive gastritis)	50
Portal hypertension and splenomegaly, with weakness, anorexia, abdominal pain, malaise, and at least minor weight loss	30
Symptoms such as weakness, anorexia, abdominal pain, and malaise	10
NOTE: For evaluation under diagnostic code 7312, documentation of cirrhosis (by biopsy or imaging) and abnormal liver function tests must be present.	
7314 Cholecystitis, chronic:	
Severe; frequent attacks of gall bladder colic	30
Moderate; gall bladder dyspepsia, confirmed by X-ray technique, and with infrequent attacks (not over two or three a year) of gall bladder colic, with or without jaundice	10
Mild	0
7315 Cholelithiasis, chronic.	
Rate as for chronic cholecystitis.	
7316 Cholangitis, chronic.	
Rate as for chronic cholecystitis.	
7317 Gall bladder, injury of.	
Rate as for peritoneal adhesions.	
7318 Gall bladder, removal of:	
With severe symptoms	30
With mild symptoms	10
Nonsymptomatic	0
Spleen, disease or injury of.	
See Hemic and Lymphatic Systems.	
7319 Irritable colon syndrome (spastic colitis, mucous colitis, etc.):	
Severe; diarrhea, or alternating diarrhea and constipation, with more or less constant abdominal distress	30
Moderate; frequent episodes of bowel disturbance with abdominal distress	10
Mild; disturbances of bowel function with occasional episodes of abdominal distress	0
7321 Amebiasis:	
Mild gastrointestinal disturbances, lower abdominal cramps, nausea, gaseous distention, chronic constipation interrupted by diarrhea	10
Asymptomatic	0
NOTE: Amebiasis with or without liver abscess is parallel in symptomatology with ulcerative colitis and should be rated on the scale provided for the latter. Similarly, lung abscess due to amebiasis will be rated under the respiratory system schedule, diagnostic code 6809.	
7322 Dysentery, bacillary.	
Rate as for ulcerative colitis..	
7323 Colitis, ulcerative:	
Pronounced; resulting in marked malnutrition, anemia, and general debility, or with serious complication as liver abscess	100
Severe; with numerous attacks a year and malnutrition, the health only fair during remissions	60
Moderately severe; with frequent exacerbations	30
Moderate; with infrequent exacerbations	10
7324 Distomiasis, intestinal or hepatic:	
Severe symptoms	30
Moderate symptoms	10
Mild or no symptoms	0
7325 Enteritis, chronic.	
Rate as for irritable colon syndrome.	
7326 Enterocolitis, chronic.	
Rate as for irritable colon syndrome.	
7327 Diverticulitis.	
Rate as for irritable colon syndrome, peritoneal adhesions, or colitis, ulcerative, depending upon the predominant disability picture.	
7328 Intestine, small, resection of:	
With marked interference with absorption and nutrition, manifested by severe impairment of health objectively supported by examination findings including material weight loss	60
With definite interference with absorption and nutrition, manifested by impairment of health objectively supported by examination findings including definite weight loss	40
Symptomatic with diarrhea, anemia and inability to gain weight	20
NOTE: Where residual adhesions constitute the predominant disability, rate under diagnostic code 7301.	
7329 Intestine, large, resection of:	
With severe symptoms, objectively supported by examination findings	40
With moderate symptoms	20
With slight symptoms	10
NOTE: Where residual adhesions constitute the predominant disability, rate under diagnostic code 7301.	
7330 Intestine, fistula of, persistent, or after attempt at operative closure:	
Copious and frequent, fecal discharge	100
Constant or frequent, fecal discharge	60
Slight infrequent, fecal discharge	30
Healed; rate for peritoneal adhesions.	
7331 Peritonitis, tuberculous, active or inactive:	
Active	100
Inactive: See §§4.88b and 4.89.	
7332 Rectum and anus, impairment of sphincter control:	
Complete loss of sphincter control	100
Extensive leakage and fairly frequent involuntary bowel movements	60
Occasional involuntary bowel movements, necessitating wearing of pad	30
Constant slight, or occasional moderate leakage	10
Healed or slight, without leakage	0
7333 Rectum and anus, stricture of:	
Requiring colostomy	100
Great reduction of lumen, or extensive leakage	50
Moderate reduction of lumen, or moderate constant leakage	30
7334 Rectum, prolapse of:	
Severe (or complete), persistent	50
Moderate, persistent or frequently recurring	30
Mild with constant slight or occasional moderate leakage	10
7335 Ano, fistula in.	
Rate as for impairment of sphincter control.	
7336 Hemorrhoids, external or internal:	
With persistent bleeding and with secondary anemia, or with fissures	20
Large or thrombotic, irreducible, with excessive redundant tissue, evidencing frequent recurrences	10
Mild or moderate	0
7337 Pruritus ani.	
Rate for the underlying condition.	
7338 Hernia, inguinal:	
Large, postoperative, recurrent, not well supported under ordinary conditions and not readily reducible, when considered inoperable	60

	Rating
Small, postoperative recurrent, or unoperated irremediable, not well supported by truss, or not readily reducible	30
Postoperative recurrent, readily reducible and well supported by truss or belt	10
Not operated, but remediable	0
Small, reducible, or without true hernia protrusion	0
NOTE: Add 10 percent for bilateral involvement, provided the second hernia is compensable. This means that the more severely disabling hernia is to be evaluated, and 10 percent, only, added for the second hernia, if the latter is of compensable degree.	
7339 Hernia, ventral, postoperative:	
Massive, persistent, severe diastasis of recti muscles or extensive diffuse destruction or weakening of muscular and fascial support of abdominal wall so as to be inoperable	100
Large, not well supported by belt under ordinary conditions	40
Small, not well supported by belt under ordinary conditions, or healed ventral hernia or post-operative wounds with weakening of abdominal wall and indication for a supporting belt	20
Wounds, postoperative, healed, no disability, belt not indicated	0
7340 Hernia, femoral.	
Rate as for inguinal hernia.	
7342 Visceroptosis, symptomatic, marked	10
7343 Malignant neoplasms of the digestive system, exclusive of skin growths	100
NOTE: A rating of 100 percent shall continue beyond the cessation of any surgical, X-ray, antineoplastic chemotherapy or other therapeutic procedure. Six months after discontinuance of such treatment, the appropriate disability rating shall be determined by mandatory VA examination. Any change in evaluation based upon that or any subsequent examination shall be subject to the provisions of § 3.105(e) of this chapter. If there has been no local recurrence or metastasis, rate on residuals.	
7344 Benign neoplasms, exclusive of skin growths:	
Evaluate under an appropriate diagnostic code, depending on the predominant disability or the specific residuals after treatment.	
7345 Chronic liver disease without cirrhosis (including hepatitis B, chronic active hepatitis, autoimmune hepatitis, hemochromatosis, drug-induced hepatitis, etc., but excluding bile duct disorders and hepatitis C):	
Near-constant debilitating symptoms (such as fatigue, malaise, nausea, vomiting, anorexia, arthralgia, and right upper quadrant pain)	100
Daily fatigue, malaise, and anorexia, with substantial weight loss (or other indication of malnutrition), and hepatomegaly, or; incapacitating episodes (with symptoms such as fatigue, malaise, nausea, vomiting, anorexia, arthralgia, and right upper quadrant pain) having a total duration of at least six weeks during the past 12-month period, but not occurring constantly	60
Daily fatigue, malaise, and anorexia, with minor weight loss and hepatomegaly, or; incapacitating episodes (with symptoms such as fatigue, malaise, nausea, vomiting, anorexia, arthralgia, and right upper quadrant pain) having a total duration of at least four weeks, but less than six weeks, during the past 12-month period	40
Daily fatigue, malaise, and anorexia (without weight loss or hepatomegaly), requiring dietary restriction or continuous medication, or; incapacitating episodes (with symptoms such as fatigue, malaise, nausea, vomiting, anorexia, arthralgia, and right upper quadrant pain) having a total duration of at least two weeks, but less than four weeks, during the past 12-month period	20
Intermittent fatigue, malaise, and anorexia, or; incapacitating episodes (with symptoms such as fatigue, malaise, nausea, vomiting, anorexia, arthralgia, and right upper quadrant pain) having a total duration of at least one week, but less than two weeks, during the past 12-month period	10
Nonsymptomatic	0
NOTE (1): Evaluate sequelae, such as cirrhosis or malignancy of the liver, under an appropriate diagnostic code, but do not use the same signs and symptoms as the basis for evaluation under DC 7354 and under a diagnostic code for sequelae. (See § 4.14.).	
NOTE (2): For purposes of evaluating conditions under diagnostic code 7345, ''incapacitating episode'' means a period of acute signs and symptoms severe enough to require bed rest and treatment by a physician.	
NOTE (3): Hepatitis B infection must be confirmed by serologic testing in order to evaluate it under diagnostic code 7345.	
7346 Hernia hiatal:	
Symptoms of pain, vomiting, material weight loss and hematemesis or melena with moderate anemia; or other symptom combinations productive of severe impairment of health	60
Persistently recurrent epigastric distress with dysphagia, pyrosis, and regurgitation, accompanied by substernal or arm or shoulder pain, productive of considerable impairment of health	30
With two or more of the symptoms for the 30 percent evaluation of less severity	10
7347 Pancreatitis:	
With frequently recurrent disabling attacks of abdominal pain with few pain free intermissions and with steatorrhea, malabsorption, diarrhea and severe malnutrition	100
With frequent attacks of abdominal pain, loss of normal body weight and other findings showing continuing pancreatic insufficiency between acute attacks	60
Moderately severe; with at least 4–7 typical attacks of abdominal pain per year with good remission between attacks	30
With at least one recurring attack of typical severe abdominal pain in the past year	10
NOTE 1: Abdominal pain in this condition must be confirmed as resulting from pancreatitis by appropriate laboratory and clinical studies.	
NOTE 2: Following total or partial pancreatectomy, rate under above, symptoms, minimum rating 30 percent.	
7348 Vagotomy with pyloroplasty or gastroenterostomy:	

	Rating
Followed by demonstrably confirmative postoperative complications of stricture or continuing gastric retention	40
With symptoms and confirmed diagnosis of alkaline gastritis, or of confirmed persisting diarrhea	30
Recurrent ulcer with incomplete vagotomy	20
NOTE: Rate recurrent ulcer following complete vagotomy under diagnostic code 7305, minimum rating 20 percent; and rate dumping syndrome under diagnostic code 7308.	
7351 Liver transplant:	
For an indefinite period from the date of hospital admission for transplant surgery	100
Minimum	30
NOTE: A rating of 100 percent shall be assigned as of the date of hospital admission for transplant surgery and shall continue. One year following discharge, the appropriate disability rating shall be determined by mandatory VA examination. Any change in evaluation based upon that or any subsequent examination shall be subject to the provisions of §3.105(e) of this chapter.	
7354 Hepatitis C (or non-A, non-B hepatitis):	
With serologic evidence of hepatitis C infection and the following signs and symptoms due to hepatitis C infection:	
Near-constant debilitating symptoms (such as fatigue, malaise, nausea, vomiting, anorexia, arthralgia, and right upper quadrant pain)	100
Daily fatigue, malaise, and anorexia, with substantial weight loss (or other indication of malnutrition), and hepatomegaly, or; incapacitating episodes (with symptoms such as fatigue, malaise, nausea, vomiting, anorexia, arthralgia, and right upper quadrant pain) having a total duration of at least six weeks during the past 12-month period, but not occurring constantly	60
Daily fatigue, malaise, and anorexia, with minor weight loss and hepatomegaly, or; incapacitating episodes (with symptoms such as fatigue, malaise, nausea, vomiting, anorexia, arthralgia, and right upper quadrant pain) having a total duration of at least four weeks, but less than six weeks, during the past 12-month period	40
Daily fatigue, malaise, and anorexia (without weight loss or hepatomegaly), requiring dietary restriction or continuous medication, or; incapacitating episodes (with symptoms such as fatigue, malaise, nausea, vomiting, anorexia, arthralgia, and right upper quadrant pain) having a total duration of at least two weeks, but less than four weeks, during the past 12-month period	20
Intermittent fatigue, malaise, and anorexia, or; incapacitating episodes (with symptoms such as fatigue, malaise, nausea, vomiting, anorexia, arthralgia, and right upper quadrant pain) having a total duration of at least one week, but less than two weeks, during the past 12-month period	10
Nonsymptomatic	0
NOTE (1): Evaluate sequelae, such as cirrhosis or malignancy of the liver, under an appropriate diagnostic code, but do not use the same signs and symptoms as the basis for evaluation under DC 7354 and under a diagnostic code for sequelae. (See §4.14.).	
NOTE (2): For purposes of evaluating conditions under diagnostic code 7354, "incapacitating episode" means a period of acute signs and symptoms severe enough to require bed rest and treatment by a physician.	

(Authority: 38 U.S.C. 1155)

[29 FR 6718, May 22, 1964, as amended at 34 FR 5063, Mar. 11, 1969; 40 FR 42540, Sept. 15, 1975; 41 FR 11301, Mar. 18, 1976; 66 FR 29488, May 31, 2001]

THE GENITOURINARY SYSTEM

§4.115 Nephritis.

Albuminuria alone is not nephritis, nor will the presence of transient albumin and casts following acute febrile illness be taken as nephritis. The glomerular type of nephritis is usually preceded by or associated with severe infectious disease; the onset is sudden, and the course marked by red blood cells, salt retention, and edema; it may clear up entirely or progress to a chronic condition. The nephrosclerotic type, originating in hypertension or arteriosclerosis, develops slowly, with minimum laboratory findings, and is associated with natural progress. Separate ratings are not to be assigned for disability from disease of the heart and any form of nephritis, on account of the close interrelationships of cardiovascular disabilities. If, however, absence of a kidney is the sole renal disability, even if removal was required because of nephritis, the absent kidney and any hypertension or heart disease will be separately rated. Also, in the event that chronic renal disease has progressed to the point where regular dialysis is required, any coexisting hypertension or heart disease will be separately rated.

[41 FR 34258, Aug. 13, 1976, as amended at 59 FR 2527, Jan. 18, 1994]

§4.115a Ratings of the genitourinary system—dysfunctions.

Diseases of the genitourinary system generally result in disabilities related

to renal or voiding dysfunctions, infections, or a combination of these. The following section provides descriptions of various levels of disability in each of these symptom areas. Where diagnostic codes refer the decisionmaker to these specific areas dysfunction, only the predominant area of dysfunction shall be considered for rating purposes. Since the areas of dysfunction described below do not cover all symptoms resulting from genitourinary diseases, specific diagnoses may include a description of symptoms assigned to that diagnosis.

	Rating
Renal dysfunction:	
Requiring regular dialysis, or precluding more than sedentary activity from one of the following: persistent edema and albuminuria; or, BUN more than 80mg%; or, creatinine more than 8mg%; or, markedly decreased function of kidney or other organ systems, estpecially cardiovascular	100
Persistent edema and albuminuria with BUN 40 to 80mg%; or, creatinine 4 to 8mg%; or, generalized poor health characterized by lethargy, weakness, anorexia, weight loss, or limitation of exertion	80
Constant albuminuria with some edema; or, definite decrease in kidney function; or, hypertension at least 40 percent disabling under diagnostic code 7101	60
Albumin constant or recurring with hyaline and granular casts or red blood cells; or, transient or slight edema or hypertension at least 10 percent disabling under diagnostic code 7101	30
Albumin and casts with history of acute nephritis; or, hypertension non-compensable under diagnostic code 7101	0
Voiding dysfunction:	
Rate particular condition as urine leakage, frequency, or obstructed voiding	
Continual Urine Leakage, Post Surgical Urinary Diversion, Urinary Incontinence, or Stress Incontinence:	
Requiring the use of an appliance or the wearing of absorbent materials which must be changed more than 4 times per day	60
Requiring the wearing of absorbent materials which must be changed 2 to 4 times per day	40
Requiring the wearing of absorbent materials which must be changed less than 2 times per day	20
Urinary frequency:	
Daytime voiding interval less than one hour, or; awakening to void five or more times per night	40
Daytime voiding interval between one and two hours, or; awakening to void three to four times per night	20
Daytime voiding interval between two and three hours, or; awakening to void two times per night	10
Obstructed voiding:	
Urinary retention requiring intermittent or continuous catheterization	30
Marked obstructive symptomatology (hesitancy, slow or weak stream, decreased force of stream) with any one or combination of the following:	
1. Post void residuals greater than 150 cc.	
2. Uroflowmetry; markedly diminished peak flow rate (less than 10 cc/sec).	
3. Recurrent urinary tract infections secondary to obstruction.	
4. Stricture disease requiring periodic dilatation every 2 to 3 months	10
Obstructive symptomatology with or without stricture disease requiring dilatation 1 to 2 times per year	0
Urninary tract infection:	
Poor renal function: Rate as renal dysfunction.	
Recurrent symptomatic infection requiring drainage/frequent hospitalization (greater than two times/year), and/or requiring continuous intensive management	30
Long-term drug therapy, 1–2 hospitalizations per year and/or requiring intermittent intensive management	10

[59 FR 2527, Jan. 18, 1994; 59 FR 10676, Mar. 7, 1994]

§ 4.115b Ratings of the genitourinary system—diagnoses.

	Rating
Note: When evaluating any claim involving loss or loss of use of one or more creative organs, refer to § 3.350 of this chapter to determine whether the veteran may be entitled to special monthly compensation. Footnotes in the schedule indicate conditions which potentially establish entitlement to special monthly compensation; however, there are other conditions in this section which under certain circumstances also establish entitlement to special monthly compensation.	
7500 Kidney, removal of one:	
Minimum evaluation	30
Or rate as renal dysfunction if there is nephritis, infection, or pathology of the other.	
7501 Kidney, abscess of:	
Rate as urinary tract infection	.....

	Rating
7502 Nephritis, chronic:	
Rate as renal dysfunction.	
7504 Pyelonephritis, chronic:	
Rate as renal dysfunction or urinary tract infection, whichever is predominant.	
7505 Kidney, tuberculosis of:	
Rate in accordance with §§4.88b or 4.89, whichever is appropriate.	
7507 Nephrosclerosis, arteriolar:	
Rate according to predominant symptoms as renal dysfunction, hypertension or heart disease. If rated under the cardiovascular schedule, however, the percentage rating which would otherwise be assigned will be elevated to the next higher evaluation.	
7508 Nephrolithiasis:	
Rate as hydronephrosis, *except for* recurrent stone formation requiring one or more of the following:	
1. diet therapy	
2. drug therapy	
3. invasive or non-invasive procedures more than two times/year	30
7509 Hydronephrosis:	
Severe; Rate as renal dysfunction.	
Frequent attacks of colic with infection (pyonephrosis), kidney function impaired	30
Frequent attacks of colic, requiring catheter drainage	20
Only an occasional attack of colic, not infected and not requiring catheter drainage	10
7510 Ureterolithiasis:	
Rate as hydronephrosis, *except for* recurrent stone formation requiring one or more of the following:	
1. diet therapy	
2. drug therapy	
3. invasive or non-invasive procedures more than two times/year	30
7511 Ureter, stricture of:	
Rate as hydronephrosis, *except for* recurrent stone formation requiring one or more of the following:	
1. diet therapy	
2. drug therapy	
3. invasive or non-invasive procedures more than two times/year	30
7512 Cystitis, chronic, includes interstitial and all etiologies, infectious and non-infectious:	
Rate as voiding dysfunction.	
7515 Bladder, calculus in, with symptoms interfering with function:	
Rate as voiding dysfunction	
7516 Bladder, fistula of:	
Rate as voiding dysfunction or urinary tract infection, whichever is predominant.	
Postoperative, suprapubic cystotomy	100
7517 Bladder, injury of:	
Rate as voiding dysfunction.	
7518 Urethra, stricture of:	
Rate as voiding dysfunction.	
7519 Urethra, fistual of:	
Rate as voiding dysfunction.	
Multiple urethroperineal fistulae	100
7520 Penis, removal of half or more	30
Or rate as voiding dysfunction.	
7521 Penis removal of glans	20
Or rate as voiding dysfunction.	
7522 Penis, deformity, with loss of erectile power—20 [1].	
7523 Testis, atrophy complete:.	
Both—20 [1]	
One—0 [1]	
7524 Testis, removal:.	
Both—30 [1]	
One—0 [1]	
Note: In cases of the removal of one testis as the result of a service-incurred injury or disease, other than an undescended or congenitally undeveloped testis, with the absence or nonfunctioning of the other testis unrelated to service, an evaluation of 30 percent will be assigned for the service-connected testicular loss. Testis, underscended, or congenitally undeveloped is not a ratable disability.	
7525 Epididymo-orchitis, chronic only:	
Rate as urinary tract infection.	
For tubercular infections: Rate in accordance with §§4.88b or 4.89, whichever is appropriate.	
7527 Prostate gland injuries, infections, hypertrophy, postoperative residuals:	
Rate as voiding dysfunction or urinary tract infection, whichever is predominant.	
7528 Malignant neoplasms of the genitourinary system	100
Note—Following the cessation of surgical, X-ray, antineoplastic chemotherapy or other therapeutic procedure, the rating of 100 percent shall continue with a mandatory VA examination at the expiration of six months. Any change in evaluation based upon that or any subsequent examination shall be subject to the provisions of §3.105(e) of this chapter. If there has been no local reoccurrence or metastasis, rate on residuals as voiding dysfunction or renal dysfunction, whichever is predominant.	
7529 Benign neoplasms of the genitourinary system:	
Rate as voiding dysfunction or renal dysfunction, whichever is predominant.	
7530 Chronic renal disease requiring regular dialysis:	
Rate as renal dysfunction.	
7531 Kidney transplant:	
Following transplant surgery	100
Thereafter: Rate on residuals as renal dysfunction, minimum rating	30

	Rating
Note—The 100 percent evaluation shall be assigned as of the date of hospital admission for transplant surgery and shall continue with a mandatory VA examination one year following hospital discharge. Any change in evaluation based upon that or any subsequent examination shall be subject to the provisions of § 3.105(e) of this chapter.	
7532 Renal tubular disorders (such as renal glycosurias, aminoacidurias, renal tubular acidosis, Fanconi's syndrome, Bartter's syndrome, related disorders of Henle's loop and proximal or distal nephron function, etc.):	
Minimum rating for symptomatic condition	20
Or rate as renal dysfunction.	
7533 Cystic diseases of the kidneys (polycystic disease, uremic medullary cystic disease, Medullary sponge kidney, and similar conditions):	
Rate as renal dysfunction.	
7534 Atherosclerotic renal disease (renal artery stenosis or atheroembolic renal disease):	
Rate as renal dysfunction.	
7535 Toxic nephropathy (antibotics, radiocontrast agents, nonsteroidal anti-inflammatory agents, heavy metals, and similar agents):	
Rate as renal dysfunction.	
7536 Glomerulonephritis:	
Rate as renal dysfunction.	
7537 Interstitial nephritis:	
Rate as renal dysfunction.	
7538 Papillary necrosis:	
Rate as renal dysfunction.	
7539 Renal amyloid disease:	
Rate as renal dysfunction.	
7540 Disseminated intravascular coagulation with renal cortical necrosis:	
Rate as renal dysfunction.	
7541 Renal involvement in diabetes mellitus, sickle cell anemia, systemic lupus erythematosus, vasculitis, or other systemic disease processes.	
Rate as renal dysfunction.	
7542 Neurogenic bladder:	
Rate as voiding dysfunction.	

[1] Review for entitlement to special monthly compensation under § 3.350 of this chapter.

[59 FR 2527, Jan. 18, 1994; 59 FR 14567, Mar. 29, 1994, as amended at 59 FR 46339, Sept. 8, 1994]

GYNECOLOGICAL CONDITIONS AND DISORDERS OF THE BREAST

§ 4.116 Schedule of ratings—gynecological conditions and disorders of the breast.

	Rating
Note 1: Natural menopause, primary amenorrhea, and pregnancy and childbirth are not disabilities for rating purposes. Chronic residuals of medical or surgical complications of pregnancy may be disabilities for rating purposes.	
Note 2: When evaluating any claim involving loss or loss of use of one or more creative organs or anatomical loss of one or both breasts, refer to § 3.350 of this chapter to determine whether the veteran may be entitled to special monthly compensation. Footnotes in the schedule indicate conditions which potentially establish entitlement to special monthly compensation; however, almost any condition in this section might, under certain circumstances, establish entitlement to special monthly compensation.	
7610 Vulva or clitoris, disease or injury of (including vulvovaginitis)	
7611 Vagina, disease or injury of.	
7612 Cervix, disease or injury of.	
7613 Uterus, disease, injury, or adhesions of.	
7614 Fallopian tube, disease, injury, or adhesions of (including pelvic inflammatory disease (PID)).	
7615 Ovary, disease, injury, or adhesions of.	
General Rating Formula for Disease, Injury, or Adhesions of Female Reproductive Organs (diagnostic codes 7610 through 7615):	
Symptoms not controlled by continuous treatment	30
Symptoms that require continuous treatment	10
Symptoms that do not require continuous treatment	0
Note: For the purpose of VA disability evaluation, a disease, injury, or adhesions of the ovaries resulting in ovarian dysfunction affecting the menstrual cycle, such as dysmenorrhea and secondary amenorrhea, shall be rated under diagnostic code 7615	
7617 Uterus and both ovaries, removal of, complete:	
For three months after removal	[1] 100
Thereafter	[1] 50
7618 Uterus, removal of, including corpus:	
For three months after removal	[1] 100
Thereafter	[1] 30
7619 Ovary, removal of:	
For three months after removal	[1] 100
Thereafter:	
Complete removal of both ovaries	[1] 30
Removal of one with or without partial removal of the other	[1] 0
Note: In cases of the removal of one ovary as the result of a service-connected injury or disease, with the absence or nonfunctioning of a second ovary unrelated to service, an evaluation of 30 percent will be assigned for the service-connected ovarian loss	
7620 Ovaries, atrophy of both, complete	[1] 20

	Rating
7621 Complete or incomplete pelvic organ prolapse due to injury, disease, or surgical complications of pregnancy	10
Note: Pelvic organ prolapse occurs when a pelvic organ such as bladder, urethra, uterus, vagina, small bowel, or rectum drops (prolapse) from its normal place in the abdomen. Conditions associated with pelvic organ prolapse include: uterine or vaginal vault prolapse, cystocele, urethrocele, rectocele, enterocele, or any combination thereof. Evaluate pelvic organ prolapse under DC 7621. Evaluate separately any genitourinary, digestive, or skin symptoms under the appropriate diagnostic code(s) and combine all evaluations with the 10 percent evaluation under DC 7621	
7624 Fistula, rectovaginal:	
Vaginal fecal leakage at least once a day requiring wearing of pad	100
Vaginal fecal leakage four or more times per week, but less than daily, requiring wearing of pad	60
Vaginal fecal leakage one to three times per week requiring wearing of pad	30
Vaginal fecal leakage less than once a week	10
Without leakage	0
7625 Fistula, urethrovaginal:	
Multiple urethrovaginal fistulae	100
Requiring the use of an appliance or the wearing of absorbent materials which must be changed more than four times per day	60
Requiring the wearing of absorbent materials which must be changed two to four times per day	40
Requiring the wearing of absorbent materials which must be changed less than two times per day	20
7626 Breast, surgery of:	
Following radical mastectomy:	
Both	[1]80
One	[1]50
Following modified radical mastectomy:	
Both	[1]60
One	[1]40
Following simple mastectomy or wide local excision with significant alteration of size or form:	
Both	[1]50
One	[1]30
Following wide local excision without significant alteration of size or form:	
Both or one	0
Note: For VA purposes:	
(1) *Radical mastectomy* means removal of the entire breast, underlying pectoral muscles, and regional lymph nodes up to the coracoclavicular ligament..	
(2) *Modified radical mastectomy* means removal of the entire breast and axillary lymph nodes (in continuity with the breast). Pectoral muscles are left intact..	
(3) *Simple (or total) mastectomy* means removal of all of the breast tissue, nipple, and a small portion of the overlying skin, but lymph nodes and muscles are left intact..	
(4) *Wide local excision* (including partial mastectomy, lumpectomy, tylectomy, segmentectomy, and quadrantectomy) means removal of a portion of the breast tissue..	
7627 Malignant neoplasms of gynecological system	100
Note: A rating of 100 percent shall continue beyond the cessation of any surgical, radiation, antineoplastic chemotherapy or other therapeutic procedures. Six months after discontinuance of such treatment, the appropriate disability rating shall be determined by mandatory VA examination. Any change in evaluation based upon that or any subsequent examination shall be subject to the provisions of §3.105(e) of this chapter. Rate chronic residuals to include scars, lymphedema, disfigurement, and/or other impairment of function under the appropriate diagnostic code(s) within the appropriate body system	
7628 Benign neoplasms of gynecological system. Rate chronic residuals to include scars, lymphedema, disfigurement, and/or other impairment of function under the appropriate diagnostic code(s) within the appropriate body system	
7629 Endometriosis:	
Lesions involving bowel or bladder confirmed by laparoscopy, pelvic pain or heavy or irregular bleeding not controlled by treatment, and bowel or bladder symptoms	50
Pelvic pain or heavy or irregular bleeding not controlled by treatment	30
Pelvic pain or heavy or irregular bleeding requiring continuous treatment for control	10
Note: Diagnosis of endometriosis must be substantiated by laparoscopy.	
7630 Malignant neoplasms of the breast	100
Note: A rating of 100 percent shall continue beyond the cessation of any surgical, radiation, antineoplastic chemotherapy or other therapeutic procedure. Six months after discontinuance of such treatment, the appropriate disability rating shall be determined by mandatory VA examination. Any change in evaluation based upon that or any subsequent examination shall be subject to the provisions of §3.105(e) of this chapter. Rate chronic residuals according to impairment of function due to scars, lymphedema, or disfigurement (e.g., limitation of arm, shoulder, and wrist motion, or loss of grip strength, or loss of sensation, or residuals from harvesting of muscles for reconstructive purposes), and/or under diagnostic code 7626	
7631 Benign neoplasms of the breast and other injuries of the breast. Rate chronic residuals according to impairment of function due to scars, lymphedema, or disfigurement (e.g., limitation of arm, shoulder, and wrist motion, or loss of grip strength, or loss of sensation, or residuals from harvesting of muscles for reconstructive purposes), and/or under diagnostic code 7626	
7632 Female sexual arousal disorder (FSAD)	[1]0

[1] Review for entitlement to special monthly compensation under §3.350 of this chapter.

(Authority: 38 U.S.C. 1155)

[60 FR 19855, Apr. 21, 1995, as amended at 67 FR 6874, Feb. 14, 2002; 67 FR 37695, May 30, 2002; 83 FR 15071, Apr. 9, 2018]

THE HEMATOLOGIC AND LYMPHATIC SYSTEMS

§ 4.117 Schedule of ratings—hemic and lymphatic systems.

	Rating
7702 Agranulocytosis, acquired:	
Requiring bone marrow transplant; or infections recurring, on average, at least once every six weeks per 12-month period	100
Requiring intermittent myeloid growth factors (granulocyte colony-stimulating factor (G–CSF) or granulocyte-macrophage colony-stimulating factor (GM–CSF) or continuous immunosuppressive therapy such as cyclosporine to maintain absolute neutrophil count (ANC) greater than 500/microliter (μl) but less than 1000/μl; or infections recurring, on average, at least once every three months per 12-month period	60
Requiring intermittent myeloid growth factors to maintain ANC greater than 1000/μl; or infections recurring, on average, at least once per 12-month period but less than once every three months per 12-month period	30
Requiring continuous medication (e.g., antibiotics) for control; or requiring intermittent use of a myeloid growth factor to maintain ANC greater than or equal to 1500/μl	10
Note: A 100 percent evaluation for bone marrow transplant shall be assigned as of the date of hospital admission and shall continue with a mandatory VA examination six months following hospital discharge. Any change in evaluation based upon that or any subsequent examination shall be subject to the provisions of § 3.105(e) of this chapter.	
7703 Leukemia (except for chronic myelogenous leukemia):	
When there is active disease or during a treatment phase	100
Otherwise rate residuals under the appropriate diagnostic code(s).	
Chronic lymphocytic leukemia or monoclonal B-cell lymphocytosis (MBL), asymptomatic, Rai Stage 0	0
Note (1): A 100 percent evaluation shall continue beyond the cessation of any surgical therapy, radiation therapy, antineoplastic chemotherapy, or other therapeutic procedures. Six months after discontinuance of such treatment, the appropriate disability rating shall be determined by mandatory VA examination. Any change in evaluation based upon that or any subsequent examination shall be subject to the provisions of § 3.105(e) of this chapter. If there has been no recurrence, rate on residuals	
Note (2): Evaluate symptomatic chronic lymphocytic leukemia that is at Rai Stage I, II, III, or IV the same as any other leukemia evaluated under this diagnostic code	
Note (3): Evaluate residuals of leukemia or leukemia therapy under the appropriate diagnostic code(s). Myeloproliferative Disorders: (Diagnostic Codes 7704, 7718, 7719)	
7704 Polycythemia vera:	
Requiring peripheral blood or bone marrow stem-cell transplant or chemotherapy (including myelosuppressants) for the purpose of ameliorating the symptom burden	100
Requiring phlebotomy 6 or more times per 12-month period or molecularly targeted therapy for the purpose of controlling RBC count	60
Requiring phlebotomy 4–5 times per 12-month period, or if requiring continuous biologic therapy or myelosuppressive agents, to include interferon, to maintain platelets <200,000 or white blood cells (WBC) <12,000	30
Requiring phlebotomy 3 or fewer times per 12-month period or if requiring biologic therapy or interferon on an intermittent basis as needed to maintain all blood values at reference range levels	10
Note (1): Rate complications such as hypertension, gout, stroke, or thrombotic disease separately	
Note (2): If the condition undergoes leukemic transformation, evaluate as leukemia under diagnostic code 7703	
Note (3): A 100 percent evaluation shall be assigned as of the date of hospital admission for peripheral blood or bone marrow stem cell transplant; or during the period of treatment with chemotherapy (including myelosuppressants). Six months following hospital discharge or, in the case of chemotherapy treatment, six months after completion of treatment, the appropriate disability rating shall be determined by mandatory VA examination. Any reduction in evaluation based upon that or any subsequent examination shall be subject to the provisions of § 3.105(e) of this chapter	
7705 Immune thrombocytopenia:	
Requiring chemotherapy for chronic refractory thrombocytopenia; or a platelet count 30,000 or below despite treatment	100
Requiring immunosuppressive therapy; or for a platelet count higher than 30,000 but not higher than 50,000, with history of hospitalization because of severe bleeding requiring intravenous immune globulin, high-dose parenteral corticosteroids, and platelet transfusions	70
Platelet count higher than 30,000 but not higher than 50,000, with either immune thrombocytopenia or mild mucous membrane bleeding which requires oral corticosteroid therapy or intravenous immune globulin	30
Platelet count higher than 30,000 but not higher than 50,000, not requiring treatment	10
Platelet count above 50,000 and asymptomatic; or for immune thrombocytopenia in remission	0
Note (1): Separately evaluate splenectomy under diagnostic code 7706 and combine with an evaluation under this diagnostic code	
Note (2): A 100 percent evaluation shall continue beyond the cessation of chemotherapy. Six months after discontinuance of such treatment, the appropriate disability rating shall be determined by mandatory VA examination. Any reduction in evaluation based upon that or any subsequent examination shall be subject to the provisions of § 3.105(e) of this chapter	
7706 Splenectomy	20

	Rating
Note: Separately rate complications such as systemic infections with encapsulated bacteria	
Note: Separately rate complications such as systemic infections with encapsulated bacteria	
7707 Spleen, injury of, healed.	
Rate for any residuals.	
7709 Hodgkin's lymphoma:	
With active disease or during a treatment phase	100
Note: A 100 percent evaluation shall continue beyond the cessation of any surgical therapy, radiation therapy, antineoplastic chemotherapy, or other therapeutic procedures. Six months after discontinuance of such treatment, the appropriate disability rating shall be determined by mandatory VA examination. Any reduction in evaluation based upon that or any subsequent examination shall be subject to the provisions of §3.105(e) of this chapter. If there has been no local recurrence or metastasis, rate on residuals under the appropriate diagnostic code(s).	
7710 Adenitis, tuberculous, active or inactive:	
Rate under §4.88c or 4.89 of this part, whichever is appropriate.	
7712 Multiple myeloma:	
Symptomatic multiple myeloma	100
Asymptomatic, smoldering, or monoclonal gammopathy of undetermined significance (MGUS)	0
Note (1): Current validated biomarkers of symptomatic multiple myeloma and asymptomatic multiple myeloma, smoldering, or monoclonal gammopathy of undetermined significance (MGUS) are acceptable for the diagnosis of multiple myeloma as defined by the American Society of Hematology (ASH) and International Myeloma Working Group (IMWG)	
Note (2): The 100 percent evaluation shall continue for five years after the diagnosis of symptomatic multiple myeloma, at which time the appropriate disability evaluation shall be determined by mandatory VA examination. Any reduction in evaluation based upon that or any subsequent examination shall be subject to the provisions of §3.105(e) and §3.344 (a) and (b) of this chapter	
7714 Sickle cell anemia:	
With at least 4 or more painful episodes per 12-month period, occurring in skin, joints, bones, or any major organs, caused by hemolysis and sickling of red blood cells, with anemia, thrombosis, and infarction, with residual symptoms precluding even light manual labor	100
With 3 painful episodes per 12-month period or with symptoms precluding other than light manual labor	60
With 1 or 2 painful episodes per 12-month period	30
Asymptomatic, established case in remission, but with identifiable organ impairment	10
Note: Sickle cell trait alone, without a history of directly attributable pathological findings, is not a ratable disability. Cases of symptomatic sickle cell trait will be forwarded to the Director, Compensation Service, for consideration under §3.321(b)(1) of this chapter	
7715 Non-Hodgkin's lymphoma:	
When there is active disease, during treatment phase, or with indolent and noncontiguous phase of low grade NHL	100
Note: A 100 percent evaluation shall continue beyond the cessation of any surgical therapy, radiation therapy, antineoplastic chemotherapy, or other therapeutic procedures. Two years after discontinuance of such treatment, the appropriate disability rating shall be determined by mandatory VA examination. Any reduction in evaluation based upon that or any subsequent examination shall be subject to the provisions of §3.105(e) of this chapter. If there has been no recurrence, rate on residuals under the appropriate diagnostic code(s)	
7716 Aplastic anemia:	
Requiring peripheral blood or bone marrow stem cell transplant; or requiring transfusion of platelets or red cells, on average, at least once every six weeks per 12-month period; or infections recurring, on average, at least once every six weeks per 12-month period	100
Requiring transfusion of platelets or red cells, on average, at least once every three months per 12-month period; or infections recurring, on average, at least once every three months per 12-month period; or using continuous therapy with immunosuppressive agent or newer platelet stimulating factors	60
Requiring transfusion of platelets or red cells, on average, at least once per 12-month period; or infections recurring, on average, at least once per 12-month period	30
Note (1): A 100 percent evaluation for peripheral blood or bone marrow stem cell transplant shall be assigned as of the date of hospital admission and shall continue with a mandatory VA examination six months following hospital discharge. Any change in evaluation based upon that or any subsequent examination shall be subject to the provisions of §3.105(e) of this chapter	
Note (2): The term ''newer platelet stimulating factors'' includes medication, factors, or other agents approved by the United States Food and Drug Administration	
7717 AL amyloidosis (primary amyloidosis)	100
7718 Essential thrombocythemia and primary myelofibrosis:	
Requiring either continuous myelosuppressive therapy or, for six months following hospital admission, peripheral blood or bone marrow stem cell transplant, or chemotherapy, or interferon treatment	100
Requiring continuous or intermittent myelosuppressive therapy, or chemotherapy, or interferon treatment to maintain platelet count $<500 \times 10^9$/L	70
Requiring continuous or intermittent myelosuppressive therapy, or chemotherapy, or interferon treatment to maintain platelet count of 200,000–400,000, or white blood cell (WBC) count of 4,000–10,000	30
Asymptomatic	0
Note (1): If the condition undergoes leukemic transformation, evaluate as leukemia under diagnostic code 7703	

	Rating
Note (2): A 100 percent evaluation shall be assigned as of the date of hospital admission for peripheral blood or bone marrow stem cell transplant; or during the period of treatment with chemotherapy (including myelosuppressants). Six months following hospital discharge or, in the case of chemotherapy treatment, six months after completion of treatment, the appropriate disability rating shall be determined by mandatory VA examination. Any reduction in evaluation based upon that or any subsequent examination shall be subject to the provisions of § 3.105(e) of this chapter	
7719 Chronic myelogenous leukemia (CML) (chronic myeloid leukemia or chronic granulocytic leukemia):	
Requiring peripheral blood or bone marrow stem cell transplant, or continuous myelosuppressive or immunosuppressive therapy treatment	100
Requiring intermittent myelosuppressive therapy, or molecularly targeted therapy with tyrosine kinase inhibitors, or interferon treatment when not in apparent remission	60
In apparent remission on continuous molecularly targeted therapy with tyrosine kinase inhibitors	30
Note (1): If the condition undergoes leukemic transformation, evaluate as leukemia under diagnostic code 7703	
Note (2): A 100 percent evaluation shall be assigned as of the date of hospital admission for peripheral blood or bone marrow stem cell transplant; or during the period of treatment with chemotherapy (including myelosuppressants). Six months following hospital discharge or, in the case of chemotherapy treatment, six months after completion of treatment, the appropriate disability rating shall be determined by mandatory VA examination. Any reduction in evaluation based upon that or any subsequent examination shall be subject to the provisions of § 3.105 of this chapter	
7720 Iron deficiency anemia:	
Requiring intravenous iron infusions 4 or more times per 12-month period	30
Requiring intravenous iron infusions at least 1 time but less than 4 times per 12-month period, or requiring continuous treatment with oral supplementation	10
Asymptomatic or requiring treatment only by dietary modification	0
Note: Do not evaluate iron deficiency anemia due to blood loss under this diagnostic code. Evaluate iron deficiency anemia due to blood loss under the criteria for the condition causing the blood loss	
7721 Folic acid deficiency:	
Requiring continuous treatment with high-dose oral supplementation	10
Asymptomatic or requiring treatment only by dietary modification	0
7722 Pernicious anemia and Vitamin B_{12} deficiency anemia:	
For initial diagnosis requiring transfusion due to severe anemia, or if there are signs or symptoms related to central nervous system impairment, such as encephalopathy, myelopathy, or severe peripheral neuropathy, requiring parenteral B_{12} therapy	100
Requiring continuous treatment with Vitamin B_{12} injections, Vitamin B_{12} sublingual or high-dose oral tablets, or Vitamin B_{12} nasal spray or gel	10
Note: A 100 percent evaluation for pernicious anemia and Vitamin B_{12} deficiency shall be assigned as of the date of the initial diagnosis requiring transfusion due to severe anemia or parenteral B_{12} therapy and shall continue with a mandatory VA examination six months following hospital discharge or cessation of parenteral B_{12} therapy. Any reduction in evaluation based upon that or any subsequent examination shall be subject to the provisions of § 3.105(e) of this chapter. Thereafter, evaluate at 10 percent and separately evaluate any residual effects of pernicious anemia, such as neurologic involvement causing peripheral neuropathy, myelopathy, dementia, or related gastrointestinal residuals, under the most appropriate diagnostic code	
7723 Acquired hemolytic anemia:	
Requiring a bone marrow transplant or continuous intravenous or immunosuppressive therapy (e.g., prednisone, Cytoxan, azathioprine, or rituximab)	100
Requiring immunosuppressive medication 4 or more times per 12-month period	60
Requiring at least 2 but less than 4 courses of immunosuppressive therapy per 12-month period	30
Requiring one course of immunosuppressive therapy per 12-month period	10
Asymptomatic	0
Note (1): A 100 percent evaluation for bone marrow transplant shall be assigned as of the date of hospital admission and shall continue for six months after hospital discharge with a mandatory VA examination six months following hospital discharge. Any reduction in evaluation based upon that or any subsequent examination shall be subject to the provisions of § 3.105(e) of this chapter	
Note (2): Separately evaluate splenectomy under diagnostic code 7706 and combine with an evaluation under diagnostic code 7723	
7724 Solitary plasmacytoma:	
Solitary plasmacytoma, when there is active disease or during a treatment phase	100
Note (1): A 100 percent evaluation shall continue beyond the cessation of any surgical therapy, radiation therapy, antineoplastic chemotherapy, or other therapeutic procedures (including autologous stem cell transplantation). Six months after discontinuance of such treatment, the appropriate disability rating shall be determined by mandatory VA examination. Any change in evaluation based upon that or any subsequent examination shall be subject to the provisions of § 3.105(e) of this chapter. If there has been no recurrence, rate residuals under the appropriate diagnostic codes	
Note (2): Rate a solitary plasmacytoma that has developed into multiple myeloma as symptomatic multiple myeloma	
Note (3): Rate residuals of plasma cell dysplasia (e.g., thrombosis) and adverse effects of medical treatment (e.g., neuropathy) under the appropriate diagnostic codes	
7725 Myelodysplastic syndromes:	
Requiring peripheral blood or bone marrow stem cell transplant; or requiring chemotherapy	100

	Rating
Requiring 4 or more blood or platelet transfusions per 12-month period; or infections requiring hospitalization 3 or more times per 12-month period	60
Requiring at least 1 but no more than 3 blood or platelet transfusions per 12-month period; infections requiring hospitalization at least 1 but no more than 2 times per 12-month period; or requiring biologic therapy on an ongoing basis or erythropoiesis stimulating agent (ESA) for 12 weeks or less per 12-month period	30
Note (1): If the condition progresses to leukemia, evaluate as leukemia under diagnostic code 7703	
Note (2): A 100 percent evaluation shall be assigned as of the date of hospital admission for peripheral blood or bone marrow stem cell transplant, or during the period of treatment with chemotherapy, and shall continue with a mandatory VA examination six months following hospital discharge or, in the case of chemotherapy treatment, six months after completion of treatment. Any reduction in evaluation based upon that or any subsequent examination shall be subject to the provisions of §3.105(e) of this chapter. If there has been no recurrence, residuals will be rated under the appropriate diagnostic codes	

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THE SKIN

§4.118 Schedule of ratings—skin.

(a) For the purposes of this section, systemic therapy is treatment that is administered through any route (orally, injection, suppository, intranasally) other than the skin, and topical therapy is treatment that is administered through the skin.

(b) Two or more skin conditions may be combined in accordance with §4.25 only if separate areas of skin are involved. If two or more skin conditions involve the same area of skin, then only the highest evaluation shall be used.

	Rating
7800 Burn scar(s) of the head, face, or neck; scar(s) of the head, face, or neck due to other causes; or other disfigurement of the head, face, or neck:	
With visible or palpable tissue loss and either gross distortion or asymmetry of three or more features or paired sets of features (nose, chin, forehead, eyes (including eyelids), ears (auricles), cheeks, lips), or; with six or more characteristics of disfigurement	80
With visible or palpable tissue loss and either gross distortion or asymmetry of two features or paired sets of features (nose, chin, forehead, eyes (including eyelids), ears (auricles), cheeks, lips), or; with four or five characteristics of disfigurement	50
With visible or palpable tissue loss and either gross distortion or asymmetry of one feature or paired set of features (nose, chin, forehead, eyes (including eyelids), ears (auricles), cheeks, lips), or; with two or three characteristics of disfigurement	30
With one characteristic of disfigurement	10
Note (1): The 8 characteristics of disfigurement, for purposes of evaluation under §4.118, are:	
Scar 5 or more inches (13 or more cm.) in length.	
Scar at least one-quarter inch (0.6 cm.) wide at widest part.	
Surface contour of scar elevated or depressed on palpation.	
Scar adherent to underlying tissue.	
Skin hypo-or hyper-pigmented in an area exceeding six square inches (39 sq. cm.).	
Skin texture abnormal (irregular, atrophic, shiny, scaly, etc.) in an area exceeding six square inches (39 sq. cm.).	
Underlying soft tissue missing in an area exceeding six square inches (39 sq. cm.).	
Skin indurated and inflexible in an area exceeding six square inches (39 sq. cm.).	
Note (2): Rate tissue loss of the auricle under DC 6207 (loss of auricle) and anatomical loss of the eye under DC 6061 (anatomical loss of both eyes) or DC 6063 (anatomical loss of one eye), as appropriate.	
Note (3): Take into consideration unretouched color photographs when evaluating under these criteria.	
Note (4): Separately evaluate disabling effects other than disfigurement that are associated with individual scar(s) of the head, face, or neck, such as pain, instability, and residuals of associated muscle or nerve injury, under the appropriate diagnostic code(s) and apply §4.25 to combine the evaluation(s) with the evaluation assigned under this diagnostic code.	
Note (5): The characteristic(s) of disfigurement may be caused by one scar or by multiple scars; the characteristic(s) required to assign a particular evaluation need not be caused by a single scar in order to assign that evaluation.	
7801 Burn scar(s) or scar(s) due to other causes, not of the head, face, or neck, that are associated with underlying soft tissue damage:	
Area or areas of 144 square inches (929 sq. cm.) or greater	40
Area or areas of at least 72 square inches (465 sq. cm.) but less than 144 square inches (929 sq. cm.)	30
Area or areas of at least 12 square inches (77 sq. cm.) but less than 72 square inches (465 sq. cm.)	20

	Rating
Area or areas of at least 6 square inches (39 sq. cm.) but less than 12 square inches (77 sq. cm.)	10
Note (1): For the purposes of DCs 7801 and 7802, the six (6) zones of the body are defined as each extremity, anterior trunk, and posterior trunk. The midaxillary line divides the anterior trunk from the posterior trunk.	
Note (2): A separate evaluation may be assigned for each affected zone of the body under this diagnostic code if there are multiple scars, or a single scar, affecting multiple zones of the body. Combine the separate evaluations under § 4.25. Alternatively, if a higher evaluation would result from adding the areas affected from multiple zones of the body, a single evaluation may also be assigned under this diagnostic code.	
7802 Burn scar(s) or scar(s) due to other causes, not of the head, face, or neck, that are not associated with underlying soft tissue damage:	
Area or areas of 144 square inches (929 sq. cm.) or greater	10
Note (1): For the purposes of DCs 7801 and 7802, the six (6) zones of the body are defined as each extremity, anterior trunk, and posterior trunk. The midaxillary line divides the anterior trunk from the posterior trunk.	
Note (2): A separate evaluation may be assigned for each affected zone of the body under this diagnostic code if there are multiple scars, or a single scar, affecting multiple zones of the body. Combine the separate evaluations under § 4.25. Alternatively, if a higher evaluation would result from adding the areas affected from multiple zones of the body, a single evaluation may also be assigned under this diagnostic code.	
7804 Scar(s), unstable or painful:.	
Five or more scars that are unstable or painful	30
Three or four scars that are unstable or painful	20
One or two scars that are unstable or painful	10
Note (1): An unstable scar is one where, for any reason, there is frequent loss of covering of skin over the scar.	
Note (2): If one or more scars are both unstable and painful, add 10 percent to the evaluation that is based on the total number of unstable or painful scars	
Note (3): Scars evaluated under diagnostic codes 7800, 7801, 7802, or 7805 may also receive an evaluation under this diagnostic code, when applicable	
7805 Scars, other; and other effects of scars evaluated under diagnostic codes 7800, 7801, 7802, or 7804:	
Evaluate any disabling effect(s) not considered in a rating provided under diagnostic codes 7800–04 under an appropriate diagnostic code.	
General Rating Formula For The Skin For DCs 7806, 7809, 7813–7816, 7820–7822, and 7824:	
At least one of the following	60
Characteristic lesions involving more than 40 percent of the entire body or more than 40 percent of exposed areas affected; or	
Constant or near-constant systemic therapy including, but not limited to, corticosteroids, phototherapy, retinoids, biologics, photochemotherapy, psoralen with long-wave ultraviolet-A light (PUVA), or other immunosuppressive drugs required over the past 12-month period	60
At least one of the following	30
Characteristic lesions involving 20 to 40 percent of the entire body or 20 to 40 percent of exposed areas affected; or Systemic therapy including, but not limited to, corticosteroids, phototherapy, retinoids, biologics, photochemotherapy, PUVA, or other immunosuppressive drugs required for a total duration of 6 weeks or more, but not constantly, over the past 12-month period.	
At least one of the following	10
Characteristic lesions involving at least 5 percent, but less than 20 percent, of the entire body affected; or	
At least 5 percent, but less than 20 percent, of exposed areas affected; or	
Intermittent systemic therapy including, but not limited to, corticosteroids, phototherapy, retinoids, biologics, photochemotherapy, PUVA, or other immunosuppressive drugs required for a total duration of less than 6 weeks over the past 12-month period.	
No more than topical therapy required over the past 12-month period and at least one of the following	0
Characteristic lesions involving less than 5 percent of the entire body affected; or	
Characteristic lesions involving less than 5 percent of exposed areas affected.	
Or rate as disfigurement of the head, face, or neck (DC 7800) or scars (DCs 7801, 7802, 7804, or 7805), depending upon the predominant disability. This rating instruction does not apply to DC 7824.	
7806 Dermatitis or eczema.	
Evaluate under the General Rating Formula for the Skin.	
7807 American (New World) leishmaniasis (mucocutaneous, espundia):	
Rate as disfigurement of the head, face, or neck (DC 7800), scars (DC's 7801, 7802, 7803, 7804, or 7805), or dermatitis (DC 7806), depending upon the predominant disability.	
Note: Evaluate non-cutaneous (visceral) leishmaniasis under DC 6301 (visceral leishmaniasis).	
7808 Old World leishmaniasis (cutaneous, Oriental sore):	
Rate as disfigurement of the head, face, or neck (DC 7800), scars (DC's, 7801, 7802, 7803, 7804, or 7805), or dermatitis (DC 7806), depending upon the predominant disabililty.	
Note: Evaluate non-cutaneous (visceral) leishmaniasis under DC 6301 (visceral leishmaniasis).	
7809 Discoid lupus erythematosus.	
Evaluate under the General Rating Formula for the Skin.	
Note: Do not combine with ratings under DC 6350.	
7811 Tuberculosis luposa (lupus vulgaris), active or inactive:	
Rate under §§ 4.88c or 4.89, whichever is appropriate.	

	Rating
7813 Dermatophytosis (ringworm: Of body, tinea corporis; of head, tinea capitis; of feet, tinea pedis; of beard area, tinea barbae; of nails, tinea unguium (onychomycosis); of inguinal area (jock itch), tinea cruris; tinea versicolor).	
Evaluate under the General Rating Formula for the Skin.	
7815 Bullous disorders (including pemphigus vulgaris, pemphigus foliaceous, bullous pemphigoid, dermatitis herpetiformis, epidermolysis bullosa acquisita, benign chronic familial pemphigus (Hailey-Hailey), and porphyria cutanea tarda).	
Evaluate under the General Rating Formula for the Skin.	
Note: Rate complications and residuals of mucosal involvement (ocular, oral, gastrointestinal, respiratory, or genitourinary) separately under the appropriate diagnostic code.	
7816 Psoriasis.	
Evaluate under the General Rating Formula for the Skin.	
Note: Rate complications such as psoriatic arthritis and other clinical manifestations (*e.g.,* oral mucosa, nails) separately under the appropriate diagnostic code.	
7817 Erythroderma:	
Generalized involvement of the skin with systemic manifestations (such as fever, weight loss, or hypoproteinemia) AND one of the following	100
Constant or near-constant systemic therapy such as therapeutic doses of corticosteroids, other immunosuppressive drugs, retinoids, PUVA (psoralen with long-wave ultraviolet-A light), UVB (ultraviolet-B light) treatments, biologics, or electron beam therapy required over the past 12 month period; or	
No current treatment due to a documented history of treatment failure with 2 or more treatment regimens	100
Generalized involvement of the skin without systemic manifestations and one of the following.	
Constant or near-constant systemic therapy such as therapeutic doses of corticosteroids, other immunosuppressive drugs, retinoids, PUVA, UVB treatments, biologics, or electron beam therapy required over the past 12-month period; or	
No current treatment due to a documented history of treatment failure with 1 treatment regimen	60
Any extent of involvement of the skin, and any of the following therapies required for a total duration of 6 weeks or more, but not constantly, over the past 12-month period: systemic therapy such as therapeutic doses of corticosteroids, other immunosuppressive drugs, retinoids, PUVA, UVB treatments, biologics, or electron beam therapy	30
Any extent of involvement of the skin, and any of the following therapies required for a total duration of less than 6 weeks over the past 12-month period: systemic therapy such as therapeutic doses of corticosteroids, other immunosuppressive drugs, retinoids, PUVA, UVB treatments, biologics, or electron beam therapy	10
Any extent of involvement of the skin, and no more than topical therapy required over the past 12-month period	0
Note: Treatment failure is defined as either disease progression, or less than a 25 percent reduction in the extent and severity of disease after four weeks of prescribed therapy, as documented by medical records.	
7818 Malignant skin neoplasms (other than malignant melanoma):	
Rate as disfigurement of the head, face, or neck (DC 7800), scars (DC's 7801, 7802, 7803, 7804, or 7805), or impairment of function.	
Note: If a skin malignancy requires therapy that is comparable to that used for systemic malignancies, *i.e.*, systemic chemotherapy, X-ray therapy more extensive than to the skin, or surgery more extensive than wide local excision, a 100-percent evaluation will be assigned from the date of onset of treatment, and will continue, with a mandatory VA examination six months following the completion of such antineoplastic treatment, and any change in evaluation based upon that or any subsequent examination will be subject to the provisions of §3.105(e) of this chapter. If there has been no local recurrence or metastasis, evaluation will then be made on residuals. If treatment is confined to the skin, the provisions for a 100-percent evaluation do not apply.	
7819 Benign skin neoplasms:	
Rate as disfigurement of the head, face, or neck (DC 7800), scars (DC's 7801, 7802, 7803, 7804, or 7805), or impairment of function.	
7820 Infections of the skin not listed elsewhere (including bacterial, fungal, viral, treponemal, and parasitic diseases).	
Evaluate under the General Rating Formula for the Skin.	
7821 Cutaneous manifestations of collagen-vascular diseases not listed elsewhere (including scleroderma, calcinosis cutis, subacute cutaneous lupus erythematosus, and dermatomyositis).	
Evaluate under the General Rating Formula for the Skin.	
7822 Papulosquamous disorders not listed elsewhere (including lichen planus, large or small plaque parapsoriasis, pityriasis lichenoides et varioliformis acuta (PLEVA), lymphomatoid papulosus, mycosis fungoides, and pityriasis rubra pilaris (PRP)).	
Evaluate under the General Rating Formula for the Skin.	
7823 Vitiligo:	
With exposed areas affected	10
With no exposed areas affected	0
7824 Diseases of keratinization (including icthyoses, Darier's disease, and palmoplantar keratoderma).	

	Rating
Evaluate under the General Rating Formula for the Skin.	
7825 Chronic urticaria:	
For the purposes of this diagnostic code, chronic urticaria is defined as continuous urticaria at least twice per week, off treatment, for a period of six weeks or more.	
Chronic refractory urticaria that requires third line treatment for control (e.g., plasmapheresis, immunotherapy, immunosuppressives) due to ineffectiveness with first and second line treatments	60
Chronic urticaria that requires second line treatment (e.g., corticosteroids, sympathomimetics, leukotriene inhibitors, neutrophil inhibitors, thyroid hormone) for control	30
Chronic urticaria that requires first line treatment (antihistamines) for control	10
7826 Vasculitis, primary cutaneous:	
Persistent documented vasculitis episodes refractory to continuous immunosuppressive therapy	60
All of the following	30
Recurrent documented vasculitic episodes occurring four or more times over the past 12-month period; and	
Requiring intermittent systemic immunosuppressive therapy for control	30
At least one of the following	10
Recurrent documented vasculitic episodes occurring one to three times over the past 12-month period, and requiring intermittent systemic immunosuppressive therapy for control; or	
Without recurrent documented vasculitic episodes but requiring continuous systemic medication for control.	
Or rate as disfigurement of the head, face, or neck (DC 7800) or scars (DCs 7801, 7802, 7804, or 7805), depending upon the predominant disability.	
7827 Erythema multiforme; Toxic epidermal necrolysis:	
Recurrent mucosal, palmar, or plantar involvement impairing mastication, use of hands, or ambulation occurring four or more times over the past 12-month period despite ongoing immunosuppressive therapy	60
All of the following	30
Recurrent mucosal, palmar, or plantar involvement not impairing mastication, use of hands, or ambulation, occurring four or more times over the past 12-month period; andrequiring intermittent systemic therapy.	
At least one of the following	10
One to three episodes of mucosal, palmar, or plantar involvement not impairing mastication, use of hands, or ambulation, occurring over the past 12-month period AND requiring intermittent systemic therapy; or	
Without recurrent episodes, but requiring continuous systemic medication for control.	
Or rate as disfigurement of the head, face, or neck (DC 7800) or scars (DCs 7801, 7802, 7804, or 7805), depending upon the predominant disability.	
Note: For the purposes of this DC only, systemic therapy may consist of one or more of the following treatment agents: immunosuppressives, antihistamines, or sympathomimetics.	
7828 Acne:	
Deep acne (deep inflamed nodules and pus-filled cysts) affecting 40 percent or more of the face and neck	30
Deep acne (deep inflamed nodules and pus-filled cysts) affecting less than 40 percent of the face and neck, or deep acne other than on the face and neck	10
Superficial acne (comedones, papules, pustules) of any extent	0
Or rate as disfigurement of the head, face, or neck (DC 7800) or scars (DCs 7801, 7802, 7804, or 7805), depending upon the predominant disability.	
7829 Chloracne:	
Deep acne (deep inflamed nodules and pus-filled cysts) affecting 40 percent or more of the face and neck	30
Deep acne (deep inflamed nodules and pus-filled cysts) affecting the intertriginous areas (the axilla of the arm, the anogenital region, skin folds of the breasts, or between digits)	20
Deep acne (deep inflamed nodules and pus-filled cysts) affecting less than 40 percent of the face and neck; or deep acne affecting non-intertriginous areas of the body (other than the face and neck)	10
Superficial acne (comedones, papules, pustules) of any extent	0
Or rate as disfigurement of the head, face, or neck (DC 7800) or scars (DCs 7801, 7802, 7804, or 7805), depending upon the predominant disability.	
7830 Scarring alopecia:	
Affecting more than 40 percent of the scalp	20
Affecting 20 to 40 percent of the scalp	10
Affecting less than 20 percent of the scalp	0
7831 Alopecia areata:	
With loss of all body hair	10
With loss of hair limited to scalp and face	0
7832 Hyperhidrosis:	
Unable to handle paper or tools because of moisture, and unresponsive to therapy	30
Able to handle paper or tools after therapy	0
7833 Malignant melanoma:	
Rate as scars (DC's 7801, 7802, 7803, 7804, or 7805), disfigurement of the head, face, or neck (DC 7800), or impairment of function (under the appropriate body system).	

	Rating
Note: If a skin malignancy requires therapy that is comparable to that used for systemic malignancies, *i.e.*, systemic chemotherapy, X-ray therapy more extensive than to the skin, or surgery more extensive than wide local excision, a 100-percent evaluation will be assigned from the date of onset of treatment, and will continue, with a mandatory VA examination six months following the completion of such antineoplastic treatment, and any change in evaluation based upon that or any subsequent examination will be subject to the provisions of §3.105(e). If there has been no local recurrence or metastasis, evaluation will then be made on residuals. If treatment is confined to the skin, the provisions for a 100-percent evaluation do not apply.	

(Authority: 38 U.S.C. 1155)

[67 FR 49596, July 31, 2002; 67 FR 58448, 58449, Sept. 16, 2002; 73 FR 54710, Oct. 23, 2008; 77 FR 2910, Jan. 20, 2012; 83 FR 32597, July 13, 2018; 83 FR 38663, Aug. 7, 2018]

THE ENDOCRINE SYSTEM

§4.119 Schedule of ratings—endocrine system.

	Rating
7900 Hyperthyroidism, including, but not limited to, Graves' disease:	
For six months after initial diagnosis	30
Thereafter, rate residuals of disease or complications of medical treatment within the appropriate diagnostic code(s) within the appropriate body system.	
Note (1): If hyperthyroid cardiovascular or cardiac disease is present, separately evaluate under DC 7008 (hyperthyroid heart disease).	
Note (2): Separately evaluate eye involvement occurring as a manifestation of Graves' Disease as diplopia (DC 6090); impairment of central visual acuity (DCs 6061–6066); or under the most appropriate DCs in §4.79.	
7901 Thyroid enlargement, toxic:	
Note (1): Evaluate symptoms of hyperthyroidism under DC 7900, hyperthyroidism, including, but not limited to, Graves' disease.	
Note (2): If disfigurement of the neck is present due to thyroid disease or enlargement, separately evaluate under DC 7800 (burn scar(s) of the head, face, or neck; scar(s) of the head, face, or neck due to other causes; or other disfigurement of the head, face, or neck).	
7902 Thyroid enlargement, nontoxic:	
Note (1): Evaluate symptoms due to pressure on adjacent organs (such as the trachea, larynx, or esophagus) under the appropriate diagnostic code(s) within the appropriate body system.	
Note (2): If disfigurement of the neck is present due to thyroid disease or enlargement, separately evaluate under DC 7800 (burn scar(s) of the head, face, or neck; scar(s) of the head, face, or neck due to other causes; or other disfigurement of the head, face, or neck).	
7903 Hypothyroidism:	
Hypothyroidism manifesting as myxedema (cold intolerance, muscular weakness, cardiovascular involvement (including, but not limited to hypotension, bradycardia, and pericardial effusion), and mental disturbance (including, but not limited to dementia, slowing of thought and depression))	100
Note (1): This evaluation shall continue for six months beyond the date that an examining physician has determined crisis stabilization. Thereafter, the residual effects of hypothyroidism shall be rated under the appropriate diagnostic code(s) within the appropriate body system(s) (*e.g.,* eye, digestive, and mental disorders).	
Hypothyroidism without myxedema	30
Note (2): This evaluation shall continue for six months after initial diagnosis. Thereafter, rate residuals of disease or medical treatment under the most appropriate diagnostic code(s) under the appropriate body system (*e.g.,* eye, digestive, mental disorders).	
Note (3): If eye involvement, such as exophthalmos, corneal ulcer, blurred vision, or diplopia, is also present due to thyroid disease, also separately evaluate under the appropriate diagnostic code(s) in §4.79, Schedule of Ratings—Eye (such as diplopia (DC 6090) or impairment of central visual acuity (DCs 6061–6066)).	
7904 Hyperparathyroidism:	
For six months from date of discharge following surgery	100
Note (1): After six months, rate on residuals under the appropriate diagnostic code(s) within the appropriate body system(s) based on a VA examination.	
Hypercalcemia (indicated by at least one of the following: Total Ca greater than 12 mg/dL (3–3.5 mmol/L), Ionized Ca greater than 5.6 mg/dL (2–2.5 mmol/L), creatinine clearance less than 60 mL/min, bone mineral density T-score less than 2.5 SD (below mean) at any site or previous fragility fracture)	60
Note (2): Where surgical intervention is indicated, this evaluation shall continue until the day of surgery, at which time the provisions pertaining to a 100-percent evaluation shall apply.	
Note (3): Where surgical intervention is not indicated, this evaluation shall continue for six months after pharmacologic treatment begins. After six months, rate on residuals under the appropriate diagnostic code(s) within the appropriate body system(s) based on a VA examination.	
Symptoms such as fatigue, anorexia, nausea, or constipation that occur despite surgery; or in individuals who are not candidates for surgery but require continuous medication for control	10

	Rating
Asymptomatic	0
Note (4): Following surgery or other treatment, evaluate chronic residuals, such as nephrolithiasis (kidney stones), decreased renal function, fractures, vision problems, and cardiovascular complications, under the appropriate diagnostic codes.	
7905 Hypoparathyroidism:	
For three months after initial diagnosis	100
Thereafter, evaluate chronic residuals, such as nephrolithiasis (kidney stones), cataracts, decreased renal function, and congestive heart failure under the appropriate diagnostic codes.	
7906 Thyroiditis:	
With normal thyroid function (euthyroid)	0
Note: Manifesting as hyperthyroidism, evaluate as hyperthyroidism, including, but not limited to, Graves' disease (DC 7900); manifesting as hypothyroidism, evaluate as hypothyroidism (DC 7903).	
7907 Cushing's syndrome:	
As active, progressive disease, including areas of osteoporosis, hypertension, and proximal upper and lower extremity muscle wasting that results in inability to rise from squatting position, climb stairs, rise from a deep chair without assistance, or raise arms	100
Proximal upper or lower extremity muscle wasting that results in inability to rise from squatting position, climb stairs, rise from a deep chair without assistance, or raise arms	60
With striae, obesity, moon face, glucose intolerance, and vascular fragility	30
Note: The evaluations specifically indicated under this diagnostic code shall continue for six months following initial diagnosis. After six months, rate on residuals under the appropriate diagnostic code(s) within the appropriate body system(s).	
7908 Acromegaly:	
Evidence of increased intracranial pressure (such as visual field defect), arthropathy, glucose intolerance, and either hypertension or cardiomegaly	100
Arthropathy, glucose intolerance, and hypertension	60
Enlargement of acral parts or overgrowth of long bones	30
7909 Diabetes insipidus:	
For three months after initial diagnosis	30
Note: Thereafter, if diabetes insipidus has subsided, rate residuals under the appropriate diagnostic code(s) within the appropriate body system.	
With persistent polyuria or requiring continuous hormonal therapy	10
7911 Addison's disease (adrenocortical insufficiency):	
Four or more crises during the past year	60
Three crises during the past year, or; five or more episodes during the past year	40
One or two crises during the past year, or; two to four episodes during the past year, or; weakness and fatigability, or; corticosteroid therapy required for control	20
Note (1): An Addisonian ''crisis'' consists of the rapid onset of peripheral vascular collapse (with acute hypotension and shock), with findings that may include: anorexia; nausea; vomiting; dehydration; profound weakness; pain in abdomen, legs, and back; fever; apathy, and depressed mentation with possible progression to coma, renal shutdown, and death.	
Note (2): An Addisonian ''episode,'' for VA purposes, is a less acute and less severe event than an Addisonian crisis and may consist of anorexia, nausea, vomiting, diarrhea, dehydration, weakness, malaise, orthostatic hypotension, or hypoglycemia, but no peripheral vascular collapse.	
Note (3): Tuberculous Addison's disease will be evaluated as active or inactive tuberculosis. If inactive, these evaluations are not to be combined with the graduated ratings of 50 percent or 30 percent for non-pulmonary tuberculosis specified under § 4.88b. Assign the higher rating.	
7912 Polyglandular syndrome (multiple endocrine neoplasia, autoimmune polyglandular syndrome):	
Evaluate according to major manifestations to include, but not limited to, Type I diabetes mellitus, hyperthyroidism, hypothyroidism, hypoparathyroidism, or Addison's disease.	
7913 Diabetes mellitus:	
Requiring more than one daily injection of insulin, restricted diet, and regulation of activities (avoidance of strenuous occupational and recreational activities) with episodes of ketoacidosis or hypoglycemic reactions requiring at least three hospitalizations per year or weekly visits to a diabetic care provider, plus either progressive loss of weight and strength or complications that would be compensable if separately evaluated	100
Requiring one or more daily injection of insulin, restricted diet, and regulation of activities with episodes of ketoacidosis or hypoglycemic reactions requiring one or two hospitalizations per year or twice a month visits to a diabetic care provider, plus complications that would not be compensable if separately evaluated	60
Requiring one or more daily injection of insulin, restricted diet, and regulation of activities	40
Requiring one or more daily injection of insulin and restricted diet, or; oral hypoglycemic agent and restricted diet	20
Manageable by restricted diet only	10
Note (1): Evaluate compensable complications of diabetes separately unless they are part of the criteria used to support a 100-percent evaluation. Noncompensable complications are considered part of the diabetic process under DC 7913.	
Note (2): When diabetes mellitus has been conclusively diagnosed, do not request a glucose tolerance test solely for rating purposes.	
7914 Neoplasm, malignant, any specified part of the endocrine system	100

	Rating
NOTE: A rating of 100 percent shall continue beyond the cessation of any surgical, X-ray, antineoplastic chemotherapy or other therapeutic procedure. Six months after discontinuance of such treatment, the appropriate disability rating shall be determined by mandatory VA examination. Any change in evaluation based upon that or any subsequent examination shall be subject to the provisions of §3.105(e) of this chapter. If there has been no local recurrence or metastasis, rate on residuals.	
7915 Neoplasm, benign, any specified part of the endocrine system:	
Rate as residuals of endocrine dysfunction.	
7916 Hyperpituitarism (prolactin secreting pituitary dysfunction):	
Note: Evaluate as malignant or benign neoplasm, as appropriate.	
7917 Hyperaldosteronism (benign or malignant):	
Note: Evaluate as malignant or benign neoplasm, as appropriate.	
7918 Pheochromocytoma (benign or malignant):	
Note: Evaluate as malignant or benign neoplasm as appropriate.	
7919 C-cell hyperplasia of the thyroid:	
If antineoplastic therapy is required, evaluate as a malignant neoplasm under DC 7914. If a prophylactic thyroidectomy is performed (based upon genetic testing) and antineoplastic therapy is not required, evaluate as hypothyroidism under DC 7903.	

[61 FR 20446, May 7, 1996, as amended at 82 FR 50804, Nov. 2, 2017]

NEUROLOGICAL CONDITIONS AND CONVULSIVE DISORDERS

§4.120 Evaluations by comparison.

Disability in this field is ordinarily to be rated in proportion to the impairment of motor, sensory or mental function. Consider especially psychotic manifestations, complete or partial loss of use of one or more extremities, speech disturbances, impairment of vision, disturbances of gait, tremors, visceral manifestations, injury to the skull, etc. In rating disability from the conditions in the preceding sentence refer to the appropriate schedule. In rating peripheral nerve injuries and their residuals, attention should be given to the site and character of the injury, the relative impairment in motor function, trophic changes, or sensory disturbances.

§4.121 Identification of epilepsy.

When there is doubt as to the true nature of epileptiform attacks, neurological observation in a hospital adequate to make such a study is necessary. To warrant a rating for epilepsy, the seizures must be witnessed or verified at some time by a physician. As to frequency, competent, consistent lay testimony emphasizing convulsive and immediate post-convulsive characteristics may be accepted. The frequency of seizures should be ascertained under the ordinary conditions of life (while not hospitalized).

§4.122 Psychomotor epilepsy.

The term psychomotor epilepsy refers to a condition that is characterized by seizures and not uncommonly by a chronic psychiatric disturbance as well.

(a) Psychomotor seizures consist of episodic alterations in conscious control that may be associated with automatic states, generalized convulsions, random motor movements (chewing, lip smacking, fumbling), hallucinatory phenomena (involving taste, smell, sound, vision), perceptual illusions (deja vu, feelings of loneliness, strangeness, macropsia, micropsia, dreamy states), alterations in thinking (not open to reason), alterations in memory, abnormalities of mood or affect (fear, alarm, terror, anger, dread, well-being), and autonomic disturbances (sweating, pallor, flushing of the face, visceral phenomena such as nausea, vomiting, defecation, a rising feeling of warmth in the abdomen). Automatic states or automatisms are characterized by episodes of irrational, irrelevant, disjointed, unconventional, asocial, purposeless though seemingly coordinated and purposeful, confused or inappropriate activity of one to several minutes (or, infrequently, hours) duration with subsequent amnesia for the seizure. Examples: A person of high social standing remained seated, muttered angrily, and rubbed the arms of his chair while the National Anthem was being played; an apparently normal person suddenly disrobed in public; a man traded an expensive automobile for an antiquated automobile in poor mechanical condition and after regaining conscious control, discovered that he had signed an agreement to pay an additional sum of money in the trade. The seizure manifestations of psychomotor epilepsy vary from patient to

patient and in the same patient from seizure to seizure.

(b) A chronic mental disorder is not uncommon as an interseizure manifestation of psychomotor epilepsy and may include psychiatric disturbances extending from minimal anxiety to severe personality disorder (as distinguished from developmental) or almost complete personality disintegration (psychosis). The manifestations of a chronic mental disorder associated with psychomotor epilepsy, like those of the seizures, are protean in character.

§ 4.123 Neuritis, cranial or peripheral.

Neuritis, cranial or peripheral, characterized by loss of reflexes, muscle atrophy, sensory disturbances, and constant pain, at times excruciating, is to be rated on the scale provided for injury of the nerve involved, with a maximum equal to severe, incomplete, paralysis. See nerve involved for diagnostic code number and rating. The maximum rating which may be assigned for neuritis not characterized by organic changes referred to in this section will be that for moderate, or with sciatic nerve involvement, for moderately severe, incomplete paralysis.

§ 4.124 Neuralgia, cranial or peripheral.

Neuralgia, cranial or peripheral, characterized usually by a dull and intermittent pain, of typical distribution so as to identify the nerve, is to be rated on the same scale, with a maximum equal to moderate incomplete paralysis. See nerve involved for diagnostic code number and rating. Tic douloureux, or trifacial neuralgia, may be rated up to complete paralysis of the affected nerve.

§ 4.124a Schedule of ratings—neurological conditions and convulsive disorders.

[With the exceptions noted, disability from the following diseases and their residuals may be rated from 10 percent to 100 percent in proportion to the impairment of motor, sensory, or mental function. Consider especially psychotic manifestations, complete or partial loss of use of one or more extremities, speech disturbances, impairment of vision, disturbances of gait, tremors, visceral manifestations, etc., referring to the appropriate bodily system of the schedule. With partial loss of use of one or more extremities from neurological lesions, rate by comparison with the mild, moderate, severe, or complete paralysis of peripheral nerves]

ORGANIC DISEASES OF THE CENTRAL NERVOUS SYSTEM

	Rating
8000 Encephalitis, epidemic, chronic:	
As active febrile disease	100
Rate residuals, minimum	10
Brain, new growth of:	
8002 Malignant	100
NOTE: The rating in code 8002 will be continued for 2 years following cessation of surgical, chemotherapeutic or other treatment modality. At this point, if the residuals have stabilized, the rating will be made on neurological residuals according to symptomatology.	
Minimum rating	30
8003 Benign, minimum	60
Rate residuals, minimum	10
8004 Paralysis agitans:	
Minimum rating	30
8005 Bulbar palsy	100
8007 Brain, vessels, embolism of.	
8008 Brain, vessels, thrombosis of.	
8009 Brain, vessels, hemorrhage from:	
Rate the vascular conditions under Codes 8007 through 8009, for 6 months	100
Rate residuals, thereafter, minimum	10
8010 Myelitis:	
Minimum rating	10
8011 Poliomyelitis, anterior:	
As active febrile disease	100
Rate residuals, minimum	10
8012 Hematomyelia:	
For 6 months	100
Rate residuals, minimum	10
8013 Syphilis, cerebrospinal.	
8014 Syphilis, meningovascular.	
8015 Tabes dorsalis.	
NOTE: Rate upon the severity of convulsions, paralysis, visual impairment or psychotic involvement, etc.	
8017 Amyotrophic lateral sclerosis	100
NOTE: Consider the need for special monthly compensation.	
8018 Multiple sclerosis:	
Minimum rating	30
8019 Meningitis, cerebrospinal, epidemic:	
As active febrile disease	100
Rate residuals, minimum	10
8020 Brain, abscess of:	
As active disease	100
Rate residuals, minimum	10
Spinal cord, new growths of:.	
8021 Malignant	100
NOTE: The rating in code 8021 will be continued for 2 years following cessation of surgical, chemotherapeutic or other treatment modality. At this point, if the residuals have stabilized, the rating will be made on neurological residuals according to symptomatology.	
Minimum rating	30
8022 Benign, minimum rating	60
Rate residuals, minimum	10
8023 Progressive muscular atrophy:	
Minimum rating	30

ORGANIC DISEASES OF THE CENTRAL NERVOUS SYSTEM—Continued

	Rating
8024 Syringomyelia:	
Minimum rating	30
8025 Myasthenia gravis:	
Minimum rating	30
NOTE: It is required for the minimum ratings for residuals under diagnostic codes 8000–8025, that there be ascertainable residuals. Determinations as to the presence of residuals not capable of objective verification, *i.e.*, headaches, dizziness, fatigability, must be approached on the basis of the diagnosis recorded; subjective residuals will be accepted when consistent with the disease and not more likely attributable to other disease or no disease. It is of exceptional importance that when ratings in excess of the prescribed minimum ratings are assigned, the diagnostic codes utilized as bases of evaluation be cited, in addition to the codes identifying the diagnoses.	
8045 Residuals of traumatic brain injury (TBI):	
There are three main areas of dysfunction that may result from TBI and have profound effects on functioning: cognitive (which is common in varying degrees after TBI), emotional/behavioral, and physical. Each of these areas of dysfunction may require evaluation..	
Cognitive impairment is defined as decreased memory, concentration, attention, and executive functions of the brain. Executive functions are goal setting, speed of information processing, planning, organizing, prioritizing, self-monitoring, problem solving, judgment, decision making, spontaneity, and flexibility in changing actions when they are not productive. Not all of these brain functions may be affected in a given individual with cognitive impairment, and some functions may be affected more severely than others. In a given individual, symptoms may fluctuate in severity from day to day. Evaluate cognitive impairment under the table titled ''Evaluation of Cognitive Impairment and Other Residuals of TBI Not Otherwise Classified.''.	
Subjective symptoms may be the only residual of TBI or may be associated with cognitive impairment or other areas of dysfunction. Evaluate subjective symptoms that are residuals of TBI, whether or not they are part of cognitive impairment, under the subjective symptoms facet in the table titled ''Evaluation of Cognitive Impairment and Other Residuals of TBI Not Otherwise Classified.'' However, separately evaluate any residual with a distinct diagnosis that may be evaluated under another diagnostic code, such as migraine headache or Meniere's disease, even if that diagnosis is based on subjective symptoms, rather than under the ''Evaluation of Cognitive Impairment and Other Residuals of TBI Not Otherwise Classified'' table.	

ORGANIC DISEASES OF THE CENTRAL NERVOUS SYSTEM—Continued

	Rating
Evaluate emotional/behavioral dysfunction under §4.130 (Schedule of ratings—mental disorders) when there is a diagnosis of a mental disorder. When there is no diagnosis of a mental disorder, evaluate emotional/behavioral symptoms under the criteria in the table titled ''Evaluation of Cognitive Impairment and Other Residuals of TBI Not Otherwise Classified.''.	
Evaluate physical (including neurological) dysfunction based on the following list, under an appropriate diagnostic code: Motor and sensory dysfunction, including pain, of the extremities and face; visual impairment; hearing loss and tinnitus; loss of sense of smell and taste; seizures; gait, coordination, and balance problems; speech and other communication difficulties, including aphasia and related disorders, and dysarthria; neurogenic bladder; neurogenic bowel; cranial nerve dysfunctions; autonomic nerve dysfunctions; and endocrine dysfunctions..	
The preceding list of types of physical dysfunction does not encompass all possible residuals of TBI. For residuals not listed here that are reported on an examination, evaluate under the most appropriate diagnostic code. Evaluate each condition separately, as long as the same signs and symptoms are not used to support more than one evaluation, and combine under §4.25 the evaluations for each separately rated condition. The evaluation assigned based on the ''Evaluation of Cognitive Impairment and Other Residuals of TBI Not Otherwise Classified'' table will be considered the evaluation for a single condition for purposes of combining with other disability evaluations.	
Consider the need for special monthly compensation for such problems as loss of use of an extremity, certain sensory impairments, erectile dysfunction, the need for aid and attendance (including for protection from hazards or dangers incident to the daily environment due to cognitive impairment), being housebound, etc.	

ORGANIC DISEASES OF THE CENTRAL NERVOUS SYSTEM—Continued

	Rating
Evaluation of Cognitive Impairment and Subjective Symptoms	
The table titled ''Evaluation of Cognitive Impairment and Other Residuals of TBI Not Otherwise Classified'' contains 10 important facets of TBI related to cognitive impairment and subjective symptoms. It provides criteria for levels of impairment for each facet, as appropriate, ranging from 0 to 3, and a 5th level, the highest level of impairment, labeled ''total.'' However, not every facet has every level of severity. The Consciousness facet, for example, does not provide for an impairment level other than ''total,'' since any level of impaired consciousness would be totally disabling. Assign a 100-percent evaluation if ''total'' is the level of evaluation for one or more facets. If no facet is evaluated as ''total,'' assign the overall percentage evaluation based on the level of the highest facet as follows: 0 = 0 percent; 1 = 10 percent; 2 = 40 percent; and 3 = 70 percent. For example, assign a 70 percent evaluation if 3 is the highest level of evaluation for any facet..	
Note (1): There may be an overlap of manifestations of conditions evaluated under the table titled ''Evaluation Of Cognitive Impairment And Other Residuals Of TBI Not Otherwise Classified'' with manifestations of a comorbid mental or neurologic or other physical disorder that can be separately evaluated under another diagnostic code. In such cases, do not assign more than one evaluation based on the same manifestations. If the manifestations of two or more conditions cannot be clearly separated, assign a single evaluation under whichever set of diagnostic criteria allows the better assessment of overall impaired functioning due to both conditions. However, if the manifestations are clearly separable, assign a separate evaluation for each condition..	
Note (2): Symptoms listed as examples at certain evaluation levels in the table are only examples and are not symptoms that must be present in order to assign a particular evaluation..	
Note (3): ''Instrumental activities of daily living'' refers to activities other than self-care that are needed for independent living, such as meal preparation, doing housework and other chores, shopping, traveling, doing laundry, being responsible for one's own medications, and using a telephone. These activities are distinguished from ''Activities of daily living,'' which refers to basic self-care and includes bathing or showering, dressing, eating, getting in or out of bed or a chair, and using the toilet..	
Note (4): The terms ''mild,'' ''moderate,'' and ''severe'' TBI, which may appear in medical records, refer to a classification of TBI made at, or close to, the time of injury rather than to the current level of functioning. This classification does not affect the rating assigned under diagnostic code 8045..	

ORGANIC DISEASES OF THE CENTRAL NERVOUS SYSTEM—Continued

	Rating
Note (5): A veteran whose residuals of TBI are rated under a version of § 4.124a, diagnostic code 8045, in effect before October 23, 2008 may request review under diagnostic code 8045, irrespective of whether his or her disability has worsened since the last review. VA will review that veteran's disability rating to determine whether the veteran may be entitled to a higher disability rating under diagnostic code 8045. A request for review pursuant to this note will be treated as a claim for an increased rating for purposes of determining the effective date of an increased rating awarded as a result of such review; however, in no case will the award be effective before October 23, 2008. For the purposes of determining the effective date of an increased rating awarded as a result of such review, VA will apply 38 CFR 3.114, if applicable..	
8046 Cerebral arteriosclerosis:	
Purely neurological disabilities, such as hemiplegia, cranial nerve paralysis, etc., due to cerebral arteriosclerosis will be rated under the diagnostic codes dealing with such specific disabilities, with citation of a hyphenated diagnostic code (e.g., 8046–8207).	
Purely subjective complaints such as headache, dizziness, tinnitus, insomnia and irritability, recognized as symptomatic of a properly diagnosed cerebral arteriosclerosis, will be rated 10 percent and no more under diagnostic code 9305. This 10 percent rating will not be combined with any other rating for a disability due to cerebral or generalized arteriosclerosis. Ratings in excess of 10 percent for cerebral arteriosclerosis under diagnostic code 9305 are not assignable in the absence of a diagnosis of multi-infarct dementia with cerebral arteriosclerosis.	
NOTE: The ratings under code 8046 apply only when the diagnosis of cerebral arteriosclerosis is substantiated by the entire clinical picture and not solely on findings of retinal arteriosclerosis.	

EVALUATION OF COGNITIVE IMPAIRMENT AND OTHER RESIDUALS OF TBI NOT OTHERWISE CLASSIFIED

Facets of cognitive impairment and other residuals of TBI not otherwise classified	Level of impairment	Criteria
Memory, attention, concentration, executive functions.	0	No complaints of impairment of memory, attention, concentration, or executive functions.

EVALUATION OF COGNITIVE IMPAIRMENT AND OTHER RESIDUALS OF TBI NOT OTHERWISE CLASSIFIED—Continued

Facets of cognitive impairment and other residuals of TBI not otherwise classified	Level of impairment	Criteria
	1	A complaint of mild loss of memory (such as having difficulty following a conversation, recalling recent conversations, remembering names of new acquaintances, or finding words, or often misplacing items), attention, concentration, or executive functions, but without objective evidence on testing.
	2	Objective evidence on testing of mild impairment of memory, attention, concentration, or executive functions resulting in mild functional impairment.
	3	Objective evidence on testing of moderate impairment of memory, attention, concentration, or executive functions resulting in moderate functional impairment.
	Total	Objective evidence on testing of severe impairment of memory, attention, concentration, or executive functions resulting in severe functional impairment.
Judgment	0	Normal.
	1	Mildly impaired judgment. For complex or unfamiliar decisions, occasionally unable to identify, understand, and weigh the alternatives, understand the consequences of choices, and make a reasonable decision.
	2	Moderately impaired judgment. For complex or unfamiliar decisions, usually unable to identify, understand, and weigh the alternatives, understand the consequences of choices, and make a reasonable decision, although has little difficulty with simple decisions.

EVALUATION OF COGNITIVE IMPAIRMENT AND OTHER RESIDUALS OF TBI NOT OTHERWISE CLASSIFIED—Continued

Facets of cognitive impairment and other residuals of TBI not otherwise classified	Level of impairment	Criteria
	3	Moderately severely impaired judgment. For even routine and familiar decisions, occasionally unable to identify, understand, and weigh the alternatives, understand the consequences of choices, and make a reasonable decision.
	Total	Severely impaired judgment. For even routine and familiar decisions, usually unable to identify, understand, and weigh the alternatives, understand the consequences of choices, and make a reasonable decision. For example, unable to determine appropriate clothing for current weather conditions or judge when to avoid dangerous situations or activities.
Social interaction	0	Social interaction is routinely appropriate.
	1	Social interaction is occasionally inappropriate.
	2	Social interaction is frequently inappropriate.
	3	Social interaction is inappropriate most or all of the time.
Orientation	0	Always oriented to person, time, place, and situation.
	1	Occasionally disoriented to one of the four aspects (person, time, place, situation) of orientation.
	2	Occasionally disoriented to two of the four aspects (person, time, place, situation) of orientation or often disoriented to one aspect of orientation.
	3	Often disoriented to two or more of the four aspects (person, time, place, situation) of orientation.
	Total	Consistently disoriented to two or more of the four aspects (person, time, place, situation) of orientation.
Motor activity (with intact motor and sensory system).	0	Motor activity normal.

EVALUATION OF COGNITIVE IMPAIRMENT AND OTHER RESIDUALS OF TBI NOT OTHERWISE CLASSIFIED—Continued

Facets of cognitive impairment and other residuals of TBI not otherwise classified	Level of impairment	Criteria
	1	Motor activity normal most of the time, but mildly slowed at times due to apraxia (inability to perform previously learned motor activities, despite normal motor function).
	2	Motor activity mildly decreased or with moderate slowing due to apraxia.
	3	Motor activity moderately decreased due to apraxia.
	Total	Motor activity severely decreased due to apraxia.
Visual spatial orientation	0	Normal.
	1	Mildly impaired. Occasionally gets lost in unfamiliar surroundings, has difficulty reading maps or following directions. Is able to use assistive devices such as GPS (global positioning system).
	2	Moderately impaired. Usually gets lost in unfamiliar surroundings, has difficulty reading maps, following directions, and judging distance. Has difficulty using assistive devices such as GPS (global positioning system).
	3	Moderately severely impaired. Gets lost even in familiar surroundings, unable to use assistive devices such as GPS (global positioning system).
	Total	Severely impaired. May be unable to touch or name own body parts when asked by the examiner, identify the relative position in space of two different objects, or find the way from one room to another in a familiar environment.
Subjective symptoms	0	Subjective symptoms that do not interfere with work; instrumental activities of daily living; or work, family, or other close relationships. Examples are: mild or occasional headaches, mild anxiety.

EVALUATION OF COGNITIVE IMPAIRMENT AND OTHER RESIDUALS OF TBI NOT OTHERWISE CLASSIFIED—Continued

Facets of cognitive impairment and other residuals of TBI not otherwise classified	Level of impairment	Criteria
	1	Three or more subjective symptoms that mildly interfere with work; instrumental activities of daily living; or work, family, or other close relationships. Examples of findings that might be seen at this level of impairment are: intermittent dizziness, daily mild to moderate headaches, tinnitus, frequent insomnia, hypersensitivity to sound, hypersensitivity to light.
	2	Three or more subjective symptoms that moderately interfere with work; instrumental activities of daily living; or work, family, or other close relationships. Examples of findings that might be seen at this level of impairment are: marked fatigability, blurred or double vision, headaches requiring rest periods during most days.
Neurobehavioral effects ..	0	One or more neurobehavioral effects that do not interfere with workplace interaction or social interaction. Examples of neurobehavioral effects are: Irritability, impulsivity, unpredictability, lack of motivation, verbal aggression, physical aggression, belligerence, apathy, lack of empathy, moodiness, lack of cooperation, inflexibility, and impaired awareness of disability. Any of these effects may range from slight to severe, although verbal and physical aggression are likely to have a more serious impact on workplace interaction and social interaction than some of the other effects.

EVALUATION OF COGNITIVE IMPAIRMENT AND OTHER RESIDUALS OF TBI NOT OTHERWISE CLASSIFIED—Continued

Facets of cognitive impairment and other residuals of TBI not otherwise classified	Level of impairment	Criteria
	1	One or more neurobehavioral effects that occasionally interfere with workplace interaction, social interaction, or both but do not preclude them.
	2	One or more neurobehavioral effects that frequently interfere with workplace interaction, social interaction, or both but do not preclude them.
	3	One or more neurobehavioral effects that interfere with or preclude workplace interaction, social interaction, or both on most days or that occasionally require supervision for safety of self or others.
Communication	0	Able to communicate by spoken and written language (expressive communication), and to comprehend spoken and written language.
	1	Comprehension or expression, or both, of either spoken language or written language is only occasionally impaired. Can communicate complex ideas.
	2	Inability to communicate either by spoken language, written language, or both, more than occasionally but less than half of the time, or to comprehend spoken language, written language, or both, more than occasionally but less than half of the time. Can generally communicate complex ideas.
	3	Inability to communicate either by spoken language, written language, or both, at least half of the time but not all of the time, or to comprehend spoken language, written language, or both, at least half of the time but not all of the time. May rely on gestures or other alternative modes of communication. Able to communicate basic needs.
	Total	Complete inability to communicate either by spoken language, written language, or both, or to comprehend spoken language, written language, or both. Unable to communicate basic needs.
Consciousness	Total	Persistently altered state of consciousness, such as vegetative state, minimally responsive state, coma.

MISCELLANEOUS DISEASES

	Rating
8100 Migraine:	
With very frequent completely prostrating and prolonged attacks productive of severe economic inadaptability	50
With characteristic prostrating attacks occurring on an average once a month over last several months	30
With characteristic prostrating attacks averaging one in 2 months over last several months	10
With less frequent attacks	0
8103 Tic, convulsive:	
Severe	30
Moderate	10
Mild	0
NOTE: Depending upon frequency, severity, muscle groups involved.	
8104 Paramyoclonus multiplex (convulsive state, myoclonic type):	
Rate as tic; convulsive; severe cases	60
8105 Chorea, Sydenham's:	
Pronounced, progressive grave types	100
Severe	80
Moderately severe	50
Moderate	30
Mild	10
NOTE: Consider rheumatic etiology and complications.	
8106 Chorea, Huntington's.	

MISCELLANEOUS DISEASES—Continued

	Rating
Rate as Sydenham's chorea. This, though a familial disease, has its onset in late adult life, and is considered a ratable disability.	
8107 Athetosis, acquired.	
Rate as chorea.	
8108 Narcolepsy.	
Rate as for epilepsy, petit mal.	

DISEASES OF THE CRANIAL NERVES

	Rating
Disability from lesions of peripheral portions of first, second, third, fourth, sixth, and eighth nerves will be rated under the Organs of Special Sense. The ratings for the cranial nerves are for unilateral involvement; when bilateral, combine but without the bilateral factor.	
Fifth (trigeminal) cranial nerve	
8205 Paralysis of:	
Complete	50
Incomplete, severe	30
Incomplete, moderate	10
NOTE: Dependent upon relative degree of sensory manifestation or motor loss.	
8305 Neuritis.	
8405 Neuralgia.	
NOTE: Tic douloureux may be rated in accordance with severity, up to complete paralysis.	
Seventh (facial) cranial nerve	
8207 Paralysis of:	
Complete	30
Incomplete, severe	20
Incomplete, moderate	10
NOTE: Dependent upon relative loss of innervation of facial muscles.	
8307 Neuritis.	
8407 Neuralgia.	
Ninth (glossopharyngeal) cranial nerve.	
8209 Paralysis of:	
Complete	30
Incomplete, severe	20
Incomplete, moderate	10
NOTE: Dependent upon relative loss of ordinary sensation in mucous membrane of the pharynx, fauces, and tonsils.	
8309 Neuritis.	
8409 Neuralgia.	
Tenth (pneumogastric, vagus) cranial nerve.	
8210 Paralysis of:	
Complete	50
Incomplete, severe	30
Incomplete, moderate	10
NOTE : Dependent upon extent of sensory and motor loss to organs of voice, respiration, pharynx, stomach and heart.	
8310 Neuritis.	
8410 Neuralgia.	
Eleventh (spinal accessory, external branch) cranial nerve.	
8211 Paralysis of:	
Complete	30
Incomplete, severe	20
Incomplete, moderate	10
NOTE: Dependent upon loss of motor function of sternomastoid and trapezius muscles.	
8311 Neuritis.	
8411 Neuralgia.	
Twelfth (hypoglossal) cranial nerve.	
8212 Paralysis of:	

DISEASES OF THE CRANIAL NERVES—Continued

	Rating
Complete	50
Incomplete, severe	30
Incomplete, moderate	10
NOTE: Dependent upon loss of motor function of tongue.	
8312 Neuritis.	
8412 Neuralgia.	

DISEASES OF THE PERIPHERAL NERVES

Schedule of ratings	Rating	
	Major	Minor
The term "incomplete paralysis," with this and other peripheral nerve injuries, indicates a degree of lost or impaired function substantially less than the type picture for complete paralysis given with each nerve, whether due to varied level of the nerve lesion or to partial regeneration. When the involvement is wholly sensory, the rating should be for the mild, or at most, the moderate degree. The ratings for the peripheral nerves are for unilateral involvement; when bilateral, combine with application of the bilateral factor.		
Upper radicular group (fifth and sixth cervicals)		
8510 Paralysis of:		
Complete; all shoulder and elbow movements lost or severely affected, hand and wrist movements not affected	70	60
Incomplete:		
Severe	50	40
Moderate	40	30
Mild	20	20
8610 Neuritis.		
8710 Neuralgia.		
Middle radicular group		
8511 Paralysis of:		
Complete; adduction, abduction and rotation of arm, flexion of elbow, and extension of wrist lost or severely affected	70	60
Incomplete:		
Severe	50	40
Moderate	40	30
Mild	20	20
8611 Neuritis.		
8711 Neuralgia.		
Lower radicular group		
8512 Paralysis of:		
Complete; all intrinsic muscles of hand, and some or all of flexors of wrist and fingers, paralyzed (substantial loss of use of hand)	70	60
Incomplete:		
Severe	50	40
Moderate	40	30
Mild	20	20
8612 Neuritis.		
8712 Neuralgia.		
All radicular groups		
8513 Paralysis of:		
Complete	90	80

DISEASES OF THE PERIPHERAL NERVES—Continued

Schedule of ratings	Rating	
	Major	Minor
Incomplete:		
Severe	70	60
Moderate	40	30
Mild	20	20
8613 Neuritis.		
8713 Neuralgia.		
The musculospiral nerve (radial nerve)		
8514 Paralysis of:		
Complete; drop of hand and fingers, wrist and fingers perpetually flexed, the thumb adducted falling within the line of the outer border of the index finger; can not extend hand at wrist, extend proximal phalanges of fingers, extend thumb, or make lateral movement of wrist; supination of hand, extension and flexion of elbow weakened, the loss of synergic motion of extensors impairs the hand grip seriously; total paralysis of the triceps occurs only as the greatest rarity	70	60
Incomplete:		
Severe	50	40
Moderate	30	20
Mild	20	20
8614 Neuritis.		
8714 Neuralgia.		
NOTE: Lesions involving only ''dissociation of extensor communis digitorum'' and ''paralysis below the extensor communis digitorum,'' will not exceed the moderate rating under code 8514.		
The median nerve		
8515 Paralysis of:		
Complete; the hand inclined to the ulnar side, the index and middle fingers more extended than normally, considerable atrophy of the muscles of the thenar eminence, the thumb in the plane of the hand (ape hand); pronation incomplete and defective, absence of flexion of index finger and feeble flexion of middle finger, cannot make a fist, index and middle fingers remain extended; cannot flex distal phalanx of thumb, defective opposition and abduction of the thumb, at right angles to palm; flexion of wrist weakened; pain with trophic disturbances	70	60
Incomplete:		
Severe	50	40
Moderate	30	20
Mild	10	10

DISEASES OF THE PERIPHERAL NERVES—Continued

Schedule of ratings	Rating	
	Major	Minor
8615 Neuritis.		
8715 Neuralgia.		
The ulnar nerve		
8516 Paralysis of:		
Complete; the ''griffin claw'' deformity, due to flexor contraction of ring and little fingers, atrophy very marked in dorsal interspace and thenar and hypothenar eminences; loss of extension of ring and little fingers cannot spread the fingers (or reverse), cannot adduct the thumb; flexion of wrist weakened	60	50
Incomplete:		
Severe	40	30
Moderate	30	20
Mild	10	10
8616 Neuritis.		
8716 Neuralgia.		
Musculocutaneous nerve		
8517 Paralysis of:		
Complete; weakness but not loss of flexion of elbow and supination of forearm	30	20
Incomplete:		
Severe	20	20
Moderate	10	10
Mild	0	0
8617 Neuritis.		
8717 Neuralgia.		
Circumflex nerve		
8518 Paralysis of:		
Complete; abduction of arm is impossible, outward rotation is weakened; muscles supplied are deltoid and teres minor	50	40
Incomplete:		
Severe	30	20
Moderate	10	10
Mild	0	0
8618 Neuritis.		
8718 Neuralgia.		
Long thoracic nerve		
8519 Paralysis of:		
Complete; inability to raise arm above shoulder level, winged scapula deformity	30	20
Incomplete:		
Severe	20	20
Moderate	10	10
Mild	0	0
NOTE: Not to be combined with lost motion above shoulder level.		
8619 Neuritis.		
8719 Neuralgia.		
NOTE: Combined nerve injuries should be rated by reference to the major involvement, or if sufficient in extent, consider radicular group ratings.		

	Rating
Sciatic nerve	
8520 Paralysis of:	
Complete; the foot dangles and drops, no active movement possible of muscles below the knee, flexion of knee weakened or (very rarely) lost	80
Incomplete:	
Severe, with marked muscular atrophy	60
Moderately severe	40
Moderate	20
Mild	10
8620 Neuritis.	
8720 Neuralgia.	
External popliteal nerve (common peroneal)	
8521 Paralysis of:	
Complete; foot drop and slight droop of first phalanges of all toes, cannot dorsiflex the foot, extension (dorsal flexion) of proximal phalanges of toes lost; abduction of foot lost, adduction weakened; anesthesia covers entire dorsum of foot and toes	40
Incomplete:	
Severe	30
Moderate	20
Mild	10
8621 Neuritis.	
8721 Neuralgia.	
Musculocutaneous nerve (superficial peroneal)	
8522 Paralysis of:	
Complete; eversion of foot weakened	30
Incomplete:	
Severe	20
Moderate	10
Mild	0
8622 Neuritis.	
8722 Neuralgia.	
Anterior tibial nerve (deep peroneal)	
8523 Paralysis of:	
Complete; dorsal flexion of foot lost	30
Incomplete:	
Severe	20
Moderate	10
Mild	0
8623 Neuritis.	
8723 Neuralgia.	
Internal popliteal nerve (tibial)	
8524 Paralysis of:	
Complete; plantar flexion lost, frank adduction of foot impossible, flexion and separation of toes abolished; no muscle in sole can move; in lesions of the nerve high in popliteal fossa, plantar flexion of foot is lost	40
Incomplete:	
Severe	30
Moderate	20
Mild	10
8624 Neuritis.	
8724 Neuralgia.	
Posterior tibial nerve	
8525 Paralysis of:	
Complete; paralysis of all muscles of sole of foot, frequently with painful paralysis of a causalgic nature; toes cannot be flexed; adduction is weakened; plantar flexion is impaired	30
Incomplete:	
Severe	20
Moderate	10
Mild	10
8625 Neuritis.	
8725 Neuralgia.	
Anterior crural nerve (femoral)	
8526 Paralysis of:	
Complete; paralysis of quadriceps extensor muscles	40
Incomplete:	
Severe	30
Moderate	20
Mild	10
8626 Neuritis.	
8726 Neuralgia.	
Internal saphenous nerve	
8527 Paralysis of:	
Severe to complete	10
Mild to moderate	0
8627 Neuritis.	
8727 Neuralgia.	
Obturator nerve	
8528 Paralysis of:	
Severe to complete	10
Mild or moderate	0
8628 Neuritis.	
8728 Neuralgia.	
External cutaneous nerve of thigh	
8529 Paralysis of:	
Severe to complete	10
Mild or moderate	0
8629 Neuritis.	
8729 Neuralgia.	
Ilio-inguinal nerve	
8530 Paralysis of:	
Severe to complete	10
Mild or moderate	0
8630 Neuritis.	
8730 Neuralgia.	
8540 Soft-tissue sarcoma (of neurogenic origin)	100

NOTE: The 100 percent rating will be continued for 6 months following the cessation of surgical, X-ray, antineoplastic chemotherapy or other therapeutic procedure. At this point, if there has been no local recurrence or metastases, the rating will be made on residuals.

THE EPILEPSIES

	Rating
A thorough study of all material in §§4.121 and 4.122 of the preface and under the ratings for epilepsy is necessary prior to any rating action.	
8910 Epilepsy, grand mal.	
Rate under the general rating formula for major seizures.	
8911 Epilepsy, petit mal.	
Rate under the general rating formula for minor seizures.	
NOTE (1): A major seizure is characterized by the generalized tonic-clonic convulsion with unconsciousness.	
NOTE (2): A minor seizure consists of a brief interruption in consciousness or conscious control associated with staring or rhythmic blinking of the eyes or nodding of the head (''pure'' petit mal), or sudden jerking movements of the arms, trunk, or head (myoclonic type) or sudden loss of postural control (akinetic type).	
General Rating Formula for Major and Minor Epileptic Seizures:	
Averaging at least 1 major seizure per month over the last year	100
Averaging at least 1 major seizure in 3 months over the last year; or more than 10 minor seizures weekly	80
Averaging at least 1 major seizure in 4 months over the last year; or 9–10 minor seizures per week	60
At least 1 major seizure in the last 6 months or 2 in the last year; or averaging at least 5 to 8 minor seizures weekly	40
At least 1 major seizure in the last 2 years; or at least 2 minor seizures in the last 6 months	20
A confirmed diagnosis of epilepsy with a history of seizures	10
NOTE (1): When continuous medication is shown necessary for the control of epilepsy, the minimum evaluation will be 10 percent. This rating will not be combined with any other rating for epilepsy.	
NOTE (2): In the presence of major and minor seizures, rate the predominating type.	
NOTE (3): There will be no distinction between diurnal and nocturnal major seizures.	
8912 Epilepsy, Jacksonian and focal motor or sensory.	
8913 Epilepsy, diencephalic.	
Rate as minor seizures, except in the presence of major and minor seizures, rate the predominating type.	
8914 Epilepsy, psychomotor.	

THE EPILEPSIES—Continued

	Rating
Major seizures:	
Psychomotor seizures will be rated as major seizures under the general rating formula when characterized by automatic states and/or generalized convulsions with unconsciousness.	
Minor seizures:	
Psychomotor seizures will be rated as minor seizures under the general rating formula when characterized by brief transient episodes of random motor movements, hallucinations, perceptual illusions, abnormalities of thinking, memory or mood, or autonomic disturbances.	

Mental Disorders in Epilepsies: A nonpsychotic organic brain syndrome will be rated separately under the appropriate diagnostic code (e.g., 9304 or 9326). In the absence of a diagnosis of non-psychotic organic psychiatric disturbance (psychotic, psychoneurotic or personality disorder) if diagnosed and shown to be secondary to or directly associated with epilepsy will be rated separately. The psychotic or psychroneurotic disorder will be rated under the appropriate diagnostic code. The personality disorder will be rated as a dementia (e.g., diagnostic code 9304 or 9326).

Epilepsy and Unemployability: (1) Rating specialists must bear in mind that the epileptic, although his or her seizures are controlled, may find employment and rehabilitation difficult of attainment due to employer reluctance to the hiring of the epileptic.

(2) Where a case is encountered with a definite history of unemployment, full and complete development should be undertaken to ascertain whether the epilepsy is the determining factor in his or her inability to obtain employment.

(3) The assent of the claimant should first be obtained for permission to conduct this economic and social survey. The purpose of this survey is to secure all the relevant facts and data necessary to permit of a true judgment as to the reason for his or her unemployment and should include information as to:

(a) Education;
(b) Occupations prior and subsequent to service;
(c) Places of employment and reasons for termination;
(d) Wages received;
(e) Number of seizures.

(4) Upon completion of this survey and current examination, the case should have rating board consideration. Where in the judgment of the rating board the veteran's unemployability is due to epilepsy and jurisdiction is not vested in that body by reason of schedular evaluations, the case should be submitted to the Compensation Service or the Director, Pension and Fiduciary Service.

(Authority: 38 U.S.C. 1155)

[29 FR 6718, May 22, 1964, as amended at 40 FR 42540, Sept. 15, 1975; 41 FR 11302, Mar. 18, 1976; 43 FR 45362, Oct. 2, 1978; 54 FR 4282, Jan. 30, 1989; 54 FR 49755, Dec. 1, 1989; 55 FR 154, Jan. 3, 1990; 56 FR 51653, Oct. 15, 1991; 57 FR 24364, June 9, 1992; 70 FR 75399, Dec. 20, 2005; 73 FR 54705, Sept. 23, 2008; 73 FR 69554, Nov. 19, 2008; 76 FR 78824, Dec. 20, 2011; 79 FR 2100, Jan. 13, 2014]

MENTAL DISORDERS

§4.125 Diagnosis of mental disorders.

(a) If the diagnosis of a mental disorder does not conform to DSM–5 or is not supported by the findings on the examination report, the rating agency shall return the report to the examiner

to substantiate the diagnosis. Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM–5), American Psychiatric Association (2013), is incorporated by reference into this section with the approval of the Director of the Federal Register under 5 U.S.C. 552(a) and 1 CFR part 51. To enforce any edition other than that specified in this section, the Department of Veterans Affairs must publish notice of change in the FEDERAL REGISTER and the material must be available to the public. All approved material is available from the American Psychiatric Association, 1000 Wilson Boulevard, Suite 1825, Arlington, VA 22209–3901, 703–907–7300, *http://www.dsm5.org*. It is also available for inspection at the Office of Regulation Policy and Management, Department of Veterans Affairs, 810 Vermont Avenue NW., Room 1068, Washington, DC 20420. It is also available for inspection at the National Archives and Records Administration (NARA). For information on the availability of this information at NARA, call 202–741–6030 or go to *http://www.archives.gov/federal_register/code_of_federal_regulations/ibr_publications.html*.

(b) If the diagnosis of a mental disorder is changed, the rating agency shall determine whether the new diagnosis represents progression of the prior diagnosis, correction of an error in the prior diagnosis, or development of a new and separate condition. If it is not clear from the available records what the change of diagnosis represents, the rating agency shall return the report to the examiner for a determination.

(Authority: 38 U.S.C. 1155)

[61 FR 52700, Oct. 8, 1996, as amended at 79 FR 45099, Aug. 4, 2014]

§ 4.126 Evaluation of disability from mental disorders.

(a) When evaluating a mental disorder, the rating agency shall consider the frequency, severity, and duration of psychiatric symptoms, the length of remissions, and the veteran's capacity for adjustment during periods of remission. The rating agency shall assign an evaluation based on all the evidence of record that bears on occupational and social impairment rather than solely on the examiner's assessment of the level of disability at the moment of the examination.

(b) When evaluating the level of disability from a mental disorder, the rating agency will consider the extent of social impairment, but shall not assign an evaluation solely on the basis of social impairment.

(c) Neurocognitive disorders shall be evaluated under the general rating formula for mental disorders; neurologic deficits or other impairments stemming from the same etiology (e.g., a head injury) shall be evaluated separately and combined with the evaluation for neurocognitive disorders (see § 4.25).

(d) When a single disability has been diagnosed both as a physical condition and as a mental disorder, the rating agency shall evaluate it using a diagnostic code which represents the dominant (more disabling) aspect of the condition (see § 4.14).

(Authority: 38 U.S.C. 1155)

[61 FR 52700, Oct. 8, 1996, as amended at 79 FR 45099, Aug. 4, 2014]

§ 4.127 Intellectual disability (intellectual developmental disorder) and personality disorders.

Intellectual disability (intellectual developmental disorder) and personality disorders are not diseases or injuries for compensation purposes, and, except as provided in § 3.310(a) of this chapter, disability resulting from them may not be service-connected. However, disability resulting from a mental disorder that is superimposed upon intellectual disability (intellectual developmental disorder) or a personality disorder may be service-connected.

(Authority: 38 U.S.C. 1155)

[79 FR 45100, Aug. 4, 2014]

§ 4.128 Convalescence ratings following extended hospitalization.

If a mental disorder has been assigned a total evaluation due to a continuous period of hospitalization lasting six months or more, the rating agency shall continue the total evaluation indefinitely and schedule a mandatory examination six months after the veteran is discharged or released to nonbed care. A change in evaluation

based on that or any subsequent examination shall be subject to the provisions of §3.105(e) of this chapter.

(Authority: 38 U.S.C. 1155)

[61 FR 52700, Oct. 8, 1996]

§4.129 Mental disorders due to traumatic stress.

When a mental disorder that develops in service as a result of a highly stressful event is severe enough to bring about the veteran's release from active military service, the rating agency shall assign an evaluation of not less than 50 percent and schedule an examination within the six month period following the veteran's discharge to determine whether a change in evaluation is warranted.

(Authority: 38 U.S.C. 1155)

[61 FR 52700, Oct. 8, 1996]

§4.130 Schedule of ratings—Mental disorders.

The nomenclature employed in this portion of the rating schedule is based upon the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM–5) (see §4.125 for availability information). Rating agencies must be thoroughly familiar with this manual to properly implement the directives in §4.125 through §4.129 and to apply the general rating formula for mental disorders in §4.130. The schedule for rating for mental disorders is set forth as follows:

9201 Schizophrenia
9202 [Removed]
9203 [Removed]
9204 [Removed]
9205 [Removed]
9208 Delusional disorder
9210 Other specified and unspecified schizophrenia spectrum and other psychotic disorders
9211 Schizoaffective disorder
9300 Delirium
9301 Major or mild neurocognitive disorder due to HIV or other infections
9304 Major or mild neurocognitive disorder due to traumatic brain injury
9305 Major or mild vascular neurocognitive disorder
9310 Unspecified neurocognitive disorder
9312 Major or mild neurocognitive disorder due to Alzheimer's disease
9326 Major or mild neurocognitive disorder due to another medical condition or substance/medication-induced major or mild neurocognitive disorder
9327 [Removed]
9400 Generalized anxiety disorder
9403 Specific phobia; social anxiety disorder (social phobia)
9404 Obsessive compulsive disorder
9410 Other specified anxiety disorder
9411 Posttraumatic stress disorder
9412 Panic disorder and/or agoraphobia
9413 Unspecified anxiety disorder
9416 Dissociative amnesia; dissociative identity disorder
9417 Depersonalization/Derealization disorder
9421 Somatic symptom disorder
9422 Other specified somatic symptom and related disorder
9423 Unspecified somatic symptom and related disorder
9424 Conversion disorder (functional neurological symptom disorder)
9425 Illness anxiety disorder
9431 Cyclothymic disorder
9432 Bipolar disorder
9433 Persistent depressive disorder (dysthymia)
9434 Major depressive disorder
9435 Unspecified depressive disorder
9440 Chronic adjustment disorder

GENERAL RATING FORMULA FOR MENTAL DISORDERS

	Rating
Total occupational and social impairment, due to such symptoms as: gross impairment in thought processes or communication; persistent delusions or hallucinations; grossly inappropriate behavior; persistent danger of hurting self or others; intermittent inability to perform activities of daily living (including maintenance of minimal personal hygiene); disorientation to time or place; memory loss for names of close relatives, own occupation, or own name.	100
Occupational and social impairment, with deficiencies in most areas, such as work, school, family relations, judgment, thinking, or mood, due to such symptoms as: suicidal ideation; obsessional rituals which interfere with routine activities; speech intermittently illogical, obscure, or irrelevant; near-continuous panic or depression affecting the ability to function independently, appropriately and effectively; impaired impulse control (such as unprovoked irritability with periods of violence); spatial disorientation; neglect of personal appearance and hygiene; difficulty in adapting to stressful circumstances (including work or a worklike setting); inability to establish and maintain effective relationships.	70

GENERAL RATING FORMULA FOR MENTAL DISORDERS—Continued

	Rating
Occupational and social impairment with reduced reliability and productivity due to such symptoms as: flattened affect; circumstantial, circumlocutory, or stereotyped speech; panic attacks more than once a week; difficulty in understanding complex commands; impairment of short- and long-term memory (e.g., retention of only highly learned material, forgetting to complete tasks); impaired judgment; impaired abstract thinking; disturbances of motivation and mood; difficulty in establishing and maintaining effective work and social relationships.	50
Occupational and social impairment with occasional decrease in work efficiency and intermittent periods of inability to perform occupational tasks (although generally functioning satisfactorily, with routine behavior, self-care, and conversation normal), due to such symptoms as: depressed mood, anxiety, suspiciousness, panic attacks (weekly or less often), chronic sleep impairment, mild memory loss (such as forgetting names, directions, recent events).	30
Occupational and social impairment due to mild or transient symptoms which decrease work efficiency and ability to perform occupational tasks only during periods of significant stress, or symptoms controlled by continuous medication.	10
A mental condition has been formally diagnosed, but symptoms are not severe enough either to interfere with occupational and social functioning or to require continuous medication.	0

9520 Anorexia nervosa
9521 Bulimia nervosa

RATING FORMULA FOR EATING DISORDERS

	Rating
Self-induced weight loss to less than 80 percent of expected minimum weight, with incapacitating episodes of at least six weeks total duration per year, and requiring hospitalization more than twice a year for parenteral nutrition or tube feeding.	100
Self-induced weight loss to less than 85 percent of expected minimum weight with incapacitating episodes of six or more weeks total duration per year.	60
Self-induced weight loss to less than 85 percent of expected minimum weight with incapacitating episodes of more than two but less than six weeks total duration per year.	30
Binge eating followed by self-induced vomiting or other measures to prevent weight gain, or resistance to weight gain even when below expected minimum weight, with diagnosis of an eating disorder and incapacitating episodes of up to two weeks total duration per year.	10
Binge eating followed by self-induced vomiting or other measures to prevent weight gain, or resistance to weight gain even when below expected minimum weight, with diagnosis of an eating disorder but without incapacitating episodes.	0

Note 1: An incapacitating episode is a period during which bed rest and treatment by a physician are required.
Note 2: Ratings under diagnostic codes 9201 to 9440 will be evaluated using the General Rating Formula for Mental Disorders. Ratings under diagnostic codes 9520 and 9521 will be evaluated using the General Rating Formula for Eating Disorders.

(Authority: 38 U.S.C. 1155)

[79 FR 45100, Aug. 4, 2014]

DENTAL AND ORAL CONDITIONS

§ 4.149 [Reserved]

§ 4.150 Schedule of ratings—dental and oral conditions.

	Rating
Note (1): For VA compensation purposes, diagnostic imaging studies include, but are not limited to, conventional radiography (X-ray), computed tomography (CT), magnetic resonance imaging (MRI), positron emission tomography (PET), radionuclide bone scanning, or ultrasonography	
Note (2): Separately evaluate loss of vocal articulation, loss of smell, loss of taste, neurological impairment, respiratory dysfunction, and other impairments under the appropriate diagnostic code and combine under § 4.25 for each separately rated condition	
9900 Maxilla or mandible, chronic osteomyelitis, osteonecrosis or osteoradionecrosis of:	
Rate as osteomyelitis, chronic under diagnostic code 5000..	
9901 Mandible, loss of, complete, between angles	100

	Rating
9902 Mandible, loss of, including ramus, unilaterally or bilaterally:	
Loss of one-half or more,.	
Involving temporomandibular articulation.	
Not replaceable by prosthesis	70
Replaceable by prosthesis	50
Not involving temporomandibular articulation.	
Not replaceable by prosthesis	40
Replaceable by prosthesis	30
Loss of less than one-half,	
Involving temporomandibular articulation.	
Not replaceable by prosthesis	70
Replaceable by prosthesis	50
Not involving temporomandibular articulation.	
Not replaceable by prosthesis	20
Replaceable by prosthesis	10
9903 Mandible, nonunion of, confirmed by diagnostic imaging studies:	
Severe, with false motion	30
Moderate, without false motion	10
9904 Mandible, malunion of:	
Displacement, causing severe anterior or posterior open bite	20
Displacement, causing moderate anterior or posterior open bite	10
Displacement, not causing anterior or posterior open bite	0
9905 Temporomandibular disorder (TMD):	
Interincisal range:	
0 to 10 millimeters (mm) of maximum unassisted vertical opening.	
With dietary restrictions to all mechanically altered foods	50
Without dietary restrictions to mechanically altered foods	40
11 to 20 mm of maximum unassisted vertical opening.	
With dietary restrictions to all mechanically altered foods	40
Without dietary restrictions to mechanically altered foods	30
21 to 29 mm of maximum unassisted vertical opening.	
With dietary restrictions to full liquid and pureed foods	40
With dietary restrictions to soft and semi-solid foods	30
Without dietary restrictions to mechanically altered foods	20
30 to 34 mm of maximum unassisted vertical opening.	
With dietary restrictions to full liquid and pureed foods	30
With dietary restrictions to soft and semi-solid foods	20
Without dietary restrictions to mechanically altered foods	10
Lateral excursion range of motion:	
0 to 4 mm	10

	Rating
Note (1): Ratings for limited interincisal movement shall not be combined with ratings for limited lateral excursion.	
Note (2): For VA compensation purposes, the normal maximum unassisted range of vertical jaw opening is from 35 to 50 mm.	
Note (3): For VA compensation purposes, mechanically altered foods are defined as altered by blending, chopping, grinding or mashing so that they are easy to chew and swallow. There are four levels of mechanically altered foods: full liquid, puree, soft, and semisolid foods. To warrant elevation based on mechanically altered foods, the use of texture-modified diets must be recorded or verified by a physician.	
9908 Condyloid process, loss of, one or both sides	30
9909 Coronoid process, loss of:	
Bilateral	20
Unilateral	10
9911 Hard palate, loss of:	
Loss of half or more, not replaceable by prosthesis	30
Loss of less than half, not replaceable by prosthesis	20
Loss of half or more, replaceable by prosthesis	10
Loss of less than half, replaceable by prosthesis	0
9913 Teeth, loss of, due to loss of substance of body of maxilla or mandible without loss of continuity:	
Where the lost masticatory surface cannot be restored by suitable prosthesis:	
Loss of all teeth	40
Loss of all upper teeth	30
Loss of all lower teeth	30
All upper and lower posterior teeth missing	20
All upper and lower anterior teeth missing	20
All upper anterior teeth missing	10
All lower anterior teeth missing	10
All upper and lower teeth on one side missing	10
Where the loss of masticatory surface can be restored by suitable prosthesis	0
NOTE—These ratings apply only to bone loss through trauma or disease such as osteomyelitis, and not to the loss of the alveolar process as a result of periodontal disease, since such loss is not considered disabling.	
9914 Maxilla, loss of more than half:	
Not replaceable by prosthesis	100
Replaceable by prosthesis	50
9915 Maxilla, loss of half or less:	
Loss of 25 to 50 percent:	
Not replaceable by prosthesis	40
Replaceable by prosthesis	30
Loss of less than 25 percent:	
Not replaceable by prosthesis	20
Replaceable by prosthesis	0
9916 Maxilla, malunion or nonunion of:	
Nonunion,	
With false motion	30
Without false motion	10
Malunion,	
With displacement, causing severe anterior or posterior open bite	30
With displacement, causing moderate anterior or posterior open bite	10

	Rating
With displacement, causing mild anterior or posterior open bite ..	0
Note: For VA compensation purposes, the severity of maxillary nonunion is dependent upon the degree of abnormal mobility of maxilla fragments following treatment (*i.e.*, presence or absence of false motion), and maxillary nonunion must be confirmed by diagnostic imaging studies.	
9917 Neoplasm, hard and soft tissue, benign:	
Rate as loss of supporting structures (bone or teeth) and/or functional impairment due to scarring.	
9918 Neoplasm, hard and soft tissue, malignant ...	100
Note: A rating of 100 percent shall continue beyond the cessation of any surgical, radiation, antineoplastic chemotherapy or other therapeutic procedure. Six months after discontinuance of such treatment, the appropriate disability rating shall be determined by mandatory VA examination. Any change in evaluation based upon that or any subsequent examination shall be subject to the provisions of § 3.105(e) of this chapter. If there has been no local recurrence or metastasis, rate on residuals such as loss of supporting structures (bone or teeth) and/or functional impairment due to scarring.	

[59 FR 2530, Jan. 18, 1994, as amended at 82 FR 36083, Aug. 3, 2017]

Appendix A to Part 4—Table of Amendments and Effective Dates Since 1946

Sec.	Diagnostic code No.	
4.71a	5000	Evaluation February 1, 1962.
	5001	Evaluation March 11, 1969.
	5002	Evaluation March 1, 1963.
	5003	Added July 6, 1950.
	5012	Criterion March 10, 1976.
	5024	Criterion March 1, 1963.
	5025	Added May 7, 1996.
	5051	Added September 22, 1978. Note July 16, 2015.
	5052	Added September 22, 1978. Note July 16, 2015.
	5053	Added September 22, 1978. Note July 16, 2015.
	5054	Added September 22, 1978. Note July 16, 2015.
	5055	Added September 22, 1978. Note July 16, 2015.
	5056	Added September 22, 1978. Note July 16, 2015.
	5100–5103	Removed March 10, 1976.
	5104	Criterion March 10, 1976.
	5105	Criterion March 10, 1976.
	5164	Evaluation June 9, 1952.
	5166	Criterion September 22, 1978.
	5172	Added July 6, 1950.
	5173	Added June 9, 1952.
	5174	Added September 9, 1975; removed September 22, 1978.
	5211	Criterion September 22, 1978.
	5212	Criterion September 22, 1978.
	5214	Criterion September 22, 1978.
	5216	Preceding paragraph criterion September 22, 1978.
	5217	Criterion August 26, 2002.
	5218	Criterion August 26, 2002.
	5219	Criterion September 22, 1978; criterion August 26, 2002.
	5220	Preceding paragraph criterion September 22, 1978; criterion August 26, 2002.
	5223	Criterion August 26, 2002.
	5224	Criterion August 26, 2002.
	5225	Criterion August 26, 2002.
	5226	Criterion August 26, 2002.
	5227	Criterion September 22, 1978; criterion August 26, 2002.
	5228	Added August 26, 2002.
	5229	Added August 26, 2002.
	5230	Added August 26, 2002.
	5235–5243	Replaces 5285–5295 September 26, 2003.
	5243	Criterion September 26, 2003.
	5255	Criterion July 6, 1950.
	5257	Evaluation July 6, 1950.
	5264	Added September 9, 1975; removed September 22, 1978.
	5275	Criterion March 10, 1976; criterion September 22, 1978.
	5285–5292	Revised to 5235–5243 September 26, 2003.
	5293	Criterion March 10, 1976; criterion September 23, 2002; revised and moved to 5235–5243 September 26, 2003.
	5294	Evaluation March 10, 1976; revised and moved to 5235–5243 September 26, 2003.
	5295	Evaluation March 10, 1976; revised and moved to 5235–5243 September 26, 2003.
	5296	Criterion March 10, 1976.

Sec.	Diagnostic code No.	
	5297	Criterion August 23, 1948; criterion February 1, 1962.
	5298	Added August 23, 1948.
4.73	.....	Introduction NOTE criterion July 3, 1997.
	5317	Criterion September 22, 1978.
	5324	Added February 1, 1962.
	5325	Criterion July 3, 1997.
	5327	Added March 10, 1976; criterion October 15, 1991; criterion July 3, 1997.
	5328	Added NOTE March 10, 1976.
	5329	Added NOTE July 3, 1997.
4.77	.....	Revised May 13, 2018.
4.78	.....	Revised May 13, 2018.
4.79	.....	Introduction criterion May 13, 2018; Revised General Rating Formula for Diseases of the Eye NOTE revised May 13, 2018.
	6000	Criterion May 13, 2018.
	6001	Criterion May 13, 2018.
	6002	Criterion May 13, 2018.
	6006	Title May 13, 2018. Criterion May 13, 2018.
	6007	Criterion May 13, 2018.
	6008	Criterion May 13, 2018.
	6009	Criterion May 13, 2018.
	6011	Evaluation May 13, 2018.
	6012	Evaluation May 13, 2018.
	6013	Evaluation May 13, 2018.
	6014	Title May 13, 2018.
	6015	Title May 13, 2018.
	6017	Evaluation May 13, 2018.
	6018	Evaluation May 13, 2018.
	6019	Evaluation.
	6026	Evaluation May 13, 2018.
	6027	Evaluation *May 13, 2018.*
	6034	Evaluation May 13, 2018.
	6035	Evaluation *May 13, 2018.*
	6036	Evaluation May 13, 2018.
	6040	Added May 13, 2018.
	6042	Added May 13, 2018.
	6046	Added May 13, 2018.
	6091	Evaluation May 13, 2018.
4.84a	.....	Table V criterion July 1, 1994.
	6010	Criterion March 11, 1969.
	6019	Criterion September 22, 1978.
	6029	NOTE August 23, 1948; criterion September 22, 1978.
	6035	Added September 9, 1975.
	6050–6062	Removed March 10, 1976.
	6061	Added March 10, 1976.
	6062	Added March 10, 1976.
	6063–6079	Criterion September 22, 1978.
	6064	Criterion March 10, 1976.
	6071	Criterion March 10, 1976.
	6076	Evaluation August 23, 1948.
	6080	Criterion September 22, 1978.
	6081	Criterion March 10, 1976.
	6090	Criterion September 22, 1978; criterion September 12, 1988.
4.84b	6260	Added October 1, 1961; criterion October 1, 1961; evaluation March 10, 1976; removed December 18, 1987; re-designated § 4.87a December 18, 1987.
4.87	.....	Tables VI and VII replaced by new Tables VI, VIA, and VII December 18, 1987. 6200–6260 revised and re-designated § 4.87 June 10, 1999.
4.87a	6200–6260	Moved to § 4.87 June 10, 1999.
	6275–6276	Moved from § 4.87b June 10, 1999.
	6277–6297	March 23, 1956 removed, December 17, 1987; Table II revised Table V March 10, 1976; Table II revised to Table VII September 22, 1978; text from § 4.84b Schedule of ratings-ear re-designated from § 4.87 December 17, 1987.
	6286	Removed December 17, 1987.
	6291	Criterion March 10, 1976; removed December 17, 1987.
	6297	Criterion March 10, 1976; removed December 17, 1987.
4.87b	.....	Removed June 10, 1999.
4.88a	.....	March 11, 1969; re-designated § 4.88b November 29, 1994; § 4.88a added to read ''Chronic fatigue syndrome''; criterion November 29, 1994.
4.88b	.....	Added March 11, 1969; re-designated § 4.88c November 29, 1994; § 4.88a re-designated to § 4.88b November 29, 1994.
	6300	Criterion August 30, 1996.
	6302	Criterion September 22, 1978; criterion August 30, 1996.
	6304	Evaluation August 30, 1996.
	6305	Criterion March 1, 1989; evaluation August 30, 1996.

Sec.	Diagnostic code No.	
	6306	Evaluation August 30, 1996.
	6307	Criterion August 30, 1996.
	6308	Criterion August 30, 1996.
	6309	Added March 1, 1963; criterion March 1, 1989; criterion August 30, 1996.
	6314	Evaluation March 1, 1989; evaluation August 30, 1996.
	6315	Criterion August 30, 1996.
	6316	Evaluation March 1, 1989; evaluation August 30, 1996.
	6317	Criterion August 30, 1996.
	6318	Added March 1, 1989; criterion August 30, 1996.
	6319	Added August 30, 1996.
	6320	Added August 30, 1996.
	6350	Evaluation March 1, 1963; evaluation March 10, 1976; evaluation August 30, 1996.
	6351	Added March 1, 1989; evaluation March 24, 1992; criterion August 30, 1996.
	6352	Added March 1, 1989; removed March 24, 1992.
	6353	Added March 1, 1989; removed March 24, 1992.
	6354	Added November 29, 1994; criterion August 30, 1996.
4.88c		Re-designated from § 4.88b November 29, 1994.
4.89		Ratings for nonpulmonary TB December 1, 1949; criterion March 11, 1969.
4.97	6502	Criterion October 7, 1996.
	6504	Criterion October 7, 1996.
	6510–6514	Criterion October 7, 1996.
	6515	Criterion March 11, 1969.
	6516	Criterion October 7, 1996.
	6517	Removed October 7, 1996.
	6518	Criterion October 7, 1996.
	6519	Criterion October 7, 1996.
	6520	Criterion October 7, 1996.
	6521	Added October 7, 1996.
	6522	Added October 7, 1996.
	6523	Added October 7, 1996.
	6524	Added October 7, 1996.
	6600	Evaluation September 9, 1975; criterion October 7, 1996.
	6601	Criterion October 7, 1996.
	6602	Criterion September 9, 1975; criterion October 7, 1996.
	6603	Added September 9, 1975; criterion October 7, 1996.
	6604	Added October 7, 1996.
	6701	Evaluation October 7, 1996.
	6702	Evaluation October 7, 1996.
	6703	Evaluation October 7, 1996.
	6704	Subparagraph (1) following December 1, 1949; criterion March 11, 1969; criterion September 22, 1978.
	6705	Removed March 11, 1969.
	6707–6710	Added March 11, 1969; removed September 22, 1978.
	6721	Criterion July 6, 1950; criterion September 22, 1978.
	6724	Second note following December 1, 1949; criterion March 11, 1969; evaluation October 7, 1996.
	6725–6728	Added March 11, 1969; removed September 22, 1978.
	6730	Added September 22, 1978; criterion October 7, 1996.
	6731	Evaluation September 22, 1978; criterion October 7, 1996.
	6732	Criterion March 11, 1969.
	6800	Criterion September 9, 1975; removed October 7, 1996.
	6801	Removed October 7, 1996.
	6802	Criterion September 9, 1975; removed October 7, 1996.
	6810–6813	Removed October 7, 1996.
	6814	Criterion March 10, 1976; removed October 7, 1996.
	6815	Removed October 7, 1996.
	6816	Removed October 7, 1996.
	6817	Evaluation October 7, 1996.
	6818	Removed October 7, 1996.
	6819	Criterion March 10, 1976; criterion October 7, 1996.
	6821	Evaluation August 23, 1948.
	6822–6847	Added October 7, 1996.
4.104	7000	Evaluation July 6, 1950; evaluation September 22, 1978; evaluation January 12, 1998.
	7001	Evaluation January 12, 1998.
	7002	Evaluation January 12, 1998.
	7003	Evaluation January 12, 1998.
	7004	Criterion September 22, 1978; evaluation January 12, 1998.
	7005	Evaluation September 9, 1975; evaluation September 22, 1978; evaluation January 12, 1998.
	7006	Evaluation January 12, 1998.
	7007	Evaluation September 22, 1978; evaluation January 12, 1998.

Sec.	Diagnostic code No.	
	7008	Evaluation January 12, 1998; criterion December 10, 2017.
	7010	Evaluation January 12, 1998.
	7011	Evaluation January 12, 1998.
	7013	Removed January 12, 1998.
	7014	Removed January 12, 1998.
	7015	Evaluation September 9, 1975; criterion January 12, 1998.
	7016	Added September 9, 1975; evaluation January 12, 1998.
	7017	Added September 22, 1978; evaluation January 12, 1998.
	7018	Added January 12, 1998.
	7019	Added January 12, 1998.
	7020	Added January 12, 1998.
	7100	Evaluation July 6, 1950.
	7101	Criterion September 1, 1960; criterion September 9, 1975; criterion January 12, 1998.
	7110	Evaluation September 9, 1975; evaluation January 12, 1998.
	7111	Criterion September 9, 1975; evaluation January 12, 1998.
	7112	Evaluation January 12, 1998.
	7113	Evaluation January 12, 1998.
	7114	Added June 9, 1952; evaluation January 12, 1998.
	7115	Added June 9, 1952; evaluation January 12, 1998.
	7116	Added June 9, 1952; evaluation March 10, 1976; removed January 12, 1998.
	7117	Added June 9, 1952; evaluation January 12, 1998.
	7118	Criterion January 12, 1998.
	7119	Evaluation January 12, 1998.
	7120	Note following July 6, 1950; evaluation January 12, 1998.
	7121	Criterion July 6, 1950; evaluation March 10, 1976; evaluation January 12, 1998.
	7122	Last sentence of Note following July 6, 1950; evaluation January 12, 1998; criterion August 13, 1998.
	7123	Added October 15, 1991; criterion January 12, 1998.
4.114	.....	Introduction paragraph revised March 10, 1976.
	7304	Evaluation November 1, 1962.
	7305	Evaluation November 1, 1962.
	7308	Evaluation April 8, 1959.
	7311	Criterion July 2, 2001.
	7312	Evaluation March 10, 1976; evaluation July 2, 2001.
	7313	Evaluation March 10, 1976; removed July 2, 2001.
	7319	Evaluation November 1, 1962.
	7321	Evaluation July 6, 1950; criterion March 10, 1976.
	7328	Evaluation November 1, 1962.
	7329	Evaluation November 1, 1962.
	7330	Evaluation November 1, 1962.
	7331	Criterion March 11, 1969.
	7332	Evaluation November 1, 1962.
	7334	Evaluation July 6, 1950; evaluation November 1, 1962.
	7339	Criterion March 10, 1976.
	7341	Removed March 10, 1976.
	7343	Criterion March 10, 1976; criterion July 2, 2001.
	7344	Criterion July 2, 2001.
	7345	Evaluation August 23, 1948; evaluation February 17, 1955; evaluation July 2, 2001.
	7346	Evaluation February 1, 1962.
	7347	Added September 9, 1975.
	7348	Added March 10, 1976.
	7351	Added July 2, 2001.
	7354	Added July 2, 2001.
4.115a	.....	Re-designated and revised as § 4.115b; new § 4.115a ''Ratings of the genito-urinary system-dysfunctions'' added February 17, 1994.
4.115b	7500	Note July 6, 1950; evaluation February 17, 1994, criterion September 8, 1994.
	7501	Evaluation February 17, 1994.
	7502	Evaluation February 17, 1994.
	7503	Removed February 17, 1994.
	7504	Criterion February 17, 1994.
	7505	Criterion March 11, 1969; evaluation February 17, 1994.
	7507	Criterion February 17, 1994.
	7508	Evaluation February 17, 1994.
	7509	Criterion February 17, 1994.
	7510	Evaluation February 17, 1994.
	7511	Evaluation February 17, 1994.
	7512	Evaluation February 17, 1994.
	7513	Removed February 17, 1994.
	7514	Criterion March 11, 1969; removed February 17, 1994.
	7515	Criterion February 17, 1994.
	7516	Criterion February 17, 1994.

Sec.	Diagnostic code No.	
	7517	Criterion February 17, 1994.
	7518	Evaluation February 17, 1994.
	7519	Evaluation March 10, 1976; evaluation February 17, 1994.
	7520	Criterion February 17, 1994.
	7521	Criterion February 17, 1994.
	7522	Criterion September 8, 1994.
	7523	Criterion September 8, 1994.
	7524	Note July 6, 1950; evaluation February 17, 1994; evaluation September 8, 1994.
	7525	Criterion March 11, 1969; evaluation February 17, 1994.
	7526	Removed February 17, 1994.
	7527	Criterion February 17, 1994.
	7528	Criterion March 10, 1976; criterion February 17, 1994.
	7529	Criterion February 17, 1994.
	7530	Added September 9, 1975; evaluation February 17, 1994.
	7531	Added September 9, 1975; criterion February 17, 1994.
	7532–7542	Added February 17, 1994.
4.116	.....	§ 4.116 removed and § 4.116a re-designated § 4.116 ''Schedule of ratings-gynecological conditions and disorders of the breasts'' May 22, 1995.
	7610	Criterion May 22, 1995; title May 13, 2018.
	7611	Criterion May 22, 1995.
	7612	Criterion May 22, 1995.
	7613	Criterion May 22, 1995.
	7614	Criterion May 22, 1995.
	7615	Criterion May 22, 1995; note May 13, 2018.
	7617	Criterion May 22, 1995.
	7618	Criterion May 22, 1995.
	7619	Criterion May 22, 1995; note May 13, 2018.
	7620	Criterion May 22, 1995.
	7621	Criterion May 22, 1995; evaluation May 13, 2018.
	7622	Removed May 13, 2018.
	7623	Removed May 13, 2018.
	7624	Criterion August 9, 1976; evaluation May 22, 1995.
	7625	Criterion August 9, 1976; evaluation May 22, 1995.
	7626	Criterion May 22, 1995; criterion March 18, 2002.
	7627	Criterion March 10, 1976; criterion May 22, 1995; title, note May 13, 2018.
	7628	Added May 22, 1995; title, criterion May 13, 2018.
	7629	Added May 22, 1995.
	7630	Added May 13, 2018.
	7631	Added May 13, 2018.
	7632	Added May 13, 2018.
4.117	7700	Removed December 9, 2018.
	7701	Removed October 23, 1995.
	7702	Evaluation October 23, 1995; title December 9, 2018; evaluation December 9, 2018.
	7703	Evaluation August 23, 1948; criterion October 23, 1995; evaluation December 9, 2018; criterion December 9, 2018.
	7704	Evaluation October 23, 1995; evaluation December 9, 2018.
	7705	Evaluation October 23, 1995; title December 9, 2018; evaluation December 9, 2018; criterion December 9, 2018.
	7706	Evaluation October 23, 1995; note December 9, 2018; criterion October 23, 1995.
	7707	Criterion October 23, 1995.
	7709	Evaluation March 10, 1976; criterion October 23, 1995; title December 9, 2018; criterion December 9, 2018.
	7710	Criterion October 23, 1995; criterion December 9, 2018.
	7711	Criterion October 23, 1995.
	7712	Added December 9, 2018.
	7713	Removed October 23, 1995.
	7714	Added September 9, 1975; criterion October 23, 1995; criterion December 9, 2018.
	7715	Added October 26, 1990; criterion December 9, 2018.
	7716	Added October 23, 1995; evaluation December 9, 2018; criterion December 9, 2018.
	7717	Added March 9, 2012.
	7718	Added December 9, 2018.
	7719	Added December 9, 2018.
	7720	Added December 9, 2018.
	7721	Added December 9, 2018.
	7722	Added December 9, 2018.
	7723	Added December 9, 2018.
	7724	Added December 9, 2018.
	7725	Added December 9, 2018.
4.118	7800	Evaluation August 30, 2002; criterion October 23, 2008.

Sec.	Diagnostic code No.	
	7801	Criterion July 6, 1950; criterion August 30, 2002; criterion October 23, 2008; title, note 1, note 2 August 13, 2018.
	7802	Criterion September 22, 1978; criterion August 30, 2002; criterion October 23, 2008; title, note 1, note 2 August 13, 2018.
	7803	Criterion August 30, 2002; removed October 23, 2008.
	7804	Criterion July 6, 1950; criterion September 22, 1978; criterion and evaluation October 23, 2008.
	7805	Criterion October 23, 2008; title August 13, 2018.
		General Rating Formula for DCs 7806, 7809, 7813–7816, 7820–7822, and 7824 added August 13, 2018.
	7806	Criterion September 9, 1975; evaluation August 30, 2002; criterion August 13, 2018.
	7807	Criterion August 30, 2002.
	7808	Criterion August 30, 2002.
	7809	Criterion August 30, 2002; title, criterion August 13, 2018.
	7810	Removed August 30, 2002.
	7811	Criterion March 11, 1969; evaluation August 30, 2002.
	7812	Removed August 30, 2002.
	7813	Criterion August 30, 2002; title, criterion August 13, 2018.
	7814	Removed August 30, 2002.
	7815	Evaluation August 30, 2002; criterion, note August 13, 2018.
	7816	Evaluation August 30, 2002; criterion, note August 13, 2018.
	7817	Evaluation August 30, 2002; title, criterion, note August 13, 2018.
	7818	Criterion August 30, 2002.
	7819	Criterion August 30, 2002.
	7820	Added August 30, 2002; criterion August 13, 2018.
	7821	Added August 30, 2002; title, criterion August 13, 2018.
	7822	Added August 30, 2002; title, criterion August 13, 2018.
	7823	Added August 30, 2002; criterion August 13, 2018.
	7824	Added August 30, 2002; criterion August 13, 2018.
	7825	Added August 30, 2002; title, criterion August 13, 2018.
	7826	Added August 30, 2002; criterion August 13, 2018.
	7827	Added August 30, 2002; criterion August 13, 2018.
	7828	Added August 30, 2002; criterion August 13, 2018.
	7829	Added August 30, 2002; criterion August 13, 2018.
	7830	Added August 30, 2002; criterion August 13, 2018.
	7831	Added August 30, 2002; criterion August 13, 2018.
	7832	Added August 30, 2002; criterion August 13, 2018.
	7833	Added August 30, 2002; criterion August 13, 2018.
4.119	7900	Criterion August 13, 1981; evaluation June 9, 1996; title December 10, 2017; evaluation December 10, 2017; criterion December 10, 2017; note December 10, 2017.
	7901	Criterion August 13, 1981; evaluation June 9, 1996; title December 10, 2017; evaluation December 10, 2017; criterion December 10, 2017; note December 10, 2017.
	7902	Evaluation August 13, 1981; criterion June 9, 1996; title December 10, 2017; evaluation December 10, 2017; criterion December 10, 2017; note December 10, 2017.
	7903	Criterion August 13, 1981; evaluation June 9, 1996; evaluation December 10, 2017; criterion December 10, 2017; note December 10, 2017.
	7904	Criterion August 13, 1981; evaluation June 9, 1996; evaluation December 10, 2017; criterion December 10, 2017; note *December 10, 2017.*
	7905	Evaluation; August 13, 1981; evaluation June 9, 1996; evaluation December 10, 2017; criterion December 10, 2017.
	7906	Added December 10, 2017.
	7907	Evaluation; August 13, 1981; evaluation June 9, 1996; criterion December 10, 2017; note December 10, 2017.
	7908	Criterion August 13, 1981; criterion June 9, 1996; criterion December 10, 2017.
	7909	Evaluation August 13, 1981; criterion June 9, 1996; evaluation June 9, 1996; criterion December 10, 2017; evaluation *December 10, 2017;* note *December 10, 2017.*
	7910	Removed June 9, 1996.
	7911	Evaluation March 11, 1969; evaluation August 13, 1981; criterion June 9, 1996; title December 10, 2017; note *December 10, 2017.*
	7912	Title December 10, 2017; criterion *December 10, 2017.*
	7913	Criterion September 9, 1975; criterion August 13, 1981; criterion June 6, 1996; evaluation June 9, 1996; criterion December 10, 2017; note *December 10, 2017.*
	7914	Criterion March 10, 1976; criterion August 13, 1981; criterion June 9, 1996.
	7915	Criterion June 9, 1996; criterion *December 10, 2017.*
	7916	Added June 9, 1996; note *December 10, 2017.*
	7917	Added June 9, 1996; note *December 10, 2017.*
	7918	Added June 9, 1996; note *December 10, 2017.*

Sec.	Diagnostic code No.	
	7919	Added June 9, 1996; evaluation June 9, 1996; criterion December 10, 2017; note *December 10, 2017.*
4.124a	8002	Criterion September 22, 1978.
	8021	Criterion September 22, 1978; criterion October 1, 1961; criterion March 10, 1976; criterion March 1, 1989.
	8045	Criterion and evaluation October 23, 2008.
	8046	Added October 1, 1961; criterion March 10, 1976; criterion March 1, 1989.
	8100	Evaluation June 9, 1953.
	8540	Added October 15, 1991.
	8910	Added October 1, 1961.
	8911	Added October 1, 1961; evaluation September 9, 1975.
	8912	Added October 1, 1961.
	8913	Added October 1, 1961.
	8914	Added October 1, 1961; criterion September 9, 1975; criterion March 10, 1976.
	8910–8914	Evaluations September 9, 1975.
4.125—4.132		All Diagnostic Codes under Mental Disorders October 1, 1961; except as to evaluation for Diagnostic Codes 9500 through 9511 September 9, 1975.
4.130		Re-designated from § 4.132 November 7, 1996.
	9200	Removed February 3, 1988.
	9201	Criterion February 3, 1988; Title August 4, 2014.
	9202	Criterion February 3, 1988; removed August 4, 2014.
	9203	Criterion February 3, 1988; removed August 4, 2014.
	9204	Criterion February 3, 1988; removed August 4, 2014.
	9205	Criterion February 3, 1988; criterion November 7, 1996; Removed August 4, 2014.
	9206	Criterion February 3, 1988; removed November 7, 1996.
	9207	Criterion February 3, 1988; removed November 7, 1996.
	9208	Criterion February 3, 1988; removed November 7, 1996.
	9209	Criterion March 10, 1976; criterion February 3, 1988; removed November 7, 1996.
	9210	Criterion March 10, 1976; criterion February 3, 1988; criterion November 7, 1996; Title August 4, 2014.
	9211	Added November 7, 1996.
	9300	Criterion March 10, 1976; criterion February 3, 1988; criterion November 7, 1996.
	9301	Criterion March 10, 1976; criterion February 3, 1988; criterion November 7, 1996; Title August 4, 2014.
	9302	Criterion March 10, 1976; criterion February 3, 1988; removed November 7, 1996.
	9303	Criterion March 10, 1976; criterion February 3, 1988; removed November 7, 1996.
	9304	Criterion March 10, 1976; criterion February 3, 1988; criterion November 7, 1996; Title August 4, 2014.
	9305	Criterion March 10, 1976; criterion February 3, 1988; criterion November 7, 1996; Title August 4, 2014.
	9306	Criterion March 10, 1976; criterion February 3, 1988; removed November 7, 1996.
	9307	Criterion March 10, 1976; criterion February 3, 1988; removed November 7, 1996.
	9308	Criterion March 10, 1976; criterion February 3, 1988; removed November 7, 1996.
	9309	Criterion March 10, 1976; criterion February 3, 1988; removed November 7, 1996.
	9310	Criterion March 10, 1976; criterion February 3, 1988; criterion November 7, 1996; Title August 4, 2014.
	9311	Criterion March 10, 1976; criterion February 3, 1988; removed November 7, 1996.
	9312	Added March 10, 1976; criterion February 3, 1988; criterion November 7, 1996; Title August 4, 2014.
	9313	Added March 10, 1976; removed February 3, 1988.
	9314	Added March 10, 1976; removed February 3, 1988.
	9315	Added March 10, 1976; criterion February 3, 1988; removed November 7, 1996.
	9316–9321	Added March 10, 1976; removed February 3, 1988.
	9322	Added March 10, 1976; criterion February 3, 1988; removed November 7, 1996.
	9323	Added March 10, 1976; removed February 3, 1988.
	9324	Added March 10, 1976; criterion February 3, 1988; removed November 7, 1996.
	9325	Added March 10, 1976; criterion February 3, 1988; removed November 7, 1996.
	9326	Added March 10, 1976; removed February 3, 1988; added November 7, 1996; Title August 4, 2014.
	9327	Added November 7, 1996; removed August 4, 2014.
	9400–9411	Evaluations February 3, 1988.
	9400	Criterion March 10, 1976; criterion February 3, 1988.
	9401	Criterion March 10, 1976; criterion February 3, 1988; removed November 7, 1996.

Sec.	Diagnostic code No.	
	9402	Criterion March 10, 1976; criterion February 3, 1988; removed November 7, 1996.
	9403	Criterion March 10, 1976; criterion February 3, 1988; criterion November 7, 1996; Title August 4, 2014.
	9410	Added March 10, 1976; criterion February 3, 1988; Title August 4, 2014.
	9411	Added February 3, 1988.
	9412	Added November 7, 1996.
	9413	Added November 7, 1996; Title August 4, 2014.
	9416	Added November 7, 1996; Title August 4, 2014.
	9417	Added November 7, 1996; Title August 4, 2014.
	9421	Added November 7, 1996; Title August 4, 2014.
	9422	Added November 7, 1996; Title August 4, 2014.
	9423	Added November 7, 1996; Title August 4, 2014.
	9424	Added November 7, 1996; Title August 4, 2014.
	9425	Added November 7, 1996; Title August 4, 2014.
	9431	Added November 7, 1996.
	9432	Added November 7, 1996.
	9433	Added November 7, 1996; Title August 4, 2014.
	9434	Added November 7, 1996.
	9435	Added November 7, 1996; Title August 4, 2014.
	9440	Added November 7, 1996.
	9500	Criterion March 10, 1976; criterion February 3, 1988.
	9501	Criterion March 10, 1976; criterion February 3, 1988.
	9502	Criterion March 10, 1976; criterion February 3, 1988.
	9503	Removed March 10, 1976.
	9504	Criterion September 9, 1975; removed March 10, 1976.
	9505	Added March 10, 1976; criterion February 3, 1988.
	9506	Added March 10, 1976; criterion February 3, 1988.
	9507	Added March 10, 1976; criterion February 3, 1988.
	9508	Added March 10, 1976; criterion February 3, 1988.
	9509	Added March 10, 1976; criterion February 3, 1988.
	9510	Added March 10, 1976; criterion February 3, 1988.
	9511	Added March 10, 1976; criterion February 3, 1988.
	9520	Added November 7, 1996.
	9521	Added November 7, 1996.
4.132	.....	Re-designated as § 4.130 November 7, 1996.
4.150	9900	Criterion September 22, 1978; criterion February 17, 1994; title September 10, 2017.
	9901	Criterion February 17, 1994.
.....	9902	Criterion February 17, 1994; evaluation September 10, 2017; title September 10, 2017.
.....	9903	Criterion February 17, 1994; evaluation September 10, 2017; title September 10, 2017.
.....	9904	Criterion September 10, 2017.
	9905	Criterion September 22, 1978; evaluation February 17, 1994; evaluation September 10, 2017; title September 10, 2017.
	9906	Removed September 10, 2017.
	9907	Removed September 10, 2017.
	9910	Removed February 17, 1994.
	9911	Criterion and title September 10, 2017.
	9912	Removed September 10, 2017.
	9913	Criterion February 17, 1994.
	9914	Added February 17, 1994.
	9915	Added February 17, 1994.
	9916	Added February 17, 1994; criterion September 10, 2017.
	9917	Added September 10, 2017.
	9918	Added September 10, 2017.

[72 FR 12983, Mar. 20, 2007; 72 FR 16728, Apr. 5, 2007, as amended at 73 FR 54708, 54711, Sept. 23, 2008; 73 FR 69554, Nov. 19, 2008; 77 FR 6467, Feb. 8, 2012; 79 FR 45101, Aug. 4, 2014; 80 FR 42042, July 16, 2015; 82 FR 36084, Aug. 3, 2017; 82 FR 50806, Nov. 2, 2017; 83 FR 15072, Apr. 9, 2018; 83 FR 15323, Apr. 10, 2018; 83 FR 32600, July 13, 2018; 83 FR 54257, Oct. 29, 2018]

EFFECTIVE DATE NOTE: At 84 FR 28233, June 18, 2019, appendix A to part 4 was amended by revising the entry before the entry for diagnostic code 6300, revising the entry for diagnostic code 6300, adding in numerical order an entry for diagnostic code 6301, revising the entries for diagnostic codes 6302 and 6304 through 6309, adding in numerical order entries for diagnostic codes 6310 through 6312, revising the entries for diagnostic codes 6316 through 6320, adding in numerical order entries for diagnostic codes 6325, 6326, 6329 through 6331, and 6333 through 6335; and revising the entries for diagnostic codes 6351 and 6354, effective Aug. 11, 2019. For the convenience of the user, the added and revised text is set forth as follows:

APPENDIX A TO PART 4—TABLE OF AMENDMENTS AND EFFECTIVE DATES SINCE 1946

Sec.	Diagnostic code No.	
*	*	* * * * *
4.88b		Added March 11, 1969; re-designated § 4.88c November 29, 1994; § 4.88a re-designated to § 4.88b November 29, 1994; General Rating Formula for Infectious Diseases added August 11, 2019.
	6300	Criterion August 30, 1996; title, criterion, and note August 11, 2019.
	6301	Criterion, note August 11, 2019.
	6302	Criterion September 22, 1978; criterion August 30, 1996; criterion, note August 11, 2019.
	6304	Evaluation August 30, 1996; criterion, note August 11, 2019.
	6305	Criterion March 1, 1989; evaluation August 30, 1996; title, criterion, note August 11, 2019.
	6306	Evaluation August 30, 1996; criterion, note August 11, 2019.
	6307	Criterion May 13, 2018; criterion, note August 11, 2019.
	6308	Criterion August 30, 1996; criterion, note August 11, 2019.
	6309	Added March 1, 1963; criterion March 1, 1989; criterion August 30, 1996; criterion, note August 11, 2019.
	6310	Criterion, note August 11, 2019.
	6311	Criterion, note August 11, 2019.
	6312	Added August 11, 2019.
*	*	* * * * *
	6316	Evaluation March 1, 1989; evaluation August 30, 1996; criterion, note August 11, 2019.
	6317	Criterion August 30, 1996; title, criterion, note August 11, 2019.
	6318	Added March 1, 1989; criterion August 30, 1996; criterion, note August 11, 2019.
	6319	Added August 30, 1996; criterion, note August 11, 2019.
	6320	Added August 30, 1996; criterion, note August 11, 2019.
	6325	Added August 11, 2019.
	6326	Added August 11, 2019.
	6329	Added August 11, 2019.
	6330	Added August 11, 2019.
	6331	Added August 11, 2019.
	6333	Added August 11, 2019.
	6334	Added August 11, 2019.
	6335	Added August 11, 2019.
*	*	* * * * *
	6351	Added March 1, 1989; evaluation March 24, 1992; criterion August 30, 1996; criterion, note August 11, 2019.
*	*	* * * * *
	6354	Added November 29, 1994; criterion August 30, 1996; title, criterion, note August 11, 2019.
*	*	* * * * *

APPENDIX B TO PART 4—NUMERICAL INDEX OF DISABILITIES

Diagnostic Code No.	
	THE MUSCULOSKELETAL SYSTEM **Acute, Subacute, or Chronic Diseases**
5000	Osteomyelitis, acute, subacute, or chronic.
5001	Bones and Joints, tuberculosis.
5002	Arthritis, rheumatoid (atrophic).
5003	Arthritis, degenerative (hypertrophic or osteoarthritis).
5004	Arthritis, gonorrheal.
5005	Arthritis, pneumococcic.
5006	Arthritis, typhoid.
5007	Arthritis, syphilitic.
5008	Arthritis, streptococcic.
5009	Arthritis, other types (specify).
5010	Arthritis, due to trauma.
5011	Bones, caisson disease.
5012	Bones, new growths, malignant.
5013	Osteoporosis, with joint manifestations.
5014	Osteomalacia.

Diagnostic Code No.	
5015	Bones, new growths, benign.
5016	Osteitis deformans.
5017	Gout.
5018	Hydrarthrosis, intermittent.
5019	Bursitis.
5020	Synovitis.
5021	Myositis.
5022	Periostitis.
5023	Myositis ossificans.
5024	Tenosynovitis.
5025	Fibromyalgia.
Prosthetic Implants	
5051	Shoulder replacement (prosthesis).
5052	Elbow replacement (prosthesis).
5053	Wrist replacement (prosthesis).
5054	Hip replacement (prosthesis).
5055	Knee replacement (prosthesis).
5056	Ankle replacement (prosthesis).
Combination of Disabilities	
5104	Anatomical loss of one hand and loss of use of one foot.
5105	Anatomical loss of one foot and loss of use of one hand.
5106	Anatomical loss of both hands.
5107	Anatomical loss of both feet.
5108	Anatomical loss of one hand and one foot.
5109	Loss of use of both hands.
5110	Loss of use of both feet.
5111	Loss of use of one hand and one foot.
Amputations: Upper Extremity	
Arm amputation of:	
5120	Disarticulation.
5121	Above insertion of deltoid.
5122	Below insertion of deltoid.
Forearm amputation of:	
5123	Above insertion of pronator teres.
5124	Below insertion of pronator teres.
5125	Hand, loss of use of.
Multiple Finger Amputations	
5126	Five digits of one hand.
Four digits of one hand:	
5127	Thumb, index, long and ring.
5128	Thumb, index, long and little.
5129	Thumb, index, ring and little.
5130	Thumb, long, ring and little.
5131	Index, long, ring and little.
Three digits of one hand:	
5132	Thumb, index and long.
5133	Thumb, index and ring.
5134	Thumb, index and little.
5135	Thumb, long and ring.
5136	Thumb, long and little.
5137	Thumb, ring and little.
5138	Index, long and ring.
5139	Index, long and little.
5140	Index, ring and little.
5141	Long, ring and little.
Two digits of one hand:	
5142	Thumb and index.
5143	Thumb and long.
5144	Thumb and ring.
5145	Thumb and little.
5146	Index and long.
5147	Index and ring.
5148	Index and little.

Diagnostic Code No.	
5149	Long and ring.
5150	Long and little.
5151	Ring and little.
Single finger:	
5152	Thumb.
5153	Index finger.
5154	Long finger.
5155	Ring finger.
5156	Little finger.
Amputations: Lower Extremity	
Thigh amputation of:	
5160	Disarticulation.
5161	Upper third.
5162	Middle or lower thirds.
Leg amputation of:	
5163	With defective stump.
5164	Not improvable by prosthesis controlled by natural knee action.
5165	At a lower level, permitting prosthesis.
5166	Forefoot, proximal to metatarsal bones.
5167	Foot, loss of use of.
5170	Toes, all, without metatarsal loss.
5171	Toe, great.
5172	Toes, other than great, with removal of metatarsal head.
5173	Toes, three or more, without metatarsal involvement.
Shoulder and Arm	
5200	Scapulohumeral articulation, ankylosis.
5201	Arm, limitation of motion.
5202	Humerus, other impairment.
5203	Clavicle or scapula, impairment.
Elbow and Forearm	
5205	Elbow, ankylosis.
5206	Forearm, limitation of flexion.
5207	Forearm, limitation of extension.
5208	Forearm, flexion limited.
5209	Elbow, other impairment.
5210	Radius and ulna, nonunion.
5211	Ulna, impairment.
5212	Radius, impairment.
5213	Supination and pronation, impairment.
Wrist	
5214	Wrist, ankylosis.
5215	Wrist, limitation of motion.
Limitation of Motion	
Multiple Digits: Unfavorable Ankylosis:	
5216	Five digits of one hand.
5217	Four digits of one hand.
5218	Three digits of one hand.
5219	Two digits of one hand.
Multiple Digits: Favorable Ankylosis:	
5220	Five digits of one hand.
5221	Four digits of one hand.
5222	Three digits of one hand.
5223	Two digits of one hand.
Ankylosis of Individual Digits:	
5224	Thumb.
5225	Index finger.
5226	Long finger.
5227	Ring or little finger.

Limitation of Motion of Individual Digits:

Diagnostic Code No.	
5228	Thumb.
5229	Index or long finger.
5230	Ring or little finger.
Spine	
5235	Vertebral fracture or dislocation.
5236	Sacroiliac injury and weakness.
5237	Lumbosacral or cervical strain.
5238	Spinal stenosis.
5239	Spondylolisthesis or segmental instability.
5240	Ankylosing spondylitis.
5241	Spinal fusion.
5242	Degenerative arthritis.
5243	Intervertebral disc syndrome.
Hip and Thigh	
5250	Hip, ankylosis.
5251	Thigh, limitation of extension.
5252	Thigh, limitation of flexion.
5253	Thigh, impairment.
5254	Hip, flail joint.
5255	Femur, impairment.
Knee and Leg	
5256	Knee, ankylosis.
5257	Knee, other impairment.
5258	Cartilage, semilunar, dislocated.
5259	Cartilage, semilunar, removal.
5260	Leg, limitation of flexion.
5261	Leg, limitation of extension.
5262	Tibia and fibula, impairment.
5263	Genu recurvatum.
Ankle	
5270	Ankle, ankylosis.
5271	Ankle, limited motion.
5272	Subastragalar or tarsal joint, ankylosis.
5273	Os calcis or astragalus, malunion.
5274	Astragalectomy.
Shortening of the Lower Extremity	
5275	Bones, of the lower extremity
The Foot	
5276	Flatfoot, acquired.
5277	Weak foot, bilateral.
5278	Claw foot (pes cavus), acquired.
5279	Metatarsalgia, anterior (Morton's disease).
5280	Hallux valgus.
5281	Hallux rigidus.
5282	Hammer toe.
5283	Tarsal or metatarsal bones.
5284	Foot injuries, other.
The Skull	
5296	Loss of part of.
The Ribs	
5297	Removal of.
The Coccyx	
5298	Removal of.
MUSCLE INJURIES Shoulder Girdle and Arm	
5301	Group I Function: Upward rotation of scapula.

Diagnostic Code No.	
5302	Group II Function: Depression of arm.
5303	Group III Function: Elevation and abduction of arm.
5304	Group IV Function: Stabilization of shoulder.
5305	Group V Function: Elbow supination.
5306	Group VI Function: Extension of elbow.
Forearm and Hand	
5307	Group VII Function: Flexion of wrist and fingers.
5308	Group VIII Function: Extension of wrist, fingers, thumb.
5309	Group IX Function: Forearm muscles.
Foot and Leg	
5310	Group X Function: Movement of forefoot and toes.
5311	Group XI Function: Propulsion of foot.
5312	Group XII Function: Dorsiflexion.
Pelvic Girdle and Thigh	
5313	Group XIII Function: Extension of hip and flexion of knee.
5314	Group XIV Function: Extension of knee.
5315	Group XV Function: Adduction of hip.
5316	Group XVI Function: Flexion of hip.
5317	Group XVII Function: Extension of hip.
5318	Group XVIII Function: Outward rotation of thigh.
Torso and Neck	
5319	Group XIX Function: Abdominal wall and lower thorax.
5320	Group XX Function: Postural support of body.
5321	Group XXI Function: Respiration.
5322	Group XXII Function: Rotary and forward movements, head.
5323	Group XXIII Function: Movements of head.
Miscellaneous	
5324	Diaphragm, rupture.
5325	Muscle injury, facial muscles.
5326	Muscle hernia.
5327	Muscle, neoplasm of, malignant.
5328	Muscle, neoplasm of, benign.
5329	Sarcoma, soft tissue.
THE EYE **Diseases of the Eye**	
6000	Choroidopathy, including uveitis, iritis, cyclitis, or choroiditis.
6001	Keratopathy.
6002	Scleritis.
6003	Iritis.
6004	Cyclitis.
6005	Choroiditis.
6006	Retinopathy or maculopathy not otherwise specified.
6007	Intraocular hemorrhage.
6008	Detachment of retina.
6009	Unhealed eye injury.
6010	Tuberculosis of eye.
6011	Retinal scars, atrophy, or irregularities.
6012	Angle-closure glaucoma.
6013	Open-angle glaucoma.
6014	Malignant neoplasms of the eye, orbit, and adnexa (excluding skin).
6015	Benign neoplasms of the eye, orbit, and adnexa (excluding skin).
6016	Nystagmus, central.
6017	Conjunctivitis, trachomatous, chronic.
6018	Conjunctivitis, other, chronic.
6019	Ptosis unilateral or bilateral.
6020	Ectropion.
6021	Entropion.
6022	Lagophthalmos.
6023	Eyebrows, loss.
6024	Eyelashes, loss.
6025	Disorders of the lacrimal apparatus (epiphora, dacrocystitis, etc.).
6026	Optic neuropathy.
6027	Cataract.

Diagnostic Code No.	
6028	Cataract, senile, and others.
6029	Aphakia.
6030	Accommodation, paralysis.
6031	Dacryocystitis.
6032	Eyelids, loss of portion.
6033	Lens, crystalline, dislocation.
6034	Pterygium.
6035	Keratoconus.
6036	Status post corneal transplant.
6040	Diabetic retinopathy.
6042	Retinal dystrophy (including retinitis pigmentosa, wet or dry macular degeneration, early-onset macular degeneration, rod and/or cone dystrophy).
6046	Post-chiasmal disorders.
Impairment of Central Visual Acuity	
6061	Anatomical loss both eyes.
6062	Blindness, both eyes, only light perception.
Anatomical loss of 1 eye:	
6063	Other eye 5/200 (1.5/60).
6064	Other eye 10/200 (3/60).
6064	Other eye 15/200 (4.5/60).
6064	Other eye 20/200 (6/60).
6065	Other eye 20/100 (6/30).
6065	Other eye 20/70 (6/21).
6065	Other eye 20/50 (6/15).
6066	Other eye 20/40 (6/12).
Blindness in 1 eye, only light perception:	
6067	Other eye 5/200 (1.5/60).
6068	Other eye 10/200 (3/60).
6068	Other eye 15/200 (4.5/60).
6068	Other eye 20/200 (6/60).
6069	Other eye 20/100 (6/30).
6069	Other eye 20/70 (6/21).
6069	Other eye 20/50 (6/15).
6070	Other eye 20/40 (6/12).
Vision in 1 eye 5/200 (1.5/60):	
6071	Other eye 5/200 (1.5/60).
6072	Other eye 10/200 (3/60).
6072	Other eye 15/200 (4.5/60).
6072	Other eye 20/200 (6/60).
6073	Other eye 20/100 (6/30).
6073	Other eye 20/70 (6/21).
6073	Other eye 20/50 (6/15).
6074	Other eye 20/40 (6/12).
Vision in 1 eye 10/200 (3/60):	
6075	Other eye 10/200 (3/60).
6075	Other eye 15/200 (4.5/60).
6075	Other eye 20/200 (6/60).
6076	Other eye 20/100 (6/30).
6076	Other eye 20/70 (6/21).
6076	Other eye 20/50 (6/15).
6077	Other eye 20/40 (6/12).
Vision in 1 eye 15/200 (4.5/60):	
6075	Other eye 15/200 (4.5/60).
6075	Other eye 20/200 (6/60).
6076	Other eye 20/100 (6/30).
6076	Other eye 20/70 (6/21).
6076	Other eye 20/50 (6/15).
6077	Other eye 20/40 (6/12).
Vision in 1 eye 20/200 (6/60):	
6075	Other eye 20/200 (6/60).
6076	Other eye 20/100 (6/30).
6076	Other eye 20/70 (6/21).
6076	Other eye 20/50 (6/15).
6077	Other eye 20/40 (6/12).
Vision in 1 eye 20/100 (6/30):	
6078	Other eye 20/100 (6/30).

Diagnostic Code No.	
6078	Other eye 20/70 (6/21).
6078	Other eye 20/50 (6/15).
6079	Other eye 20/40 (6/12).
Vision in 1 eye 20/70 (6/21):	
6078	Other eye 20/70 (6/21).
6078	Other eye 20/50 (6/15).
6079	Other eye 20/40 (6/12).
Vision in 1 eye 20/50 (6/15):	
6078	Other eye 20/50 (6/15).
6079	Other eye 20/40 (6/12).
Impairment of Field Vision:	
6080	Field vision, impairment.
6081	Scotoma.
Impairment of Muscle Function:	
6090	Diplopia.
6091	Symblepharon.
6092	Diplopia, limited muscle function.
THE EAR	
6200	Chronic suppurative otitis media.
6201	Chronic nonsuppurative otitis media.
6202	Otosclerosis.
6204	Peripheral vestibular disorders.
6205	Meniere's syndrome.
6207	Loss of auricle.
6208	Malignant neoplasm.
6209	Benign neoplasm.
6210	Chronic otitis externa.
6211	Tympanic membrane.
6260	Tinnitus, recurrent.
OTHER SENSE ORGANS	
6275	Smell, complete loss.
6276	Taste, complete loss.
INFECTIOUS DISEASES, IMMUNE DISORDERS AND NUTRITIONAL DEFICIENCIES	
6300	Cholera, Asiatic.
6301	Visceral Leishmaniasis.
6302	Leprosy (Hansen's Disease).
6304	Malaria.
6305	Lymphatic Filariasis.
6306	Bartonellosis.
6307	Plague.
6308	Relapsing fever.
6309	Rheumatic fever.
6310	Syphilis.
6311	Tuberculosis, miliary.
6313	Avitaminosis.
6314	Beriberi.
6315	Pellagra.
6316	Brucellosis.
6317	Typhus, scrub.
6318	Melioidosis.
6319	Lyme disease.
6320	Parasitic diseases.
6350	Lupus erythematosus.
6351	HIV-Related Illness.
6354	Chronic Fatigue Syndrome (CFS).
THE RESPIRATORY SYSTEM **Nose and Throat**	
6502	Septum, nasal, deviation.
6504	Nose, loss of part of, or scars.
6510	Sinusitis, pansinusitis, chronic.
6511	Sinusitis, ethmoid, chronic.
6512	Sinusitis, frontal, chronic.
6513	Sinusitis, maxillary, chronic.

Diagnostic Code No.	
6514	Sinusitis, sphenoid, chronic.
6515	Laryngitis, tuberculous.
6516	Laryngitis, chronic.
6518	Laryngectomy, total.
6519	Aphonia, complete organic.
6520	Larynx, stenosis of.
6521	Pharynx, injuries to.
6522	Allergic or vasomotor rhinitis.
6523	Bacterial rhinitis.
6524	Granulomatous rhinitis.
Trachea and Bronchi	
6600	Bronchitis, chronic.
6601	Bronchiectasis.
6602	Asthma, bronchial.
6603	Emphysema, pulmonary.
6604	Chronic obstructive pulmonary disease.
Lungs and Pleura Tuberculosis	
Ratings for Pulmonary Tuberculosis (Chronic) Entitled on August 19, 1968:	
6701	Active, far advanced.
6702	Active, moderately advanced.
6703	Active, minimal.
6704	Active, advancement unspecified.
6721	Inactive, far advanced.
6722	Inactive, moderately advanced.
6723	Inactive, minimal.
6724	Inactive, advancement unspecified.
Ratings for Pulmonary Tuberculosis Initially Evaluated After August 19, 1968:	
6730	Chronic, active.
6731	Chronic, inactive.
6732	Pleurisy, active or inactive.
Nontuberculous Diseases	
6817	Pulmonary Vascular Disease.
6819	Neoplasms, malignant.
6820	Neoplasms, benign.
Bacterial Infections of the Lung	
6822	Actinomycosis.
6823	Nocardiosis.
6824	Chronic lung abscess.
Interstitial Lung Disease	
6825	Fibrosis of lung, diffuse interstitial.
6826	Desquamative interstitial pneumonitis.
6827	Pulmonary alveolar proteinosis.
6828	Eosinophilic granuloma.
6829	Drug-induced, pneumonitis & fibrosis.
6830	Radiation-induced, pneumonitis & fibrosis.
6831	Hypersensitivity pneumonitis.
6832	Pneumoconiosis.
6833	Asbestosis.
Mycotic Lung Disease	
6834	Histoplasmosis.
6835	Coccidioidomycosis.
6836	Blastomycosis.
6837	Cryptococcosis.
6838	Aspergillosis.
6839	Mucormycosis.
Restrictive Lung Disease	
6840	Diaphragm paralysis or paresis.
6841	Spinal cord injury with respiratory insufficiency.
6842	Kyphoscoliosis, pectus excavatum/carinatum.
6843	Traumatic chest wall defect.

Diagnostic Code No.	
6844	Post-surgical residual.
6845	Pleural effusion or fibrosis.
6846	Sarcoidosis.
6847	Sleep Apnea Syndromes.
THE CARDIOVASCULAR SYSTEM	
Diseases of the Heart	
7000	Valvular heart disease.
7001	Endocarditis.
7002	Pericarditis.
7003	Pericardial adhesions.
7004	Syphilitic heart disease.
7005	Arteriosclerotic heart disease.
7006	Myocardial infarction.
7007	Hypertensive heart disease.
7008	Hyperthyroid heart disease.
7010	Supraventricular arrhythmias.
7011	Ventricular arrhythmias.
7015	Atrioventricular block.
7016	Heart valve replacement.
7017	Coronary bypass surgery.
7018	Implantable cardiac pacemakers.
7019	Cardiac transplantation.
7020	Cardiomyopathy.
Diseases of the Arteries and Veins	
7101	Hypertensive vascular disease.
7110	Aortic aneurysm.
7111	Aneurysm, large artery.
7112	Aneurysm, small artery.
7113	Arteriovenous fistula, traumatic.
7114	Arteriosclerosis obliterans.
7115	Thrombo-angiitis obliterans (Buerger's Disease).
7117	Raynaud's syndrome.
7118	Angioneurotic edema.
7119	Erythromelalgia.
7120	Varicose veins.
7121	Post-phlebitic syndrome.
7122	Cold injury residuals.
7123	Soft tissue sarcoma.
THE DIGESTIVE SYSTEM	
7200	Mouth, injuries.
7201	Lips, injuries.
7202	Tongue, loss.
7203	Esophagus, stricture.
7204	Esophagus, spasm.
7205	Esophagus, diverticulum.
7301	Peritoneum, adhesions.
7304	Ulcer, gastric.
7305	Ulcer, duodenal.
7306	Ulcer, marginal.
7307	Gastritis, hypertrophic.
7308	Postgastrectomy syndromes.
7309	Stomach, stenosis.
7310	Stomach, injury of, residuals.
7311	Liver, injury of, residuals.
7312	Liver, cirrhosis.
7314	Cholecystitis, chronic.
7315	Cholelithiasis, chronic.
7316	Cholangitis, chronic.
7317	Gall bladder, injury.
7318	Gall bladder, removal.
7319	Colon, irritable syndrome.
7321	Amebiasis.
7322	Dysentery, bacillary.
7323	Colitis, ulcerative.
7324	Distomiasis, intestinal or hepatic.
7325	Enteritis, chronic.
7326	Enterocolitis, chronic.
7327	Diverticulitis.

Diagnostic Code No.	
7328	Intestine, small, resection.
7329	Intestine, large, resection.
7330	Intestine, fistula.
7331	Peritonitis.
7332	Rectum & anus, impairment.
7333	Rectum & anus, stricture.
7334	Rectum, prolapse.
7335	Ano, fistula in.
7336	Hemorrhoids.
7337	Pruritus ani.
7338	Hernia, inguinal.
7339	Hernia, ventral, postoperative.
7340	Hernia, femoral.
7342	Visceroptosis.
7343	Neoplasms, malignant.
7344	Neoplasms, benign.
7345	Liver disease, chronic, without cirrhosis.
7346	Hernia, hiatal.
7347	Pancreatitis.
7348	Vagotomy.
7351	Liver transplant.
7354	Hepatitis C.
THE GENITOURINARY SYSTEM	
7500	Kidney, removal.
7501	Kidney, abscess.
7502	Nephritis, chronic.
7504	Pyelonephritis, chronic.
7505	Kidney, tuberculosis.
7507	Nephrosclerosis, arteriolar.
7508	Nephrolithiasis.
7509	Hydronephrosis.
7510	Ureterolithiasis.
7511	Ureter, stricture.
7512	Cystitis, chronic.
7515	Bladder, calculus.
7516	Bladder, fistula.
7517	Bladder, injury.
7518	Urethra, stricture.
7519	Urethra, fistula.
7520	Penis, removal of half or more.
7521	Penis, removal of glans.
7522	Penis, deformity, with loss of erectile power.
7523	Testis, atrophy, complete.
7524	Testis, removal.
7525	Epididymo-orchitis, chronic only.
7527	Prostate gland.
7528	Malignant neoplasms.
7529	Benign neoplasms.
7530	Renal disease, chronic.
7531	Kidney transplant.
7532	Renal tubular disorders.
7533	Kidneys, cystic diseases.
7534	Atherosclerotic renal disease.
7535	Toxic nephropathy.
7536	Glomerulonephritis.
7537	Interstitial nephritis.
7538	Papillary necrosis.
7539	Renal amyloid disease.
7540	Disseminated intravascular coagulation.
7541	Renal involvement in systemic diseases.
7542	Neurogenic bladder.
GYNECOLOGICAL CONDITIONS AND DISORDERS OF THE BREAST	
7610	Vulva or clitoris, disease or injury of (including vulvovaginitis).
7611	Vagina, disease or injury.
7612	Cervix, disease or injury.
7613	Uterus, disease or injury.
7614	Fallopian tube, disease or injury.
7615	Ovary, disease or injury.
7617	Uterus and both ovaries, removal.
7618	Uterus, removal.

Diagnostic Code No.	
7619	Ovary, removal.
7620	Ovaries, atrophy of both.
7621	Complete or incomplete pelvic organ prolapse due to injury or disease or surgical complications of pregnancy.
7624	Fistula, rectovaginal.
7625	Fistula, urethrovaginal.
7626	Breast, surgery.
7627	Malignant neoplasms of gynecological system.
7628	Benign neoplasms of gynecological system.
7629	Endometriosis.
7630	Malignant neoplasms of the breast.
7631	Benign neoplasms of the breast and other injuries of the breast.
7632	Female sexual arousal disorder (FSAD).
The Hematologic and Lymphatic Systems	
7700	[Removed]
7702	Agranulocytosis, acquired.
7703	Leukemia.
7704	Polycythemia vera.
7705	Immune thrombocytopenia.
7706	Splenectomy.
7707	Spleen, injury of, healed.
7709	Hodgkin's lymphoma.
7710	Adenitis, tuberculous.
7712	Multiple myeloma
7714	Sickle cell anemia.
7715	Non-Hodgkin's lymphoma.
7716	Aplastic anemia.
7717	AL amyloidosis (primary amyloidosis).
7718	Essential thrombocythemia and primary myelofibrosis.
7719	Chronic myelogenous leukemia (CML) (chronic myeloid leukemia or chronic granulocytic leukemia).
7720	Iron deficiency anemia.
7721	Folic acid deficiency.
7722	Pernicious anemia and Vitamin B_{12} deficiency anemia.
7723	Acquired hemolytic anemia.
7724	Solitary plasmacytoma.
7725	Myelodysplastic syndromes.
THE SKIN	
7800	Burn scar(s) of the head, face, or neck; scar(s) of the head, face, or neck due to other causes; or other disfigurement of the head, face, or neck.
7801	Burn scar(s) or scar(s) due to other causes, not of the head, face, or neck that are associated with underlying soft tissue damage.
7802	Burn scar(s) or scar(s) due to other causes, not of the head, face, or neck that are not associated with underlying soft tissue damage.
7804	Scar(s), unstable or painful.
7805	Scars, other; and other effects of scars evaluated under diagnostic codes 7800, 7801, 7802, or 7804.
7806	Dermatitis or eczema.
7807	Leishmaniasis, American (New World).
7808	Leishmaniasis, Old World.
7809	Discoid lupus erythematosus.
7811	Tuberculosis luposa (lupus vulgaris).
7813	Dermatophytosis.
7815	Bullous disorders.
7816	Psoriasis.
7817	Erythroderma.
7818	Malignant skin neoplasms.
7819	Benign skin neoplasms.
7820	Infections of the skin.
7821	Cutaneous manifestations of collagen-vascular diseases not listed elsewhere.
7822	Papulosquamous disorders not listed elsewhere.
7823	Vitiligo.
7824	Keratinization, diseases.
7825	Chronic urticaria.
7826	Vasculitis, primary cutaneous.
7827	Erythema multiforme.
7828	Acne.
7829	Chloracne.
7830	Scarring alopecia.
7831	Alopecia areata.

Diagnostic Code No.	
7832	Hyperhidrosis.
7833	Malignant melanoma.
THE ENDOCRINE SYSTEM	
7900	Hyperthyroidism, including, but not limited to, Graves' disease.
7901	Thyroid enlargement, toxic.
7902	Thyroid enlargement, nontoxic.
7903	Hypothyroidism.
7904	Hyperparathyroidism.
7905	Hypoparathyroidism.
7906	Thyroiditis.
7907	Cushing's syndrome.
7908	Acromegaly.
7909	Diabetes insipidus.
7911	Addison's disease (adrenocortical insufficiency).
7912	Polyglandular syndrome (multiple endocrine neoplasia, autoimmune polyglandular syndrome).
7913	Diabetes mellitus.
7914	Malignant neoplasm.
7915	Benign neoplasm.
7916	Hyperpituitarism.
7917	Hyperaldosteronism.
7918	Pheochromocytoma.
7919	C-cell hyperplasia, thyroid.
NEUROLOGICAL CONDITIONS AND CONVULSIVE DISORDERS Organic Diseases of the Central Nervous System	
8000	Encephalitis, epidemic, chronic.
Brain, New Growth of	
8002	Malignant.
8003	Benign.
8004	Paralysis agitans.
8005	Bulbar palsy.
8007	Brain, vessels, embolism.
8008	Brain, vessels, thrombosis.
8009	Brain, vessels, hemorrhage.
8010	Myelitis.
8011	Poliomyelitis, anterior.
8012	Hematomyelia.
8013	Syphilis, cerebrospinal.
8014	Syphilis, meningovascular.
8015	Tabes dorsalis.
8017	Amyotrophic lateral sclerosis.
8018	Multiple sclerosis.
8019	Meningitis, cerebrospinal, epidemic.
8020	Brain, abscess.
Spinal Cord, New Growths	
8021	Malignant.
8022	Benign.
8023	Progressive muscular atrophy.
8024	Syringomyelia.
8025	Myasthenia gravis.
8045	Residuals of traumatic brain injury (TBI).
8046	Cerebral arteriosclerosis.
Miscellaneous Diseases	
8100	Migraine
8103	Tic, convulsive.
8104	Paramyoclonus multiplex.
8105	Chorea, Sydenham's.
8106	Chorea, Huntington's.
8107	Athetosis, acquired.
8108	Narcolepsy.
The Cranial Nerves	
8205	Fifth (trigeminal), paralysis.
8207	Seventh (facial), paralysis.
8209	Ninth (glossopharyngeal), paralysis.

Diagnostic Code No.	
8210	Tenth (pneumogastric, vagus), paralysis.
8211	Eleventh (spinal accessory, external branch), paralysis.
8212	Twelfth (hypoglossal), paralysis.
8305	Neuritis, fifth cranial nerve.
8307	Neuritis, seventh cranial nerve.
8309	Neuritis, ninth cranial nerve.
8310	Neuritis, tenth cranial nerve.
8311	Neuritis, eleventh cranial nerve.
8312	Neuritis, twelfth cranial nerve.
8405	Neuralgia, fifth cranial nerve.
8407	Neuralgia, seventh cranial nerve.
8409	Neuralgia, ninth cranial nerve.
8410	Neuralgia, tenth cranial nerve.
8411	Neuralgia, eleventh cranial nerve.
8412	Neuralgia, twelfth cranial nerve.
Peripheral Nerves	
8510	Upper radicular group, paralysis.
8511	Middle radicular group, paralysis.
8512	Lower radicular group, paralysis.
8513	All radicular groups, paralysis.
8514	Musculospiral nerve (radial), paralysis.
8515	Median nerve, paralysis.
8516	Ulnar nerve, paralysis.
8517	Musculocutaneous nerve, paralysis.
8518	Circumflex nerve, paralysis.
8519	Long thoracic nerve, paralysis.
8520	Sciatic nerve, paralysis.
8521	External popliteal nerve (common peroneal), paralysis.
8522	Musculocutaneous nerve (superficial peroneal), paralysis.
8523	Anterior tibial nerve (deep peroneal), paralysis.
8524	Internal popliteal nerve (tibial), paralysis.
8525	Posterior tibial nerve, paralysis.
8526	Anterior crural nerve (femoral), paralysis.
8527	Internal saphenous nerve, paralysis.
8528	Obturator nerve, paralysis.
8529	External cutaneous nerve of thigh, paralysis.
8530	Ilio-inguinal nerve, paralysis.
8540	Soft-tissue sarcoma (Neurogenic origin).
8610	Neuritis, upper radicular group.
8611	Neuritis, middle radicular group.
8612	Neuritis, lower radicular group.
8613	Neuritis, all radicular group.
8614	Neuritis, musculospiral (radial) nerve.
8615	Neuritis, median nerve.
8616	Neuritis, ulnar nerve.
8617	Neuritis, musculocutaneous nerve.
8618	Neuritis, circumflex nerve.
8619	Neuritis, long thoracic nerve.
8620	Neuritis, sciatic nerve.
8621	Neuritis, external popliteal (common peroneal) nerve.
8622	Neuritis, musculocutaneous (superficial peroneal) nerve.
8623	Neuritis, anterior tibial (deep peroneal) nerve.
8624	Neuritis, internal popliteal (tibial) nerve.
8625	Neuritis, posterior tibial nerve.
8626	Neuritis, anterior crural (femoral) nerve.
8627	Neuritis, internal saphenous nerve.
8628	Neuritis, obturator nerve.
8629	Neuritis, external cutaneous nerve of thigh.
8630	Neuritis, ilio-inguinal nerve.
8710	Neuralgia, upper radicular group.
8711	Neuralgia, middle radicular group.
8712	Neuralgia, lower radicular group.
8713	Neuralgia, all radicular groups.
8714	Neuralgia, musculospiral nerve (radial).
8715	Neuralgia, median nerve.
8716	Neuralgia, ulnar nerve.
8717	Neuralgia, musculocutaneous nerve.
8718	Neuralgia, circumflex nerve.
8719	Neuralgia, long thoracic nerve.
8720	Neuralgia, sciatic nerve.
8721	Neuralgia, external popliteal nerve (common peroneal).
8722	Neuralgia, musculocutaneous nerve (superficial peroneal).

Diagnostic Code No.	
8723	Neuralgia, anterior tibial nerve (deep peroneal).
8724	Neuralgia, internal popliteal nerve (tibial).
8725	Neuralgia, posterior tibial nerve.
8726	Neuralgia, anterior crural nerve (femoral).
8727	Neuralgia, internal saphenous nerve.
8728	Neuralgia, obturator nerve.
8729	Neuralgia, external cutaneous nerve of thigh.
8730	Neuralgia, ilio-inguinal nerve.
The Epilepsies	
8910	Grand mal.
8911	Petit mal.
8912	Jacksonian and focal motor or sensory.
8913	Diencephalic.
8914	Psychomotor.
Mental Disorders	
9201	Schizophrenia.
9208	Delusional disorder.
9210	Other specified and unspecified schizophrenia spectrum and other psychotic disorders.
9211	Schizoaffective Disorder.
9300	Delirium.
9301	Major or mild neurocognitive disorder due to HIV or other infections.
9304	Major or mild neurocognitive disorder due to traumatic brain injury.
9305	Major or mild vascular neurocognitive disorder.
9310	Unspecified neurocognitive disorder.
9312	Major or mild neurocognitive disorder due to Alzheimer's disease.
9326	Major or mild neurocognitive disorder due to another medical condition or substance/medication-induced major or mild neurocognitive disorder.
9400	Generalized anxiety disorder.
9403	Specific phobia; social anxiety disorder (social phobia).
9404	Obsessive compulsive disorder.
9410	Other specified anxiety disorder.
9411	Posttraumatic stress disorder.
9412	Panic disorder and/or agoraphobia.
9413	Unspecified anxiety disorder.
9416	Dissociative amnesia; dissociative identity disorder.
9417	Depersonalization/derealization disorder.
9421	Somatic symptom disorder.
9422	Other specified somatic symptom and related disorder.
9423	Unspecified somatic symptom and related disorder.
9424	Conversion disorder (functional neurological symptom disorder).
9425	Illness anxiety disorder.
9431	Cyclothymic disorder.
9432	Bipolar disorder.
9433	Persistent depressive disorder (dysthymia).
9434	Major depressive disorder.
9435	Unspecified depressive disorder.
9440	Chronic adjustment disorder.
9520	Anorexia nervosa.
9521	Bulimia nervosa.
DENTAL AND ORAL CONDITIONS	
9900	Maxilla or mandible, chronic osteomyelitis, osteonecrosis, or osteoradionecrosis of.
9901	Mandible, loss of, complete.
9902	Mandible loss of, including ramus, unilaterally or bilaterally.
9903	Mandible, nonunion of, confirmed by diagnostic imaging studies.
9904	Mandible, malunion.
9905	Temporomandibular disorder (TMD).
9908	Condyloid process.
9909	Coronoid process.
9911	Hard palate, loss of.
9913	Teeth, loss of.
9914	Maxilla, loss of more than half.
9915	Maxilla, loss of half or less.
9916	Maxilla, malunion or nonunion of.
9917	Neoplasm, hard and soft tissue, benign.
9918	Neoplasm, hard and soft tissue, malignant.

[72 FR 12990, Mar. 20, 2007, as amended at 73 FR 54708, 54711, Sept. 23, 2008; 74 FR 18467, Apr. 23, 2009; 77 FR 6467, Feb. 8, 2012; 79 FR 45102, Aug. 4, 2014; 82 FR 36085, Aug. 3, 2017; 82 FR 50807, Nov. 2, 2017; 83 FR 15073, Apr. 9, 2018; 83 FR 15323, Apr. 10, 2018; 83 FR 32600, July 13, 2018; 83 FR 54258, Oct. 29, 2018]

EFFECTIVE DATE NOTE: At 84 FR 28234, June 18, 2019, appendix B to part 4, is amended by revising the entries for diagnostic codes 6300 and 6305, adding in numerical order an entry for diagnostic code 6312, revising the entry for diagnostic code 6317; and adding in numerical order entries for diagnostic codes 6325, 6326, 6329 through 6331, and 6333 through 6335, effective Aug. 11, 2019. For the convenience of the user, the added and revised text is set forth as follows:

APPENDIX B TO PART 4—NUMERICAL INDEX OF DISABILITIES

Diagnostic code No.	
* * * * * * *	
Infectious Diseases, Immune Disorders and Nutrional Deficiencies	
6300	Vibriosis (Cholera, Non-cholera).
* * * * * * *	
6305	Lymphatic filariasis, to include elephantiasis.
* * * * * * *	
6312	Nontuberculosis mycobacterium infection.
* * * * * * *	
6317	Rickettsial, ehrlichia, and anaplasma infections.
* * * * * * *	
6325	Hyperinfection syndrome or disseminated strongyloidiasis.
6326	Schistosomiasis.
6329	Hemorrhagic fevers, including dengue, yellow fever, and others.
6330	Campylobacter jejuni infection.
6331	Coxiella burnetii infection (Q Fever).
6333	Nontyphoid salmonella infections.
6334	Shigella infections.
6335	West Nile virus infection.
* * * * * * *	

APPENDIX C TO PART 4—ALPHABETICAL INDEX OF DISABILITIES

	Diagnostic code No.
Abscess:	
Brain	8020
Kidney	7501
Lung	6824
Acne	7828
Acromegaly	7908
Actinomycosis	6822
Addison's disease	7911
Agranulocytosis, acquired	7702
AL amyloidosis	7717
Alopecia areata	7831
Amebiasis	7321
Amputation:	
Arm:	
Disarticulation	5120
Above insertion of deltoid	5121
Below insertion of deltoid	5122
Digits, five of one hand	5126
Digits, four of one hand:	

	Diagnostic code No.
Thumb, index, long and ring	5127
Thumb, index, long and little	5128
Thumb, index, ring and little	5129
Thumb, long, ring and little	5130
Index, long, ring and little	5131
Digits, three of one hand:	
Thumb, index and long	5132
Thumb, index and ring	5133
Thumb, index and little	5134
Thumb, long and ring	5135
Thumb, long and little	5136
Thumb, ring and little	5137
Index, long and ring	5138
Index, long and little	5139
Index, ring and little	5140
Long, ring and little	5141
Digits, two of one hand:	
Thumb and index	5142
Thumb and long	5143
Thumb and ring	5144
Thumb and little	5145
Index and long	5146
Index and ring	5147
Index and little	5148
Long and ring	5149
Long and little	5150
Ring and little	5151
Single finger:	
Thumb	5152
Index finger	5153
Long finger	5154
Ring finger	5155
Little finger	5156
Forearm:	
Above insertion of pronator teres	5123
Below insertion of pronator teres	5124
Leg:	
With defective stump	5163
Not improvable by prosthesis controlled by natural knee action	5164
At a lower level, permitting prosthesis	5165
Forefoot, proximal to metatarsal bones	5166
Toes, all, without metatarsal loss	5170
Toe, great	5171
Toes, other than great, with removal of metatarsal head	5172
Toes, three or more, without metatarsal involvement	5173
Thigh:	
Disarticulation	5160
Upper third	5161
Middle or lower thirds	5162
Amyotrophic lateral sclerosis	8017
Anatomical loss of:	
Both eyes	6061
One eye, with visual acuity of other eye:	
5/200 (1.5/60)	6063
10/200 (3/60); 15/200 (4.5/60); 20/200 (6/60)	6064
20/100 (6/30); 20/70 (6/21); 20/50 (6/15)	6065
20/40 (6/12)	6066
Both feet	5107
Both hands	5106
One hand and one foot	5108
One foot and loss of use of one hand	5105
One hand and loss of use of one foot	5104
Anemia:	
Acquired hemolytic anemia	7723
Folic acid deficiency	7721
Iron deficiency anemia	7720
Pernicious anemia and Vitamin B_{12} deficiency anemia	7722
Aneurysm:	
Aortic	7110
Large artery	7111
Small artery	7112
Angioneurotic edema	7118
Ankylosis:	

	Diagnostic code No.
Ankle	5270
Digits, individual:	
Thumb	5224
Index finger	5225
Long finger	5226
Ring or little finger	5227
Elbow	5205
Hand	
Favorable:	
Five digits of one hand	5220
Four digits of one hand	5221
Three digits of one hand	5222
Two digits of one hand	5223
Unfavorable:	
Five digits of one hand	5216
Four digits of one hand	5217
Three digits of one hand	5218
Two digits of one hand	5219
Hip	5250
Knee	5256
Scapulohumeral articulation	5200
Subastragalar or tarsal joint	5272
Wrist	5214
Ankylosing spondylitis	5240
Aphakia	6029
Aphonia, organic	6519
Aplastic anemia	7716
Arrhythmia:	
Supraventricular	7010
Ventricular	7011
Arteriosclerosis obliterans	7114
Arteriosclerotic heart disease	7005
Arteriovenous fistula	7113
Arthritis:	
Degenerative (hypertrophic or osteoarthritis)	5003
Due to trauma	5010
Gonorrheal	5004
Other types	5009
Pneumococcic	5005
Rheumatoid (atrophic)	5002
Streptococcic	5008
Syphilitic	5007
Typhoid	5006
Asbestosis	6833
Aspergillosis	6838
Asthma, bronchial	6602
Astragalectomy	5274
Atherosclerotic renal disease	7534
Athetosis	8107
Atrioventricular block	7015
Avitaminosis	6313
Bartonellosis	6306
Beriberi	6314
Bladder:	
Calculus in	7515
Fistula in	7516
Injury of	7517
Neurogenic	7542
Blastomycosis	6836
Blindness: *see also* Vision and Anatomical Loss	
Both eyes, only light perception	6062
One eye, only light perception and other eye:	
5/200 (1.5/60)	6067
10/200 (3/60); 15/200 (4.5/60); 20/200 (6/60)	6068
20/100 (6/30); 20/70 (6/21); 20/50 (6/15)	6069
20/40 (6/12)	6070
Bones:	
Caisson disease	5011
New growths, benign	5015
New growths, malignant	5012
Shortening of the lower extremity	5275
Brain:	
Abscess	8020

	Diagnostic code No.
Breast surgery	7626
Bronchiectasis	6601
Bronchitis	6600
Brucellosis	6316
Buerger's disease	7115
Bulbar palsy	8005
Bullous disorders	7815
Bursitis	5019
Cardiac:	
Pacemakers, implantable	7018
Transplantation	7019
Cardiomyopathy	7020
C-cell hyperplasia, thyroid	7919
Cataract:	
Senile and others	6028
Traumatic	6027
Cerebral arteriosclerosis	8046
Cervical strain	5237
Cervix disease or injury	7612
Chorea:	
Huntington's	8106
Sydenham's	8105
Chloracne	7829
Cholangitis, chronic	7316
Cholecystitis, chronic	7314
Cholelithiasis, chronic	7315
Cholera, Asiatic	6300
Choroiditis	6005
Chronic Fatigue Syndrome (CFS)	6354
Chronic lung abscess	6824
Chronic obstructive pulmonary disease	6604
Coccidioidomycosis	6835
Cold injury residuals	7122
Colitis, ulcerative	7323
Complete or incomplete pelvic organ prolapse due to injury or disease or surgical complications of pregnancy, including uterine or vaginal vault prolapse, cystocele, urethrocele, rectocele, enterocele, or combination	7621
Conjunctivitis:	
Trachomatous	6017
Other	6018
Coronary bypass surgery	7017
Cryptococcosis	6837
Cushing's syndrome	7907
Cutaneous manifestations of collagen-vascular diseases not listed elsewhere	7821
Cyclitis	6004
Cystitis, chronic	7512
Dacryocystitis	6031
Dermatitis or eczema	7806
Dermatophytosis	7813
Desquamative interstitial pneumonitis	6826
Diabetes:	
Insipidus	7909
Mellitus	7913
Diaphragm:	
Paralysis or paresis	6840
Rupture	5324
Diplopia	6090
Diplopia, limited muscle function, eye	6092
Disease:	
Addison's	7911
Buerger's	7115
Chronic obstructive pulmonary disease	6604
Hodgkin's	7709
Leprosy (Hansen's)	6302
Lyme	6319
Morton's	5279
Parasitic	6320
Disfigurement of, head, face or neck	7800
Dislocated:	
Cartilage, semilunar	5258
Lens, crystalline	6033
Disseminated intravascular coagulation	7540
Distomiasis, intestinal or hepatic	7324
Diverticulitis	7327

	Diagnostic code No.
Dysentery, bacillary	7322
Ectropion	6020
Embolism, brain	8007
Emphysema, pulmonary	6603
Encephalitis, epidemic, chronic	8000
Endocarditis	7001
Endometriosis	7629
Enteritis, chronic	7325
Enterocolitis, chronic	7326
Entropion	6021
Eosinophilic granuloma of lung	6828
Epididymo-orchitis	7525
Epilepsies:	
Diencephalic	8913
Grand mal	8910
Jacksonian and focal motor or sensory	8912
Petit mal	8911
Psychomotor	8914
Epiphora	6025
Erythema multiforme	7827
Erythroderma	7817
Erythromelalgia	7119
Esophagus:	
Diverticulum	7205
Spasm	7204
Stricture	7203
Fallopian tube	7614
Female sexual arousal disorder (FSAD)	7632
Fever:	
Relapsing	6308
Rheumatic	6309
Fibrosis of lung, diffuse interstitial	6825
Fibromyalgia	5025
Fistula in ano	7335
Fistula:	
Rectovaginal	7624
Urethrovaginal	7625
Flatfoot, acquired	5276
Gastritis, hypertrophic	7307
Genu recurvatum	5263
Glaucoma:	
Congestive or inflammatory	6012
Simple, primary, noncongestive	6013
Glomerulonephritis	7536
Gout	5017
Graves' disease	7900
Hallux:	
Rigidus	5281
Valgus	5280
Hammer toe	5282
Heart valve replacement	7016
Hematologic:	
Essential thrombocythemia and primary myelofibrosis	7718
Immune thrombocytopenia	7705
Multiple myeloma	7712
Myelodysplastic syndromes	7725
Solitary plasmacytoma	7724
Hematomyelia	8012
Hemorrhage:	
Brain	8009
Intra-ocular	6007
Hemorrhoids	7336
Hepatitis C	7354
Hernia:	
Femoral	7340
Hiatal	7346
Inguinal	7338
Muscle	5326
Ventral	7339
Hip:	
Degenerative arthritis	5242
Flail joint	5254
Histoplasmosis	6834

	Diagnostic code No.
HIV-Related Illness	6351
Hodgkin's disease	7709
Hodgkin's lymphoma	7709
Hydrarthrosis, intermittent	5018
Hydronephrosis	7509
Hyperaldosteronism	7917
Hyperhidrosis	7832
Hyperparathyroidism	7904
Hyperpituitarism	7916
Hypersensitivity	6831
Hypertensive:	
Heart disease	7007
Vascular disease	7101
Hyperthyroid heart disease	7008
Hyperthyroidism	7900
Hypoparathyroidism	7905
Hypothyroidism	7903
Impairment of:	
Humerus	5202
Clavicle or scapula	5203
Elbow	5209
Thigh	5253
Femur	5255
Knee, other	5257
Field vision	6080
Tibia and fibula	5262
Rectum & anus	7332
Ulna	5211
Implantable cardiac pacemakers	7018
Infections of the skin	7820
Injury:	
Bladder	7517
Breast	7631
Eye, unhealed	6009
Foot	5284
Gall bladder	7317
Lips	7201
Liver, residuals	7311
Mouth	7200
Muscle:	
Facial	5325
Group I Function: Upward rotation of scapula	5301
Group II Function: Depression of arm	5302
Group III Function: Elevation and abduction of arm	5303
Group IV Function: Stabilization of shoulder	5304
Group V Function: Elbow supination	5305
Group VI Function: Extension of elbow	5306
Group VII Function: Flexion of wrist and fingers	5307
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Group IX Function: Forearm muscles	5309
Group X Function: Movement of forefoot and toes	5310
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Group XII Function: Dorsiflexion	5312
Group XIII Function: Extension of hip and flexion of knee	5313
Group XIV Function: Extension of knee	5314
Group XV Function: Adduction of hip	5315
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Group XVIII Function: Outward rotation of thigh	5318
Group XIX Function: Abdominal wall and lower thorax	5319
Group XX Function: Postural support of body	5320
Group XXI Function: Respiration	5321
Group XXII Function: Rotary and forward movements, head	5322
Group XXIII Function: Movements of head	5323
Pharynx	6521
Sacroiliac	5236
Spinal cord	6841
Stomach, residuals of	7310
Iritis	6003
Interstitial nephritis	7537
Intervertebral disc syndrome	5243
Intestine, fistula of	7330
Irritable colon syndrome	7319

	Diagnostic code No.
Keratinization, diseases of	7824
Keratitis	6001
Keratoconus	6035
Kidney:	
Abscess	7501
Cystic diseases	7533
Removal	7500
Transplant	7531
Tuberculosis	7505
Kyphoscoliosis, pectus excavatum / carinatum	6842
Lagophthalmos	6022
Laryngectomy	6518
Laryngitis:	
Tuberculous	6515
Chronic	6516
Larynx, stenosis of	6520
Leishmaniasis:	
American (New World)	7807
Old World	7808
Leprosy (Hansen's Disease)	6302
Leukemia:	
Chronic myelogenous leukemia (CML) (chronic myeloid leukemia or chronic granulocytic leukemia)	7719
Leukemia	7703
Limitation of extension:	
Forearm	5207
Leg	5261
Radius	5212
Supination and pronation	5213
Thigh	5251
Limitation of extension and flexion:	
Forearm	5208
Limitation of flexion:	
Forearm	5206
Leg	5260
Thigh	5252
Limitation of motion:	
Ankle	5271
Arm	5201
Index or long finger	5229
Ring or little finger	5230
Temporomandibular	9905
Thumb	5228
Wrist, limitation of motion	5215
Liver:	
Disease, chronic, without cirrhosis	7345
Transplant	7351
Cirrhosis	7312
Loss of:	
Auricle	6207
Condyloid process	9908
Coronoid process	9909
Eyebrows	6023
Eyelashes	6024
Eyelids	6032
Palate, hard	9911
Mandible:	
Including ramus, unilaterally or bilaterally	9902
Maxilla:	
More than half	9914
Less than half	9915
Nose, part of, or scars	6504
Skull, part of	5296
Smell, sense of	6275
Taste, sense of	6276
Teeth, loss of	9913
Tongue, loss of whole or part	7202
Loss of use of:	
Both feet	5110
Both hands	5109
Foot	5167
Hand	5125
One hand and one foot	5111
Lumbosacral strain	5237

	Diagnostic code No.
Lupus:	
Erythematosus	6350
Erythematosus, discoid	7809
Lyme disease	6319
Lymphatic filariasis	6305
Malaria	6304
Malignant melanoma	7833
Malunion:	
Mandible	9904
Os calcis or astragalus	5273
Maxilla, malunion or nonunion	9916
Maxilla or mandible, chronic osteomyelitis, osteonecrosis, or osteoradionecrosis of	9900
Melioidosis	6318
Meniere's syndrome	6205
Meningitis, cerebrospinal, epidemic	8019
Mental disorders:	
Anorexia nervosa	9520
Bipolar disorder	9432
Bulimia nervosa	9521
Chronic adjustment disorder	9440
Conversion disorder (functional neurological symptom disorder).	9424
Cyclothymic disorder	9431
Delirium	9300
Delusional disorder	9208
Depersonalization/derealization disorder	9417
Dissociative amnesia; dissociative identity disorder	9416
Generalized anxiety disorder	9400
Illness anxiety disorder	9425
Major depressive disorder	9434
Major or mild neurocognitive disorder due to Alzheimer's disease	9312
Major or mild neurocognitive disorder due to another medical condition or substance/medication-induced major or mild neurocognitive disorder	9326
Major or mild neurocognitive disorder due to HIV or other infections	9301
Major or mild neurocognitive disorder due to traumatic brain injury	9304
Major or mild vascular neurocognitive disorder	9305
Obsessive compulsive disorder	9404
Other specified and unspecified schizophrenia spectrum and other psychotic disorders	9210
Other specified anxiety disorder	9410
Other specified somatic symptom and related disorder	9422
Panic disorder and/or agoraphobia	9412
Persistent depressive disorder (dysthymia)	9433
Posttraumatic stress disorder	9411
Schizoaffective disorder	9211
Schizophrenia	9201
Somatic symptom disorder	9421
Specific phobia; social anxiety disorder (social phobia)	9403
Unspecified somatic symptom and related disorder	9423
Unspecified anxiety disorder	9413
Unspecified depressive disorder	9435
Unspecified neurocognitive disorder	9310
Metatarsalgia	5279
Migraine	8100
Morton's disease	5279
Mucormycosis	6839
Multiple sclerosis	8018
Myasthenia gravis	8025
Myelitis	8010
Myocardial infarction	7006
Myositis ossificans	5023
Myositis	5021
Narcolepsy	8108
Neoplasms:	
Benign:	
Breast	7631
Digestive system	7344
Ear	6209
Endocrine	7915
Genitourinary	7529
Gynecological	7628
Hard and soft tissue	9917
Muscle	5328
Respiratory	6820
Skin	7819

	Diagnostic code No.
Malignant:	
Breast	7630
Digestive system	7343
Ear	6208
Endocrine	7914
Genitourinary	7528
Gynecological	7627
Hard and soft tissue	9918
Muscle	5327
Respiratory	6819
Skin	7818
Nephritis, chronic	7502
Nephrolithiasis	7508
Nephrosclerosis, arteriolar	7507
Neuralgia:	
Cranial Nerves	
Fifth (trigeminal)	8405
Seventh (facial)	8407
Ninth (glossopharyngeal)	8409
Tenth (pneumogastric, vagus)	8410
Eleventh (spinal accessory, external branch)	8411
Twelfth (hypoglossal)	8412
Peripheral Nerves	
Upper radicular group	8710
Middle radicular group	8711
Lower radicular group	8712
All radicular groups	8713
Musculospiral (radial)	8714
Median	8715
Ulnar	8716
Musculocutaneous	8717
Circumflex	8718
Long thoracic	8719
Sciatic	8720
External popliteal (common peroneal)	8721
Musculocutaneous (superficial peroneal)	8722
Anterior tibial (deep peroneal)	8723
Internal popliteal (tibial)	8724
Posterior tibial	8725
Anterior crural (femoral)	8726
Internal saphenous	8727
Obturator	8728
External cutaneous nerve of thigh	8729
Ilio-inguinal	8730
Neuritis:	
Cranial nerves	
Fifth (trigeminal)	8305
Seventh (facial)	8307
Ninth (glossopharyngeal)	8309
Tenth (pneumogastric, vagus)	8310
Eleventh (spinal accessory, external branch)	8311
Twelfth (hypoglossal)	8312
Optic	6026
Peripheral Nerves	
Upper radicular group	8610
Middle radicular group	8611
Lower radicular group	8612
All radicular groups	8613
Musculospiral (radial)	8614
Median	8615
Ulnar	8616
Musculocutaneous	8617
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Musculocutaneous (superficial peroneal)	8622
Anterior tibial (deep peroneal)	8623
Internal popliteal (tibial)	8624
Posterior tibial	8625
Anterior crural (femoral)	8626
Internal saphenous	8627
Obturator	8628

	Diagnostic code No.
External cutaneous nerve of thigh	8629
Ilio-inguinal	8630
Neurogenic bladder	7542
New growths:	
Benign	
Bones	5015
Brain	8003
Eye, orbit, and adnexa	6015
Spinal cord	8022
Malignant	
Bones	5012
Brain	8002
Eye, orbit, and adnexa	6014
Spinal cord	8021
Nocardiosis	6823
Non-Hodgkin's lymphoma	7715
Nonunion:	
Mandible, confirmed by diagnostic imaging studies	9903
Radius and ulna	5210
Nystagmus, central	6016
Osteitis deformans	5016
Osteomalacia	5014
Osteomyelitis	5000
Osteoporosis, with joint manifestations	5013
Otitis media:	
Externa	6210
Nonsuppurative	6201
Suppurative	6200
Otosclerosis	6202
Ovaries, atrophy of both	7620
Ovary:	
Disease or injury	7615
Removal	7619
Palsy, bulbar	8005
Pancreatitis	7347
Papillary necrosis	7538
Papulosquamous disorders	7822
Paralysis:	
Accommodation	6030
Agitans	8004
Paralysis, nerve:	
Cranial nerves	
Fifth (trigeminal)	8205
Seventh (facial)	8207
Ninth (glossopharyngeal)	8209
Tenth (pneumogastric, vagus)	8210
Eleventh (spinal accessory, external branch)	8211
Twelfth (hypoglossal)	8212
Peripheral Nerves:	
Upper radicular group	8510
Middle radicular group	8511
Lower radicular group	8512
All radicular groups	8513
Musculospiral (radial)	8514
Median	8515
Ulnar	8516
Musculocutaneous	8517
Circumflex	8518
Long thoracic	8519
Sciatic	8520
External popliteal (common peroneal)	8521
Musculocutaneous (superficial peroneal)	8522
Anterior tibial nerve (deep peroneal)	8523
Internal popliteal (tibial)	8524
Posterior tibial nerve	8525
Anterior crural nerve (femoral)	8526
Internal saphenous	8527
Obturator	8528
External cutaneous nerve of thigh	8529
Ilio-inguinal	8530
Paramyoclonus multiplex	8104
Parasitic disease	6320
Pellagra	6315

	Diagnostic code No.
Penis	
Deformity, with loss of erectile power	7522
Removal of glans	7521
Removal of half or more	7520
Pericardial adhesions	7003
Pericarditis	7002
Periostitis	5022
Peripheral vestibular disorders	6204
Peritoneum, adhesions	7301
Peritonitis	7331
Pes cavus (Claw foot) acquired	5278
Pheochromocytoma	7918
Plague	6307
Pleural effusion or fibrosis	6845
Pluriglandular syndrome	7912
Pneumoconiosis	6832
Pneumonitis & fibrosis:	
Drug-induced	6829
Radiation-induced	6830
Poliomyelitis, anterior	8011
Polycythemia vera	7704
Polyglandular syndrome	7912
Post-chiasmal disorders	6046
Postgastrectomy syndromes	7308
Post-phlebitic syndrome	7121
Post-surgical residual	6844
Progressive muscular atrophy	8023
Prostate gland	7527
Prosthetic Implants:	
Ankle replacement	5056
Elbow replacement	5052
Hip replacement	5054
Knee replacement	5055
Shoulder replacement	5051
Wrist replacement	5053
Psoriasis	7816
Pterygium	6034
Ptosis	6019
Pulmonary:	
Alveolar proteinosis	6827
Vascular disease	6817
Pruritus ani	7337
Pyelonephritis, chronic	7504
Raynaud's syndrome	7117
Rectum:	
Rectum & anus, stricture	7333
Prolapse	7334
Removal:	
Cartilage, semilunar	5259
Coccyx	5298
Gall bladder	7318
Kidney	7500
Penis glans	7521
Penis half or more	7520
Ribs	5297
Testis	7524
Ovary	7619
Uterus	7618
Uterus and both ovaries	7617
Renal:	
Amyloid disease	7539
Disease, chronic	7530
Involvement in systemic diseases	7541
Tubular disorders	7532
Retina detachment of	6008
Retinal dystrophy (including retinitis pigmentosa, wet or dry macular degeneration, early-onset macular degeneration, rod and/or cone dystrophy)	6042
Retinopathy, diabetic	6040
Retinopathy or maculopathy not otherwise specified	6006
Rhinitis:	
Allergic or vasomotor	6522
Bacterial	6523
Granulomatous	6524

	Diagnostic code No.
Resection of intestine:	
Large	7329
Small	7328
Sarcoidosis	6846
Scarring alopecia	7830
Scars:	
Burn scar(s) of the head, face, or neck; scar(s) of the head, face, or neck due to other causes; or other disfigurement of the head, face, or neck	7800
Burn scar(s) or scar(s) due to other causes, not of the head, face, or neck that are associated with underlying soft tissue damage	7801
Burn scar(s) or scar(s) due to other causes, not of the head, face, or neck that are not associated with underlying soft tissue damage	7802
Retina	6011
Scars, other; and other effects of scars evaluated under diagnostic codes 7800, 7801, 7802, or 7804	7805
Unstable or painful	7804
Sinusitis:	
Ethmoid	6511
Frontal	6512
Maxillary	6513
Pansinusitis	6510
Sphenoid	6514
Sleep Apnea Syndrome	6847
Soft tissue sarcoma:	
Muscle, fat, or fibrous connected	5329
Neurogenic origin	8540
Vascular origin	7123
Spinal fusion	5241
Spinal stenosis	5238
Spleen, injury of, healed	7707
Splenectomy	7706
Spondylolisthesis or segmental instability, spine	5239
Stomach, stenosis of	7309
Symblepharon	6091
Syndromes:	
Chronic Fatigue Syndrome (CFS)	6354
Cushing's	7907
Meniere's	6205
Raynaud's	7117
Sleep Apnea	6847
Synovitis	5020
Syphilis	6310
Syphilis:	
Cerebrospinal	8013
Meningovascular	8014
Syphilitic heart disease	7004
Syringomyelia	8024
Tabes dorsalis	8015
Tarsal or metatarsal bones	5283
Tenosynovitis	5024
Testis:	
Atrophy, complete	7523
Removal	7524
Thrombocytopenia	7705
Thrombosis, brain	8008
Thyroid gland:.	
Nontoxic thyroid enlargement	7902
Toxic thyroid enlargement	7901
Thyroiditis	7906
Tic, convulsive	8103
Tinnitus, recurrent	6260
Toxic nephropathy	7535
Traumatic brain injury residuals	8045
Traumatic chest wall defect	6843
Tuberculosis:	
Adenitis	7710
Bones and joints	5001
Eye	6010
Kidney	7505
Luposa (lupus vulgaris)	7811
Miliary	6311
Pleurisy, active or inactive	6732
Pulmonary:	
Active, far advanced	6701

	Diagnostic code No.
Active, moderately advanced	6702
Active, minimal	6703
Active, advancement unspecified	6704
Active, chronic	6730
Inactive, chronic	6731
Inactive, far advanced	6721
Inactive, moderately advanced	6722
Inactive, minimal	6723
Inactive, advancement unspecified	6724
Tuberculosis luposa (lupus vulgaris)	7811
Tympanic membrane	6211
Typhus, scrub	6317
Ulcer:	
Duodenal	7305
Gastric	7304
Marginal	7306
Ureter, stricture of	7511
Ureterolithiasis	7510
Urethra.	
Fistula	7519
Stricture	7518
Urticaria, chronic.	7825
Uterus:	
And both ovaries, removal	7617
Disease or injury	7613
Prolapse	7621
Removal	7618
Uveitis	6000
Vagina, disease or injury	7611
Vagotomy	7348
Valvular heart disease	7000
Varicose veins	7120
Vasculitis, primary cutaneous	7826
Vertebral fracture or dislocation	5235
Visceral Leishmaniasis	6301
Visceroptosis	7342
Vision: *see also* Blindness and Loss of	
One eye 5/200 (1.5/60), with visual acuity of other eye:	
5/200 (1.5/60)	6071
10/200 (3/60); 15/200 (4.5/60); 20/200 (6/60)	6072
20/100 (6/30); 20/70 (6/21); 20/50 (6/15)	6073
20/40 (6/12)	6074
One eye 10/200 (3/60), with visual acuity of other eye:	
10/200 (3/60); 15/200 (4.5/60); 20/200 (6/60)	6075
20/100 (6/30); 20/70 (6/21); 20/50 (6/15)	6076
20/40 (6/12)	6077
One eye 15/200 (4.5/60), with visual acuity of other eye:	
15/200 (4.5/60) or 20/200 (6/60)	6075
20/100 (6/30); 20/70 (6/21); 20/50 (6/15)	6076
20/40 (6/12)	6077
One eye 20/200 (6/60), with visual acuity of other eye:	
20/200 (6/60)	6075
20/100 (6/30); 20/70 (6/21); 20/50 (6/15)	6076
20/40 (6/12)	6077
One eye 20/100 (6/30), with visual acuity of other eye: and other eye:	
20/100 (6/30); 20/70 (6/21); 20/50 (6/15)	6078
20/40 (6/12)	6079
One eye 20/70 (6/21), with visual acuity of other eye:	
20/70 (6/21) or 20/50 (6/15)	6078
20/40 (6/12)	6079
One eye 20/50 (6/15), with visual acuity of other eye:	
20/50 (6/15)	6078
20/40 (6/12)	6079
Each eye 20/40 (6/12)	6079
Vitiligo	7823
Vulva or clitoris, disease or injury of	7610
Weak foot	5277

[72 FR 13003, Mar. 20, 2007, as amended at 73 FR 54708, 54712, Sept. 23, 2008; 73 FR 69554, Nov. 19, 2008; 74 FR 18467, Apr. 23, 2009; 77 FR 6467, Feb. 8, 2012; 79 FR 45103, Aug. 4, 2014; 82 FR 36085, Aug. 3, 2017; 82 FR 50807, Nov. 2, 2017; 83 FR 15073, Apr. 9, 2018; 83 FR 15323, Apr. 10, 2018; 83 FR 32601, July 13, 2018; 83 FR 54259, Oct. 29, 2018]

EFFECTIVE DATE NOTE: At 84 FR 28234, June 18, 2019, appendix C to part 4 was amended by adding in alphabetical order an entry for ''Campylobacter jejuni infection'', removing the entry for ''Cholera, Asiatic'', adding in alphabetical order entries for ''Coxiella burnetii infection (Q Fever)'', ''Hemorrhagic fevers, including dengue, yellow fever, and others'', and ''Hyperinfection syndrome or disseminated strongyloidiasis'', removing the entry for ''Lymphatic filariasis'', adding in alphabetical order entries for ''Lymphatic filariasis, to include elephantiasis'', ''Nontuberculosis mycobacterium infection'', ''Nontyphoid salmonella infection'', ''Rickettsial, erlichial, and Anaplasma infections'', ''Schistosomiasis'' and ''Shigella infections'', removing the entry for ''Typhus, scrub''; and adding in alphabetical order entries for ''Vibriosis (Cholera, Non-cholera)'' and ''West Nile virus infection'', effective Aug. 11, 2019. For the convenience of the user, the added text is set forth as follows:

APPENDIX C TO PART 4—ALPHABETICAL INDEX OF DISABILITIES

	Diagnostic code No.
* * * * * *	*
Campylobacter jejuni infection	6330
* * * * * *	*
Coxiella burnetii infection (Q Fever)	6331
* * * * * *	*
Hemorrhagic fevers, including dengue, yellow fever, and others	6329
* * * * * *	*
Hyperinfection syndrome or disseminated strongyloidiasis	6325
* * * * * *	*
Lymphatic filariasis, to include elephantiasis	6305
* * * * * *	*
Nontuberculosis mycobacterium infection	6312
Nontyphoid salmonella infection	6333
* * * * * *	*
Rickettsial, ehrlichia, and anaplasma Infections	6317
* * * * * *	*
Schistosomiasis	6326
* * * * * *	*
Shigella infections	6334
* * * * * *	*
Vibriosis (Cholera, Non-cholera)	6300
* * * * * *	*
West Nile virus infection	6335

PART 5 [RESERVED]

PART 6—UNITED STATES GOVERNMENT LIFE INSURANCE

AGE

Sec.
6.1 Misstatement of age.

PREMIUMS

6.2 Premium rate.

POLICIES

6.3 Incontestability of United States Government life insurance.

BENEFICIARY OF UNITED STATES GOVERNMENT LIFE INSURANCE

6.4 Proof of age, relationship and marriage.
6.5 Conditional designation of beneficiary.
6.6 Change of beneficiary.
6.7 Claims of creditors, taxation.

OPTIONAL SETTLEMENT

6.8 Selection, revocation and election.

6.9 Election of optional settlement by beneficiary.
6.10 Options.

DIVIDENDS

6.11 How dividends are paid.
6.12 Special dividends.

LOANS

6.13 Policy loans.

CASH VALUE

6.14 Cash value; other than special endowment at age 96 plan policy.
6.15 Cash value; special endowment at age 96 plan policy.
6.16 Payment of cash value in monthly installments.

INDEBTEDNESS

6.17 Collection of any indebtedness.

TOTAL PERMANENT DISABILITY BENEFITS

6.18 Other disabilities deemed to be total and permanent.

DEATH BENEFITS

6.19 Evidence to establish death of the insured.

DETERMINATION OF LIABILITY UNDER SECTIONS 302 AND 313, WORLD WAR VETERANS' ACT, 1924, SECTIONS 607 AND 602(v)(2), NATIONAL SERVICE LIFE INSURANCE ACT, 1940, AS AMENDED, AND SECTIONS 1921 AND 1957 OF TITLE 38, UNITED STATES CODE

6.20 Jurisdiction.

APPEALS

6.21 Guardian: definition and authority.

AUTHORITY: 38 U.S.C. 501, 1940–1963, 1981–1988, unless otherwise noted.

AGE

§ 6.1 Misstatement of age.

If the age of the insured under a United States Government life insurance policy has been understated, the amount of the insurance payable under the policy shall be such exact amount as the premium paid would have purchased at the correct age; if overstated, the excess of premiums paid shall be refunded without interest. Guaranteed surrender and loan values will be modified accordingly. The age of the insured will be admitted by the Department of Veterans Affairs at any time upon satisfactory proof.

[13 FR 7089, Nov. 27, 1948. Redesignated at 61 FR 29024, June 7, 1996]

PREMIUMS

§ 6.2 Premium rate.

Effective January 1, 1983, United States Government Life Insurance policies, and total disability income provisions, on a premium paying status are paid-up and no premiums are required to maintain such policies and provisions in force.

[48 FR 1960, Jan. 17, 1983. Redesignated and amended at 61 FR 29024, 29025, June 7, 1996]

POLICIES

§ 6.3 Incontestability of United States Government life insurance.

Discharge or release of an insured from military or naval service for the reason of fraudulent enlistment shall not invalidate United States Government life insurance issued on the basis of such service unless the Secretary determines that the insured was mentally or legally incapable of entering into a contract of enlistment. In such case the United States Government life insurance so issued will be canceled as of the effective date of such insurance.

[13 FR 7091, Nov. 27, 1948, as amended at 17 FR 3162, Apr. 10, 1952; 24 FR 7321, Sept. 11, 1959. Redesignated and amended at 61 FR 29024, 29025, June 7, 1996]

BENEFICIARY OF UNITED STATES GOVERNMENT LIFE INSURANCE

§ 6.4 Proof of age, relationship and marriage.

Whenever it is necessary for a claimant to prove age, relationship or marriage, the provisions of 38 U.S.C. 103(c) and Part 3 this chapter will be followed.

[26 FR 1856, Mar. 3, 1961. Redesignated and amended at 61 FR 29024, 29025, June 7, 1996]

§ 6.5 Conditional designation of beneficiary.

If the insured by notice in writing to the Department of Veterans Affairs during his or her lifetime has provided that a designated beneficiary shall be entitled to the proceeds of United States Government life insurance only if such beneficiary shall survive him or her for such period (not more than 30 days), as specified by the insured, no right to the insurance shall vest as to

such beneficiary during that period. In the event such beneficiary fails to survive the specified period, payment of the proceeds of United States Government life insurance will be made as if the beneficiary had predeceased the insured.

[14 FR 7175, Nov. 29, 1949, as amended at 46 FR 57043, Nov. 20, 1981. Redesignated at 61 FR 29024, June 7, 1996]

§6.6 Change of beneficiary.

The insured under United States Government life insurance shall have the right at any time and from time to time and without the consent or knowledge of the beneficiary to change the beneficiary. A change of beneficiary must be made by written notice to the Department of Veterans Affairs over the signature of the insured and shall not be binding on the United States unless received by the Department of Veterans Affairs. A change of beneficiary must be forwarded to the Department of Veterans Affairs by the insured or his or her agent and must contain sufficient information to identify the insured. Whenever practicable, such notices shall be given on forms prescribed by the Department of Veterans Affairs. Upon receipt by the Department of Veterans Affairs, a change of beneficiary shall be deemed effective as of the date the insured signed the written notice. The United States shall be protected in all payments made to the beneficiary last of record and before receipt of notice of a change of beneficiary, and no payments so made shall be paid again to the changed beneficiary. The insured may exercise any right or privilege given under the provisions of a United States Government life insurance policy without the consent of the beneficiary. An original designation of a beneficiary may be made by the last will and testament, but no change of beneficiary may be made by the last will and testament. The provisions of the ''beneficiary'' clause in United States Government life insurance policies are hereby amended accordingly.

[17 FR 11071, Dec. 5, 1952, as amended at 46 FR 57043, Nov. 20, 1981. Redesignated at 61 FR 29024, June 7, 1996]

§6.7 Claims of creditors, taxation.

(a) Effective January 1, 1958, payments of insurance to a beneficiary under a United States Government life insurance policy shall be subject to levy for taxes due the United States by such beneficiary.

(b) The provisions of 38 U.S.C. 5301(b) which entitle the United States to collect by setoff out of benefits payable to any beneficiary under a United States Government life insurance policy do not apply to dividends being held to the credit of the insured for the payment of premiums under the provisions of section 1946 of title 38 U.S.C.

(Authority: 38 U.S.C. 5301)

[23 FR 681, Feb. 1, 1958, as amended at 24 FR 15, Jan. 1, 1959; 24 FR 582, Jan. 27, 1959; 46 FR 57043, Nov. 20, 1981. Redesignated and amended at 61 FR 29024, 29025, June 7, 1996]

OPTIONAL SETTLEMENT

§6.8 Selection, revocation and election.

The insured under a United States Government Life Insurance policy may, upon written notice, select an optional settlement. Such optional settlement may be revoked by written notice. If the insured does not select one of the optional settlements, as set out under the provisions of the policy, the insurance shall be payable in 240 monthly installments unless the beneficiary elects in writing a different option.

[61 FR 29025, June 7, 1996]

§6.9 Election of optional settlement by beneficiary.

If the insured has selected an optional settlement then at the death of the insured the designated beneficiary may elect to receive the proceeds of insurance in installments spread over a greater period of time than that selected by the insured and in accordance with the following provisions.

(Authority: 38 U.S.C. 1952)

(a) If the insured has selected Option 1, the beneficiary may elect to receive payment under Option 2, 3, or 4.

(b) If the insured has selected Option 2 with monthly installments not in excess of 120, the beneficiary may elect to

receive payment in a greater number of installments under Option 2, or may elect to receive payment under Option 3 or 4.

(c) If the insured has selected Option 2 with monthly installments in excess of 120, the beneficiary may elect to receive payment in a greater number of installments under Option 2, or may elect to receive payment under Option 3.

(d) If the insured has selected Option 3, and named no contingent beneficiary, the beneficiary may elect to receive payment under Option 4.

(e) If the insured has selected Option 4, the beneficiary may elect to receive payment under Option 3.

If the insured has selected settlement under Option 1, a beneficiary who has elected to receive payment under Option 2, 3, or 4 may elect to receive the commuted value of any remaining unpaid installments certain (240 less the number paid in case of Option 3, or 120 less the number paid in the case of Option 4): *Provided*, That where the commutation is elected under Option 3 or 4 after payment under such option has commenced, and the beneficiary survives the period certain, such beneficiary shall be entitled to the resumption of monthly installments payable for life in accordance with the monthly income option previously selected by such beneficiary. The entitlement to the resumption of monthly installments will be effective as of the monthly payment date next following the expiration of the period certain. Settlement under any one of the options or payment to the beneficiary of said commuted value under Option 2 or payment of said commuted value under Options 3 and 4 to the beneficiary who does not survive the period certain shall be in full and complete discharge of all liability under the contract. Any other change in the mode of settlement may, within the limitations set forth in paragraphs (a) through (e) of this section, be made by a beneficiary after payment has commenced, provided the change is made within 1 year of the original election and in those instances where Option 3 is changed to Option 1 or 2; or Option 4 is changed to Option 1, 2, or 3, satisfactory proof is submitted to establish that the beneficiary's state of health is the same as it was at time of original election. The effective date of the original election for this purpose will be the date it was delivered to the Department of Veterans Affairs. If such election was forwarded by mail, properly addressed to the Department of Veterans Affairs, the postmark date will be taken as the date of delivery. Such change will be made on the premise that the new election was made initially, and the account will be adjusted accordingly. A condition precedent to any such change will be the repayment of any amount received by the beneficiary in excess of that which would have been due had the new election been made initially.

[32 FR 14274, Oct. 14, 1967, as amended at 48 FR 8069, Feb. 25, 1983. Redesignated and amended at 61 FR 29025, June 7, 1996]

§ 6.10 Options.

Insurance will be payable in one sum only when selected by the insured during his or her lifetime or by his or her last will and testament.

[61 FR 29025, June 7, 1996]

DIVIDENDS

§ 6.11 How dividends are paid.

(a) Regular annual dividends becoming payable on or after December 31, 1958, shall be payable on the date preceding the anniversary of the policy unless the Secretary shall declare them payable on some other date.

(b) If the insured has a National Service Life Insurance policy or policies in force, dividends used to pay premiums in advance will be held to the credit of the insured, unless otherwise directed by the insured.

(c) In the event premiums on more than one policy having the same premium due date are unpaid and the dividend credit of the insured for application to payment of premiums is not sufficient to keep all policies in force, in the absence of instructions to the contrary by the insured, such dividend credit will be applied to pay premiums in such manner as will provide the maximum amount of insurance protection.

(d) Dividend credit of the insured held for payment of premiums as provided in section 1946 of title 38 U.S.C.,

may not be used to satisfy any indebtedness due the United States without the insured's consent. If the insured requests payment of such dividend credit, or any unused portion thereof, in cash, or requests that such credit be left to accumulate on deposit, then any indebtedness due the United States, such as described in §6.7 will be recovered therefrom.

(e) Dividend credit of the insured held for payment of premiums or dividends left to accumulate on deposit may be applied to the payment of premiums in advance on any National Service Life Insurance policy upon written request of the insured made before default in payment of premium. Upon maturity of the policy, any unpaid dividend will be paid to the person(s) currently entitled to receive payments under the policy.

(Authority: 38 U.S.C. 1944)

[24 FR 15, Jan. 1, 1959, as amended at 25 FR 7369, Aug. 5, 1960; 28 FR 12544, Nov. 23, 1963; 32 FR 13927, Oct. 6, 1967; 48 FR 1962, Jan. 17, 1983. Redesignated and amended at 61 FR 29025, June 7, 1996]

§6.12 Special dividends.

Any special U.S. Government Life Insurance dividend that may be declared shall be paid in cash. Such special dividends shall not be accepted to accumulate on deposit or as a dividend credit.

(Authority: 38 U.S.C. 1944)

[36 FR 368, Jan. 12, 1971, as amended at 48 FR 1963, Jan. 17, 1983. Redesignated at 61 FR 29025, June 7, 1996]

LOANS

§6.13 Policy loans.

At any time after the first policy year and upon the execution of a loan agreement satisfactory to the Secretary the United States will lend to the insured on the sole security of his/her United States Government Life Insurance policy any amount which shall not exceed 94 percent of the cash value, and any indebtedness shall be deducted from the amount advanced on such loan. The loan shall bear interest at a rate not to exceed 5 percent per annum, payable annually, and the loan may be repaid in full or in amounts of $5 or more. Failure to pay either the amount of the loan or the interest thereon shall not void the policy unless the total indebtedness shall equal or exceed the cash value thereof. When the amount of the indebtedness equals or exceeds the cash value, the policy shall cease and become void.

(Authority: 38 U.S.C. 1944)

[48 FR 1963, Jan. 17, 1983. Redesignated and amended at 61 FR 29025, June 7, 1996]

CASH VALUE

§6.14 Cash value; other than special endowment at age 96 plan policy.

Provisions for cash value shall become effective at the completion of the first policy year on any plan of United States Government Life Insurance other than the special endowment at age 96 plan policy; all values, reserves, and net single premiums being based on the American Experience Table of Mortality, with interest at the rate of 3½ percent per annum. The cash value shall be the reserve together with any dividend accumulations. For each month after the first policy year the reserve at the end of the preceding policy year shall be increased by one-twelfth of the increase in reserve for the current policy year. Upon written request therefor and upon complete surrender of the insurance with all claims thereunder made by the insured the United States will pay to the insured the cash value of the policy less any indebtedness. Unless otherwise requested by the insured, a surrender will be deemed completed as of the end of the month in which the application for cash surrender is delivered to the Department of Veterans Affairs, or as of the date of the check for the cash value, whichever is later. If the application is forwarded by mail, properly addressed, the postmark date will be taken as the date of delivery.

(Authority: 38 U.S.C. 1944)

[48 FR 1963, Jan. 17, 1983. Redesignated and amended at 61 FR 29025, June 7, 1996]

§6.15 Cash value; special endowment at age 96 plan policy.

Provisions for cash value shall become effective at the completion of the first policy year; all values and net single premiums are as prescribed by the

Secretary and published in VA Pamphlet 90–2A. The cash value at the end of the first policy year and at the end of any policy year thereafter shall be the reserve as set forth in the policy together with any dividend accumulations. For each month after the first policy year the reserve at the end of the preceding policy year shall be increased by one-twelfth of the increase in reserve for the current policy year. Upon written request therefor and upon complete surrender of the insurance with all claims thereunder made by the insured, the United States will pay to the insured the cash value of the policy less any indebtedness, provided the policy has been in force for at least 1 year. Unless otherwise requested by the insured, a surrender will be deemed completed as of the end of the month in which the application for cash surrender is delivered to the Department of Veterans Affairs, or as of the date of the check for the cash value, whichever is later. If the application is forwarded by mail, properly addressed, the postmark date will be taken as the date of delivery. If it is forwarded through military channels, the date the application is placed in military channels will be taken as the date of delivery.

(Authority: 38 U.S.C. 1944)

[48 FR 1963, Jan. 17, 1983. Redesignated at 61 FR 29025, June 7, 1996]

§ 6.16 Payment of cash value in monthly installments.

Effective January 1, 1971, in lieu of payment of cash value in one sum, the insured may elect to receive payment in monthly installments under option 2 as set forth in the insurance contract or as a refund life income option. If the insured dies before the agreed number of monthly installments have been paid, the remaining unpaid monthly installments will be payable to the designated beneficiary in one sum, unless the insured or such beneficiary has elected to continue the installments under the option selected by the insured. If no designated beneficiary survives, the present value of any remaining unpaid installments shall be paid to the estate of the insured, provided such payment would not escheat.

[61 FR 29025, June 7, 1996]

INDEBTEDNESS

§ 6.17 Collection of any indebtedness.

At the maturity of a United States Government life insurance policy by total permanent disability or death, any indebtedness, unless paid off in cash, shall be liquidated by reducing the amount of each monthly installment in the proportion which the indebtedness bears to the commuted value of monthly installments as may then be payable under the policy, excluding dividend accumulations. If the policy is payable in one sum at death, any indebtedness shall be deducted from the amount payable under the policy.

[13 FR 7096, Nov. 27, 1948. Redesignated at 61 FR 29025, June 7, 1996]

TOTAL PERMANENT DISABILITY BENEFITS

§ 6.18 Other disabilities deemed to be total and permanent.

(a) In addition to the conditions specified in 38 U.S.C. 1958, the following also will be deemed to be total and permanent disabilities: Organic loss of speech; permanently helpless or permanently bedridden.

(b) Organic loss of speech will mean the loss of the ability to express oneself, both by voice and whisper, through the normal organs of speech if such loss is caused by organic changes in such organs. Where such loss exists, the fact that some speech can be produced through the use of an artificial appliance or other organs of the body will be disregarded.

[61 FR 29025, June 7, 1996]

DEATH BENEFITS

§ 6.19 Evidence to establish death of the insured.

Whenever a claim is filed on account of the death of a person insured under yearly renewable term insurance or United States Government life insurance, the proof of death shall be established in accordance with the provisions of Part 3 of this chapter.

[26 FR 1856, Mar. 3, 1961. Redesignated and amended at 61 FR 29025, June 7, 1996]

DETERMINATION OF LIABILITY UNDER SECTIONS 302 AND 313, WORLD WAR VETERANS' ACT, 1924, SECTIONS 607 AND 602 (v)(2), NATIONAL SERVICE LIFE INSURANCE ACT, 1940, AS AMENDED, AND SECTIONS 1921 AND 1957 OF TITLE 38 UNITED STATES CODE

§ 6.20 Jurisdiction.

The Insurance Claims Sections are vested with exclusive jurisdiction in determining the liability of the United States and the United States Government Life Insurance Fund for waiver of payment of premiums, payment of total, total permanent disability, and death insurance benefits under United States Government life insurance and to determine the liability of the United States and the National Service Life Insurance Fund for waiver of payment of premiums due to total disability, payment of total disability insurance benefits, and death insurance benefits under National Service life insurance.

(Authority: 38 U.S.C. 1944)

[27 FR 9604, Sept. 28, 1962, as amended at 48 FR 1965, Jan. 17, 1983. Redesignated at 61 FR 29025, June 7, 1996]

APPEALS

§ 6.21 Guardian: definition and authority.

(a) *Definition*. For the purpose of this section, the term *guardian* includes any fiduciary certified by the appropriate Veterans Service Center Manager under § 13.55 of this title to receive benefits in a fiduciary capacity for an insured or beneficiary.

(b) *Authority*. For the purpose of this part, a guardian of an insured or beneficiary shall have authority to: Apply for conversion of a policy or change of plan; reinstate a policy; withdraw dividends held on deposit or credit; select or change a dividend option; obtain a policy loan; cash surrender a policy; authorize a deduction from benefits or allotment from military retired pay to pay premiums; apply for and receive payment of the proceeds on a matured policy; select or change the premium payment option; apply for waiver of premiums; select or change the settlement option for beneficiaries; assign a beneficiary's interest as provided under section 1953 of title 38 U.S.C.

(Authority: 38 U.S.C. 1944)

[56 FR 9627, Mar. 7, 1991. Redesignated at 61 FR 29025, June 7, 1996, as amended at 71 FR 28586, May 17, 2006]

PART 7—SOLDIERS' AND SAILORS' CIVIL RELIEF

SOLDIERS' AND SAILORS' CIVIL RELIEF ACT AMENDMENTS OF 1942

Sec.
7.2 Certification of military service.
7.3 The policy.
7.4 The premium.
7.5 Application.
7.6 Benefits.
7.7 Maturity.
7.8 Beneficiary or assignee.

AUTHORITY: 50 U.S.C. app. 511, 540–547, unless otherwise noted.

SOURCE: 13 FR 7103, Nov. 27, 1948, unless otherwise noted.

SOLDIERS' AND SAILORS' CIVIL RELIEF ACT AMENDMENTS OF 1942

§ 7.2 Certification of military service.

(a) A statement over the signature of the Commanding Officer or a commissioned officer of equal or higher rank than the insured, on the insured's application, may be accepted as a certification that the insured is a person in the military service.

(b) If the insured is unavailable because of service, the application may be certified by the person who has custody of the insured's service record.

(c) If an application is submitted by a person designated by the insured or by the insured's beneficiary, the Department of Veterans Affairs will obtain from the service department evidence that the insured is a person in the military service.

(Authority 50 U.S.C. app. 547)

[61 FR 29026, June 7, 1996]

§ 7.3 The policy.

(a) Any provision in a policy that may limit or eliminate a benefit other than the primary death benefit will not, because of such provision, place the policy outside the protection of the Act if it is otherwise eligible for protection.

(b) An annuity contract, if it provides payment of a substantial death benefit in the nature of life insurance, may be included within the provisions of the Act if otherwise eligible. Group insurance will not be included unless an individual and separate contract of insurance is completely released to the insured and thereafter comes within the provisions of the Act as a policy.

(c) The phrase *Face amount of insurance* as used in the regulations in this part will mean the amount of insurance payable as a death benefit; *Provided*, That any indebtedness, or any accruals (such as paid-up additions, dividend accumulations, etc.) that may be added to or taken from the amount payable as the death benefits will not be used in calculating the face amount of a policy.

[13 FR 7103, Nov. 27, 1948, as amended at 21 FR 7297, Sept. 25, 1956. Redesignated and amended at 61 FR 29026, June 7, 1996]

§ 7.4 The premium.

The term premium as defined under 50 U.S.C. app. 540(b) shall include membership dues and assessments in an association.

(a) The premium on a policy will be calculated on an annual basis, and if the annual premium is not stated on the policy, the insurer will make a calculation of the premiums for payment in advance and discounted at not less than 3½ percent, subject to approval by the Department of Veterans Affairs.

(b) Premiums will not be guaranteed for benefits additional to the primary death benefit if, when combined with the amount of the primary death benefit, the total benefit would result in a payment in excess of $10,000 or if liability for such benefits is excluded or restricted by military service or any activity which the insured may be called upon to perform in connection with military service. In the event that premiums for the primary and additional benefits are not separable under the terms of the policy the entire policy will be guaranteed, if the policy is otherwise eligible for protection under the law.

[13 FR 7103, Nov. 27, 1948. Redesignated and amended at 61 FR 29026, June 7, 1996]

§ 7.5 Application.

(a) The benefits of the Act are not available except upon application. The insured may designate any person, firm, or corporation to submit an application on his or her behalf. The designation must be in writing, signed by the insured and attached to the application.

(b) When an application for benefits is received by an insurer, a report thereof will be made within 30 days to the Department of Veterans Affairs Regional Office and Insurance Center at Philadelphia, Pennsylvania. The insurer may submit with the report a statement setting forth any additional information deemed necessary to the adjudication of the application, and any facts and reasoning as to why the policy should or should not be protected under the Act.

[13 FR 7103, Nov. 27, 1948, as amended at 26 FR 11802, Dec. 8, 1961; 27 FR 656, Jan. 23, 1962. Redesignated and amended at 61 FR 29026, June 7, 1996]

§ 7.6 Benefits.

Any policy found to be entitled to protection under the provisions of the Act will not lapse or otherwise terminate or be forfeited for the nonpayment of a premium or the nonpayment of any indebtedness or interest during the period of military service of the insured and two years after the expiration of such service. If the insured reenters military service during the two-year period following separation from such service and the policy is under the protection of the Act on the date of reentry, such reentrance shall be deemed to be a continuation of the previous military service. In such case, in the absence of written instruction from the insured to the contrary, the protection under the Act will continue during the period of military service of the insured and two years after the expiration of such service, but the guarantee will not extend for more than two years after the date when the Act ceases to be in force.

(a) For the period during which a policy is protected by the provisions of the Act, any dividends, return of premiums, or other such monetary benefits arising out of the contract or by reason thereof, will be held subject to

disposal or to be applied as may be approved by the Department of Veterans Affairs.

(b) A policy will not be removed from the protection of the Act by reason of a payment made to the insurer by or on behalf of the insured, but any tender of a premium (in whole or in part) shall be applied on the indebtedness established under authority of the Act against the policy: *Provided*, That nothing herein shall prevent an insured from continuing payment to the insurer of premiums to cover any additional benefits (such as double indemnity, waiver of premium, etc.) where such premiums may not be included in the amount guaranteed by the Government.

[13 FR 7103, Nov. 27, 1948, as amended at 27 FR 2287, Mar. 9, 1962. Redesignated and amended at 61 FR 29026, June 7, 1996]

§ 7.7 Maturity.

(a) The phrase *maturity of a policy as a death claim or otherwise* (SSCRA, as amended) will not include a termination or maturity of a policy as a disability claim, and the policy will continue under the provisions of the Act as if there had been no maturity, but the Government shall not be liable for any premiums that the insured would have been relieved of paying under any provisions for payment of premiums in the policy.

(b) Upon the expiration of the period of protection, the insurer will submit to the Department of Veterans Affairs a complete statement of the account on each policy, which will show the amount of indebtedness by reason of the premiums with interest and the credits, if any, then available and will be subject to audit and approval by the Department of Veterans Affairs. The statement of account will include the rate of interest charged on all indebtedness, the date of debit and credit entries, and such other information as may be deemed necessary in making an audit of the account.

[13 FR 7103, Nov. 27, 1948, as amended at 27 FR 656, Jan. 23, 1962. Redesignated and amended at 61 FR 29026, June 7, 1996]

§ 7.8 Beneficiary or assignee.

The consent of a beneficiary, assignee, or any other person who may have a right or interest in the proceeds of the policy is not a prerequisite for placing a policy under the protection of the Act.

[61 FR 29026, June 7, 1996]

PART 8—NATIONAL SERVICE LIFE INSURANCE

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8.30 Review of Decisions and Appeal to Board of Veterans' Appeals.
8.31 Total disability for twenty years or more.
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AUTHORITY: 38 U.S.C. 501, 1901–1929, 1981–1988, unless otherwise noted.

APPLICATIONS

§ 8.0 Definitions of terms used in connection with title 38 CFR, part 8, National Service Life Insurance.

(a) *What does the term ''good health'' mean?* The term *good health* means that the applicant is, from clinical or other evidence, free from any condition that would tend to:

(1) Weaken normal physical or mental functions; or

(2) Shorten life.

NOTE TO PARAGRAPH (a): Conditions that would affect ''good health'' are diseases or injuries or residuals of diseases or injuries. A ''residual'' is a disability that remains following the original disease or injury.

(b) *What does the term ''good health criteria'' mean?* The term *good health criteria* means the underwriting standards that determine whether a person is in good health. ''Good health criteria'' are based whenever possible, as far as practicable, on general insurance usage. ''Underwriting'' is the process that sets the terms, conditions, and prices for an insurance policy, by rating an applicant's mortality risk.

(c) *What does the term ''organic loss of speech'' mean?* The term *organic loss of speech* means the loss of the ability to express oneself, both by voice and whisper, through the normal organs of speech if the loss is caused by physical changes in such organs. The fact that some speech can be produced through the use of artificial appliance or other organs of the body will not impact this definition.

(d) *What does the term ''disease or injury traceable to the extra hazards of the military service'' mean?* The term *disease or injury traceable to the extra hazards of the military service* means a disease or injury that was either caused by or can be traced back to the performance of duty in the active military, naval, or air service.

(e) *What does the term ''guardian'' mean?* The term *guardian* means any representative certified by the appropriate Veterans Service Center Manager, under § 13.55 of this chapter, to receive benefits in a fiduciary capacity

on behalf of the insured or the beneficiary, or to take the actions listed in § 8.32.

[67 FR 54738, Aug. 26, 2002]

EFFECTIVE DATE

§ 8.1 Effective date for an insurance policy issued under section 1922(a) of title 38 U.S.C. (Service-Disabled Veterans' Insurance).

(a) *What is the effective date of the policy?* The effective date is the date policy coverage begins. Benefits due under the policy are payable any time after the effective date.

(b) *How is the effective date established?* The effective date is the date you deliver both of the following to VA:

(1) A valid application.

(2) A premium payment.

NOTE 1 TO PARAGRAPH (b): If your valid application and premium are mailed to VA, the postmark date will be the date of delivery.

NOTE 2 TO PARAGRAPH (b): If a postmark date is not available, the date of delivery will be the date your valid application and premium are received by VA.

(c) *Can you have a different effective date?* Yes, if you would like an effective date other than the date of delivery as described in paragraph (b) of this section, you may choose one of the following three options as an effective date:

(1) The first day of the month in which you deliver your valid application and premium payment to VA. For example, if VA receives your application and premium payment on August 15, you may request an effective date of August 1.

(2) The first day of the month following the month in which you deliver your valid application and premium payment. For example, if VA receives your application and premium payment on August 15, you may request an effective date of September 1.

(3) The first day of any month up to six months prior to the month in which you deliver your valid application and premium payment. For example, if VA receives your application and premium payment on August 15, you may request an effective date of February 1 or the first day of any month following up to August 1. However, you must pay the following:

(i) The insurance reserve amount for the time period for each month starting with the requested effective date up to the first day of the month prior to the month in which you delivered your application to VA; and

(ii) The premium for the month in which you delivered your application to VA.

NOTE TO PARAGRAPH (c): For example, if your postmark date is August 15 and you request an effective date of February 1, you must pay the insurance reserve amount for February 1 through July 31, and also pay the August premium.

[67 FR 54738, Aug. 26, 2002]

PREMIUMS

§ 8.2 Payment of premiums.

(a) *What is a premium?* A premium is a payment that a policyholder is required to make for an insurance policy.

(b) *How can policyholders pay premiums?* Premiums can be paid by:

(1) Cash, check, or money order directly to VA.

(2) Allotment from service or retirement pay.

(3) Automatic deduction from VA benefits (pension, compensation or insurance dividends (see § 8.4)).

(4) Pre-authorized debit from a checking account.

(c) *When should policyholders pay premiums?* (1) Unless premiums are paid in advance, policyholders must pay premiums on the effective date shown on the policy and on the same date of each following month. This is called the ''due date.''

(2) Policyholders may pay premiums quarterly, semi-annually, or annually in advance.

(d) *What happens if a policyholder does not pay a premium on time?* (1) When a policyholder pays a premium within 31 days from the ''due date,'' the policy remains in force. This 31-day period is called a ''grace period.'' If the insured dies within the 31-day grace period, VA deducts the unpaid premium from the amount of insurance payable.

(2) If a policyholder pays a premium after the 31-day grace period, VA will not accept the payment and the policy lapses effective the date the premium

was due; Except that VA will accept a premium paid after the 31-day grace period as a timely payment if:

(i) The policyholder pays the premium within 61 days of the due date; and

(ii) The policyholder is alive at the time the payment is mailed.

(3) When a policyholder pays the premium by mail, the postmark date is the date of payment.

(4) When a policyholder pays a premium by check or money order which is not honored and it is shown by satisfactory evidence that:

The bank did not pay the check or money order because of:	Then:
An error by the bank	The policyholder has an additional 31 days (from the date stamped on VA's notification letter) to pay the premium and any other premiums due through the current month.
An error in the check or money order	The policyholder has an additional 31 days (same as above).
Lack of funds	The premium is considered not paid.

[65 FR 7437, Feb. 15, 2000]

§ 8.3 Revival of insurance.

(a) If the sole reason death or total disability benefits under a policy of National Service life insurance cannot be granted is that the policy had lapsed, the insurance will be considered in force under premium-paying conditions on the date of death or the date of commencement of total disability if,

(1) On the date of lapse there were accrued dividends, not then payable, resulting from premiums paid since the last anniversary date of the policy and such dividends were equal to or greater in amount than the total of the monthly premiums which have become due from and including the date of lapse to the date of death or date of commencement of total disability, and/or

(2) At the end of the grace period for the unpaid premium causing lapse there were due and payable to the policyholder unpaid dividends, refundable premiums, pure insurance risk credits, other refundable credits or total disability benefit payments arising from the policyholder's U.S. Government or National Service life insurance which are equal to or greater in amount than the total of the monthly premiums which have become due from and including the date of lapse to the date of death or date of commencement of total disability.

(3) For purposes of this section amounts under paragraphs (a)(1) and (2) of this section may be combined. In that case, the amount, if any, of dividend accrued under paragraph (a)(1) of this section will first be determined and the amount available under paragraph (a)(2) of this section, if any, will be added thereto for the purpose of determining if the total amount thus available is equal to or greater than the total of monthly premiums which have become due.

(4) In determining the amount of monthly premiums which have become due under paragraphs (a)(1) and (2) of this section a shortage of 10 percent per monthly premium may be allowed for a period not to exceed 3 months.

(5) In determining the monthly premiums which have become due for adjustment purposes under paragraphs (a)(1) and (2) of this section, the premium for the monthly due date immediately preceding the date of death or date of commencement of total disability may be omitted because of the coverage provided by the allowable grace period (§ 8.2(d)) and if the conditions of paragraph (b) of this section are met, the premium for the second due date immediately preceding the date of death or date of commencement of total disability may be omitted.

(6) When a policy is deemed in force under premium-paying conditions by operation of this section, the amount of any shortage included in the calculation and the premium for any monthly due date omitted in the calculation will become a lien against the policy.

(7) The provisions of this section may be applied if, on the date of death, the insurance is in force under the extended term insurance provision (§ 8.14) and a policy loan was outstanding on the date of lapse or a dividend deposit

balance was included in the cash value as determined at time of lapse.

(8) If accrued dividends under paragraph (a)(1) of this section and/or amounts due and payable under paragraph (a)(2) of this section exist in connection with more than one policy of the same veteran and one or more policies lapsed prior to the date of death or date of commencement of total disability, the amounts available will be related first to the policy or policies on which they arose if such policy or policies are lapsed. Any amount available under paragraphs (a)(1) and (2) of this section which is not required to place in force the policy upon which it arose or which is insufficient to place in force the policy upon which it arose, may be combined with similar amounts available on any other policy whenever the total of such amounts is sufficient to place another policy in force.

(9) Where more than one policy is involved and credits are not needed or are insufficient to revive the policy on which the credits arose, the credits will be used insofar as they are sufficient to revive the policy or policies under which the most insurance is payable.

(10) No total disability income provision will be considered in force under this section unless it lapsed at the same time as the life insurance contract and both the life insurance and total disability income provision can be considered in force through the same date and benefits are payable under the total disability income provision. An exception will be a paid-in-full limited pay contract on which total disability income provision premiums are due and payable to age 65.

(11) When a total disability income provision lapsed at the same time as the life insurance, the premium for the provision will be considered separately in determining if the amounts available are equal to or in excess of the monthly premiums which have become due. In such a case if the amounts available are sufficient, both the life insurance and the provision will be revived. If the amounts are insufficient for that purpose, they will be applied to revive the policy or policies with the greatest amount payable in death cases or the policy or policies providing the greatest life insurance and total disability benefit in total disability cases.

(12) Accrued dividends and/or credits on any policy of National Service or U.S. Government life insurance held by the policyholder may be considered for the purpose of this section.

(b) If the sole reason death or total disability benefits under a policy of National Service life insurance cannot be granted is that the policy had lapsed, the insurance will be considered in force on the date of death or date of commencement of total disability if,

(1) The policyholder died or became totally disabled within 61 days of the due date of the unpaid premiums, and

(2) The policy prior to the lapse had been in force for 5 years or more. In determining in-force status under this subparagraph if the original effective date of the insurance (when necessary, include predecessor contracts involving renewal, conversion or replacement/reinstatement under 38 U.S.C. 1981) is 5 years or more earlier than the date of death or date of total disability and during the 5 years immediately preceding the date of lapse the insurance has not been lapsed at any one time in excess of 6 months, the requirement will be satisfied. When insurance is considered in force under this section the amount of the monthly premium due on the date of lapse and the following monthly premium(s) will become a lien against the policy.

(3) The provisions of this section may be applied if, on the date of death, the insurance is in force under the extended term insurance provision (§ 8.14) and a policy loan was outstanding on the date of lapse or a dividend deposit balance was included in the cash value as determined at time of lapse.

[33 FR 17915, Dec. 3, 1968. Redesignated and amended at 61 FR 29290, 29291, June 10, 1996. Redesignated at 65 FR 7437, Feb. 15, 2000; 65 FR 19658, Apr. 12, 2000]

§ 8.4 Deduction of insurance premiums from compensation, retirement pay, or pension.

The insured under a National Service life insurance policy which is not lapsed may authorize the monthly deduction of premiums from disability compensation, death compensation, dependency and indemnity compensation,

retirement pay, disability pension, or death pension that may be due and payable to him under any laws administered by the Department of Veterans Affairs in accordance with the following provisions.

(a) The authorization may be made by an insured or the insured's legal representative. If the authorization is made by the insured's legal representative, it must be in writing over the signature of the representative and forwarded to the Department of Veterans Affairs along with a copy of the document which evidences the individual's authority to act on behalf of the insured. If an insured is incompetent and has no legal representative and has a spouse to whom benefits are being paid pursuant to Part 13 of this chapter, the spouse may authorize payment of insurance premiums through the deduction system. If an insured is incompetent and has no legal representative and an institutional award has been made in his or her behalf, the authorization may be executed by the Director of the field facility in which the insured is hospitalized or receiving domiciliary care, and in appropriate cases by the chief officers of State hospitals or other institutions to whom similar awards may have been approved.

(b) The monthly disability compensation, death compensation, dependency and indemnity compensation, retirement pay, disability pension, or death pension so due and payable must be equal to, or in excess of, the amount of the insurance premium figured on a monthly basis.

(c) The authorization may be cancelled by the insured at any time. Such cancellation will be effective on the first day of the month following the month in which it is received by the Department of Veterans Affairs.

(d) If the benefits payable to the insured are apportioned under the regulations of the Department of Veterans Affairs now in effect or hereafter issued, the deduction authorized by the insured shall be from that portion awarded to the insured under such regulations.

(e) The deduction authorized by a policyholder issued insurance under 38 U.S.C. 1925 will be automatically adjusted by the Department of Veterans Affairs to take cognizance of any premium adjustment made by the Secretary on such insurance provided the benefit payments due and payable to the insured are of an amount sufficient to pay the monthly insurance premium.

(Authority: 38 U.S.C. 1908)

[13 FR 7110, Nov. 27, 1948, as amended at 14 FR 5241, Aug. 24, 1949; 24 FR 7327, Sept. 9, 1959; 28 FR 1542, Feb. 19, 1963; 30 FR 3645, Mar. 19, 1965; 54 FR 46231, Nov. 2, 1989. Redesignated and amended at 61 FR 29290, 29291, June 10, 1996. Redesignated at 65 FR 7437, Feb. 15, 2000]

§ 8.5 Authorization for deduction of premiums from compensation, retirement pay, or pension.

Deductions from benefits for the payment of premiums shall be effective on the month the authorization for such deduction is received by the Department of Veterans Affairs or on any successive month specified by the insured. Such deduction shall be applied to the premium due in the succeeding calendar month and shall continue monthly so long as the benefit payments are due and payable to the insured and the amount is sufficient to pay the premium or until such authorization is revoked by the veteran or otherwise terminated. When premium deductions are authorized by the insured, the premium will be treated as paid for purposes of preventing lapse of the insurance, so long as there is due and payable to the insured a benefit amount sufficient to provide the premium payment. If authorization was executed by the Director of a VA hospital or domiciliary or chief officer of a State hospital or other institution to make deductions from an institutional award, the authorization will cease and terminate at the termination of the institutional award and the insurance shall lapse unless another authorization for deduction from monthly benefit payments is executed by the insured. The insured will be notified by letter directed to the last address of record of the termination of the authorization to deduct premiums, but failure to give such notice shall not prevent lapse.

[61 FR 29291, June 10, 1996. Redesignated at 65 FR 7437, Feb. 15, 2000]

CALCULATION OF TIME PERIOD

§ 8.6 Calculation of time period.

If the last day of a time period specified in §§ 8.2 or 8.3 or allowed for filing an application for National Service life insurance or for applying for reinstatement thereof, or paying premiums due thereon, falls on a Saturday, Sunday, or legal holiday, the time period will be extended to include the following workday.

[33 FR 17916, Dec. 3, 1968. Redesignated and amended at 61 FR 29290, 29291, June 10, 1996. Redesignated at 65 FR 7437, Feb. 15, 2000; 65 FR 19659, Apr. 12, 2000]

REINSTATEMENT

§ 8.7 Reinstatement of National Service Life Insurance except insurance issued pursuant to section 1925 of title 38 U.S.C.

(a) Any policy which lapses and which is not surrendered for a cash value or for paid-up insurance, may be reinstated upon written application signed by the applicant, payment of all premiums in arrears, and evidence of good health as required under § 8.8 (a) or (b), whichever is applicable. If a policy is not reinstated within 6 months from the due date of the premium in default, interest must be paid in addition to premiums for all months in arrears from their respective due dates at the rate of 5 percent per annum, compounded annually. The payment or reinstatement of any indebtedness against a policy must be made upon application for reinstatement, and any excess of indebtedness and interest over the reserve of the policy must be paid at that time. A lapsed National Service Life Insurance policy which is in force under extended term insurance may be reinstated within 5 years from the date extended insurance would expire upon application and payment of all premiums in arrears with the required interest. In any case in which the extended insurance under an endowment policy provides protection to the end of the endowment period, the policy may be reinstated at any time before maturity upon application and payment of the premiums with the required interest. A policy on the level term premium plan may be reinstated within 5 years of the date of lapse upon written application signed by the insured, evidence of insurability and payment of two monthly premiums, one for the month of the lapse, the other for the month of reinstatement.

(b) *Reinstatement of insurance issued under section 1925, title 38 U.S.C.* Any policy of insurance issued under 38 U.S.C. 1925 which has been lapsed for not more than 5 years shall be reinstated under the same provisions of paragraph (a) of this section.

(c) *Effective date of reinstatements.* Reinstatement is effected on the date an acceptable application and the required monetary payments are delivered to the Department of Veterans Affairs. If application for reinstatement is submitted by mail, properly addressed to the Department of Veterans Affairs, the postmark date shall be the date of delivery. The effective date of reinstatement of the insurance shall be the last monthly premium due date prior to the delivery or postmark date of the application for reinstatement, except where reinstatement is effected on the due date of a premium, then in such case that date shall be the reinstatement date.

(d) *Inquiry during the grace period.* When the insured makes inquiry prior to the expiration of the grace period disclosing a clear intent to continue insurance protection, such as a request for information concerning premium rates or conversion privileges, etc., an additional reasonable period not exceeding 60 days may be granted for payment of premiums due; but the premiums in any such case must be paid during the lifetime of the insured.

[61 FR 29291, June 10, 1996. Redesignated at 65 FR 7437, Feb. 15, 2000; 65 FR 19659, Apr. 12, 2000]

§ 8.8 Health requirements.

National Service life insurance on any plan may be reinstated if application and tender of premiums are made:

(a) Within 6 premium months including the premium month for which the unpaid premium was due, provided the applicant be in as good health on the date of application and tender of premiums as he or she was on the last day of the grace period of the premium in

default and furnishes satisfactory evidence thereof.

(b) After expiration of the 6-month period mentioned in paragraph (a) of this section, provided applicant is in good health (§ 8.0) on the date of application and tender of premiums and furnishes satisfactory evidence. If the insurance to be reinstated was issued under 38 U.S.C. 1922(a), 1925(b), or 1925(c) and application is made within 1 year of the date of lapse, any service-connected disability existing at the time the insurance was issued will be waived for the purpose of reinstatement (including natural progression of the condition since time of issuance). If the insurance to be reinstated was issued under 38 U.S.C. 1925(a) and application is made within 1 year of the date of lapse, any nonservice-connected disability, or service-connected disability which combined with a nonservice-connected disability rendered the insured uninsurable as of October 13, 1964, will be waived for the purpose of reinstatement (including natural progression).

[33 FR 365, Jan. 10, 1968, as amended at 33 FR 12002, Aug. 23, 1968; 47 FR 11657, Mar. 18, 1982. Redesignated and amended at 61 FR 29290, 29292, June 10, 1996. Redesignated at 65 FR 7437, Feb. 15, 2000]

§ 8.9 Application and medical evidence.

The applicant for reinstatement of National Service Life Insurance, during his or her lifetime, and within 5 years after the date of lapse if the insurance was issued under 38 U.S.C. 1925, must submit a written application signed by him or her and furnish satisfactory evidence of health as required in § 8.8 at the time of application. Applicant's own statement of comparative health may be accepted as proof of insurability for the purpose of reinstatement under § 8.8(a), but, whenever deemed necessary in any such case, report of physical examination may be required. Applications for reinstatement submitted after expiration of the applicable period mentioned in § 8.8(a) must be accompanied by satisfactory evidence of good health. If the insurance becomes a claim after the tender of the amount necessary to meet reinstatement requirements but before full compliance with the requirements of this section, and the applicant was in a required state of health at the date that he or she made the tender of the amount necessary to meet reinstatement requirements, and that there is satisfactory reason for his or her noncompliance, the Assistant Director for Insurance, VA Center, Philadelphia, Pennsylvania may, if the applicant be dead, waive any or all requirements of this section (except payment of the necessary premiums) or, if the applicant be living, allow compliance with this section as of the date the required amount necessary to reinstate was received by the Department of Veterans Affairs.

(Authority: 38 U.S.C. 1925)

[47 FR 11657, Mar. 18, 1982. Redesignated and amended at 61 FR 29290, 29292, June 10, 1996. Redesignated at 65 FR 7437, Feb. 15, 2000; 65 FR 19659, Apr. 12, 2000]

DIVIDENDS

§ 8.10 How paid.

(a) Except as hereinafter provided in this paragraph, a National Service Life Insurance policy shall participate in and receive such dividends from gains and savings as may be determined by the Secretary of Veterans Affairs. Dividends becoming payable after January 1, 1952, shall be payable on the date preceding the anniversary of the policy unless the Secretary shall declare them payable on some other date. Dividends are not payable on insurance:

(1) Issued or reinstated under the provisions of section 602(c)(2) of the National Service Life Insurance Act, as amended, where the requirements of good health were waived at the time of such issue or reinstatement;

(2) Issued under sections 620 and 621 of the National Service Life Insurance Act, as amended;

(3) Issued under sections 1904(c) and 1922(a) of title 38 U.S.C.;

(Authority: 38 U.S.C. 1923(b) and 725)

(4) Issued on the ordinary life plan under section 1904(d) of title 38 U.S.C., to replace the amount of insurance reduced under a modified life plan policy issued under 38 U.S.C. 1904(c); and

(5) On which premiums are waived, in whole or in part, under the provisions

of section 622 of the National Service Life Insurance Act, as amended, and 38 U.S.C. 1924 for the period during which such premium waiver is in effect.

(b) Unless and until VA receives a written request from the insured that National Service Life Insurance dividends be paid in cash, or that they be used to pay an insurance indebtedness, or that they be placed on deposit or be used to pay premiums in advance, or that they be used to pay the premiums on a particular policy or policies, or that they be used to purchase paid-up additions, any such dividends shall be held to the credit of the insured to be applied to pay monthly premiums becoming due and unpaid after the date such dividends are payable on any National Service or United States Government Life Insurance policy or policies held by the insured: *Provided,* That such dividend credits will be applied as of the due date of any unpaid premium. Dividend credits will earn interest at such rate and in such manner as the Secretary may determine.

(Authority: 38 U.S.C. 1907(a))

(c) In the event premiums on more than one policy having the same premium due date are unpaid and the dividend credit of the insured for application to payment of premiums is not sufficient to keep all policies in force, in the absence of instructions to the contrary by the insured, such dividend credit will be applied to pay premiums in such manner as will provide the maximum amount of insurance protection.

(d) At the expiration of any term period, dividend credit of the insured held for payment of premiums will be applied to pay the required premium for renewal of term insurance unless the insured requests otherwise in writing prior to the expiration of the term period.

(e) A request for payment of dividends in cash or for other disposition will be effective as of the date the request is delivered to the Department of Veterans Affairs: If forwarded by mail, properly addressed, the postmark date will be taken as the date of delivery: If forwarded through military channels by the insured while in military service, the date the request is placed in military channels will be accepted as the date of delivery. Unless otherwise stipulated by the insured, such request will remain in force until revoked in writing signed by the insured and delivered to the Department of Veterans Affairs.

(f) Dividend credit of the insured held for payment of premiums may not be used to satisfy any indebtedness due the United States without the insured's consent. If the insured requests payment of such dividend credit, or any unused portion thereof, in cash, or requests that such credit be left to accumulate on deposit, as provided in paragraph (g) of this section, then any indebtedness due the United States, such as described in §5301 of title 38 U.S.C. will be recovered therefrom.

(g) At the written request of the insured, National Service life insurance dividends may be left to accumulate on deposit at interest which will be credited in such manner and at such rate as the Secretary may determine: *Provided,* That the policy is in force on a basis other than extended term insurance or level premium term insurance. Dividend credit of the insured held for payment of premiums or dividends left to accumulate on deposit as provided in this paragraph may be applied to the payment of premiums in advance upon written request of the insured made before default in payment of a premium. Dividends on deposit under the provisions of this paragraph will be used in addition to the reserve on the policy for the purpose of computing the period of extended term insurance or the amount of paid-up insurance as provided in §§8.14 and 8.15, respectively. Any dividend credit of a person who no longer has insurance in force by payment or waiver of premiums will be paid in cash to such person. If a person has a dividend credit option on a lapsed level premium term policy or a permanent plan policy on which extended term insurance has expired and such person has another policy in force by payment or waiver of premiums, any dividend credit or unpaid dividends on the lapsed policy, in the absence of instructions from the insured to the contrary, will be transferred to the policy which is in force and will be held on such policy as a dividend credit. Such

dividend credit will be deemed to have accrued on the policy which is in force. Upon maturity of the policy, any dividend on deposit, any unpaid dividend payable in cash, and any dividend credit accruing from such policy which cannot be used to pay premiums will be paid to the person currently entitled to receive payments under the policy. If the policy is not in force at death, any such unpaid dividends and dividend credits will be paid to the insured's estate.

(h) Any insured receiving an annual dividend in cash may return such dividend check or an equivalent amount of money in order to have the dividend retained under the deposit or credit option. The return of such dividend must be made during the lifetime of the insured and before the end of the calendar year during which the dividend was paid. Dividends returned under this provision are not available for the payment of premiums, receipt of interest, or calculation of cash value prior to the postmark date of the returned check.

[17 FR 2362, Mar. 19, 1952, as amended at 18 FR 3715, June 30, 1953; 24 FR 5021, June 20, 1959; 25 FR 7369, Aug. 5, 1960; 28 FR 12545, Nov. 23, 1963; 30 FR 3646, Mar. 19, 1965; 32 FR 13927, Oct. 6, 1967; 37 FR 3352, Feb. 15, 1972; 46 FR 57043, Nov. 20, 1981; 50 FR 12252, Mar. 28, 1985. Redesignated and amended at 61 FR 29290, 29292, June 10, 1996. Redesignated at 65 FR 7437, Feb. 15, 2000; 65 FR 19659, Apr. 12, 2000]

CASH VALUE AND POLICY LOAN

§ 8.11 Cash value and policy loan.

(a) Provisions for cash value, paid-up insurance, and extended term insurance, except as provided in § 8.14(b), shall become effective at the completion of the first policy year on any plan of National Service Life Insurance other than the 5-year level premium term plan. The cash value at the end of the first policy year and at the end of any policy year thereafter, for which premiums have been paid in full, shall be the reserve with any dividend accumulations, where applicable.

(b) Upon written request and upon complete surrender of the insurance and all claims thereunder, the United States will pay to the insured the cash value of the policy less any indebtedness, provided the policy has been in force by payment or waiver of the premiums for at least 1 year. Paid-up additions do not have to be in force for 1 year before they have cash values. Unless otherwise requested by the insured, a surrender will be deemed completed as of the end of the premium month in which the application for cash surrender is delivered to the Department of Veterans Affairs, or as of the date of the check for the cash value, whichever is later. If the application is forwarded by mail, properly addressed, the postmark date will be taken as the date of delivery. If it is forwarded through military channels, the date the application is placed in military channels will be taken as the date of delivery.

(c) All values, reserves and net single premiums on participating National Service Life Insurance, other than as provided in paragraph (e) of this section, shall be based on the American Experience Table of Mortality, with interest at the rate of 3 percent per annum. For each month after the first policy year for which month a premium has been paid or waived, the reserve at the end of the preceding policy year shall be increased by one-twelfth of the increase in reserve for the current policy year.

(Authority: 38 U.S.C. 1902, 1906)

(d) All values on insurance, reserves, and net single premiums issued under the provisions of section 1922(a) of title 38 U.S.C., and on modified life and ordinary life plans of insurance issued under section 1904(c), (d), and (e), respectively, shall be based on the Commissioners 1941 Standard Ordinary Table of Mortality with interest at the rate of 2¼ percent per annum. Values between policy years shall be proportionally adjusted.

(Authority: 38 U.S.C. 1904, 1906)

(e) All values on insurance, reserves, and net single premiums issued under the provisions of section 1923(b) of title 38 U.S.C., and on modified life and ordinary life plans of such insurance issued under section 1904 (c), (d), and (e), respectively, shall be based on table X–18 (1950–54 Intercompany Table of Mortality) with interest at the rate of 2½ percent per annum. Values between

policy years shall be proportionally adjusted.

(Authority: 38 U.S.C. 1904, 1923)

(f) All values, reserves, and net single premiums on nonparticipating insurance on which the requirements of good health were waived under the provisions of section 602(c)(2) of the National Service Life Insurance Act, as amended (''H'' Insurance), and on the modified life and ordinary life plans of such ''H'' insurance issued under section 1904 (c), (d), and (e), respectively, of title 38 U.S.C. shall be based on the American Experience Table of Mortality, with interest at the rate of 3 percent per annum. Values between policy years shall be proportionally adjusted. The provisions of the ''Net Cash Value'' clause in National Service Life Insurance policies are hereby amended accordingly.

(g) All values, reserves, and net single premiums on participating modified life and ordinary life plan insurance issued under section 1904 (b), (d), and (e), respectively, of title 38 U.S.C. shall be based on the 1958 Commissioners Standard Ordinary Basic Table of Mortality and interest at the rate of 3 percent per annum. Values between policy years shall be proportionally adjusted.

(h) All values, reserves, and net single premiums on insurance issued under the provisions of section 1925(b) of title 38 U.S.C, and on modified life and ordinary life plans of such insurance issued under section 1904 (c), (d), and (e), respectively, shall be based on the 1958 Commissioners Standard Ordinary Basic Mortality Table and interest at the rate of 3½ percent per annum. Values between policy years shall be proportionally adjusted.

(i) All values, reserves, and net single premiums on insurance issued under the provisions of section 1925(c) of title 38 U.S.C., and on modified life, ordinary life, 20-payment life and 30-payment life plans, where appropriate, of such insurance issued under section 1904 (c), (d), and (e), respectively, shall be based on the American Experience Table of Mortality and interest at the rate of 3½ percent per annum. Values between policy years shall be proportionally adjusted.

(Authority: 38 U.S.C. 1906)

[61 FR 29292, June 10, 1996. Redesignated at 65 FR 7437, Feb. 15, 2000; 65 FR 19659, Apr. 12, 2000]

§8.12 Payment of the cash value of National Service Life Insurance in monthly installments under section 1917(e) of title 38 U.S.C.

(a) Effective January 1, 1971, in lieu of payment of the cash surrender value in one sum the insured may elect to receive payment in monthly installments under option 2 or as a refund life income. If the insured dies before the agreed number of monthly installments have been paid, the remaining unpaid monthly installments will be payable as provided in title 38 U.S.C. 1917. Unless otherwise requested by the insured, a surrender under this section will be deemed completed as of the premium month in which the application for cash surrender is delivered to the Department of Veterans Affairs, or as of the date of the first check released thereunder, whichever is later.

(b) [Reserved]

[36 FR 4384, Mar. 5, 1971. Redesignated and amended at 61 FR 29290, 29292, June 10, 1996. Redesignated at 65 FR 7437, Feb. 15, 2000]

§8.13 Policy loans.

(a) At any time after the premiums for the first policy year have been paid and earned and before default in payment of any subsequent premium, and upon the execution of a loan agreement satisfactory to the Secretary, the United States will lend to the insured on the security of his or her National Service Life Insurance policy, any amount which will not exceed 94 percent of the reserve, and any indebtedness on the policy shall be deducted from the amount advanced on such loan. At any time before default in the payment of the premium, the loan may be repaid in full or in amounts of $5 or more. Failure to pay either the amount of the loan or the interest thereon shall not make the policy voidable unless the total indebtedness shall equal or exceed the cash value. When the amount of the indebtedness equals or exceeds the cash value, the policy shall become voidable. On loans applied for

before the effective date of this regulation (November 2, 1987) and not exchanged pursuant to paragraph (b) of this section, the policy loan interest rate in effect when the loan was applied for shall not be increased for the term of the loan.

(b) Loans applied for or exchanged on and after the effective date of this regulation (November 2, 1987) shall bear interest at a rate which may be varied during the term of the loan, not more frequently than once a year, as provided by paragraphs (c) and (d) of this section. After October 1, 1988, the policy loan rate shall not be varied more frequently than once a year. Notification of the initial rate of interest on new loans will be forwarded at the time the loan is made. Policyholders with existing variable rate loans will be forwarded reasonable advance notice of any increase in the rate. Reasonable advance notice of any change in the variable loan rate will be published in the FEDERAL REGISTER. A notice pertaining to variable loans which is sent to the policyholder's last address of record will constitute sufficient evidence of notice.

(c) Subject to the provisions of paragraph (d) of this section, loan rates established pursuant to paragraph (b) of this section shall equal the yield on the Ten-Year Constant Maturities Index for U.S. Treasury Securities for the month of June of the year of calculation rounded down to the next whole percentage. Such loan rate shall be effective on the date on or after the first day of October on which the rate change is made in the insurance automatic data processing system, and shall remain in effect for not less than one year after the date of establishment. The prevailing variable loan rate shall apply to all loans granted under paragraph (b) of this section.

(d) Notwithstanding any other provisions of this section, the variable loan rate shall not exceed 12 percent or be lower than 5 percent per annum.

(Authority: 38 U.S.C. 1906)

[52 FR 39626, Oct. 2, 1987, as amended at 53 FR 17466, May 17, 1988; 59 FR 65717, Dec. 21, 1994. Redesignated at 61 FR 29290, June 10, 1996. Redesignated at 65 FR 7437, Feb. 15, 2000]

EXTENDED TERM AND PAID-UP INSURANCE

§ 8.14 Provision for extended term insurance—other than 5-year level premium term or limited convertible 5-year level premium term policies.

(a) After the expiration of the first policy year and upon default in the payment of a premium within the grace period, if a permanent plan National Service Life Insurance policy other than the modified life plan has not been surrendered for cash or for paid-up insurance, the policy shall be extended automatically as term insurance. The extended term insurance shall be for an amount of the insurance equal to the face value of the policy less any indebtedness for such time from the due date of the premium in default as the cash value less any indebtedness and a charge for administrative cost for insurance issued under 38 U.S.C. 1925, will purchase when applied as a net single premium at the attained age of the insured. For this purpose the attained age is the age on the birthday anniversary nearest to the effective date of the policy plus the number of years and months from that date to the date the extended term insurance becomes effective. The extended term insurance shall not have a loan value, but shall have a cash value.

(b) Upon default in payment of a premium within the grace period on any permanent plan of National Service Life Insurance other than the modified life plan and any plan of insurance issued under 38 U.S.C. 1925, if the policy has been in force by payment or waiver of premiums for not less than 3 months nor more than 11 months, the policy shall be extended automatically as term insurance. The extended term insurance shall be for an amount of insurance equal to the face value of the policy less any indebtedness for such time from the due date of the premium in default as the reserve of the policy less any indebtedness will purchase when applied as a net single premium at the attained age of the insured. For this purpose the attained age is the age on the birthday anniversary nearest to the effective date of the policy plus the number of months from that date to

the date extended term insurance becomes effective. Extended term insurance under this provision shall not have a cash or loan value. This paragraph shall be effective from and after August 2, 1948.

(c) Upon default in payment of a premium within the grace period, if a modified life plan of National Service Life Insurance has not been surrendered for cash or paid-up insurance and if the policy has been in force by payment or waiver of premiums for not less than 3 months, or for not less than 1 year for insurance issued under 38 U.S.C. 1925, the policy shall be extended automatically as of insurance equal to (1) the Initial Face Amount of Insurance (face amount of policy in force prior to insured's 65th birthday) less any indebtedness, for lapses which occur prior to the insured's 65th birthday, or (2) the Ultimate Face Amount of Insurance (face amount of policy in force on or after insured's 65th birthday) less any indebtedness, for lapses which occur on or after the insured's 65th birthday. The extended term insurance shall be for an amount of insurance equal to:

(i) The initial face amount of insurance (face amount of policy in force prior to the insured's 65th or 70th birthday, depending on the plan of insurance), less any indebtedness, for lapses which occur prior to the insured's 65th or 70th birthday, depending on the plan of insurance, or

(ii) The ultimate face amount of insurance (face amount of policy in force on or after insured's 65th or 70th birthday, depending on the plan of insurance) less any indebtedness, for lapses which occur on or after the insured's 65th or 70th birthday, depending on the plan of insurance. If a modified life plan policy is on extended term insurance at the end of the day preceding the insured's 65th or 70th birthday, depending on the plan of insurance, the amount of extended term insurance in effect under such policy shall be automatically reduced by one-half thereof. If the policy lapsed prior to the end of the first policy year, the extended term insurance shall not have a cash or loan value. If the policy lapsed after the first policy year, the extended term insurance shall not have a loan value, but shall have a cash value.

(Authority: 38 U.S.C. 1906)

[30 FR 3647, Mar. 19, 1965, as amended at 47 FR 11658, Mar. 18, 1982. Redesignated at 61 FR 29290, June 10, 1996. Redesignated at 65 FR 7437, Feb. 15, 2000]

§8.15 Provision for paid-up insurance; other than 5-year level premium term or limited convertible 5-year level premium term policies.

If a National Service Life Insurance policy on any plan other than 5-year level premium term or limited convertible 5-year level premium term plan has not been surrendered for cash, upon written request of the insured and complete surrender of the insurance with all claims thereunder, after the expiration of the first policy year and while the policy is in force under premium-paying conditions, the United States will issue paid-up insurance for such amount as the cash value less any indebtedness, and a charge for administrative cost for insurance issued under 38 U.S.C. 1925, will purchase when applied as a net single premium at the attained age of the insured. For this purpose the attained age is the age on the birthday anniversary nearest to the effective date of the policy plus the number of years and months from that date to the date the paid-up insurance becomes effective. Such paid-up insurance will be effective as of the expiration of the period for which premiums have been paid and earned; and, any premiums paid in advance for months subsequent to that in which the application for paid-up insurance is made shall be refunded to the insured. The paid-up insurance, if eligible to participate in and to receive dividends, shall be with the right to dividends. The insured may at any time surrender the paid-up policy for its cash value or obtain a loan on such paid-up insurance.

[30 FR 3648, Mar. 19, 1965. Redesignated and amended at 61 FR 29290, 29293, June 10, 1996. Redesignated at 65 FR 7437, Feb. 15, 2000]

CHANGE IN PLAN

§ 8.16 Conversion of a 5-year level premium term policy as provided for under § 1904 of title 38 U.S.C.

National Service Life Insurance on the level premium term plan which is in force may be exchanged for a permanent plan policy upon written application by the insured and the payment of the current monthly premium at the attained age for the plan of insurance selected (except where premium waiver under 38 U.S.C. 1912 is effective). The reserve (if any) on the policy will be allowed as a credit on the current monthly premium except where premium waiver is effective. Conversion to an endowment plan may not be made while the insured is totally disabled. The conversion will be made without medical examination, except when deemed necessary to determine whether an applicant for conversion to an endowment plan is totally disabled, and upon complete surrender of the term insurance while in force by payment or waiver of premium.

(Authority: 38 U.S.C. 1904)

[61 FR 29293, June 10, 1996. Redesignated at 65 FR 7437, Feb. 15, 2000]

PREMIUM WAIVERS AND TOTAL DISABILITY

§ 8.17 Discontinuance of premium waiver.

(a) The Secretary may require proof of continuance of total disability at any time the Secretary may deem same necessary. In the event it is found that an insured is no longer totally disabled, the waiver of premiums shall cease as of the date of such finding, and the insurance may be continued by payment of premiums, the due date of the first premium payable being the next regular monthly due date of the premium under the policy. The insurance shall not lapse prior to the date of expiration of the grace period allowed for the payment of such premium or prior to the expiration of 31 days after date of notice to the insured of the termination of the premium waiver, whichever is the later date. Such notice shall be sent by registered mail or by certified mail and sufficient notice will be deemed to have been given when such letter has been placed in the mails by the Department of Veterans Affairs: *Provided*, That the Secretary may grant an additional period of not more than 31 days for payment of the premiums in any case in which it is shown that the failure to make payment within 31 days after notice as defined in this paragraph was due to circumstances beyond the insured's control; but the premiums in any such case must be paid during the lifetime of the insured. The failure of the insured to furnish a correct current address at which mail will reach him or her promptly shall not be grounds for a further extension of time for payment of premiums under this section.

(b) In the event a finding that insured is no longer totally disabled is made at the same time a finding is made of total disability entitling the insured to a waiver of premiums while so disabled, the waiver of premiums shall cease as of the date on which total disability ceased and continuance of the insurance in such cases shall be subject to the timely payment of the premiums as they become or have become due and payable. The due date of the first premium payable subsequent to the date total disability ceased is the next regular due date of the premium under the policy, and if such premium was not paid within 31 days after the due date, the insurance lapsed.

(c) If the insured shall fail to cooperate with the Secretary in securing any evidence he may require to determine whether total disability has continued, the premium waiver shall cease effective as of the date finding is made of such failure to cooperate, and the insurance may be continued by payment of the premiums within 31 days after notice of termination as provided in paragraph (a) of this section.

[13 FR 7114, Nov. 27, 1948, as amended at 25 FR 8776, Sept. 13, 1960; 47 FR 11658, Mar. 18, 1982. Redesignated at 61 FR 29290, June 10, 1996. Redesignated at 65 FR 7437, Feb. 15, 2000]

§ 8.18 Total disability—speech.

The organic loss of speech shall be deemed to be total disability under National Service Life Insurance.

[67 FR 54738, Aug. 26, 2002]

BENEFICIARIES

§ 8.19 Beneficiary and optional settlement changes.

The insured shall have the right at any time, and from time to time, and without the knowledge or consent of the beneficiary to cancel or change a beneficiary and/or optional settlement designation. A change of beneficiary or optional settlement to be effective must be made by notice in writing signed by the insured and forwarded to the Department of Veterans Affairs by the insured or designated agent, and must contain sufficient information to identify the insured. A beneficiary designation and an optional settlement selection, but not a change of beneficiary, may be made by last will and testament duly probated. Upon receipt by the Department of Veterans Affairs, a valid designation or change of beneficiary or option shall be deemed to be effective as of the date of execution. Any payment made before proper notice of designation or change of beneficiary has been received in the Department of Veterans Affairs shall be deemed to have been properly made and to satisfy fully the obligations of the United States under such insurance policy to the extent of such payments.

[61 FR 29293, June 10, 1996. Redesignated at 65 FR 7437, Feb. 15, 2000]

PROOF OF DEATH, AGE, OR RELATIONSHIP

§ 8.20 Proof of death, age, relationship and marriage.

Whenever it is necessary for a claimant to prove death, age, relationship or marriage, the provisions found in Part 3 of this chapter will be followed.

[26 FR 1856, Mar. 3, 1961. Redesignated and amended at 61 FR 29290, 29293, June 10, 1996. Redesignated at 65 FR 7437, Feb. 15, 2000]

AGE

§ 8.21 Misstatement of age.

If the age of the insured under a National Service life insurance policy has been understated, the amount of the insurance payable under the policy shall be such exact amount as the premium paid would have purchased at the correct age; if overstated, the excess of premiums paid shall be refunded without interest. Guaranteed surrender and loan values will be modified accordingly. The age of the insured will be admitted by the Department of Veterans Affairs at any time upon satisfactory proof.

[13 FR 7115, Nov. 27, 1948. Redesignated at 61 FR 29290, June 10, 1996. Redesignated at 65 FR 7437, Feb. 15, 2000]

EXAMINATIONS

§ 8.22 Examination of applicants for insurance or reinstatement.

Where physical or mental examination is required of an applicant for National Service Life Insurance or of an applicant for reinstatement of National Service Life Insurance, such examination may be made by a medical officer of the United States Army, Navy, Air Force, or Public Health Service, or may be made free of charge to him or her by a full-time or part-time salaried physician or a physician's assistant at a regional office or medical facility of the Department of Veterans Affairs. Such examination may also be made, at the applicant's own expense, by a physician duly licensed for the practice of medicine by a State, possession of the United States, Commonwealth of Puerto Rico, or the District of Columbia, or by a duly licensed osteopathic physician who is a graduate of a recognized and approved college of osteopathy and who is listed in the current directory of the American Osteopathic Association. Such examination may be made by a physician or osteopath who is not related to the applicant by blood or marriage, associated with him or her in business, or pecuniarily interested in the insurance or reinstatement of the policy. Examinations made in a foreign country by a physician duly licensed for the practice of medicine and otherwise acceptable may be accepted if submitted through the American consul. The Secretary of Veterans Affairs may require such further medical examination or additional medical evidence as may be deemed necessary and proper to establish the physical and

mental condition of the applicant at the time of the application.

(Authority: 38 U.S.C. 1904 and 1905)

[30 FR 3650, Mar. 19, 1965, as amended at 47 FR 11659, Mar. 18, 1982. Redesignated and amended at 61 FR 29290, 29293, June 10, 1996. Redesignated at 65 FR 7437, Feb. 15, 2000]

§ 8.23 Examination in connection with total disability benefits.

Physical examination in connection with claim for total disability benefits may be made by a medical officer of the United States Army, Navy, Air Force, or Public Health Service, or may be made at Government expense by a full-time or part-time salaried physician or physician's assistant at a regional office or medical facility of the Department of Veterans Affairs. If an insured is unable to travel, because of physical or mental condition, the Director of a regional office or of a medical facility may, on his or her own initiative or at the request of the Insurance activity concerned, authorize at Government expense examination at the residence of the insured. The Secretary of Veterans Affairs may require such further medical examination or such additional medical evidence as may be deemed necessary and proper to establish the physical and mental condition of the insured.

(Authority: 38 U.S.C. 1912(b))

[47 FR 11659, Mar. 18, 1982. Redesignated at 61 FR 29290, June 10, 1996. Redesignated at 65 FR 7437, Feb. 15, 2000]

§ 8.24 Expenses incident to examinations for insurance purposes.

Except as provided in § 8.22, necessary transportation expenses incident to physical or mental examinations for insurance purposes at regional offices or medical facilities shall be furnished when the insured is ordered to report for examination at the specific request of the insurance activity concerned, or the Director of a regional office or of a medical facility. Such expenses will be borne by the United States and will be paid from the applicable appropriation of the Veterans Health Services and Research Administration. Transportation, meal and lodging requests in connection with reporting to and returning from the place of examination may be furnished the applicant, or the applicant may travel at his or her own expense and claim reimbursement for such travel on a mileage basis, provided prior authority has been given for the travel. Travel incident to such an examination by salaried employees of the Department of Veterans Affairs will be in accordance with the Federal Travel Regulations. If such an examination is made by a medical examiner on a fee basis, payment will be made at a fee not in excess of the schedule of fees in effect and approved by the Department of Veterans Affairs for medical and professional services in the State in which the examination is made. Where no approved State fee schedule is in effect or where a fee for the type of examination authorized is not listed in the approved State fee schedule in effect, such examinations will be furnished at a fee not in excess of that listed in the ''Guide for Charges for Medical and Ancillary Services'' of the Veterans Health Services and Research Administration in effect at the time the examination is authorized. If the particular examination is not covered by a schedule in effect and/or the said guide, a fee not in excess of what is reasonable and customarily charged in the community concerned may be allowed.

[30 FR 3650, Mar. 19, 1965, as amended at 47 FR 11659, Mar. 18, 1982. Redesignated and amended at 61 FR 29290, 29293, June 10, 1996. Redesignated at 65 FR 7437, Feb. 15, 2000; 65 FR 19659, Apr. 12, 2000]

OPTIONAL SETTLEMENTS

§ 8.25 Options.

Insurance will be paid in a lump sum only when selected by the insured during his or her lifetime or by his or her last will and testament.

[61 FR 29293, June 10, 1996. Redesignated at 65 FR 7437, Feb. 15, 2000, and further redesignated at 67 FR 54739, Aug. 26, 2002]

RENEWAL OF TERM INSURANCE

§ 8.26 Renewal of National Service Life Insurance on the 5-year level premium term plan.

(a) Effective July 23, 1953, all or any part of National Service Life Insurance on the 5-year level premium term plan,

in any multiple of $500 and not less than $1,000, which is not lapsed at the expiration of any 5-year term period, shall be automatically renewed without application or medical examination for a successive 5-year period at the applicable level premium term rate for the then attained age of the insured: *Provided,* That on or after September 1, 1984, National Service Life Insurance ''V'' 5-year level premium term rates shall not exceed the renewal age 70 term premium rate, or that on or after (the date the regulation is published as final), Veterans Special Life Insurance ''RS'' five-year level premium term rates shall not exceed the renewal age 70 ''RS'' term premium rate: *Provided further,* That in any case in which the insured is shown by satisfactory evidence to be totally disabled at the expiration of the term period of his or her insurance under conditions which would entitle the insured to continued insurance protection but for such expiration, such insurance, if subject to renewal under this paragraph shall be automatically renewed for an additional period of 5 years at the applicable premium rate. The renewal of insurance for any successive 5-year period will become effective as of the day following the expiration of the preceding term period, and the premium for such renewal will be the applicable level premium term rate on that day: *Provided further,* That no insurance is subject to renewal if the policyholder has exercised the insured's right to change to another plan of insurance.

(Authority: 38 U.S.C. 1905, 1906)

(b) Effective June 25, 1970, a 5-year level premium term policy which lapsed for nonpayment of the premium due and subsequently expired may be renewed subsequently to the expiration of the old term period provided the insured within 5 years of the date of lapse:

(1) Submits written application for reinstatement of the insurance.

(2) Tenders two monthly premiums, one for the month of lapse at the rate for the expired term and the other for the month of reinstatement at the rate for the new term.

(3)(i) If application for reinstatement is submitted and the premiums tendered within 6 premium months after lapse, including the premium month for which the unpaid premium was due, insurance will be reinstated provided the applicant be in as good health on the date of application and tender of premiums as he was on the last day of the grace period of the premium in default and furnishes satisfactory evidence thereof.

(ii) If application for reinstatement is submitted and the premiums tendered after expiration of the 6-month period mentioned in subdivision (i) of this subparagraph, insurance will be reinstated provided applicant is in good health (§ 8.0) on the date of application and tender of premiums and furnishes satisfactory evidence thereof.

[21 FR 6544, Aug. 30, 1956, as amended at 24 FR 21, Jan. 1, 1959; 30 FR 3652, Mar. 19, 1965; 33 FR 365, Jan. 10, 1968; 36 FR 4384, Mar. 5, 1971; 49 FR 34484, Aug. 31, 1984; 54 FR 5931, Feb. 7, 1989. Redesignated and amended at 61 FR 29290, 29293, June 10, 1996. Redesignated at 65 FR 7437, Feb. 15, 2000, and further redesignated at 67 FR 54739, Aug. 26, 2002]

SETTLEMENT OF INSURANCE MATURING ON OR AFTER AUGUST 1, 1946

§ 8.27 Conditional designation of beneficiary.

If the insured by notice in writing to the Department of Veterans Affairs during his lifetime has provided that a designated beneficiary shall be entitled to the proceeds of National Service life insurance only if such beneficiary shall survive him for such period (not more than 30 days), as specified by the insured, no right to the insurance shall vest as to such beneficiary during that period. In the event such beneficiary fails to survive the specified period, payment of the proceeds of National Service life insurance will be made as if the beneficiary had predeceased the insured.

[14 FR 7175, Nov. 29, 1949. Redesignated at 61 FR 29290, June 10, 1996. Redesignated at 65 FR 7437, Feb. 15, 2000, and further redesignated at 67 FR 54739, Aug. 26, 2002]

§ 8.28 Application for reinstatement of total disability income provision.

A total disability income provision which is lapsed may be reinstated if the insured meets the same requirements as those for reinstatement of the

policy to which the total disability income provision is attached; except that in no event shall the requirement of a health statement or other medical evidence be waived in connection with the reinstatement of the total disability income provision.

[61 FR 29293, June 10, 1996. Redesignated at 65 FR 7437, Feb. 15, 2000, and further redesignated at 67 FR 54739, Aug. 26, 2002]

NATIONAL SERVICE LIFE INSURANCE POLICY

§ 8.29 Policy provisions.

Contracts of insurance authorized to be made in accordance with the terms and conditions set forth in the forms and policy plans are subject in all respects to the applicable provisions of title 38 U.S.C., amendments and supplements thereto, and applicable Department of Veterans Affairs regulations promulgated pursuant thereto, all of which together with the insured's application, required evidence of health, including physical examination, if required, and tender of premium shall constitute the contract.

[61 FR 29293, June 10, 1996. Redesignated at 65 FR 7437, Feb. 15, 2000, and further redesignated at 67 FR 54739, Aug. 26, 2002]

APPEALS

§ 8.30 Review of Decisions and Appeal to Board of Veterans' Appeals.

(a) *Decisions*. This section pertains to insurance decisions involving questions arising under parts 6, 7, 8, and 8a of this chapter, to include the denial of applications for insurance, total disability income provision, or reinstatement; disallowance of claims for insurance benefits; and decisions holding fraud or imposing forfeiture. The applicant or claimant and his or her representative, if any, will be notified in writing of such a decision, which must include, in the notice letter or enclosures or a combination thereof, all of the following elements:

(1) Identification of the issues adjudicated.

(2) A summary of the evidence considered.

(3) A summary of the applicable laws and regulations relevant to the decision.

(4) Identification of findings that are favorable to the claimant.

(5) For denials, identification of the element(s) not satisfied that led to the denial.

(6) An explanation of how to obtain or access the evidence used in making the decision.

(7) A summary of the applicable review options available for the claimant to seek further review of the decision.

(b) *Favorable findings*. Any finding favorable to the claimant or applicant is binding on all subsequent agency of original jurisdiction and Board of Veterans' Appeals adjudicators, unless rebutted by evidence that identifies a clear and unmistakable error in the favorable finding.

(c) *Review of decisions*. Within one year from the date on which the agency of original jurisdiction issues notice of an insurance decision as outlined in paragraph (a) of this section, applicants or claimants may elect one of the following administrative review options by timely filing the appropriate form prescribed by the Secretary:

(1) *Supplemental claim review*. The nature of this review will accord with § 3.2501 of this title to the extent the terms used therein apply to insurance matters.

(2) *Request for a higher-level review*. The nature of this review will accord with § 3.2601 of this title to the extent the terms used therein apply to insurance matters. Higher-level reviews will be conducted by an experienced adjudicator who did not participate in the prior decision. Selection of a higher-level adjudicator to conduct a higher-level review is at VA's discretion.

(3) Appeal to *Board of Veterans' Appeals*. See 38 CFR part 20.

(d) *Part 3 provisions*. See § 3.2500(b) through (d) of this chapter for principles that generally apply to a veteran's election of review of an insurance decision.

(e) *Applicability*. This section applies where notice of an insurance decision was provided to an applicant or claimant on or after the effective date of the modernized review system as provided in § 19.2(a) of this chapter, or where an

applicant or claimant has elected review of a legacy claim under the modernized review system as provided in § 3.2400(c) of this title.

(f) *Unpaid premiums.* When a claimant or applicant elects a review option under paragraph (c) of this section, any unpaid premiums, normally due under the policy from effective date of issue or reinstatement (as appropriate), will become an interest-bearing lien, enforceable as a legal debt due the United States and subject to all available collection procedures in the event of a favorable result for the claimant or applicant.

(g) *Premium payments.* Despite a claimant's or applicant's election of a review option under paragraph (c) of this section, where the agency of original jurisdiction's decision involved a change in or addition to insurance currently in force, premium payments must be continued on the existing contract.

(h) *Section 1984.* Nothing in this section shall limit an applicant's or claimant's right to pursue actions under 38 U.S.C. 1984.

(Authority: 38 U.S.C. 501, 1901–1929, 1981–1988)

[84 FR 173, Jan. 18, 2019]

§ 8.31 Total disability for twenty years or more.

Where the Disability Insurance Claims activity has made a finding of total disability for insurance purposes and it is found that such disability remained continuously in effect for 20 or more years, the finding will not be discontinued thereafter, except upon a showing that such a determination was based on fraud. The 20-year period will be computed from the date the continuous total disability commenced, as determined by the Disability Insurance Claims activity.

[27 FR 11893, Dec. 1, 1962. Redesignated at 61 FR 29290, June 10, 1996. Redesignated at 65 FR 7437, Feb. 15, 2000, and further redesignated at 67 FR 54739, Aug. 26, 2002]

§ 8.32 Authority of the guardian.

What actions does a guardian have the authority to take for insurance purposes? The guardian of an insured or beneficiary has the authority to take the following actions:

(a) Apply for insurance or for conversion of a policy or change of plan;

(b) Reinstate a policy;

(c) Withdraw dividends held on deposit or credit;

(d) Select or change a dividend option;

(e) Obtain a policy loan;

(f) Cash surrender a policy;

(g) Authorize a deduction from benefits or allotment from military retired pay to pay premiums;

(h) Apply for and receive payment of proceeds on a matured policy;

(i) Select or change the premium payment option;

(j) Apply for waiver of premiums and total disability income benefits;

(k) Select or change settlement options for beneficiaries; and

(l) Assign a beneficiary's interest as provided under section 1918 of title 38 U.S.C.

(Authority: 38 U.S.C. 1906)

[67 FR 54739, Aug. 26, 2002]

§ 8.33 Cash value for term-capped policies.

(a) *What is a term-capped policy?* A term-capped policy is a National Service Life Insurance policy prefixed with ''V'' or Veterans Special Life Insurance policy prefixed with ''RS,'' issued on a 5-year level premium term plan in which premiums have been capped (frozen) at the renewal age 70 rate.

(b) *How can a term-capped policy accrue cash value?* Normally, a policy issued on a 5-year level premium term plan does not accrue cash value (see section 8.14). However, notwithstanding any other provisions of this part, reserves have been established to provide for cash value for term-capped policies.

(c) *On what basis have the reserve values been established?* Reserve values have been established based upon the 1980 Commissioners Standard Ordinary Basic Table and interest at five per centum per annum in accordance with accepted actuarial practices.

(d) *How much cash value does a term-capped policy have?* The cash value for each policy will depend on the age of the insured, the type of policy, and the amount of coverage in force and will be calculated in accordance with accepted actuarial practices. For illustrative purposes, below are some examples of

cash values based upon a $10,000 policy at various attained ages for an NSLI ''V'' policy and a VSLI ''RS'' policy:

Age	Cash value ''V''	Cash value ''RS''
75	$1,494	$1,716
80	3,212	3,358
85	4,786	4,818
90	6,249	6,217
95	8,887	7,286

(e) *What can be done with this cash value?* Upon cancellation or lapse of the policy, a policyholder may receive the cash value in a lump sum or may use the cash value to purchase paid-up insurance. If a term-capped policy is kept in force, cash values will continue to grow.

(f) *How much paid-up insurance can be obtained for the cash value?* The amount of paid-up insurance that can be purchased will depend on the amount of cash value that the policy has accrued and will be calculated in accordance with accepted actuarial practices. For illustrative purposes, below are some examples of paid-up insurance that could be purchased by the cash value of a ''V'' and an ''RS'' $10,000 policy at various attained ages:

Age	Paid-up ''V'' insurance	Paid-up ''RS'' insurance
75	$2,284	$2,625
80	4,452	4,654
85	6,109	6,149
90	7,421	7,115
95	9,331	7,650

(g) *If the policy lapses due to non-payment of the premium, does the policyholder nonetheless have a choice of receiving the cash value or paid-up insurance?* Yes, the policyholder will have that choice, along with the option to reinstate the policy (see section 8.10 for reinstatement of a policy). However, if a policyholder does not make a selection, VA will apply the cash value to purchase paid-up insurance. Paid-up insurance may be surrendered for cash at any time.

(h) *If a policyholder elects to receive either the cash surrender or paid-up insurance due to lapse or voluntary cancellation of a term-capped policy, may the original term-capped policy be reinstated?* Yes, the term-capped policy may be reinstated but the policyholder, in addition to meeting the reinstatement requirements of term policies, must also pay the current reserve value of the reinstated policy.

[65 FR 54799, Sept. 11, 2000. Redesignated at 67 FR 54739, Aug. 26, 2002]

§ 8.34 Ineligibility for insurance under 38 U.S.C. 1922A (supplemental Service-Disabled Veterans' Insurance) if person insured under 38 U.S.C. 1922(b).

A person who is granted Service-Disabled Veterans' Insurance under 38 U.S.C. 1922(b) is not eligible for supplemental Service-Disabled Veterans' Insurance under 38 U.S.C. 1922A.

[83 FR 18422, Apr. 27, 2018]

PART 8a—VETERANS MORTGAGE LIFE INSURANCE

Sec.
8a.1 Definitions.
8a.2 Maximum amount of insurance.
8a.3 Effective date.
8a.4 Coverage.

AUTHORITY: 38 U.S.C. 501, and 2101 through 2106, unless otherwise noted.

SOURCE: 37 FR 282, Jan. 8, 1972, unless otherwise noted.

§ 8a.1 Definitions.

(a) The term *housing unit* means a family dwelling or unit, together with the necessary land therefor, that has been or will be purchased, constructed, or remodeled with a grant to meet the needs of an eligible individual and of his or her family, and is or will be owned and occupied by the eligible individual as his or her home, or a family dwelling or unit, including the necessary land therefor, acquired by an eligible individual to be used as his or her residence after selling or otherwise disposing of title to the housing unit for which his or her grant was made.

(b) The term *Veterans Mortgage Life Insurance (VMLI)* means the mortgage protection life insurance authorized for individuals under 38 U.S.C. 2106.

(c) The term *initial amount of insurance* means the amount of insurance selected by the insured, which may be less than the statutory maximum of

$200,000 and less than the amount necessary to pay the mortgage indebtedness in full.

(d) The term *mortgage loan* means any loan, lien, or other indebtedness incurred by an eligible individual to buy, build, remodel, or enlarge a housing unit, the payment of which loan, lien, or indebtedness is secured by a mortgage lien, or other equivalent security of record, on the housing unit in the usual legal form employed in the community in which the property is situated. The term also includes refinancing of such an indebtedness to avoid a default, to consolidate liens, to renew or extend the time for payment of the indebtedness, and in cases where the housing unit is being bought, built, remodeled, or enlarged by increasing the amount of such an indebtedness.

(e) The term *owned* means the eligible individual has or will acquire an interest in the housing unit which is:

(1) A fee simple estate, or

(2) A leasehold estate, the unexpired term of which, including renewals at the option of the lessee, is not less than 50 years, or

(3) An interest in a residential unit in a cooperative or a condominium type development which in the judgment of the Under Secretary for Benefits or the Director, Loan Guaranty Service, provides a right of occupancy for a period of not less than 50 years: *Provided,* The title to such estate or interest is or shall be such as is acceptable to prudent lending institutions, informed buyers, title companies, and attorneys, generally, in the community.

(f) The term *eligible individual* means a person who has been determined by the Secretary to be eligible for benefits pursuant to 38 U.S.C. chapter 21.

(Authority: 38 U.S.C. 501, 2101, 2101A, 2106)

[37 FR 282, Jan. 8, 1972, as amended at 42 FR 43835, Aug. 31, 1977; 61 FR 29027, June 7, 1996; 82 FR 48631, Oct. 19, 2017]

§8a.2 Maximum amount of insurance.

(a) Each eligible individual is authorized an initial amount of insurance up to a maximum of $200,000 in VMLI to insure his or her life during periods he or she is obligated under a mortgage loan, except that, as to an individual housing unit, whenever there is a reduction in the actual amount of insurance in force as provided for in §8a.4(a) the amount of VMLI thereafter available to insure the life of the same individual on the same housing unit is permanently reduced by a like amount.

(b) The maximum amount of insurance in force on any one life at one time shall not exceed the lesser of the following amounts:

(1) $200,000.

(2) For insurance issued prior to December 24, 1987, the reduced maximum amount of insurance then available to an eligible individual.

(3) The amount of the unpaid principal of the mortgage loan outstanding on the date of approval of the grant on a housing unit then owned and occupied by the eligible individual, or on a housing unit being or to be constructed or remodeled for the eligible individual, and such initial amount of insurance may be adjusted upward, subject to the maximum insurance available to the eligible individual, or downward, depending upon the amount of the mortgage loans outstanding on the date of full disbursement of the grant, or on the date of final settlement of the purchase, construction, or remodeling agreement, whichever date is the later date.

(4) Where an eligible individual ceases to own the housing unit which was subject to a mortgage loan that resulted in his or her life being insured under VMLI, and becomes obligated under a mortgate loan on another housing unit occupied or to be occupied by the eligible individual, the amount of the unpaid principal outstanding on the mortgage loan on the newly acquired housing unit on the date insurance hereunder is placed in effect.

(5) Where an eligible individual incurs or refinances a mortgage loan, subject to the provisions of paragraph (a) of this section, the amount of the incurred or refinanced mortgage loan.

(6) If title to an undivided interest in a housing unit is or will be vested in a person other than the spouse of an eligible individual, the amount of VMLI or his or her life shall be computed to be such part of the total of the unpaid principal of the loan outstanding on the housing unit as is proportionate to the undivided interest of the individual in the entire property.

(7) All claims, arising out of the deaths of insured individuals occurring prior to October 1, 1976, shall be subject to the $30,000 lifetime maximum amount of insurance then in effect. All claims, arising out of the deaths of insured individuals occurring on or after October 1, 1976, but prior to December 1, 1992, shall be subject to the $40,000 lifetime maximum amount of insurance then in effect.

(8) All claims, arising out of the deaths of insured individuals occurring prior to December 24, 1987, shall be subject to the provisions of paragraph (a) of this section then in effect which limited the amount of VMLI coverage to a lifetime maximum per eligible individual.

(c) Any eligible individual who prior to October 1, 1976, was covered by $30,000 VMLI and who on that date became eligible to have his or her coverage increased may elect to retain the lesser amount of coverage he or she had in effect prior to that date.

(Authority: 38 U.S.C. 501, 2101, 2101A, 2106)

[52 FR 48682, Dec. 24, 1987, as amended at 59 FR 59921, Nov. 21, 1994; 61 FR 29027, June 7, 1996; 82 FR 48631, Oct. 19, 2017]

§ 8a.3 Effective date.

(a) Where the grant was approved prior to August 11, 1971, VMLI shall be effective August 11, 1971, if on that date, the eligible individual was obligated under a mortgage loan, and any such eligible individual is automatically insured, unless he or she elects in writing not to be insured, or fails to respond within 60 days after the date a final request is made or mailed to the eligible individual for information on which his or her premium can be based.

(b) Where the grant is approved on or after August 11, 1971, VMLI shall be effective on the date of approval of the grant, if on that date the eligible individual is obligated under a mortgage loan, and any such eligible individual is automatically insured, unless he or she elects in writing not to be insured, or fails to respond within 60 days after the date a final request is made or mailed to the eligible individual for information on which his or her premium can be based.

(c) In any case in which an individual would have been eligible for VMLI on August 11, 1971, or on the date of approval of his or her grant, whichever date is the later date, but such insurance did not become effective because he or she was not obligated under a mortgage loan on that date, or because he or she elected in writing not to be insured, or failed to timely respond to a request for information on which his or her premium could be based, the insurance will be effective on a date agreed upon by the individual and the Secretary, but only if the individual files an application in writing with the Department of Veterans Affairs for such insurance, submits evidence that he or she meets the health requirements of the Secretary, together with information on which his or her premiums can be based, and is or becomes obligated under a mortgage loan upon the date agreed upon as the effective date of his or her insurance.

(d) In any case in which an eligible individual disposes of the housing unit purchased, constructed or remodeled in part with a grant, or a subsequently acquired housing unit, and becomes obligated under a mortgage loan on another housing unit occupied or to be occupied by the eligible individual, the insurance will be effective upon a date requested by the individual and agreed to by the Secretary, but only if the eligible individual files an application for such insurance, submits evidence that he or she meets the health requirements of the Secretary, furnishes information on which his or her premium can be based, and is or becomes obligated under a mortgage loan on the date the insurance is to become effective.

(e) In any case where an eligible individual insured under VMLI, refinances the mortgage loan which is the basis for such insurance on his or her life, any increase in the amount of insurance or any delay in the rate of reduction of insurance will be effective only if the eligible individual files an application for insurance, submits evidence

that he or she meets the health requirements of the Secretary, and furnishes information on which his or her premium can be based.

(Authority: 38 U.S.C. 501, 2101, 2101A, 2106)

[42 FR 43835, Aug. 31, 1977, as amended at 61 FR 29027, June 7, 1996; 82 FR 48631, Oct. 19, 2017]

§8a.4 Coverage.

(a) The amount of VMLI in force on his or her life at any one time shall be reduced simultaneously (1) with the reduction in the principal of the mortgage loan, whether or not the mortgage loan is amortized, and (2) in addition, if the mortgage loan is amortized, according to the schedule for the reduction of the principal of the mortgage loan whether or not the schedule payments are timely made.

(b) If the amount of the mortgage loan exceeds $200,000, or the reduced maximum amount of insurance selected by an eligible individual, whichever amount is the lesser, the amount of insurance in force on the life of the individual shall remain at a constant level until the principal amount of the mortgage loan which is basis for establishing the amount of insurance is reduced to $200,000, or to the amount of the reduced maximum amount of insurance selected by the individual, at which time the amount of insurance in force on his or her life shall be reduced in accordance with the schedule for the reduction of the principal of the mortgage loan, and whether or not the scheduled payments are timely made.

(c) Subject to the $200,000 maximum amount of insurance, and to the reduced maximum amount of insurance selected by the eligible individual, he or she is entitled to be insured under VMLI or to apply for such insurance as often as he or she becomes obligated under a mortgage loan or a refinanced mortgage loan on a housing unit or a successor housing unit owned and occupied by the eligible individual. Where an individual who is not automatically insured under VMLI applies for such insurance, he or she shall be required to meet the health standards and other conditions established by the Secretary for such insureds.

(Authority: 38 U.S.C. 501, 2101, 2101A, 2106)

[37 FR 282, Jan. 8, 1972, as amended at 42 FR 43836, Aug. 31, 1977; 52 FR 48682, Dec. 24, 1987; 59 FR 59921, Nov. 21, 1994; 61 FR 29027, June 7, 1996; 82 FR 48631, Oct. 19, 2017]

PART 9—SERVICEMEMBERS' GROUP LIFE INSURANCE AND VETERANS' GROUP LIFE INSURANCE

Sec.
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AUTHORITY: 38 U.S.C. 501, 1965–1980A, unless otherwise noted.

SOURCE: 40 FR 4135, Jan. 28, 1975, unless otherwise noted.

EDITORIAL NOTE: Nomenclature changes to part 9 appear at 62 FR 35970, July 3, 1997, and 62 FR 45733, Sept. 9, 1997.

§9.1 Definitions.

The following definitions are in addition to those definitions in 38 U.S.C. 101 and 1965:

(a) The term *policy* means Group Policy No. G–32000, which was effective September 29, 1965, purchased from the insurer pursuant to 38 U.S.C. 1966, executed and attested on December 30, 1965, and amended thereafter.

(b) The term *administrative office* means the Office of Servicemembers' Group Life Insurance, located at 80 Livingston Avenue, Roseland, New Jersey 07068.

(c) The term *insurer* means the commercial life insurance company or

companies selected under 38 U.S.C. 1966 to provide insurance coverage specified in the policy.

(d) The term *reinsurer* means any life insurance company meeting all the criteria set forth in § 9.10 which reinsures a portion of the total amount of insurance covered by the policy and issues individual life insurance policies to members under the provisions of 38 U.S.C. 1968(b) and 1977(e).

(e) The term *converter* means any life insurance company meeting all the criteria set forth in § 9.10 which issues individual life insurance policies to members under the provisions of 38 U.S.C. 1968(b) and 1977(e).

(f) The term *coverage* means Servicemembers' Group Life Insurance or Veterans' Group Life Insurance payable while the member is insured under the policy.

(g) The term *termination of duty* means (1) In the case of active duty or active duty for training being performed under a call or order that does not specify a period of less than 31 days-discharge, release or separation from such duty.

(2) In the case of other duty—the member's release from his or her obligation to perform any duty in his or her uniformed service (active duty, or active duty for training or inactive duty training) whether arising from limitations included in a contract of enlistment or similar form of obligation or arising from resignation, retirement or other voluntary action by which the obligation to perform such duty ceases.

(h) The term *break in service* means the situation(s) in which: (1) A member terminates duty or obligation to perform duty in one service and enters on duty or assumes the obligation to perform duty in another uniformed service, regardless of the length of time intervening.

(2) A member reenters on duty or resumes an obligation to perform duty as a Reserve in the same uniformed service and 1 calendar day or more has elapsed following termination of the prior period of duty or obligation to perform duty.

(i) The term *disability* means any type of injury or disease whether mental or physical.

(j) The term *total disability* means any impairment of mind or body which continuously renders it impossible for the insured to follow any substantially gainful occupation. Without prejudice to any other cause of disability, the permanent loss of the use of both feet, of both hands, or of both eyes, or of one foot and one hand, or of one foot and one eye, or of one hand and one eye, or the total loss of hearing of both ears, or the organic loss of speech shall be deemed to be total disability. Organic loss of speech will mean the loss of the ability to express oneself, both by voice and whisper, through the normal organs of speech if such loss is caused by organic changes in such organs. Where such loss exists, the fact that some speech can be produced through the use of an artificial appliance or other organs of the body will be disregarded.

(k)(1) The term *member's stillborn child* means a member's biological child—

(i) Whose death occurs before expulsion, extraction, or delivery; and

(ii) Whose—

(A) Fetal weight is 350 grams or more; or

(B) If fetal weight is unknown, duration in utero is 20 completed weeks of gestation or more, calculated from the date the last normal menstrual period began to the date of expulsion, extraction, or delivery.

(2) The term does not include any fetus or child extracted for purposes of an abortion.

(l) The term *member of the family* as used in § 9.5(e)(2) means an individual with any of the following relationships to a person who is convicted of intentionally and wrongfully killing the decedent or determined in a civil proceeding to have intentionally and wrongfully killed the decedent:

(1) Spouse;

(2) Biological, adopted, or step child;

(3) Biological, adoptive, or step parent;

(4) Biological, adopted, or step sibling; or

(5) Biological, adoptive, or step grandparent or grandchild.

(Authority: 38 U.S.C. 501(a), 1980A)

[40 FR 4135, Jan. 28, 1975, as amended at 53 FR 17698, May 18, 1988; 61 FR 20135, May 6, 1996; 67 FR 52413, Aug. 12, 2002; 70 FR 75946, Dec. 22, 2005; 73 FR 71930, Nov. 26, 2008; 74 FR 59479, Nov. 18, 2009; 74 FR 62706, Dec. 1, 2009; 77 FR 60306, Oct. 3, 2012; 77 FR 70376, Nov. 26, 2012]

§9.2 Effective date; applications.

(a) The effective date of Servicemembers' Group Life Insurance will be in accordance with provisions set forth in 38 U.S.C. 1967.

(b) The effective date of Veterans' Group Life Insurance will be as follows:

(1) For members whose Servicemembers' Group Life Insurance coverage ceases under 38 U.S.C. 1968 (a)(1)(A) and 38 U.S.C. 1968(a)(4), the effective date shall be the 121st day after termination of duty. An application and the initial premium must be received by the administrative office within 120 days following termination of duty or separation or release from such assignment.

(2) For members whose Servicemembers' Group Life Insurance coverage was extended because of total disability, the effective date shall be the day following the end of the 2-year period of extended coverage or the day following the end of the total disability, whichever is the earlier date, but in no event before the 121st day following termination of duty. An application and the initial Veterans' Group Life Insurance premium must be received by the administrative office within 1 year following termination of SGLI coverage.

(3) For members who qualify for coverage under 38 U.S.C. 1967(b), the effective date shall be the 121st day after termination of duty. An application, the initial premium, and proof of disability must be received by the administrative office within 120 days following termination of duty.

(4) For members of the Individual Ready Reserve or the Inactive National Guard, the effective date shall be the date an application and the initial premium are received by the administrative office. The application and initial premium must be received by the administrative office within 120 days of becoming a member of either organization.

(5) Pursuant to 38 U.S.C. 1977(a)(3), former members under the age of 60 can elect to increase their Veterans' Group Life Insurance coverage by $25,000, up to the existing Servicemembers' Group Life Insurance maximum. The insured's first opportunity to elect to increase coverage is on the one-year Veterans' Group Life Insurance coverage anniversary date. Thereafter, the insured could elect to increase coverage on the five-year anniversary date of the first VGLI coverage increase election opportunity and subsequently every five years from the anniversary date of the insured's last VGLI coverage increase election opportunity. Increases of less than $25,000 are only available when existing Veterans' Group Life Insurance coverage is within less than $25,000 of the Servicemembers' Group Life Insurance maximum and any increases of less than $25,000 must be only in the amount needed to bring the insurance coverage up to the statutory maximum allowable amount of Servicemembers' Group Life Insurance. The eligible former members must apply for the increased coverage through the administrative office, within 120 days of invitation prior to the initial one-year anniversary date or within 120 days prior to each subsequent five-year coverage anniversary date from the first VGLI coverage increase election opportunity. The increased coverage will be effective from the anniversary date immediately following the election.

(Authority: 38 U.S.C. 1977)

(c) If either an application or the initial premium has not been received by the administrative office within the time limits set forth above, Veterans' Group Life Insurance coverage may still be granted if an application, the initial premium, and evidence of insurability are received by the administrative office within 1 year and 120 days following termination of duty, except that evidence of insurability is not required during the initial 240 days following termination of duty.

(d) The effective date for Servicemembers' Group Life Insurance

or Veterans' Group Life Insurance in any case not otherwise covered under this section or under 38 U.S.C. 1967(a) shall be the date an application and the initial premium are received by the administrative office.

(e) For purposes of this section, an application, an initial premium, and any evidence necessary to effect Servicemembers' Group Life Insurance or Veterans' Group Life Insurance coverage will be considered to have been received by the administrative office if:

(1) They are properly addressed to the administrative office, and

(2) The proper postage is affixed, and

(3) They are legibly postmarked within the time limit required for receipt by the administrative office.

(Authority: 38 U.S.C. 501, 1967, 1968, 1977)

[61 FR 20135, May 6, 1996, as amended at 62 FR 35970, July 3, 1997; 77 FR 66071, Nov. 1, 2012; 79 FR 44299, July 31, 2014; 83 FR 65528, Dec. 21, 2018]

§ 9.3 Waiver or reduction of coverage.

(a) Full-time coverage which is in effect will terminate or be reduced at midnight of the last day of the month a member's written notice requesting such termination or reduction is received by his or her uniformed service. In the case of a member paying premiums directly to the administrative office, full-time coverage will terminate or be reduced as of the last day of the month for which the last full premium was paid. Termination or reduction of coverage is effective for the entire remaining period of active duty unless the member reinstates his or her coverage under the provisions of 38 U.S.C. 1967(c). If, following termination of duty, a member reenters duty (in the same or another uniformed service), a waiver or reduction for the previous period of duty will not apply to the subsequent period of duty.

(b) Part-time coverage will terminate or be reduced at the end of the last day of the period of duty then being performed if the member is on active duty or active duty for training when the waiver or reduction is filed; at the end of the period of inactive duty training then being performed if the member is on inactive duty training when the waiver or reduction is filed; or on the date the waiver or reduction is received by his or her uniformed service if the member is not on active duty, active duty for training; or inactive duty training on the date the waiver or reduction is filed.

(1) When a member insured under part-time coverage waives his or her right to group coverage or elects a reduced amount of insurance, such waiver or election, unless changed, is effective throughout the period of the member's continuous reserve obligation in the same uniformed service. If, following termination of duty, the member reenters duty or resumes the obligation to perform duty (in the same or another uniformed service), the waiver or reduction will not apply to the subsequent period of duty or obligation.

(2) If a reservist insured under part-time coverage is called or ordered to active duty or active duty for training under a call or order that does not specify a period of less than 31 days and is separated or released from such duty and then resumes his or her reserve obligation, any waiver or election of reduced coverage made while eligible for part-time coverage, unless changed, shall be effective throughout the entire period of part-time coverage, the active duty or active duty for training period and 120 days thereafter and the period of immediately resumed reserve obligation.

(3) If a member, other than a member referred to in paragraph (b)(2) of this section, upon termination of duty qualifying him or her for full-time coverage assumes an obligation to perform duty as a reservist, any waiver or election previously made by the member shall not apply to coverage arising from his or her reservist obligation. Furthermore, during the 120 days following termination of such duty the full-time coverage shall not be reduced by any waiver or election made by a member as a reservist.

[40 FR 4135, Jan. 28, 1975, as amended at 48 FR 8070, Feb. 25, 1983; 53 FR 17698, May 18, 1988. Redesignated and amended at 61 FR 20135, May 6, 1996]

§ 9.4 Beneficiaries and options.

Any designation of beneficiary or election of settlement options is subject to the provisions of 38 U.S.C. 1970 and 1977 and the following provisions:

(a) Any designation of beneficiary or settlement option election made by any member insured under Servicemembers' Group Life Insurance for full-time coverage or part-time coverage will remain in effect until properly changed by the member or canceled automatically for any of the following reasons:

(1) The insurance terminates following separation or release from all duty in a uniformed service.

(2) The member enters on duty in another uniformed service.

(3) The member reenters on duty in the same uniformed service more than 1 calendar day after separation or release from all duty in that uniformed service.

(b) A change of beneficiary may be made at any time and without the knowledge or consent of the previous beneficiary.

(c) Until and unless otherwise changed, a beneficiary designation and settlement option election of record on the date a statutory increase in coverage takes effect shall be considered to be a beneficiary and optional settlement election for the increased amount as well, and any beneficiary named therein shall be entitled to the same percentage (%) share of the new total coverage amount as that beneficiary was entitled to prior to the statutory increase in coverage.

(Authority: 38 U.S.C. 501)

[40 FR 4135, Jan. 28, 1975, as amended at 53 FR 17699, May 18, 1988. Redesignated and amended at 61 FR 20135, 20136, May 6, 1996]

§9.5 Payment of proceeds.

Proceeds shall be paid in accordance with provisions set forth in 38 U.S.C. 1970 and the following provisions:

(a) If proceeds are to be paid in installments, the first installment will be payable as of the date of death. The amount of each installment will be computed so as to include interest on the unpaid balance at the then effective rate.

(b) If, following the death of an insured member who has designated both principal and contingent beneficiaries and elected to have payment made in 36 equal monthly installments, the principal beneficiary dies before all 36 installments have been paid, the remaining installments will be paid as they fall due to the contingent beneficiary. At the death of such a contingent beneficiary, and in other instances of a beneficiary's death, where there is no contingent beneficiary, the value of any unpaid installments, discounted to the date of his or her death at the same rate used for inclusion of interest in the computation of installments will be paid, without further accrual of interest, in one sum to the estate of the beneficiary or continent beneficiary last receiving payment.

(c) In instances where payment in installments is made at the election of the beneficiary, upon his or her request, the value of such installments as remain unpaid will be discounted to the date of payment at the same rate used for inclusion of interest in the computation of installments and paid to him or her in one sum.

(d) If a member whose coverage is extended due to total disability converts the group insurance to an individual policy which is effective before he or she ceases to be totally disabled or before the end of 2 years following termination of duty, whichever is earlier, and dies while group insurance would be in effect, except for such conversion, the group insurance will be payable, provided the individual policy is surrendered for a return of premiums and without further claim. When there is no such surrender, any amount of group insurance in excess of the amount of the individual policy will be payable.

(e)(1) The proceeds payable because of the death of an individual insured under Servicemembers' Group Life Insurance or Veterans' Group Life Insurance (''decedent'') shall not be payable to any person described in paragraph (e)(2) of this section. A Servicemembers' Group Life Insurance Traumatic Injury Protection benefit payable under §9.20(j)(3) shall not be payable to any person described in paragraph (e)(2) of this section.

(2) The persons described in this paragraph are:

(i) A person who is convicted of intentionally and wrongfully killing the decedent or determined in a civil proceeding to have intentionally and wrongfully killed the decedent;

(ii) A person who is convicted of assisting or aiding, or determined in a civil proceeding to have assisted or aided, a person described in paragraph (e)(2)(i) of this section; and

(iii) A member of the family of a person described in paragraph (e)(2)(i) or (e)(2)(ii) of this section who is not related to the decedent by blood, legal adoption, or marriage.

(3) The Servicemembers' Group Life Insurance or Veterans' Group Life Insurance proceeds or Servicemembers' Group Life Insurance Traumatic Injury Protection benefit not payable under paragraph (e)(1) of this section to any person described in paragraph (e)(2) of this section is not payable to such persons even though the criminal conviction or civil determination is pending appeal.

(4)(i) Servicemembers' Group Life Insurance or Veterans' Group Life Insurance proceeds or a Servicemembers' Group Life Insurance Traumatic Injury Protection benefit not payable under paragraphs (e)(1) and (e)(2) of this section shall be payable to the first person or persons listed in paragraphs (e)(4)(i)(A) through (F) of this section who are surviving on the date of the decedent's death in the following order of precedence:

(A) To the next eligible beneficiary designated by the decedent in a writing received by the appropriate office of the applicable uniformed service before the decedent's death in the uniformed services in the case of Servicemembers' Group Life Insurance proceeds or a Servicemembers' Group Life Insurance Traumatic Injury Protection benefit, or in a writing received by the administrative office defined in §9.1(b) of this part before the decedent's death in the case of Veterans' Group Life Insurance proceeds;

(B) To the decedent's widow or widower;

(C) To the decedent's child or children, in equal shares, and descendants of deceased children by representation;

(D) To the decedent's parents, in equal shares, or to the survivor of them;

(E) To the duly appointed executor or administrator of the decedent's estate;

(F) To other next of kin of the decedent as determined by the insurer (defined in §9.1(c) of this part) under the laws of the domicile of the decedent at the time of the decedent's death.

(ii) Payment of Servicemembers' Group Life Insurance or Veterans' Group Life Insurance proceeds or a Servicemembers' Group Life Insurance Traumatic Injury Protection benefit to any person under paragraph (e)(4)(i) of this section shall bar recovery of those proceeds or that benefit by any other person.

(f) If a stillborn child is otherwise eligible to be insured by the Servicemembers' Group Life Insurance coverage of more than one member, the child shall be insured by the coverage of the child's insured biological mother.

(Authority: 38 U.S.C. 501(a), 1965(10), 1967(a)(4)(B))

[40 FR 4135, Jan. 28, 1975, as amended at 50 FR 12252, Mar. 28, 1985. Redesignated and amended at 61 FR 20135, 20136, May 6, 1996; 77 FR 60306, Oct. 3, 2012; 77 FR 70376, Nov. 26, 2012; 79 FR 44299, July 31, 2014]

§ 9.6 Assignments.

Servicemembers' Group Life Insurance, Veterans' Group Life Insurance and benefits thereunder are not assignable.

[40 FR 4135, Jan. 28, 1975. Redesignated at 61 FR 20135, May 6, 1996]

§ 9.7 Administrative decisions.

(a) Determinations of the Department of Veterans Affairs are conclusive under the policy with respect to the following:

(1) The status of any person being within the term *member* and whether or not he or she is covered at any point of time under the policy including *travel-time* under 38 U.S.C. 1967(b) and death within 120 days thereafter from a disability incurred or aggravated while on duty.

(2) The fact and date of a member's termination of active duty, or active duty for training, and the fact, date and hours of a member's performance of inactive duty training.

(3) The fact and dates with respect to a member's absence without leave, confinement by civilian authorities under a sentence adjudged by a civil court, or confinement by military authorities

under a court-martial sentence involving total forfeiture of pay and allowances.

(4) The operation of the forfeiture provision provided in 38 U.S.C. 1973 with respect to any member.

(5) The existence of total disability or insurability at standard premium rates under 38 U.S.C. 1968.

(b) When determination is required on a claim that a member who waived coverage, or whose coverage was forfeited for one of the offenses listed under 38 U.S.C. 1973 was in fact insured, or that a member who elected to be insured was insured for an amount greater than the amount shown in the record, and there is no record of an application to be insured or to increase the amount of insurance as required under 38 U.S.C. 1967(c):

(1) The person making the claim will be required to submit all evidence available concerning the member's actions and intentions with respect to Servicemembers' Group Life Insurance or Veterans' Group Life Insurance.

(2) Request will be made to the member's uniformed service and any other likely source of information considered necessary, for whatever evidence in the form of copies of payroll or personnel records, statements of persons having knowledge of the facts, etc., is essential to a decision in the matter.

Based on the evidence obtained, a formal determination will be made as to whether the member involved is deemed to have applied to be insured, or to be insured for an amount other than the amount shown in the record. The determination will include a finding as to the member's health status for insurance purposes based on the evidence available.

(Authority: 38 U.S.C. 1967)

(c) In making the determination required under paragraph (b) of this section, the following will be considered:

(1) The possibility that due to widespread geographic distribution, inadequate means of communication and the nature of the group insurance program, members may not be adequately and accurately informed, especially in time of war or military emergency, about the detailed requirements for obtaining insurance protection.

(2) Payroll deductions made without objection by a member, following waiver or termination of coverage, representing premiums for insurance or additional insurance, may, by virtue of continuity or the circumstances surrounding their initiation, be indicative that the member did apply. Such deductions without a formal application of record may be considered as evidence that the member's application was not in proper form or misplaced. They may also be considered as evidence that an application was not made solely because of erroneous or incomplete counseling or absence of counseling on the part of the responsible personnel of the uniformed service.

(d) Questions for determination under this section as well as those involving coverage of groups and classes of members and other questions are properly referable to the Assistant Director for Insurance. Authority to make any determinations required under this section is delegated to the Under Secretary for Benefits and Assistant Director for Insurance.

[40 FR 4135, Jan. 28, 1975, as amended at 53 FR 17699, May 18, 1988. Redesignated and amended at 61 FR 20135, 20136, May 6, 1996]

§9.8 Termination of coverage.

Termination of coverage will be in accordance with the provisions of 38 U.S.C. 1968 and §9.3 of this part and the following provisions:

(a) In the case of a member whose coverage is forfeited under 38 U.S.C. 1973, coverage terminates at the end of the day preceding the day on which the act or omission forming the basis for such forfeiture occurred.

(b) In the event of discontinuance of the group policy, coverage terminates at the end of the day preceding the date of the discontinuance of the policy except for those members who are insured under Veterans' Group Life Insurance in which event coverage terminates at the expiration of the day preceding the anniversary of the effective

date of such insurance which first occurs, 90 days or more after the discontinuance of the group policy.

[40 FR 4135, Jan. 28, 1975, as amended at 48 FR 8071, Feb. 25, 1983; 53 FR 17699, May 18, 1988; 57 FR 11910, Apr. 8, 1992. Redesignated and amended at 61 FR 20135, 20136, May 6, 1996; 62 FR 35970, July 3, 1997]

§ 9.9 Conversion privilege.

(a) With respect to a member on active duty or active duty for training under a call or order to duty that specifies a period of less than 31 days, and a member insured during inactive duty training scheduled in advance by competent authority there shall be no right of conversion unless the insurance is continued in force under 38 U.S.C. 1967(b) or 1968(a) for 120 days following a period of such duty, as the result of a disability incurred or aggravated during such a period of duty.

(b) The individual policy of life insurance to which an insured may convert under 38 U.S.C. 1968(b) or 1977(e) shall not have disability or other supplementary benefits and shall not be term insurance or any policy which does not provide for cash values. Term riders providing level or decreasing insurance for which an additional premium is charged may be attached to an eligible basic conversion policy, but the rider will be excluded from the conversion pool agreement under the policy.

(c) The insurer will establish a conversion pool in cooperation with the reinsurers and converters in accordance with the terms of the policy. Its purpose will be to provide for the determination and maintenance of appropriate charges arising from excess mortality under individual conversion policies issued in accordance with this section and provide for the appropriate distribution of the risk of loss due to such excess mortality among the reinsurers and converters.

[40 FR 4135, Jan. 28, 1975, as amended at 53 FR 17699, May 18, 1988. Redesignated and amended at 61 FR 20135, 20136, May 6, 1996]

§ 9.10 Health standards.

(a) For the purpose of determining if a member who incurred a disability or aggravated a preexisting disability during a period of active duty or active duty for training under a call to duty specifying a period of less than 31 days or during a period of inactive duty was rendered uninsurable at standard premium rates, the underwriting criteria used by the insurer in determining good health for persons applying to it for life insurance in amounts not exceeding the maximum amount of coverage then available under 38 U.S.C. 1967 will be used.

(Authority: 38 U.S.C. 1967)

(b) For all other purposes of determining if a member meets the necessary health requirements except paragraph (a) of this section, the underwriting criteria used by the insurer in determining good health for group life insurance purposes will be used.

[40 FR 4135, Jan. 28, 1975, as amended at 53 FR 17699, May 18, 1988. Redesignated at 61 FR 20135, May 6, 1996]

§ 9.11 Criteria for reinsurers and converters.

The following criteria will control eligibility for reinsuring and converting companies:

(a) The company must be a legal reserve life insurance company as classified by the insurance supervisory authorities of the State of domicile. Qualified fraternal organizations are included.

(b) The company must have been in the life insurance business for a continuous period of 5 years prior to October 1, 1965, or the December 31 preceding any redeterminations of the allocations. In the event of a merger, the 5-year requirement may be satisfied by either the surviving company or by one of the absorbed companies. Upon joint application by a subsidiary of a participating company, together with the parent company, the 5-year requirement may be waived provided such parent company owns more than 50 percent of the outstanding stock of the subsidiary and has been a legal reserve life insurance company for a period of 10 years or more.

(c) The company must be licensed to engage in life insurance in at least one State of the United States or the District of Columbia.

(d) The company will not be one: (1) Certified by the Department of Defense as being under suspension for cause for

purpose of allotment or on-base solicitation privileges.

(2) That solicits life insurance applications as conversion or other replacement of Servicemembers' Group Life Insurance or Veterans' Group Life Insurance coverage in jurisdictions in which it is not licensed.

(3) That fails to take effective action to correct an improper practice followed by it or its agents within 30 days after written receipt of notice issued by the insurer or the Assistant Director for Insurance. Improper practice includes:

(i) The use for solicitation purposes of lists of names and addresses of former members without obtaining reasonable assurance that such lists have not been obtained contrary to regulations of the Department of Defense or other uniformed service;

(ii) Failure to reveal sources and copies of mailing lists upon proper request or to otherwise cooperate in an authorized investigation of a reported improper practice;

(iii) The use of written or oral representations which may mislead the person addressed as to the true role of the company or its representatives as one of the participating companies;

(iv) The use of written or oral representations which may mislead the person addressed as to rights, privileges, coverage, premiums, or similar matters under Servicemembers' Group Life Insurance, Veterans' Group Life Insurance, or any policy issued or proposed to be issued as a conversion or other replacement coverage;

(v) Violation of regulations of a uniformed service concerning solicitation of life insurance; and

(vi) The use of written or oral references to Servicemembers' Group Life Insurance, Veterans' Group Life Insurance or conversions of Servicemembers' Group Life Insurance or Veterans' Group Life Insurance in connection with the attempted sale of an insurance policy which would not be, in fact, a conversion policy or a policy issued in lieu of a conversion, if those references might lead a person addressed to believe there is a connection between the policy being sold and coverage under Servicemembers' Group Life Insurance, Veterans' Group Life Insurance or a conversion of it.

(e) Each reinsuring and converting company must agree to issue conversion policies to any qualified applicant regardless of race, color, religion, sex, or national origin, under terms and conditions established by the primary insurer.

[40 FR 4135, Jan. 28, 1975. Redesignated at 61 FR 20135, May 6, 1996]

§9.12 Reinsurance formula.

The allocation of insurance to the insurer and each reinsurer will be based upon the following:

(a) An amount of the total life insurance in force under the policy in proportion to the company's total life insurance in force in the United States where:

The first $100 million in force is counted in full,
The second $100 million in force is counted at 75 percent,
The third $100 million in force is counted at 50 percent,
The fourth $100 million in force is counted at 25 percent,
And any amount above $400 million in force is counted at 5 percent.

(b) The allocation will be redetermined at the beginning of each policy year for the primary insurer and the companies then reinsuring, with the portion as set forth in paragraph (a) of this section based upon the corresponding in force (excluding the Servicemembers' Group Life Insurance in force) as of the preceding December 31.

(c) Any life insurance company, which is not initially participating in reinsurance or conversions, but satisfies the criteria set forth in §9.11, may subsequently apply to the primary insurer to reinsure and convert, or to convert only. The participation of such company will be effective as of the beginning of the policy year following the date on which application is approved by the insurer.

[40 FR 4135, Jan. 28, 1975. Redesignated and amended at 61 FR 20135, 20136, May 6, 1996]

§9.13 Actions on the policy.

The Assistant Director for Insurance will furnish the name and address of

the insuring company upon written request of a member of the uniformed services or his or her beneficiary. Actions at law or in equity to recover on the policy, in which there is not alleged any breach of any obligation undertaken by the United States, should be brought against the insurer.

[40 FR 4135, Jan. 28, 1975. Redesignated and amended at 61 FR 20135, 20136, May 6, 1996]

§ 9.14 Accelerated Benefits.

(a) *What is an Accelerated Benefit?* An Accelerated Benefit is a payment of a portion of your Servicemembers' Group Life Insurance or Veterans' Group Life Insurance to you before you die.

(b) *Who is eligible to receive an Accelerated Benefit?* You are eligible to receive an Accelerated Benefit if you have a valid written medical prognosis from a physician of 9 months or less to live, and otherwise comply with the provisions of this section.

(c) *Who can apply for an Accelerated Benefit?* Only you, the insured member, can apply for an Accelerated Benefit. No one can apply on your behalf.

(d) *How much can you request as an Accelerated Benefit?* (1) You can request as an Accelerated Benefit an amount up to a maximum of 50% of the face value of your insurance coverage.

(2) Your request for an Accelerated Benefit must be $5,000 or a multiple of $5000 (for example, $10,000, $15,000).

(e) *How much can you receive as an Accelerated Benefit?* You can receive as an Accelerated Benefit the amount you request up to a maximum of 50% of the face value of your insurance coverage.

(f) *How do you apply for an Accelerated Benefit?* (1) You can obtain an application form by writing the Office of Servicemembers' Group Life Insurance, 80 Livingston Avenue, Roseland, New Jersey 07068–1733; calling the Office of Servicemembers' Group Life Insurance toll-free at 1–800–419–1473; or downloading the form from the Internet at *www.insurance.va.gov*. You must submit the completed application form to the Office of Servicemembers' Group Life Insurance, 80 Livingston Avenue, Roseland, New Jersey 07068–1733.

(2) As stated on the application form, you will be required to complete part of the application form and your physician will be required to complete part of the application form. If you are an active duty servicemember, your branch of service will also be required to complete part of the form.

To Be Completed by Insured

Claim for Accelerated Benefits

Your name: _____
Social Security Number: _____
Your home address: _____
Date of birth: _____
Branch of Service (if covered under SGLI): __
Your mailing address (if different from above): _____
Amount of SGLI coverage: $ _____
Amount of claim (can be no more than one-half of coverage in increments of $5,000): __
Type of coverage (check one):
SGLI (circle one of the following): *Active Duty Ready Reserve Army or Air National Guard Separated or Discharged*
VGLI

NOTE: If you checked SGLI, you must also have your military unit complete the attached form.

I acknowledge that I have read all of the attached information about the accelerated benefit. I understand that I can get this benefit only once during my lifetime and that I can use it for any purpose I choose. I further understand that the face amount of my coverage will reduce by the amount of accelerated benefit I choose to receive now.

Your signature: _____
Date: _____

Authorization To Release Medical Records

To all physicians, hospitals, medical service providers, pharmacists, employers, other insurance companies, and all other agencies and organizations:

You are authorized to release a copy of all my medical records, including examinations, treatments, history, and prescriptions, to the Office of Servicemembers' Group Life Insurance (OSGLI) or its representatives.

Printed name: _____
Signature: _____
Date: _____

A photocopy of this authorization will be considered as effective and valid as the original.

Valid for one year from date signed.

To Be Completed by Physician

Attending Physician's Certification

Patient's name: _____
Patient's Social Security Number: _____
Diagnosis: _____
ICD–9–CM Disease Code *: _____

Description of present medical condition (please attach results of x-rays, E.K.G. or other tests): _____

Is the patient capable of handling his/her own affairs? _____ Yes____ No____

The patient applied for an accelerated benefit under his/her government life insurance coverage. To qualify, the patient must have a life expectancy of nine (9) months or less.

Does your patient meet this requirement? _____ Yes____ No____

Attending Physician's name (please print): __
State in which you are licensed to practice:
Specialty: _____
Mailing address: _____
Telephone number: _____
Fax Number: _____
Signature: _____
Date: _____

*ICD–9–CM is an acronym for International Classification of Diseases, 9th revision, Clinical Modification.

To Be Completed by Personnel Office of Servicemember's Unit

(Complete this form only if the applicant for Accelerated Benefits is covered under SGLI.)

Branch of Service Statement

Servicemember's name: _____
Social Security Number: _____
Branch of Service: _____
Amount of SGLI coverage: $ _____
Monthly premium amount: $ _____
Name of person completing this form: _____
Telephone Number: _____
Fax Number: _____
Title of person completing this form: _____
Duty Station and address: _____
Signature of person completing this form: __
Date: _____

Notice: It is fraudulent to complete these forms with information you know to be false or to omit important facts. Criminal and/or civil penalties can result from such acts.

(g) *Who decides whether or not an Accelerated Benefit will be paid to you?* The Office of Servicemembers' Group Life Insurance will review your application and determine whether you meet the requirements of this section for receiving an Accelerated Benefit.

(1) They will approve your application if the requirements of this section are met.

(2) If the Office of Servicemembers' Group Life Insurance determines that your application form does not fully and legibly provide the information requested by the application form, they will contact you and request that you or your physician submit the missing information to them. They will not take action on your application until the information is provided.

(h) *How will an Accelerated Benefit be paid to you?* An Accelerated Benefit will be paid to you in a lump sum.

(i) *What happens if you change your mind about an application you filed for Accelerated Benefits?* (1) An election to receive the Accelerated Benefit is made at the time you have cashed or deposited the Accelerated Benefit. After that time, you cannot cancel your request for an Accelerated Benefit. Until that time, you may cancel your request for benefits by informing the Office of Servicemembers' Group Life Insurance in writing that you are canceling your request and by returning the check if you have received one. If you want to change the amount of benefits you requested or decide to reapply after canceling a request, you may file another application in which you request either the same or a different amount of benefits.

(2) If you die before cashing or depositing an Accelerated Benefit payment, the payment must be returned to the Office of Servicemembers' Group Life Insurance. Their mailing address is 290 W. Mt. Pleasant Avenue, Livingston, New Jersey 07039.

(j) *If you have cashed or deposited an Accelerated Benefit, are you eligible for additional Accelerated Benefits?* No.

(Approved by the Office of Management and Budget under control number 2900–0618)

(Authority: 38 U.S.C. 1965, 1966, 1967, 1980)

[67 FR 52413, Aug. 12, 2002; 79 FR 44299, July 31, 2014]

§9.20 Traumatic injury protection.

(a) *What is traumatic injury protection?* Traumatic injury protection provides for the payment of a specified benefit amount to a member insured by Servicemembers' Group Life Insurance who sustains a traumatic injury directly resulting in a scheduled loss.

(b) *What is a traumatic event?* (1) A traumatic event is the application of external force, violence, chemical, biological, or radiological weapons, or accidental ingestion of a contaminated substance causing damage to a living being occurring on or after October 7, 2001.

(2) A traumatic event does not include a medical or surgical procedure in and of itself.

(c) *What is a traumatic injury?* (1) A traumatic injury is physical damage to a living body that is caused by a traumatic event as defined in paragraph (b) of this section.

(2) For purposes of this section, the term ''traumatic injury'' does not include damage to a living body caused by—

(i) A mental disorder; or

(ii) A mental or physical illness or disease, except if the physical illness or disease is caused by a pyogenic infection, biological, chemical, or radiological weapons, or accidental ingestion of a contaminated substance.

(3) For purposes of this section, all traumatic injuries will be considered to have occurred at the same time as the traumatic event.

(d) *What are the eligibility requirements for payment of traumatic injury protection benefits?* You must meet all of the following requirements in order to be eligible for traumatic injury protection benefits.

(1) You must be a member of the uniformed services who is insured by Servicemembers' Group Life Insurance under section 1967(a)(1)(A)(i), (B) or (C)(i) of title 38, United States Code, on the date you sustained a traumatic injury, except if you are a member who experienced a traumatic injury on or after October 7, 2001, through and including November 30, 2005. (For this purpose, you will be considered a member of the uniformed services until midnight on the date of termination of your duty status in the uniformed services that established your eligibility for Servicemembers' Group Life Insurance, notwithstanding an extension of your Servicemembers' Group Life Insurance coverage under section 1968(a) of title 38, United States Code.)

(2) You must suffer a scheduled loss that is a direct result of a traumatic injury and no other cause.

(3) You must survive for a period not less than seven full days from the date of the traumatic injury. The seven day period begins on the date and Zulu (Greenwich Meridean) time of the traumatic injury and ends 168 full hours later.

(4) You must suffer a scheduled loss under paragraph (e)(7) of this section within two years of the traumatic injury.

(5) You must suffer a traumatic injury before midnight on the date of termination of your duty status in the uniformed services that established eligibility for Servicemembers' Group Life Insurance. For purposes of this section, the scheduled loss may occur after the date of termination of your duty status in the uniformed services that established eligibility for Servicemembers' Group Life Insurance.

(e) *What is a scheduled loss and what amount will be paid because of that loss?* (1) The term ''scheduled loss'' means a condition listed in the schedule in paragraph (e)(7) of this section if directly caused by a traumatic injury. A scheduled loss is payable at the amount specified in the schedule.

(2) The maximum amount payable under the schedule for all losses resulting from traumatic events occurring within a seven-day period is $100,000. We will calculate the seven-day period beginning with the day on which the first traumatic event occurs.

(3) A benefit will not be paid if a scheduled loss is due to a traumatic injury—

(i) Caused by—

(A) The member's attempted suicide, while sane or insane;

(B) An intentionally self-inflicted injury or an attempt to inflict such injury;

(C) Diagnostic procedures, preventive medical procedures such as inoculations, medical or surgical treatment for an illness or disease, or any complications arising from such procedures or treatment;

(D) Willful use of an illegal substance or a controlled substance unless administered or consumed on the advice of a medical professional; or

(ii) Sustained while a member was committing or attempting to commit a felony.

(4) A benefit will not be paid for a scheduled loss resulting from—

(i) A physical or mental illness or disease, whether or not caused by a traumatic injury, other than a pyogenic infection or physical illness or disease caused by biological, chemical,

or radiological weapons or accidental ingestion of a contaminated substance; or

(ii) A mental disorder whether or not caused by a traumatic injury.

(5) Amount Payable under the Schedule of Losses. (i) The maximum amount payable for all scheduled losses resulting from a single traumatic event is limited to $100,000. For example, if a traumatic event on April 1, 2006, results in the immediate total and permanent loss of sight in both eyes, and the loss of one foot on May 1, 2006, as a direct result of the same traumatic event, the member will be paid $100,000.

(ii) If a member suffers more than one scheduled loss from separate traumatic events occurring more than seven full days apart, the scheduled losses will be considered separately and a benefit will be paid for each loss up to the maximum amount according to the schedule. For example, if a member suffers the loss of one foot at or above the ankle on May 1, 2006, from one event, the member will be paid $50,000. If the same member suffers loss of sight in both eyes from an event that occurred on November 1, 2006, the member will be paid an additional $100,000.

(6) *Definitions*. For purposes of this paragraph (e)(6)—

(i) The term *quadriplegia* means the complete and irreversible paralysis of all four limbs.

(ii) The term *paraplegia* means the complete and irreversible paralysis of both lower limbs.

(iii) The term *hemiplegia* means the complete and irreversible paralysis of the upper and lower limbs on one side of the body.

(iv) The term *uniplegia* means the complete and irreversible paralysis of one limb of the body.

(v) The term *complete and irreversible paralysis* means total loss of voluntary movement resulting from damage to the spinal cord or associated nerves, or to the brain, that is deemed clinically stable and unlikely to improve.

(vi) The term *inability to carry out activities of daily living* means the inability to independently perform at least two of the six following functions:

(A) Bathing.

(B) Continence.

(C) Dressing.

(D) Eating.

(E) Toileting.

(F) Transferring in or out of a bed or chair with or without equipment.

(vii) The term *pyogenic infection* means a pus-producing infection.

(viii) The term *contaminated substance* means food or water made unfit for consumption by humans because of the presence of chemicals, radioactive elements, bacteria, or organisms.

(ix) The term *chemical weapon* means chemical substances intended to kill, seriously injure, or incapacitate humans through their physiological effects.

(x) The term *biological weapon* means biological agents or microorganisms intended to kill, seriously injure, or incapacitate humans through their physiological effects.

(xi) The term *radiological weapon* means radioactive materials or radiation-producing devices intended to kill, seriously injure, or incapacitate humans through their physiological effects.

(xii) The term *medical professional* means a licensed practitioner of the healing arts acting within the scope of his or her practice. Some examples include a licensed physician, optometrist, nurse practitioner, registered nurse, physician assistant, or audiologist.

(xiii) The term *hospitalization* means an inpatient stay in a facility that is:

(A)(*1*) Accredited by the Joint Commission or its predecessor, the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), or accredited or approved by a program of the qualified governmental unit in which such institution is located if the Secretary of Health and Human Services has found that the accreditation or comparable approval standards of such qualified governmental unit are essentially equivalent to those of the Joint Commission or JCAHO;

(*2*) Used primarily to provide, by or under the supervision of physicians, to inpatients diagnostic services and therapeutic services for medical diagnosis, treatment, and care of injured, disabled, or sick persons;

(*3*) Requires every patient to be under the care and supervision of a physician; and

(*4*) Provides 24-hour nursing services rendered or supervised by a registered professional nurse and has a licensed practical nurse or registered nurse on duty at all times; or

(B) Any Armed Forces medical facility that is authorized to provide inpatient and/or ambulatory care to eligible service members.

(xiv) The term *total and permanent loss of sight* means:

(A) Visual acuity in the eye of 20/200 or less (worse) with corrective lenses lasting at least 120 days;

(B) Visual acuity in the eye of greater (better) than 20/200 with corrective lenses and a visual field of 20 degrees or less lasting at least 120 days; or

(C) Anatomical loss of the eye.

(xv) The term *total and permanent loss of speech* means organic loss of speech or the ability to express oneself, both by voice and whisper, through normal organs for speech, notwithstanding the use of an artificial appliance to simulate speech. Loss of speech must be clinically stable and unlikely to improve.

(xvi) The term *total and permanent loss of hearing* means average hearing threshold sensitivity for air conduction of at least 80 decibels, based on hearing acuity measured at 500, 1,000, and 2,000 Hertz, that is clinically stable and unlikely to improve.

(xvii) The term *burns* means 2nd degree (partial thickness) or worse burns covering at least 20 percent of the body, including the face and head, or 20 percent of the face alone. Percentage of the body burned may be measured using the Rule of Nines or any means generally accepted within the medical profession.

(xviii) The term *coma* means a state of profound unconsciousness that is measured at a Glasgow Coma Score of 8 or less.

(xix) The term *limb salvage* means a series of operations designed to save an arm or leg with all of its associated parts rather than amputate it. For purposes of this section, a surgeon must certify that the option of amputation of the limb(s) was a medically justified alternative to salvage, and the patient chose to pursue salvage.

(xx) The term *amputation* means the severance or removal of a limb or genital organ or part of a limb or genital organ resulting from trauma or surgery. With regard to limbs an amputation above a joint means a severance or removal that is closer to the body than the specified joint is.

(xxi) The term *anatomical loss of the penis* is defined as amputation of the glans penis or any portion of the shaft of the penis above the glans penis (*i.e.* closer to the body) or damage to the glans penis or shaft of the penis that requires reconstructive surgery.

(xxii) The term *permanent loss of use of the penis* is defined as damage to the glans penis or shaft of the penis that results in complete loss of the ability to perform sexual intercourse that is reasonably certain to continue throughout the lifetime of the member.

(xxiii) The term *anatomical loss of the testicle(s)* is defined as the amputation of, or damage to, one or both testicles that requires testicular salvage, reconstructive surgery, or both.

(xxiv) The term *permanent loss of use of both testicles* is defined as damage to both testicles resulting in the need for hormonal replacement therapy that is medically required and reasonably certain to continue throughout the lifetime of the member.

(xxv) The term *anatomical loss of the vulva, uterus, or vaginal canal* is defined as the complete or partial amputation of the vulva, uterus, or vaginal canal or damage to the vulva, uterus, or vaginal canal that requires reconstructive surgery.

(xxvi) The term *permanent loss of use of the vulva or vaginal canal* is defined as damage to the vulva or vaginal canal that results in complete loss of the ability to perform sexual intercourse that is reasonably certain to continue throughout the lifetime of the member.

(xxvii) The term *anatomical loss of the ovary(ies)* is defined as the amputation of one or both ovaries or damage to one or both ovaries that requires ovarian salvage, reconstructive surgery, or both.

(xxviii) The term *permanent loss of use of both ovaries* is defined as damage to

both ovaries resulting in the need for hormonal replacement therapy that is medically required and reasonably certain to continue throughout the lifetime of the member.

(xxix) The term *total and permanent loss of urinary system function* is defined as damage to the urethra, ureter(s), both kidneys, bladder, or urethral sphincter muscle(s) that requires urinary diversion and/or hemodialysis, either of which is reasonably certain to continue throughout the lifetime of the member.

(f) Schedule of Losses.

For losses listed in paragraphs (f)(1) through (19) of this section, multiple losses resulting from a single traumatic event may be combined for purposes of a single payment (except where noted otherwise); however, the total payment amount may not exceed $100,000 for losses resulting from a single traumatic event.

Payments for losses listed in paragraphs (f)(20) through (21) of this section may not be made in addition to payments for losses under paragraphs (f)(1) through (19)—only the higher amount will be paid. The total payment amount may not exceed $100,000 for losses resulting from a single traumatic event.

If the loss is—	Then the amount payable for the loss is—
(1) Total and permanent loss of sight:	
• For each eye	$50,000
(2) Total and permanent loss of hearing:	
• For one ear	$25,000
• For both ears	$100,000
(3) Total and permanent loss of speech	$50,000
(4) Quadriplegia	$100,000
(5) Hemiplegia	$100,000
(6) Paraplegia	$100,000
(7) Uniplegia:	
• For each limb*	$50,000
**Note: Payment for uniplegia of arm cannot be combined with loss 9, 10, or 14 for the same arm. Payment of uniplegia of leg cannot be combined with loss 11, 12, 13, or 15 for the same leg.*	
(8) Burns	$100,000
(9) Amputation of a hand at or above the wrist:	
• For each hand*	$50,000
**Note: Payment for loss 9 cannot be made in additional to payment for loss 10 for the same hand.*	
(10) Amputation at or above the metacarpophalangeal joint(s) of either the thumb or the other 4 fingers on 1 hand:	
• For each hand*	$50,000
**Note: Payment for loss of the thumb cannot be made in addition to payment for loss of the other 4 fingers for the same hand.*	
(11) Amputation of a foot at or above the ankle:	
• For each foot.*	$50,000
**Note: Payment for loss 11 cannot be made in addition to payments for losses 12 or 13 for the same foot.*	
(12) Amputation at or above the metatarsophalangeal joints of all toes on 1 foot:	
• For each foot*	$50,000
**Note: Payment for loss 12 cannot be made in addition to payments for loss 13 for the same foot.*	
(13) Amputation at or above the metatarsophalangeal joint(s) of either the big toe, or the other 4 toes on 1 foot	

• For each foot	$25,000
(14) Limb salvage of arm:	
• For each arm*	$50,000
**Note: Payment for loss 14 cannot be made in addition to payments for losses 9 or 10 for the same arm.*	
(15) Limb salvage of leg:	
• For each leg*	$50,000
**Note: Payment for loss 15 cannot be made in addition to payments for losses 11, 12 or 13 for the same leg.*	
(16) Facial Reconstruction:	
• Jaw—surgery to correct discontinuity loss of the upper or lower jaw	$75,000
• Nose—surgery to correct discontinuity loss of 50% or more of the cartilaginous nose	$50,000
• Lips—surgery to correct discontinuity loss of 50% or more of the upper or lower lip	
—For one lip	$50,000
—For both lips	$75,000
• Eyes—surgery to correct discontinuity loss of 30% or more of the periorbita.	
—For each eye	$25,000
• Facial Tissue—surgery to correct discontinuity loss of the tissue in 50% or more of any of the following facial subunits: forehead, temple, zygomatic, mandibular, infraorbital or chin.	
—For each facial subunit	$25,000
Note 1: Losses due to facial reconstruction may be combined with each other, but the maximum benefit for facial reconstruction may not exceed $75,000.	
Note 2: Any injury or combination of losses under facial reconstruction may also be combined with other losses in paragraphs 9.20(f)(1)–(18) and treated as one loss, provided that all losses are the result of a single traumatic event. However, the total payment amount may not exceed $100,000.	
(17) Coma from traumatic injury AND/OR Traumatic Brain injury resulting in inability to perform at least 2 Activities of Daily Living (ADL):	
• at 15th consecutive day of coma or ADL loss*	$25,000
• at 30th consecutive day of coma or ADL loss*	an additional $25,000
• at 60th consecutive day of coma or ADL loss*	an additional $25,000
•; at 90th consecutive day of coma or ADL loss*	an additional $25,000
Note 1: Duration of coma and inability to perform ADLs includes date of onset of coma or inability to perform ADLs and the first date on which member is no longer in a coma or is able to perform ADLs.	
(18) Hospitalization due to traumatic brain injury:*	
• at 15 consecutive day of hospitalization**	$25,000
**Note: Payment for hospitalization replaces period in loss 17.*	
***Note: Duration of hospitalization includes dates on which member is transported from the injury site to a facility described in § 9.20(e)(6)(xiii), admitted to the facility, transferred between facilities, and discharged from the facility.*	
(19) Genitourinary Losses:	
• Anatomical loss of the penis	$50,000
• Permanent loss of use of the penis	$50,000
• Anatomical loss of one testicle	$25,000
Anatomical loss of both testicles	$50,000
• Permanent loss of use of both testicles	$50,000
• Anatomical loss of the vulva, uterus, or vaginal canal	$50,000
• Permanent loss of use of the vulva or vaginal canal	$50,000
• Anatomical loss of one ovary	$25,000
• Anatomical loss of both ovaries	$50,000

• Permanent loss of use of both ovaries	$50,000
• Total and permanent loss of urinary system function	$50,000
Note 1: Losses due to genitourinary injuries may be combined with each other, but the maximum benefit for genitourinary losses may not exceed $50,000.	
Note 2: Any genitourinary loss may be combined with other injuries listed in § 9.20(f)(1) through (18) and treated as one loss, provided that all losses are the result of a single traumatic event. However, the total payment may not exceed $100,000.	
(20) Traumatic injury, other than traumatic brain injury, resulting in inability to perform at least 2 Activities of Daily Living (ADL):	
• at 30th consecutive day of ADL loss*	$25,000
• at 60th consecutive day of ADL loss*	an additional $25,000
• at 90th consecutive day of ADL loss*	an additional $25,000
• at 120th consecutive day of ADL loss*	an additional $25,000
**Note: Duration of inability to perform ADLs includes date of onset of inability to perform ADLs and the first date on which member is able to perform ADLs.*	
(21) Hospitalization due to traumatic injury other than traumatic brain injury:*	
• at 15th consecutive day of hospitalization**	$25,000
**Note: Payment for hospitalization replaces the first payment period in loss 19.*	
***Note: Duration of hospitalization includes dates on which member is transported from the injury site to a facility described in § 9.20(e)(6)(xiii), admitted to the facility, transferred between facilities, and discharged from the facility.*	

(g) *Who will determine eligibility for traumatic injury protection benefits?* Each uniformed service will certify its own members for traumatic injury protection benefits based upon section 1032 of Public Law 109–13, section 501 of Public Law 109–233, and this section. The uniformed service will certify whether you were at the time of the traumatic injury insured under Servicemembers' Group Life Insurance and whether you have sustained a qualifying loss.

(h) *How does a member make a claim for traumatic injury protection benefits?* (1)(i) A member who believes he or she qualifies for traumatic injury protection benefits must complete Part A of the Application for TSGLI Benefits Form and sign the form.

(ii) If a member is unable to sign the Application for TSGLI Benefits Form due to the member's physical or mental incapacity, the form must be signed by the member's guardian; if none, the member's agent or attorney acting under a valid Power of Attorney; if none, the member's military trustee.

(iii) If a member suffered a scheduled loss as a direct result of the traumatic injury, survived seven full days from the date of the traumatic event, and then died before the maximum benefit for which the service member qualifies is paid, the beneficiary or beneficiaries of the member's Servicemembers' Group Life Insurance policy should complete an Application for TSGLI Benefits Form.

(2) If a member seeks traumatic injury protection benefits for a scheduled loss occurring after submission of a completed Application for TSGLI Benefits Form for a different scheduled loss, the member must submit a completed Application for TSGLI Benefits Form for the new scheduled loss and for each scheduled loss that occurs thereafter and for each increment of a scheduled loss that occurs thereafter. For example, if a member seeks traumatic injury protection benefits for a scheduled loss due to coma from traumatic injury and/or the inability to carry out activities of daily living due to traumatic brain injury (§ 9.20(f)(17)), or the inability to carry out activities

of daily living due to loss directly resulting from a traumatic injury other than an injury to the brain (§ 9.20(f)(19)), a completed Application for TSGLI Benefits Form must be submitted for each increment of time for which TSGLI is payable. Also, for example, if a service member suffers a scheduled loss due to a coma, a completed Application for TSGLI Benefits Form should be filed after the 15th consecutive day that the member is in the coma, for which $25,000 is payable. If the member remains in a coma for another 15 days, another completed Application for TSGLI Benefits Form should be submitted and another $25,000 will be paid.

(i) *How does a member or beneficiary appeal an adverse eligibility determination?* (1) Notice of a decision regarding a member's eligibility for traumatic injury protection benefits will include an explanation of the procedure for obtaining review of the decision. An appeal of an eligibility determination, such as whether the loss occurred within 365 days of the traumatic injury, whether the injury was self-inflicted or whether a loss of hearing was total and permanent, must be in writing. An appeal must be submitted by a member or a member's legal representative or by the beneficiary or the beneficiary's legal representative, within one year of the date of a denial of eligibility, to the office of the uniformed service identified in the decision regarding the member's eligibility for the benefit.

(2) An appeal regarding whether a member was insured under Servicemembers' Group Life Insurance when the traumatic injury was sustained must be in writing. An appeal must be submitted by a member or a member's legal representative or by the beneficiary or the beneficiary's legal representative within one year of the date of a denial of eligibility to the Office of Servicemembers' Group Life Insurance.

(3) Nothing in this section precludes a member from pursuing legal remedies under 38 U.S.C. 1975 and 38 CFR 9.13.

(j) *Who will be paid the traumatic injury protection benefit?* The injured member who suffered a scheduled loss will be paid the traumatic injury protection benefit in accordance with title 38 U.S.C. 1980A except under the following circumstances:

(1) If a member is legally incapacitated, the member's guardian or agent or attorney acting under a valid Power of Attorney will be paid the benefit on behalf of the member.

(2) If no guardian, agent, or attorney is authorized to act as the member's legal representative, a military trustee who has been appointed under the authority of 37 U.S.C. 602 will be paid the benefit on behalf of the member. The military trustee will report the receipt of the traumatic injury benefit payment and any disbursements from that payment to the Department of Defense.

(3) If a member dies before payment is made, the beneficiary or beneficiaries who will be paid the benefit will be determined in accordance with 38 U.S.C. 1970(a).

(k) The Traumatic Servicemembers' Group Life Insurance program will be administered in accordance with this rule, except to the extent that any regulatory provision is inconsistent with subsequently enacted applicable law.

(Authority: 37 U.S.C. 602, 603; 38 U.S.C. 501(a), 1980A)

(The Office of Management and Budget has approved the information collection requirements in this section under control number 2900–0671)

[70 FR 75946, Dec. 22, 2005, as amended at 72 FR 10365, Mar. 8, 2007; 73 FR 71930, Nov. 26, 2008; 76 FR 75460, Dec. 2, 2011; 79 FR 44299, July 31, 2014]

§ 9.21 VA's access to records maintained by the insurer, reinsurer(s), and their successors.

(a) In order to perform oversight responsibilities designed to protect the legal and financial rights of the Government and persons affected by the activities of the Department of Veterans Affairs and its agents and to ensure that the policy and the related program benefits and services are managed effectively and efficiently as required by law, the Secretary of Veterans Affairs shall have complete and unrestricted access to the records of any insurer, reinsurer(s), and their successors with respect to the policy and related benefit programs or services that are derived from the policy. This access includes access to:

(1) Any records relating to the operation and administration of benefit programs derived from the policy, which are considered to be Federal records created under the policy;

(2) Records related to the organization, functions, policies, decisions, procedures, and essential transactions, including financial information, of the insurer, reinsurer(s), and their successors; and

(3) Records of individuals insured under the policy or utilizing other related program benefits and services or who may be entitled to benefits derived through the Servicemembers' and Veterans' Group Life Insurance programs, including personally identifiable information concerning such individuals and their beneficiaries.

(b) Complete access to these records shall include the right to have the originals of such records sent to the Secretary of Veterans Affairs or a representative of the Secretary at the Secretary's direction. The records shall be available in either hard copy or readable electronic media. At the Secretary's option, copies may be provided in lieu of originals where allowed by the Federal Records Act, 44 U.S.C. chapter 31.

[79 FR 48072, Aug. 15, 2014]

§ 9.22 Submission of certain applications and forms affecting entitlement to Servicemembers' Group Life Insurance and Veterans' Group Life Insurance.

(a)(1) For purposes of this section, the terms *in writing* and *written* mean an intentional recording of words in visual form and include:

(i) Hard-copy applications and forms containing a person's name or mark written or made by that person; and

(ii) Applications and forms submitted through a VA approved electronic means that include an electronic or digital signature that identifies and authenticates a particular person as the source of the electronic message and indicates such person's approval of the information submitted through such means.

(2) With regard to the following actions, applications or forms that satisfy the definition in paragraph (a)(1) of this section will be deemed to satisfy the requirement in the referenced statutes that an application, election, or beneficiary designation be ''in writing'' or ''written'':

(i) Decline Servicemembers' Group Life Insurance for the member or Family Servicemembers' Group Life Insurance for the member's insurable spouse (38 U.S.C. 1967(a)(2)(A) or (B));

(ii) Insure the member under Servicemembers' Group Life Insurance or the member's spouse under Family Servicemembers' Group Life Insurance in an amount less than the maximum amount of such insurance (38 U.S.C. 1967(a)(3)(B));

(iii) Restore or increase coverage under Servicemembers' Group Life Insurance for the member or under Family Servicemembers' Group Life Insurance for the member's insurable spouse (38 U.S.C. 1967(c));

(iv) Designate one or more beneficiaries for the member's Servicemembers' Group Life Insurance or former member's Veterans' Group Life Insurance (38 U.S.C. 1970(a)); and

(v) Increase the amount of coverage under Veterans' Group Life Insurance (38 U.S.C. 1977(a)(3)).

(b) Applications or forms that satisfy the definition in paragraph (a)(1) of this section may be utilized to—

(1) Apply for Veterans' Group Life Insurance; and

(2) Reinstate Veterans' Group Life Insurance.

[83 FR 10623, Mar. 12, 2018]

PART 10—ADJUSTED COMPENSATION

ADJUSTED COMPENSATION; GENERAL

Sec.
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PAYMENTS

10.50 Section 601 and section 603 payments made on first day of calendar quarter.
10.51 Payments to minor child.
10.52 Duplication of payments prohibited.
10.53 Payment on duplicate certificate.

AUTHORITY: 72 Stat. 1114; 38 U.S.C. 501. Rights and benefits are continued in effect by sec. 12(b), 72 Stat. 1264, 38 U.S.C. note prec. Part 1.

SOURCE: 13 FR 7122, Nov. 27, 1948, unless otherwise noted.

ADJUSTED COMPENSATION; GENERAL

§ 10.0 Adjusted service pay entitlements.

A veteran entitled to adjusted service pay is one whose adjusted service credit does not amount to more than $50 as distinguished from a veteran whose adjusted service credit exceeds $50 and who therefore is entitled to an adjusted service certificate.

§ 10.1 Issuance of duplicate adjusted service certificate without bond.

If the veteran named in an adjusted service certificate issued pursuant to the provisions of section 501 of the World War Adjusted Compensation Act, without bad faith, has not received such certificate, or if prior to receipt by the veteran such certificate was destroyed wholly or in part or was so defaced as to impair its value, or, if after delivery it was partially destroyed or defaced so as to impair its value but can be identified to the satisfaction of the Secretary, a duplicate adjusted service certificate will be issued upon application and a bond of indemnity will not be required: *Provided,* That if the adjusted service certificate was destroyed in part or so defaced as to impair its value, the veteran or person entitled to payment thereon will be required to surrender to the Department of Veterans Affairs the original certificate or so much thereof as may remain.

§ 10.2 Evidence required of loss, destruction or mutilation of adjusted service certificate.

The veteran named in an adjusted service certificate issued pursuant to the provisions of section 501 of the World War Adjusted Compensation Act, or the person entitled to payment thereon will be required to furnish evidence of the nonreceipt of the adjusted service certificate, or of its receipt in a mutilated or defaced condition, or of the loss or destruction in whole or in part of defacement of the certificate after its receipt, as the case may be. The evidence must be sufficient to establish to the satisfaction of the Secretary that neither the veteran nor the person entitled to payment thereon, or any person for or on their behalf, received the adjusted service certificate, or that at the time of its receipt it was mutilated or defaced to such an extent as to impair its value, or that after receipt of the certificate it was lost or destroyed in whole or in part or defaced, but without bad faith on the part of the veteran, and that every effort has been made to recover the lost certificate. Unless determination is otherwise made by the Secretary the evidence must be in the form of a written statement sworn to by the veteran

or person entitled to payment thereon and witnessed by at least two persons who shall state, under oath that they personally know the affiant, that they have read his or her statement and that it is true to the best of their knowledge and belief. These statements should be supplemented by affidavits of any persons having personal knowledge of additional facts and circumstances concerning the matter, and the Secretary may require any additional evidence deemed necessary.

§ 10.3 Issuance of duplicate adjusted service certificate with bond.

An indemnity bond will be required as a prerequisite to the issuance of a duplicate adjusted service certificate in all cases where the certificate was lost after receipt by the veteran, or after receipt by the veteran was defaced or mutilated and cannot be identified to the satisfaction of the Secretary, provided the loss, defacement, or mutilation was without bad faith on the part of the veteran or the person entitled to payment thereon. The bond must be in the manner and form prescribed by the Department of Veterans Affairs and for an amount equal to the face value of the certificate, with surety or sureties residents of the United States and satisfactory to the Secretary, with condition to indemnify and save harmless the United States from any claim on account of such certificate. If the certificate was defaced or mutilated the veteran or person entitled to payment thereon will be required to surrender to the Department of Veterans Affairs the certificate or so much thereof as may remain.

§ 10.4 Loss, destruction, or mutilation of adjusted service certificate while in possession of Department of Veterans Affairs.

A new adjusted service certificate will be issued without bond in lieu of the certificate which has been lost or destroyed, or has been mutilated, defaced or damaged so as to impair its value, while in possession of the Department of Veterans Affairs.

§ 10.15 Designation of more than one beneficiary under an adjusted service certificate.

A veteran to whom an adjusted service certificate has been issued pursuant to the provisions of section 501 of the World War Adjusted Compensation Act may name more than one beneficiary to receive the proceeds of his adjusted service certificate, and may from time to time with the approval of the Secretary change such beneficiaries. The designated beneficiaries shall share equally unless otherwise specified by the veteran. Wherever the word *beneficiary* appears in the law and Department of Veterans Affairs regulations it shall be interpreted to include beneficiaries.

§ 10.16 Conditions requisite for change in designation of beneficiary.

A change of beneficiary of an adjusted service certificate to be valid must be made:

(a) By notice signed by the veteran or his duly authorized agent, and delivered or properly mailed to the Department of Veterans Affairs during the lifetime of the veteran. Such change shall not take effect until approved by the Secretary and after such approval the change shall be deemed to have been made as of the date the veteran signed said written notice and change, whether the veteran be living at the time of said approval or not.

(b) Or by last will and testament of the veteran, duly probated. Such change shall not be effective until received by the Department of Veterans Affairs and approved by the Secretary and after such approval the change shall be deemed to have been made as of the date of death of the veteran: *Provided*, That a change of beneficiary signed subsequent to the date upon which the will was executed and delivered in accordance with paragraph (a) of this section shall if approved in accordance with regulations take precedence over the designation by will.

Provided, however, That any payment made to a beneficiary of record, before notice of change of beneficiary has been received in the Department of Veterans Affairs and approved by the Secretary, shall not be made again to the changed beneficiary.

§ 10.17 Designation of beneficiary subsequent to cancellation of previous designation.

The designation of a beneficiary made subsequent to the cancellation of a previous designation of beneficiary, shall be considered as a change in beneficiary, and shall be subject to the approval of the Secretary and subject to the conditions and requirements respecting change in beneficiary as outlined in § 10.16.

§ 10.18 Approval of application for change of beneficiary heretofore made.

Any application for a change of beneficiary heretofore made may be approved if it meets the requirements set out in §§ 10.16 and 10.17.

§ 10.20 "Demand for payment" certification.

Certification to the execution of *demand for payment* forms appearing on the reverse side of adjusted service certificates issued pursuant to the World War Adjusted Compensation Act, as amended, is required in accordance with instructions printed on said forms. Such certification if made in the United States or possessions will be accepted if made by and bearing the official seal of a United States postmaster, an executive officer of an incorporated bank or trust company, notary public, or any person who is legally authorized to administer oaths in a State, Territory, District of Columbia or in a Federal judicial district of the United States. If the demand for payment be executed in a foreign country, the same shall be certified by an American consul, a recognized representative of an American embassy or legation or by a person authorized to administer oaths under the laws of the place where execution of demand is made, provided there be attached to the certificate of such latter officer a proper certification by an accredited official of the State Department of the United States that the officer certifying to the execution of the demand for payment was authorized to administer oaths in the place where certification was made.

§ 10.22 Payment to estate of decedent.

Wherever the face value of an adjusted service certificate, issued pursuant to the World War Adjusted Compensation Act, as amended, becomes payable to the estate of any decedent and the amount thereof is not over $500 and an administrator has not been or is not to be appointed, such amount will be paid to such person or persons as would, under the laws of the State of residence of the decedent, be entitled to his personal property in case of intestacy.

§ 10.24 Payment of death claim on lost, destroyed or mutilated adjusted service certificate with bond.

If the veteran named in an adjusted service certificate, issued pursuant to the provisions of section 501 of the World War Adjusted Compensation Act, is deceased, and if, after receipt by the veteran, the adjusted service certificate was lost, destroyed, or so defaced as to impair its value and cannot be identified to the satisfaction of the Secretary of Veterans Affairs, the person entitled to payment thereon will be required to furnish an indemnity bond in the manner and form prescribed by the Department of Veterans Affairs and for an amount equal to the face value of the certificate, with surety or sureties residents of the United States and satisfactory to the Secretary of Veterans Affairs with condition to indemnify and save harmless the United States from any claim on account of such certificate, before payment will be made of the proceeds of the certificate and a duplicate adjusted service certificate will not be issued.

§ 10.25 Payment of death claim on adjusted service certificate without bond.

If the veteran named in the adjusted service certificate, issued pursuant to the provisions of section 501 of the World War Adjusted Compensation Act, is deceased, and if the certificate was lost or destroyed wholly or in part or was so defaced as to impair its value prior to receipt by the veteran, or was partially destroyed or defaced after receipt by the veteran, but can be identified to the satisfaction of the Secretary of Veterans Affairs, payment will be

made of the proceeds of the certificate, a bond of indemnity will not be required, and a duplicate adjusted service certificate will not be issued: *Provided*, The person entitled to payment thereon surrenders the defaced or mutilated certificate or so much thereof as may remain.

§ 10.27 Definitions.

For the purpose of §§ 10.28 to 10.47, the word *Act* as used herein refers to the World War Adjusted Compensation Act, as amended; the word *Veteran* refers to that term as defined in section 2 of title I of said Act; the word *Director* refers to the Secretary of Veterans Affairs.

§ 10.28 Proof of death evidence.

Evidence required in establishing proof of death under the act, as amended, shall conform with the requirements set forth in the regulations of the Department of Veterans Affairs.

§ 10.29 Claims for benefits because of elimination of preferred dependent.

A dependent, in subsequent position in the order of preference as defined in section 601 of title VI of the Act, as amended, who makes claim for the benefits of the Act in consequence of the death of a dependent who made application and who stood in preferential position as defined in section 601 of the act, as amended, shall be required to furnish, in support of such claim, proof of death of said dependent. Proof of death of said dependent shall be in accordance with the requirements for proof of death as outlined in the regulations of Department of Veterans Affairs. A dependent who makes claim for the benefits of the act because of remarriage of a widow who did not make and file application before remarriage shall be required to furnish in support of such claim proof of remarriage of said widow. Proof of remarriage of said widow shall be in accordance with the requirements for proof of marriage as outlined in regulations of the Department of Veterans Affairs.

§ 10.30 Proof of remarriage.

A dependent who is receiving payments under section 601 of title VI of the Act, as amended, and who remarries after making and filing application, shall be required to furnish proof of remarriage in accordance with the requirements for proof of remarriage as outlined in regulations of the Department of Veterans Affairs.

§ 10.31 Dependency of mother or father.

Claims of a mother or father for the benefits to which either may be entitled under the World War Adjusted Compensation Act, as amended, shall be supported by a statement of fact of dependency made under oath by the claimant and witnessed by two persons.

§ 10.32 Evidence of dependency.

Evidence of a whole or entire dependency shall not be required. The mother or father shall be considered dependent for the purposes of the act when it is established as a fact that the mother or father of a deceased veteran did not have sufficient means from all sources for a reasonable livelihood at the time of the death of the veteran or at any time thereafter and on or before January 2, 1935. In those cases where because of continued and unexplained absence for seven years the veteran is declared deceased under section 312(a) of the Act as amended May 29, 1928, the mother or father shall be considered dependent when it is established that the mother or father did not have sufficient means from all sources for a reasonable livelihood at the beginning of such 7–year period or at any time thereafter and before the expiration of such period.

§ 10.33 Determination of dependency.

A determination of the existence of the alleged dependency will be made upon consideration of all facts relating to dependency, and upon such investigation of such facts as may be warranted. The following facts as existing at the time of the death of the veteran, or at any time thereafter and on or before January 2, 1935, or where it is established that the veteran is deceased as provided in section 312(a), at the beginning of such 7–year period or at any time thereafter and before the expiration of such period, shall be taken into consideration in determining dependency in a given case:

(a) Claimant's age.

(b) Amount contributed to claimant by deceased veteran.

(c) Value of all real and personal property owned by claimant.

(d) Total monthly expenses of the claimant and total monthly income.

(e) The fact that claimant did or did not receive an allotment of pay or allowance during the veteran's military or naval service.

(f) Incapability of self-support by reason of mental or physical defect.

(g) Any other fact or facts pertinent to the determination of dependency.

§ 10.34 Proof of age of dependent mother or father.

The mother or father of a veteran to be entitled to the presumption of dependency within the meaning of section 602(c) or section 312(c) of the Act, as amended, shall be required to submit proof of age in accordance with the requirements as set forth in regulations of the Department of Veterans Affairs.

§ 10.35 Claim of mother entitled by reason of unmarried status.

Claim of a mother for the benefits to which she may be entitled by reason of her unmarried status as outlined in section 202(c) or section 312(c)3 of the Act, as amended, shall be supported by a statement of fact, under oath, of such status, together with one of the following:

(a) Certified copy of public record of death of the husband.

(b) Certified copy of court record of divorce decree.

§ 10.36 Proof of marital cohabitation under section 602 or section 312 of the Act.

In order to prove marital cohabitation within the meaning of that term as used in section 602(a) or section 312(c)1 of the Act, as amended, claimant shall be required to establish:

(a) A valid marriage, such marriage to be shown by the best evidence obtainable in accordance with the provisions of regulations of the Department of Veterans Affairs.

(b) The fact of living together as man and wife, with such fact to be established by:

(1) Statement of the widow or widower showing that he or she and the veteran lived together as man and wife and also showing the place or places of residence during such marital cohabitation and the approximate time of such residence; or

(2) Statement of two competent persons showing that they personally knew the claimant and veteran and that they had personal knowledge that said claimant and veteran lived together as man and wife and were recognized as such.

(c) The fact that the marital status existed at the time of the death of the veteran or where it is established that the veteran is deceased, as provided in section 312(a)1 of the Act, as amended, at the beginning of such 7–year period, such fact to be established by:

(1) Statement by claimant that he or she and the veteran had not been divorced and that there had been no annulment of the marriage.

(2) Statement of claimant that he or she was not remarried at the time of making application.

(3) Statement of two competent persons showing that they personally knew the claimant and the veteran; that they personally knew of the marriage relationship between claimant and veteran; that to the best of their knowledge and belief there had been no divorce and no annulment of the marriage and that claimant was not remarried at the time of making and filing application.

§ 10.37 Claim of widow not living with veteran at time of veteran's death.

If a veteran and widow were not living together at the time of the death of the veteran the widow will be required to establish:

(a) That the living apart was not due to her willful act, and

(b) Actual dependency upon the veteran at the time of his death or at any time thereafter and before January 2, 1935.

(1) A determination of what shall constitute a willful act, as used in section 602(a) of the Act, as amended, will be made upon consideration of all facts relating to such act and upon such investigation of such facts as may be deemed warranted. For the purpose of

this section, the fact that a veteran lived apart from the widow because of any act by the widow involving desertion or moral turpitude will be construed as the willful act of the widow. Cause of separation and time and duration of separation at the time of the death of the veteran shall be taken into consideration in determining a willful act.

(2) A determination of the existence of actual dependency will be made under the criteria set forth in §§10.32 and 10.33 with respect to dependency of a mother or father.

§ 10.38 Proof of age of veteran's child.

A child of a veteran shall be required to submit proof of age in accordance with the requirements set forth in the regulations of the Department of Veterans Affairs.

§ 10.39 Mental or physical defect of child.

If claim is made under section 602(b), (2), of title IV of the Act as amended, alleging that a child over 18 years of age was incapable of self-support at the death of the veteran or that he became incapable of self-support subsequent to the death of the veteran but on or before January 2, 1935, or that he was incapable of self-support at the disappearance of the veteran or became incapable of self-support after the disappearance of the veteran and before the expiration of the period of seven years mentioned in section 312(c), (2), of the Act, it will be necessary to furnish evidence as to the mental or physical condition of the child at the time it is alleged he became incapable of self-support.

(a) Where incapability of self-support by reason of the mental defect of the child is alleged, the following evidence will be required:

(1) Certified copy of court order or decree declaring the child to be mentally incompetent; or

(2) A report of a licensed physician setting forth all of the facts as to the child's mental condition; or

(3) The affidavit of the person having custody and control of the child, setting forth all of the available information as to the child's mental condition. The affidavit must be substantiated by two competent disinterested persons who shall state that they personally know the child, that they have read the affidavit made by the person having custody and control of the child, and that the information therein set forth is true to the best of their knowledge and belief.

(b) Where incapability of self-support by reason of physical defect of the child is alleged, the following evidence will be required:

(1) Report of a licensed physician setting forth all of the facts as to the child's physical condition; and

(2) Affidavit of the child regarding his physical condition and the affidavits of two competent disinterested persons, who shall state that they personally know the claimant, that they have read his affidavit and that the same is true to the best of their knowledge and belief.

§ 10.40 Payment on account of minor child.

Payments to a minor child shall be made to the legally constituted guardian, curator or conservator, or to the person found by the director to be otherwise legally vested with the care of the child.

§ 10.41 Definition of "child".

The term *child* as used in the regulations in this part includes:

(a) A legitimate child;

(b) A child legally adopted;

(c) A stepchild if a member of the veteran's household at the time of the death of the veteran, or

(d) An illegitimate child but as to the father only if acknowledged in writing signed by him, or if he has been judicially ordered or decreed to contribute to such child's support or has been judicially decreed to be the putative father of such child.

§ 10.42 Claim of child other than legitimate child.

A claim of a child legally adopted by the veteran upon whose service the claim is based shall be supported by a certified copy of the court record of such adoption. A claim of a stepchild of a veteran shall be supported by an affidavit of his or her legal guardian, stating that at the time of the death of the

veteran said stepchild was a member of the veteran's household. The fact, as stated in such affidavit, and the signature of the guardian thereto, shall be attested by the court having jurisdiction over the guardian, or by two competent persons to whom the child was personally known at the time of the death of the veteran. A claim of an illegitimate child of a veteran upon whose service claim is based, shall be supported by:

(a) A statement by the veteran in writing acknowledging his parentage of such child; or

(b) Certified copy of order or decree of a court ordering the veteran to contribute to such child's support; or

(c) Certified copy of a decree of a court holding the veteran to be the putative father of such child.

§ 10.43 Claim by guardian of child of veteran.

A claim made by a legal guardian on behalf of his or her ward, a child of a veteran, shall be supported by an affidavit of said guardian, in the capacity of guardian, setting forth the names, ages, and addresses of all living children of the deceased veteran, or, if there be no living child other than the claimant child, statement of that fact shall be made. The signature of the guardian to such required affidavit shall be attested by the court having jurisdiction of the guardian and ward, or by two competent persons to whom the child is personally known.

§ 10.44 Evidence required to support claim of mother or father.

The term *mother* and *father* as referred to in the order of preference as outlined in section 601 of the Act, as amended, includes stepmothers, stepfathers, mothers and fathers through adoption, and persons who, for a period of not less than one year, have stood in the place of a mother or father to the veteran at any time prior to the beginning of his service. In addition to the evidence of dependency required from a natural mother or father, a claim of a stepmother or stepfather shall be supported by evidence of marriage to the natural parent of the veteran. This evidence shall be in accordance with the requirements of proof of marriage as set forth in regulations of the Department of Veterans Affairs. A claim of a mother or father through adoption shall be supported by a certified copy of the court record of such adoption. A claim by a person who claims to have stood in the place of a mother or father shall be supported by evidence of such relationship satisfactory to the Department of Veterans Affairs. Such evidence shall comprise:

(a) An affidavit of the claimant containing a complete detailed statement of the alleged relationship and

(b) Affidavits of two competent witnesses to whom claimant was personally known at the time of the death of the veteran, said witnesses certifying to the truth of the statement as made by the claimant.

§ 10.45 Definition of "widow".

The term *widow* as used in the regulations in this part includes widower.

§ 10.46 Authentication of statements supporting claims.

All statements, except those of licensed examining physicians under § 10.39 (a)(2) and (b)(1), required by §§ 10.28 to 10.44 shall be subscribed and sworn to before an officer vested with authority to administer oaths, in the place where such statements are made. Signatures executed in foreign countries or places shall be certified by an American consul, a recognized representative of an American consul, a recognized representative of an American embassy or legation or by a person authorized to administer oaths under the laws of the place where such statements are made, provided there be attached to the certificate of such latter officer a proper certification by an accredited official of the State Department of the United States that the officer certifying to the execution of the signature was authorized to administer oaths in the place where certification was made.

§ 10.47 Use of prescribed forms.

Statements required by the regulations in this part should be submitted on forms provided by the Department of Veterans Affairs, when conveniently available.

PAYMENTS

§ 10.50 Section 601 and section 603 payments made on first day of calendar quarter.

Cash payments and the first installment of installment payments authorized in sections 601 and 603, respectively of title VI of the World War Adjusted Compensation Act, as amended, will be made as of the first day of the calendar quarter following the finding by the director that the applicant is a dependent entitled to the benefits of the act, but in no case shall any such payments be made before March 1, 1925: *Provided, however,* That payments authorized by section 608 of title VI of the Act, as amended, shall be paid in a lump sum to the preferred dependent without reference to payments under section 603 of title VI of the Act, as amended.

§ 10.51 Payments to minor child.

Payments to minor child through legal guardian, natural guardian, or self. (See § 10.40.)

§ 10.52 Duplication of payments prohibited.

Duplication of payments shall not be made in case of change of beneficiary. (See § 10.16.)

§ 10.53 Payment on duplicate certificate.

Issuance of duplicate adjusted service certificates and payment of claims based upon lost, destroyed, or mutilated, adjusted service certificates. (See §§ 10.1 to 10.4, 10.24 and 10.25, respectively.)

PART 11—LOANS BY BANKS ON AND PAYMENT OF ADJUSTED SERVICE CERTIFICATES

LOANS BY BANKS ON ADJUSTED SERVICE CERTIFICATES UNDER SECTION 502 OF THE WORLD WAR ADJUSTED COMPENSATION ACT

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APPLICATION FOR PAYMENT OF ADJUSTED SERVICE CERTIFICATE UNDER THE WORLD WAR ADJUSTED COMPENSATION ACT, AS AMENDED (PUB. L. 120, 68TH CONG.)

11.125 Settlement of matured adjusted service certificates.
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11.129 Form of application for payment of deceased veteran's certificate.
11.130 Where to file applications.

AUTHORITY: 72 Stat. 1114; 38 U.S.C. 501. Rights and benefits are continued in effect by sec. 12(b), 72 Stat. 1264, 38 U.S.C. note prec. Part 1, unless otherwise noted.

LOANS BY BANKS ON ADJUSTED SERVICE CERTIFICATES UNDER SECTION 502 OF THE WORLD WAR ADJUSTED COMPENSATION ACT

SOURCE: 13 FR 7125, Nov. 27, 1948, unless otherwise noted.

§ 11.75 Certificates.

Adjusted service certificates are dated as of the 1st day of the month in which the applications were filed, but no certificates are dated prior to January 1, 1925. Loans on the security of such certificates may be made at any time after the date of the certificate. The fact that a certificate is stamped or marked ''duplicate'' does not destroy its value as security for a loan.

§ 11.76 To whom loan may be made.

Only the veteran named in the certificate can lawfully obtain a loan on his adjusted service certificate and neither the beneficiary nor any other person than the veteran has any rights in this respect. The person to whom the loan is made must be known to the lending bank to be the veteran named in the certificate securing such note. The consent of the beneficiary is not required, the act providing that a loan on the security of the certificate may be made ''with or without the consent of the beneficiary thereof.'' Loans may be made to veterans adjudged incompetent only through the guardians of such veterans and pursuant to specific order of the court having jurisdiction. Certified copy of court order must be submitted if note be presented for redemption by the Department of Veterans Affairs.

§ 11.77 By whom loans may be made.

Any national bank or any bank or trust company incorporated under the laws of any State, Territory, possession, or the District of Columbia, hereinafter referred to as any *bank*, is authorized to loan to any veteran upon his promissory note secured by his Adjusted Service Certificate any amount not in excess of the loan value of the certificate at the date the loan is made. Each certificate contains on its face a table for determining the loan value of the certificate, but it is provided by amendment to the World War Adjusted Compensation Act dated February 27, 1931, that the loan value of any certificate shall at no time be less than 50 percent of the face value. Upon the making of such loan, the lending bank shall promptly notify the Department of Veterans Affairs of the name of the veteran, the A-number shown immediately after the name, the number of the certificate, the amount, the rate of interest, and date of loan: However, this requirement may be waived by the Secretary of Veterans Affairs.

§ 11.80 Sale or discount of note by holding bank.

Any bank holding a note secured by an Adjusted Service Certificate may sell the note to any bank authorized to make a loan to a veteran and deliver the certificate to such bank. In case a note secured by an Adjusted Service Certificate is sold or transferred, the bank selling, discounting or rediscounting the note is required by law to notify the veteran promptly by mail at his last known post office address. No Adjusted Service Certificate is negotiable or assignable, or may serve as security for a loan, except as provided in section 502 of the World War Adjusted Compensation Act, as amended. Any negotiation, assignment or loan made in violation of section 502 of the World War Adjusted Compensation Act is void. In case of sale, discount or rediscount by the bank which made the loan, the note or notes should be accompanied by the affidavit required by § 11.85.

§ 11.81 Rediscounts with Federal Reserve Banks.

Upon the endorsement of any bank, which shall be deemed a waiver of demand, notice and protest by such bank as to its own endorsement exclusively, and subject to regulations to be prescribed by the Federal Reserve Board, any such note secured by an Adjusted Service Certificate and held by a bank is made eligible for discount or rediscount by the Federal reserve bank of the Federal reserve district in which such bank is located, whether or not the bank offering the note for discount or rediscount is a member of the Federal Reserve System and whether or

not it acquired the note in the first instance from the veteran or acquired it by transfer upon the endorsement of any other bank: *Provided*, That at the time of discount or rediscount such note has a maturity not in excess of 9 months, exclusive of days of grace, and complies in all other respects with the provisions of the law, the regulations of the Federal Reserve Board and the regulations in this part.

§ 11.83 Additional loans by reason of 50 percent loan value.

(a) It will be the policy of the Department of Veterans Affairs to redeem all loans made in accordance with the law and regulations made pursuant thereto, when such loans are made in good faith to the veteran to whom the certificate was issued. If, while his certificate is held by a bank as security for a loan, the veteran applies for the increased loan value authorized by the amendment to the World War Adjusted Compensation Act dated February 27, 1931, whether or not the loan has matured, the veteran and the bank will be informed fully of the provisions of this section and that the bank may make the loan for the additional amount or, upon request of the veteran, may send the note and certificate to the Secretary of Veterans' Affairs. The Secretary shall, if the loan was legally made, accept such certificate and note, and pay to the bank in full satisfaction of its claim the amount of the unpaid principal due it and the unpaid interest at the rate authorized by the World War Adjusted Compensation Act, as amended, up to the date of the check issued to the bank. If the veteran has not filed application for final settlement of his adjusted service certificate under the provisions of the Adjusted Compensation Payment Act, 1936, and demand is made upon the bank to present the note and certificate for redemption prior to the maturity date of the loan and during the lifetime of the veteran, interest will be payable up to the date the check is issued to the bank, or, if demanded by the bank, up to the maturity date of the loan.

(b) If, however, an application for final settlement is filed and the bank is notified to present the note and certificate to the Secretary and does so within 15 days after the mailing of such notice interest will be payable to the date the check is issued to the bank. If the bank fails to forward the note and certificate within 15 days after the mailing of the notice, interest shall be paid only up to the fifteenth day after the mailing of such notice.

§ 11.84 Redemption because of veteran's death.

If the veteran dies before the maturity of the loan, the amount of the unpaid principal and the unpaid interest shall be immediately due and payable. In such case, or if the veteran dies on the day the loan matures or within six months thereafter, the bank holding the note and certificate shall, upon notice of the death, present them to the Secretary, who shall pay to the bank, in full satisfaction of its claim the amount of the unpaid principal and unpaid interest, at the rate authorized by the World War Adjusted Compensation Act, as amended, accrued up to the date of the check issued to the bank; except that if, prior to the payment, the bank is notified of the death by the Secretary and fails to present the certificate and note to the Secretary within 15 days after the notice such interest shall be paid only up to the fifteenth day after such notice.

§ 11.85 Condition requisite for redemption.

In order to be eligible for redemption by the Department of Veterans Affairs, the note and certificate must be accompanied by an affidavit of a duly authorized officer (the capacity in which the officer serves must be shown) of the lending bank showing that the said bank has not charged or collected, or attempted to charge or collect, directly or indirectly, any fee or other compensation in respect of the loan, or any other loan made by the bank under the provisions of section 502 of the World War Adjusted Compensation Act, except the rate of interest specified in the section of the Act cited; that the person who obtained the loan is known to the lending bank to be the person named in the Adjusted Service Certificate; and that notice required by § 11.77 was promptly given. In case the note was sold or discounted by the lending

bank, there should be incorporated in the affidavit a statement that the veteran was notified promptly of the transfer by mail to his last known address. In case the note was resold or rediscounted by any other bank, affidavit shall be made by a duly authorized officer of such bank that proper notice of such resale or rediscount was promptly mailed to the veteran at his last known address. The proper execution of the appropriate affidavit on Form 6615 or 6615a will be considered as a compliance with the requirements of this section. A single affidavit setting forth the full particulars may be accepted to cover any number of veterans' notes submitted for redemption at one time. The affidavit must be executed before a judge of the United States court, a United States commissioner, a United States district attorney, a United States marshal, a collector of internal revenue, a collector of customs, a United States postmaster, a clerk of court of record under the seal of the court, an executive officer of an incorporated bank or trust company, under his official designation and the seal of the bank or trust company, or a notary public under his seal, or a diplomatic or consular officer of the United States, under his official seal.

DISPOSITION OF NOTES SECURED BY ADJUSTED CERTIFICATES REDEEMED FROM BANKS BY THE DEPARTMENT OF VETERANS AFFAIRS UNDER SECTION 502 OF THE WORLD WAR ADJUSTED COMPENSATION ACT, AS AMENDED (PUB. L. 120, 68TH CONG.)

SOURCE: 13 FR 7126, Nov. 27, 1948, unless otherwise noted.

§ 11.88 Cancellation of note.

When a veteran's note is redeemed by the Department of Veterans Affairs, the note will be canceled and both the note and certificate will be retained in the files of the Department of Veterans Affairs until such time as settlement is made.

§ 11.89 Notification of veteran.

When a note is redeemed notification will be sent to the veteran at his last known address, advising him that the Department of Veterans Affairs holds his note, and outlining the conditions governing repayment.

§ 11.91 Repayment of loans.

Should the veteran so desire, he may repay the amount due on his note in full or in installments.

§ 11.93 Failure to redeem.

(a) If the veteran fails to redeem his certificate before its maturity there will be deducted from the face value of the certificate the amount of the unpaid principal of the note of the veteran and the unpaid interest thereon through September 30, 1931.

(b) If the veteran failed to redeem his certificate and died prior to January 27, 1936, there will be deducted from the face value of the certificate the amount of the unpaid principal of the veteran's note and the unpaid interest thereon to the date of his death. If the veteran died on or after January 27, 1936, the amount to be deducted when making settlement will be the unpaid principal of the veteran's note and the unpaid interest thereon through September 30, 1931.

DEPARTMENT OF VETERANS AFFAIRS LOANS ON ADJUSTED SERVICE CERTIFICATES UNDER SECTION 502 OF THE WORLD WAR ADJUSTED COMPENSATION ACT, AS AMENDED

SOURCE: 13 FR 7126, Nov. 27, 1948, unless otherwise noted.

§ 11.96 By whom loans may be made.

Loans will be made by the Department of Veterans Affairs, Washington, DC, to any veteran, upon his promissory note secured by his adjusted service certificate, in any amount in even dollars not less than $10 and not in excess of the loan value of the certificate at the date the loan is made. Each certificate contains on its face a table for determining the loan value of the certificate but at no time is the loan value less than fifty per centum of the face value.

§ 11.99 Identification.

Before a loan is made on an adjusted service certificate, the person applying therefor will be identified as the person

entitled to the certificate offered as security. Such identification will be made in accordance with § 11.114.

[19 FR 5086, Aug. 12, 1954]

§ 11.100 Form of note.

The form of note used in making loans secured by adjusted service certificates shall follow Form 1185.

§ 11.102 Term of note.

All loans will be for a period of one year and if not paid will be automatically extended from year to year for periods of one year in the amount of the principal plus interest accrued to the end of the immediately preceding expired loan year, which total amount shall automatically become a new principal each year provided a loan may be paid off at any time by the payment of principal and accrued interest, but in no event will interest accruing after September 30, 1931, be deducted in final settlement of a certificate except as provided in § 11.93(b).

§ 11.104 Disposition of notes and certificates.

All notes and certificates shall be held in the custody of the Department of Veterans Affairs, Washington, DC 20420.

[13 FR 7126, Nov. 27, 1948, as amended at 54 FR 34982, Aug. 23, 1989]

APPLICATION FOR PAYMENT OF ADJUSTED SERVICE CERTIFICATE UNDER THE ADJUSTED COMPENSATION PAYMENT ACT, 1936 (PUB. L. 425, 74TH CONG.)

§ 11.109 Settlement of unmatured adjusted service certificates.

Where an application for final settlement of an adjusted service certificate is received in the Department of Veterans Affairs prior to the maturity date of the certificate, payment will be made under the terms of the Adjusted Compensation Payment Act, 1936. This act provides for payment of the amount due on the certificate, after deducting any unpaid loans with interest through September 30, 1931, in adjusted service bonds. These bonds will be issued by the Treasury Department in denominations of $50, in the name of the veteran only, and will bear interest at the rate of 3 percent per annum from June 15, 1936, to June 15, 1945. Any excess amount not sufficient to purchase a $50 bond will be paid by check.

[19 FR 5087, Aug. 12, 1954]

§ 11.110 Who may make application for final settlement.

A mentally competent veteran to whom an adjusted service certificate has been issued.

(a) A legally appointed guardian of an incompetent veteran. An application submitted by a legally appointed guardian must be accompanied by letters of guardianship showing the fiduciary relationship, provided such papers are not already on file in the Department of Veterans Affairs.

(b) A representative of a physically incapacitated veteran. Where application is made by a representative of a physically incapacitated veteran, the representative must attach a statement describing the veteran's incapacity. The correctness of such statement must be certified by an officer as designated in § 11.114.

(c) A superintendent or other bonded officer designated by the Secretary of the Interior to receive funds under the provision of Pub. L. No. 373, 72d Congress, may make application for an incompetent adult or minor Indian who is a recognized ward of the Government. The application must be accompanied by a certification from the superintendent or other bonded officer showing: (1) That the said beneficiary is a ward of the Government; (2) that no guardian or other fiduciary has been appointed; (3) that the officer making application has been designated by the Secretary of the Interior in accordance with Pub. L. No. 373, 72d Congress; (4) that he is properly bonded; and (5) that he will receive, handle, and account for such benefits in accordance with existing law and regulations of the Department of Interior.

(d) A manager of a Department of Veterans Affairs hospital, or a manager or superintendent of a contract hospital or State institution where the veteran is a patient may make application as custodian for the veteran. Such

application must be made with the approval of the regional chief attorney.

[19 FR 5087, Aug. 12, 1954]

§ 11.111 Form of application.

Application must be made on Department of Veterans Affairs Adjusted Compensation Form 1701.

[13 FR 7127, Nov. 27, 1948]

§ 11.114 Identification.

Before settlement is made on an adjusted service certificate, the person applying therefor will be identified as the person entitled to the settlement for which an application is made. If made in the United States or possessions, certification will be accepted if made by a United States postmaster or assistant postmaster over an impression of the post office cancellation stamp; a commissioned officer of the regular establishment of the Army, Navy, or Marine Corps; a member of the United States Senate or the House of Representatives; an officer, over his official title, of a post, chapter, or other comparable unit of an organization recognized under Veterans Regulation No. 10 (38 U.S.C. ch. 12A), or an officer over his official title, of the State or national body of such organization, or any person who is legally authorized to administer oaths in a State, Territory, possession, District of Columbia, or in a Federal judicial district, of the United States. If identification is made in a foreign country, it will be certified by an American consul, a recognized representative of an American Embassy or Legation, or by a person authorized to administer oaths under the laws of the place where identification is made; provided, there be attached to the certificate of such latter officer a proper certification by an accredited official of the State Department of the United States that such officer was authorized to administer oaths in the place where certification was made. A manager of a Department of Veterans Affairs hospital is authorized to identify patients, members, or employees of the hospital over which he has charge. An employee of the Department of Veterans Affairs who has been specifically designated in writing to do so may identify applicants during official hours and on the premises of the Department of Veterans Affairs using for this purpose, if necessary, the official records of the Department of Veterans Affairs. Field station finance employees may not be designated for this purpose.

(a) Fingerprint impressions shall be required on the application and shall be imprinted thereon in the presence of the persons identifying the veteran. In the case of veterans who are mentally incapacitated and application is being executed by a representative of the veteran, the veterans' fingerprints will be obtained if possible. If this cannot be done, as also in the case of an individual whose fingers are all missing, a statement of explanation will be required.

(b) [Reserved]

[13 FR 7127, Nov. 27, 1948, as amended at 19 FR 5087, Aug. 12, 1954]

§ 11.115 Where to file application.

The application for final settlement, accompanied by the veteran's adjusted service certificate, unless the certificate is being held in the Department of Veterans Affairs as collateral for a loan, must be forwarded to the Manager, Veterans Benefits Office, Washington, DC 20421.

[19 FR 5087, Aug. 12, 1954]

§ 11.116 Death of veteran before final settlement.

If the veteran dies after making application under the Adjusted Compensation Payment Act, 1936, but before it is filed, it may be filed by any person and will be considered valid if found to bear the bona-fide signature of the applicant, discloses an intention to claim benefits under the Act, and is filed before the maturity of the certificate and before payment is made to the beneficiary. An application made by the veteran or his legal representative shall evidence his intention to claim the benefits of this Act; no other evidence shall be acceptable.

(a) If the veteran's death occurs after the application is filed but before payment is received under this Act, or if the application is filed after death occurs but before the maturity of the certificate and before payment is made to

the beneficiary under section 501 of the World War Adjusted Compensation Act, as amended, payment under this act shall be made to the estate of the veteran irrespective of any beneficiary designation.

(b) If the veteran dies without filing a valid application under this Act, no payment under this Act shall be made. In such case, payment of the certificate will be made under the World War Adjusted Compensation Act, as amended, in accordance with § 11.128; however, in making any settlement there shall be deducted from the face value of the certificate the amount of any outstanding loans and so much of the unpaid interest as accrued prior to October 1, 1931.

[19 FR 5087, Aug. 12, 1954]

§ 11.117 Missing applications.

Where the records of the Department of Veterans Affairs show that an application, disclosing an intention to claim the benefits of this Act, has been filed and the application cannot be found, such application shall be presumed, in the absence of affirmative evidence to the contrary, to have been valid when originally filed. The determination of the correctness of this assumption shall be made by the Manager, Veterans Benefits Office, Washington, DC, or his designee.

[19 FR 5087, Aug. 12, 1954]

APPLICATION FOR PAYMENT OF ADJUSTED SERVICE CERTIFICATE UNDER THE WORLD WAR ADJUSTED COMPENSATION ACT, AS AMENDED (PUB. L. 120, 68TH CONG.)

SOURCE: 19 FR 5087, Aug. 12, 1954, unless otherwise noted.

§ 11.125 Settlement of matured adjusted service certificates.

Where an application for final settlement of an adjusted service certificate is received in the Department of Veterans Affairs subsequent to the date of maturity of the certificate, payment will be made under the terms of the World War Adjusted Compensation Act, as amended. This Act provides for payment of the face value of the certificate less any outstanding indebtedness for loans obtained on the certificate; however, interest accrued on the loans subsequent to September 30, 1931, and unpaid will be canceled insofar as the veteran is concerned.

§ 11.126 Form of application.

Either demand for payment (Form 1748) of application (Form 1701) may be used by the veteran or his legal representative in applying for final settlement of a matured certificate.

§ 11.127 Identification.

Before payment may be made on the adjusted service certificate, the person applying therefor will be identified as the person entitled to payment for which application is made. Such identification will be accepted if made by an authorized person as stated in § 11.114; also, fingerprint impressions shall be placed in the space provided on the application in accordance with § 11.114(a).

§ 11.128 Veteran dies without having filed application for final settlement.

If the veteran dies without having filed application for final settlement under the Adjusted Compensation Payment Act, 1936, and the certificate has not matured, payment will be made to the last designated beneficiary or, if no beneficiary, to his estate. If the certificate has matured, payment will be made to the veteran's estate regardless of any beneficiary designation. Payment of the amount due on a deceased veteran's certificate will be made only on an approved award based upon receipt in the Department of Veterans Affairs of an application properly executed by the person or persons entitled.

§ 11.129 Form of application for payment of deceased veteran's certificate.

Demand for payment (VA Form 8–582) is the proper form for use in applying for payment of the amount due on a deceased veteran's certificate.

§ 11.130 Where to file applications.

Application for payment of a matured certificate or a deceased veteran's certificate, accompanied by the adjusted service certificate, unless it is held in the Department of Veterans Affairs as collateral for a loan, must be

forwarded to the Manager, Veterans Benefits Office, Washington, DC, 20421.

PART 12—DISPOSITION OF VETERAN'S PERSONAL FUNDS AND EFFECTS

DISPOSITION OF VETERAN'S PERSONAL FUNDS AND EFFECTS ON FACILITY UPON DEATH, OR DISCHARGE, OR UNAUTHORIZED ABSENCE, AND OF FUNDS AND EFFECTS FOUND ON FACILITY

Sec.
12.0 Definitions.
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DISPOSITION OF PERSONAL FUNDS AND EFFECTS LEFT UPON PREMISES OF THE DEPARTMENT OF VETERANS AFFAIRS BY NON-VETERAN PATIENTS, EMPLOYEES AND OTHER PERSONS, KNOWN OR UNKNOWN

12.15 Inventory of property.
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12.18 Disposition of funds and effects left by officers and enlisted men on the active list of the Army, Navy or Marine Corps of the United States.

UNDER PUB. L. 382, 77TH CONGRESS, DECEMBER 26, 1941, AMENDING THE ACT OF JUNE 25, 1910 (24 U.S.C. 136)

12.19 Provisions of Pub. L. 382 (38 U.S.C. 17–17j).
12.20 Posting of notice provisions of Pub. L. 382.
12.21 Action upon death of veteran.
12.22 Disposition of personal property.
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OPERATION OF LOST AND FOUND SERVICE

12.24 Operation of lost and found service.

AUTHORITY: 38 U.S.C. 501, 8501–8528.

DISPOSITION OF VETERAN'S PERSONAL FUNDS AND EFFECTS ON FACILITY UPON DEATH, OR DISCHARGE, OR UNAUTHORIZED ABSENCE, AND OF FUNDS AND EFFECTS FOUND ON FACILITY

§ 12.0 Definitions.

(a) As used in respect to the disposition of property of veterans dying at Department of Veterans Affairs medical centers or other field facilities, or who are discharged or who elope, or are absent without leave therefrom, and in respect to property found thereat, the term *funds* means all types of United States currency and coin, checks payable to the decedent except checks drawn on the Treasurer of the United States which have never been negotiated, and includes deposits to the credit of the veteran in the account ''Personal Funds of Patients,'' and each competent veteran will be so advised. The term *effects* means and embraces all other property of every description, including insurance policies, certificates of stock, bonds and notes the obligation of the United States or of others, and all other papers of every character except checks drawn on the Treasurer of the United States, as well as clothing, jewelry and other forms of property, or evidences of interest therein. Checks drawn on the Treasurer of the United States which have never been negotiated will be returned to the issuing office for disposition.

(b) *Field facilities* as used in §§12.1 to 12.13 includes hospitals, centers, domiciliary activities, supply depots, and other offices over which the Department of Veterans Affairs has direct and exclusive administrative jurisdiction, and excludes State, county, city, private, and contract hospitals and hospitals or other institutions operated by the United States through agencies other than the Department of Veterans Affairs. At institutions other than field facilities as herein defined funds or effects as defined in paragraph (a) of this section, except for funds derived from VA benefits and deposited by the Department of Veterans Affairs in the account Personal Funds of Patients for incompetent veterans, will be disposed of under the laws governing such institutions. In any case where the veteran died intestate without heirs or next of

kin his or her personal property vests in the United States. Disposition of the property will be made in accordance with the provisions of §§ 12.19 to 12.23.

[13 FR 7127, Nov. 27, 1948, as amended at 25 FR 1612, Feb. 25, 1960; 79 FR 68129, Nov. 14, 2014]

§ 12.1 Designee cases; competent veterans.

(a) *Designees—general.* (1) Upon admission to a VA field facility, VA will request and encourage a competent veteran to designate in writing, on the relevant VA form, an individual to whom VA will deliver the veteran's funds and effects in the event of the veteran's death in such VA field facility. The individual named by the veteran is referred to in this part as the designee.

(2) The veteran may change or revoke a designation in writing, on the relevant VA form, at any time.

(3) If the veteran does not name a designee or if a designee is unable or unwilling to accept delivery of funds or effects, § 12.5 Nondesignee cases, applies.

(4) The designee may not be a VA employee unless such employee is a member of the veteran's family. For purposes of this section, a family member includes the spouse, parent, child, step family member, extended family member or an individual who lives with the veteran but is not a member of the veteran's family.

(5) To be effective, a completed form must be received by the facility head or facility designee prior to the veteran's death.

(b) *Delivery of funds and effects.* The delivery of the veteran's funds or effects to the designee is only a delivery of possession. Such delivery of possession does not affect in any manner:

(1) The title to such funds or effects; or

(2) The person legally entitled to ownership of such funds or effects.

(c) *Veteran becomes incompetent.* If a veteran is determined to be incompetent pursuant to an order of a state court or is determined to be unable to manage monetary VA benefits by a VA clinician after the veteran is admitted to a VA field facility, the VA field facility staff will contact the Veterans Benefits Administration for the application of 38 CFR 3.353, regarding an incompetency rating as to whether the veteran is able to manage monetary VA benefits, and, if appropriate, 38 CFR 13.55, regarding VA fiduciary appointments. If the Veterans Benefits Administration determines that a veteran is incompetent to manage monetary VA benefits, any designation by the veteran under paragraph (a) of this section will cease with respect to VA benefits that are deposited by VA into the Personal Funds of Patients. The veteran's designation will not change with respect to disposition of funds and personal effects derived from non-VA sources, unless a court-appointed guardian or conservator changes or revokes the existing designation.

(d) *Retention of funds and effects by a veteran.* Upon admission to a VA field facility, VA will encourage a competent veteran to:

(1) Place articles of little or no use to the veteran during the period of care in the custody of a family member or friend; and

(2) Retain only such funds and effects that are actually required and necessary for the veteran's immediate convenience.

(The information collection is pending Office of Management and Budget approval.)

(Authority: 38 U.S.C. 8502)

(The Office of Management and Budget has approved the information collection requirement in this section under control number 2900-0817

[79 FR 68129, Nov. 14, 2014]

§ 12.2 Designee cases; incompetent veterans.

(a) An incompetent veteran will not be informed concerning the designation of a person to receive funds or effects; but if he or she has a guardian the guardian will be requested to make such designation of himself or herself or another person to receive possession of the funds and effects (other than funds deposited by VA in Personal Funds of Patients that were derived from VA benefits) upon the incompetent's death. The guardian will sign the letter designating himself or

herself or another person with the veteran's name ''By _____, guardian of his or her estate''.

(b) No effort will be made to obtain a designation by or on behalf of an incompetent veteran who has no guardian.

[13 FR 7128, Nov. 27, 1948, as amended at 25 FR 1613, Feb. 25, 1960; 79 FR 68129, Nov. 14, 2014]

§ 12.3 Deceased veteran's cases.

(a) Immediately upon the death or the absence without leave of any beneficiary at a field facility, as defined in § 12.0(b), a survey and inventory of the funds and effects of such beneficiary will be taken in the following manner:

(1) If the death or absence without leave occurred during hospitalization, a complete inventory (VA Form 10–2687, Inventory of Funds and Effects) will be made of all personal effects (including those in the custody of the hospital, jewelry being worn by the deceased person, or jewelry and other effects in pockets of clothing he or she may have been wearing) and all funds found and moneys on deposit in Personal Funds of Patients. In the case of death of incompetent veterans after November 30, 1959, the inventory will be completed to show separately those funds deposited by VA in Personal Funds of Patients that were derived from VA benefits. For purpose of determining the source of funds, expenditures from the account will be considered as having been made from VA benefits, not to exceed the extent of deposits of such benefits. In the event death occurred during other than official working hours, the officer of the day and/or a representative of Nursing Service will collect and inventory all funds and personal effects on the person of the deceased beneficiary and on the ward, will carefully safeguard such property and, upon completion of the tour of duty, will turn the funds and effects over to the properly designated employees.

(2) If the death or absence without leave occurred while the beneficiary was assigned to a domiciliary section, or while receiving hospitalization and at time of death or absence without leave any effects are in the section, a like inventory will be made by representatives of the Chief, Domiciliary Operations and/or Medical Administration Division.

(3) The inventory report will be executed in triplicate, original and two copies. All will be signed by the employee making the inventory, and disposed of as provided for in pertinent procedural instructions.

(4) Personally owned clothing or other effects (such as tooth brushes, false teeth not containing gold, etc.), which are unserviceable by reason of wear or tear or insanitary condition, and clothing that had been supplied by the Government, will not be included in this inventory; instead, the unserviceable personally owned articles will be listed on a separate list, with their condition briefly described, and their disposition recommended in a separate report to the facility head. The facility head, if approving this recommendation, will order destruction or utilization in occupational therapy, or as wipe rags, etc., of such unserviceable articles and, when they are so destroyed or utilized, will have entered on the papers the date and nature of the disposition. The completed papers will then be placed in the correspondence file of the beneficiary. Clothing that had been supplied by the Government will be reconditioned if possible and returned to stock for issue to other eligible beneficiaries. When Government-owned clothing cannot be reconditioned it will be disposed of.

(5) When the nearest relative requests that the deceased beneficiary be clad for burial in clothing he or she personally owned, instead of burial clothing to be supplied under the contract for mortuary services, such request will be honored. A receipt in such cases will be obtained from the undertaker, specifying the articles of clothing so used. Adjustment of the undertaker's bill in the case will correspondingly be made.

(6) In accomplishing such inventories, detailed description will be given of items of material value or importance, for example:

Watch—Yellow metal (make, movement, and case number, if available without damage to watch).

Ring—Yellow metal (probably gold-plated or stamped 14–K., setting if any).

Discharge certificate.
Adjusted service certificate (number).
Bonds or stocks (name of company, registered or nonregistered, identifying number, recited par value, if any).
Bank books or other asset evidence (name of bank or other obligor, apparent value, identifying numbers, etc.).
Clothing (brief description and statement of condition). Etc.

(b) Upon completion of the survey and inventory, the effects will be turned over to the designated employee for safekeeping. Any funds found in excess of $100 which apparently were the property of the deceased will be turned over to the details clerk and delivered immediately to the agent cashier, who shall deposit same in the account ''Personal Funds of Patients''. Unendorsed checks other than Treasury checks and funds not in excess of $100 will be considered personal effects and not funds and will be handled accordingly.

[13 FR 7128, Nov. 27, 1948, as amended at 25 FR 1613, Feb. 25, 1960; 29 FR 17904, Dec. 17, 1964; 36 FR 5911, Mar. 31, 1971; 79 FR 68129, Nov. 14, 2014]

§ 12.4 Disposition of effects and funds to designee; exceptions.

(a) Upon authorization by the facility head or his or her designated representative, all funds, as defined in § 12.0 (except funds deposited by VA in Personal Funds of Patients that were derived from VA benefits where the veteran was incompetent at time of death), and effects will be delivered or sent to the designee of the deceased veteran if request therefor be made after death and within 90 days following the mailing of notice to such designee (see § 12.9(a)), unless:

(1) The executor or administrator of the estate of the deceased veteran shall have notified the facility head or his or her designated representative of his or her desire and readiness to receive such funds or effects, in which event the facility head or his or her designated representative will authorize delivery of all funds and effects to such executor or administrator upon receipt of appropriate documentary evidence of his or her qualifications and in exchange for appropriate receipts, or

(2) An heir capable of inheriting the personal property of the veteran makes claim for the funds and effects prior to delivery to the designee.

(3) Subsequent to the naming of a designee the veteran became incompetent and his or her guardian revoked such designation, in which event the facility head or his or her designated representative will deliver all funds and effects to his guardian in exchange for appropriate receipts subject to the limitation contained in paragraph (d) of this section, or

(4) Designee was the wife (or husband) of the veteran at the time of designation, and information at the disposal of the field facility indicates that she (or he) was thereafter divorced and the veteran was incompetent at or subsequent to the time of divorce, or

(5) Notwithstanding there is a designee, it is probable that title would pass to the United States under the provisions of §§ 12.19 to 12.23 issued pursuant to 38 U.S.C. 5502(e) and 38 U.S.C. 8520(a), or

(6) The facility head or his or her designated representative determines that there is reasonable ground to believe that the transfer of such possession to the designee probably would be contrary to the interests of the person legally entitled to the personal property, or there are any other special circumstances raising a serious doubt as to the propriety of such delivery to the designee.

In any case in which the facility head does not deliver the funds and effects, because of the provisions of paragraphs (a)(3), (4), and (5) of this section, he or she will develop all facts and refer the matter to the Chief Attorney of the regional office having jurisdiction over the area where the hospital is located, for advice as to the disposition which legally should be made of such funds and effects.

(b) When authorized by the facility head or his or her designated representative, the effects will be delivered or shipped to the designee. If shipped at Government expense, the shipment shall be made in the most economical manner but in no case at a cost in excess of $25. If such expenses will exceed $25, the excess amount shall be paid by the consignee to the facility head in advance. There will be no obligation on

the Government, initially or otherwise, to pay such expenses in excess of $25.

(c) When possession of funds or effects is transferred to a designee, the attention of the designee will again be directed to the fact that possession only has been transferred to him or her and that such transfer does not of itself affect title thereto and that such designee will be accountable to the owner of said funds and effects under applicable laws.

(d) Upon receipt from the proper Chief Attorney of an appropriate certification that the guardianship was in full force and effect at the time of the veteran's death and that the guardian's bond is adequate, funds (other than funds deposited by VA in Personal Funds of Patients that were derived from VA benefits) and effects of an incompetent veteran may be immediately delivered or sent to such guardian, inasmuch as the guardian had a right to possession, and he or she will be accountable therefor to the party entitled to receive the decedent's estate. If, however, it appears probable that decedent died without a valid will and left no person surviving entitled to inherit, the funds will not be paid to the former guardian but will be disposed of as provided in § 12.19(a). The effects will be sold, used, or destroyed, at the discretion of the facility head or his designated representative.

[25 FR 1613, Feb. 25, 1960, as amended at 29 FR 17904, Dec. 17, 1964; 79 FR 68129, Nov. 14, 2014]

§ 12.5 Nondesignee cases.

(a) If there exists no designee at the time of death at a hospital, domiciliary, or regional office of a veteran admitted as competent, or the designee fails or refuses to claim the funds and effects as defined in § 12.0(a) within 90 days following the mailing of notice to such designee, the facility head will take appropriate action to dispose of the effects to the person or persons legally entitled thereto, *i.e.*, the executor or administrator of the decedent, or, if no notice of such an appointment has been received, to the decedent's widow, child, grandchild, mother, father, grandmother, grandfather, brother, or sister, in the order named. Subject to the applicable provisions of §§ 12.3 and 12.4, such delivery may be made at any time before the sale contemplated by § 12.9 to the designee or other person entitled under the facts of the case. Delivery will be made to the person entitled to priority as prescribed in this paragraph, unless such person waives right to possession, in which event delivery will be to the person, if any, in whose favor such prior entitled person waives right to possession. If the waiver is not in favor of a particular person or class, delivery will be to the person or persons next in order of priority under this paragraph. If in any case there be more than one person in the class entitled to priority, initially or by reason of waiver, delivery will be made only to their joint designated agent (who may, but need not, be one of the class), or to one of such class in his or her own behalf upon written waiver of all others of the class entitled thereto. The guardian of a minor or incompetent may waive his or her ward's prior right to possession.

(b) Except where delivery is made to a designee, executor, or administrator, funds of veterans who were competent at time of death will be released to the person or persons who would ultimately be entitled to distribution under the laws of the State of the decedent's domicile. The person or persons entitled may waive in writing his or her right to the funds in favor of another heir or next of kin.

(c) Funds of veterans who were incompetent at time of death occurring after November 30, 1959, if derived from sources other than funds deposited by VA in Personal Funds of Patients that were derived from VA benefits, will be disposed of in the same manner as for competent veterans.

(d) Funds deposited by the Department of Veterans Affairs in Personal Funds of Patients, at any office, for veterans who were incompetent at time of death occurring after November 30, 1959 and which were derived from VA benefits, will be paid upon receipt of proper application to the following persons living at the time of settlement, and in the order named: the surviving spouse, the children (without regard to age or marital status) in equal parts, and the dependent parents of such veteran, in equal parts. Any funds derived

from VA benefits not disposed of in accordance with this paragraph shall be deposited to the credit of the applicable current appropriation; except that there may be paid only so much of such funds as may be necessary to reimburse a person (other than a political subdivision of the United States) who bore the expenses of last sickness or burial of the veteran for such expenses.

(e) No payment shall be made under paragraph (d) of this section unless claim therefor is filed with the Department of Veterans Affairs within 5 years after the death of the veteran, except that, if any person so entitled under such regulation is under legal disability at the time of death of the veteran, such 5–year period of limitation shall run from the termination or removal of the legal disability.

[18 FR 1854, Apr. 3, 1953 and 25 FR 1614, Feb. 25, 1960, as amended at 29 FR 17904, Dec. 17, 1964; 79 FR 68129, Nov. 14, 2014]

§ 12.6 Cases of living veterans.

(a) Except as provided in § 12.8, effects of veterans absent without leave or who have been discharged or have eloped (and who are not to be returned to the field facility) will be disposed of as follows:

(1) To the owner if competent, or if deceased to his or her administrator or executor or as directed in writing by such owner, or his or her executor or administrator.

(2) To the guardian of the owner if the latter be incompetent, or if deceased to his or her administrator or executor, or as directed in writing by such guardian, executor or administrator.

(3) To the incompetent owner if he or she has no guardian; delivery, however, to the incompetent owner may be withheld and may be made to the person who is caring for such incompetent if, in the judgment of the facility head or his or her designated representative, such delivery is to the incompetent's best interest.

NOTE: The Government will not pay expense of transportation of effects of competent or incompetent veterans discharged, on trail visit, absent without leave, or who have eloped, except that personal effects of a beneficiary discharged or on trail visit, or of a beneficiary being transferred to another facility at Government expense, which are not available at time of discharge, beginning of trail visit, or transfer of the beneficiary, due to the articles being in custody of the Government, may be shipped at Government expense.

(b) Funds of veterans absent without leave or who have been discharged or have eloped (and who are not to be returned to the station) will be disposed of in accordance with the provisions of current Department of Veterans Affairs procedures.

[13 FR 7129, Nov. 27, 1948, as amended at 17 FR 1687, Feb. 26, 1952; 19 FR 9330, Dec. 30, 1954; 29 FR 17904, Dec. 17, 1964]

§ 12.7 Cases not applicable to provisions of §§ 12.0 to 12.6.

The provisions of §§ 12.0 to 12.6 shall be inapplicable to property known to be that of any person dying in or discharged or absent without leave from a Department of Veterans Affairs field facility other than a veteran admitted as such to such field facility.

[13 FR 7129, Nov. 27, 1948]

§ 12.8 Unclaimed effects of veterans.

(a) In the case of any property of a veteran who was in receipt of hospital or domiciliary care, heretofore or hereafter left at a Department of Veterans Affairs field facility, the owner of which is discharged or absent without leave or who has eloped and is not to be returned to a Department of Veterans Affairs field facility, or has died after departure therefrom, or in case the whereabouts or identity of any owner of any property thereat be unknown, such property, unless it shall be disposed of under the provisions of §§ 12.4 and 12.6 shall be sold, used, destroyed or otherwise disposed of as the manager or his or her designated representative shall determine the circumstances in the case may warrant. Any sale of such property shall be conditioned upon the 90–day notice provided in section 6 of the Act of June 25, 1938 (38 U.S.C. 5–16e).

(b) If the circumstances are such that retention of any property as is mentioned in paragraph (a) of this section, or of any property of unknown ownership found on the premises would endanger the health or life of patients or others on the premises (by reason of

contagion, infection, or otherwise) such property shall be forthwith destroyed on order of the manager or his or her designated representative, and proper record of the action taken will be made.

(c) If there be no known claimant of any such property and if it may be used at the field facility for the benefit of the members or patients for such purposes as the General Post Fund is intended to serve, and if the value is inconsequential, the manager or his or her designated representative may authorize the retention and use of such property at the field facility.

(d) Any such property which is not destroyed or used as provided in paragraphs (b) and (c) of this section shall be sold in the manner provided in §§ 12.9 and 12.10, after notice as therein provided unless, prior to sale, claim be made for any such property by someone legally entitled thereto.

[13 FR 7129, Nov. 27, 1948]

§ 12.9 Rights of designate; sales instruction; transportation charges.

(a) Upon death of a veteran admitted as such to a field facility, the Manager or his or her designated representative will cause notice (parts I and V of VA Form 10–1171) to be sent to the designate: *Provided, however,* That if the Manager or his or her designated representative has information of the death of the primary designate, notice shall be sent to the alternate designate and all of the provisions of the regulations in this part respecting the designate will be deemed to apply to the alternate. If the designate is a minor or a person known to be incompetent, delivery of the funds or effects will be made only to the designate's guardian or custodian upon qualification. The right of the designate to receive possession ceases when he or she refuses to accept delivery or if he or she fails to respond within 90 days after VA Form 10–1171 was mailed. When the right of a designate ceases, VA Form 10–1171 will be forwarded immediately to the alternate designate, whose rights then become identical with those forfeited by the first designate, and the rights of the alternate designate shall terminate at the expiration of 90 days after VA Form 10–1171 was mailed to him or her. Delivery will not be made to a designate until he or she submits a signed statement to the effect that he or she understands that the delivery of such funds and effects constitutes a delivery of possession only and that such delivery is not intended to affect in any manner the title thereto. Such notice shall fully identify the decedent and state the fact that he or she designated the addressee to receive possession of such property; that the right to receive possession thereof does not affect the ownership but that the designate will be responsible for the ultimate disposition thereof to those who, under applicable law, are entitled to the decedent's property; and will request prompt advice as to whether the designate will accept such property and that, if he or she will, he or she furnish shipping instructions, upon receipt of which the property will be shipped at the expense of the Government. However, prior to dispatching such notice, it will be definitely determined that the shipping expense will not exceed $25. If such expense will exceed $25, the excess cost will be ascertained, and the notice will include a statement of the amount of such excess shipping cost with request that the amount thereof be remitted at the time shipping instructions are furnished. In estimating the shipping expense, it will be assumed that shipment to the designate will be to the same address as that to which the notice is sent. Each notice, however, shall contain a statement that in no event will the Government pay shipping expense in excess of $25. The notice will include a copy of the inventory of the property which it is proposed to deliver to the designate.

(b) Upon receipt of appropriate shipping instructions the property will be shipped, transportation charges prepaid, by mail, express, or freight as may be appropriate under the circumstances and most economical to the Government. The expense of such shipment, chargeable to the Government, in no case to exceed $25.00, is payable the same as other administrative expenses of the Department of Veterans Affairs.

(c) The living owner of any property left or found at a field facility will be promptly notified thereof. Except as

provided in § 12.6(a), transportation charges on property shipped to a living veteran will not be paid by the Government. In such cases, shipment shall be made as requested by the owner of the property (or his or her guardian) upon receipt of necessary transportation charges, which will be prepaid, unless the owner requests shipment with charges collect and the carrier will accept such shipment without liability for such charges, contingent or otherwise, upon the Government.

(d) If the designate refuses or, upon the lapse of 90 days, has failed to take possession or request shipment of decedent's property (paragraph (a) of this section), or if 90 days have elapsed after the finding of any property and the owner (known or unknown) has failed to request same, the manager or his or her designated representative will authorize destruction, use or sale.

(e) If sale of the property is authorized the manager will take necessary action to ascertain the names and addresses, of the owners; or, in the event of the owner's decease, of his or her executor or administrator, widow, child, grandchild, mother, father, grandmother, grandfather, brother, or sister.

(f) When in possession of the necessary information the manager will cause proper notice of sale (Form 4–1171) to be mailed. Such notice in all cases shall disclose the identity, if known, of the decedent whose property is to be sold and contain a copy of the inventory of such property. A copy of such notice (Form 4–1171), after parts I, IV, and V thereof are completed, shall be mailed to the owner, if known, or if deceased to the decedent's executor or administrator, if known, and also to the widow (or widower), child, grandchild, mother, father, grandmother, grandfather, brother and sister, if known. If more than one relative of the degree named is known, copy will be mailed to each. If the owner is living, parts IV and V only of Form 4–1171 will be completed.

(g) Copy of such notice (Form 4–1171, parts IV and V) will also be posted by a responsible employee more than 21 years of age at:

(1) The field facility where the death occurred or property shall have been found,

(2) The place where property is situated at the time such notice is posted, and

(3) The place where probate notices are posted in the county wherein the sale is to be had.

(h) In addition to showing the name of the owner, if known (alive or deceased), and the inventory of the property to be sold, such notice shall state the hour and day when and the precise place where the sale will occur and that the same will be at public auction for cash upon delivery without warranty, express or implied, and that such sale is pursuant to the act of June 25, 1938 (38 U.S.C. 16–16j); and shall also state that any person legally entitled to said property may claim the same at any time prior to sale thereof and in the event of such claim by a proper person the property will not be sold but will be delivered to the person lawfully entitled thereto. Said notice shall also contain a statement substantially to the effect that if sold the net proceeds of sale may be claimed by the person who is legally entitled at any time within 5 years after the date of notice; or in case of property the ownership of which was not originally known, within 5 years after its finding; otherwise such proceeds will be retained in the General Post Fund, subject to disbursement for the purposes of such fund.

(i) The person (or persons) posting said notice of sale (Form 4–1171) shall make appropriate affidavit on a copy thereof as to his or her action in that respect and the manager or his or her designated representative will also certify on the same copy as to the persons to whom copies of such notice were mailed and the mailing dates. The copy on which appear the affidavit and certificate as to service of the notice will be retained in the facility file pertaining to the disposition of such property.

[13 FR 7129, Nov. 27, 1948, as amended at 15 FR 663, Feb. 7, 1950; 23 FR 5, Jan. 1, 1958]

§ 12.10 Proceeds of sale.

After proper notice as prescribed, sale of any such property which it is proper to sell, will be made by public auction by the manager (or any employee designated by him or her) at the time and place stated in the notice of

sale. The property will be sold to the highest bidder (no employee except member employees of the Department of Veterans Affairs shall purchase any of this property) and forthwith delivered and the amount of the bid collected and deposited to the credit of ''General Post Fund, Department of Veterans Affairs.'' Care will be taken to segregate the property of each owner and separate account will be maintained as to the proceeds of sale thereof. Property not disposed of by public auction will be included in the next sale or will be used or destroyed as the value thereof warrants at the discretion of the manager.

[13 FR 7130, Nov. 27, 1948]

§ 12.12 Miscellaneous provisions.

If it is shown that some person other than the veteran has title to property in a veteran's possession at the time of death, nothing contained in §§ 12.0 to 12.12 shall be construed as prohibiting delivery of such property to the owner. A life insurance policy may be delivered to the beneficiary therein named if the insured is deceased, notwithstanding the veteran has designated a person to whom possession of his or her property at the field facility is to be transferred. In no case will funds or effects be delivered to a minor, or to an incompetent person other than as provided in § 12.9 (a) and (c), but where any such person is entitled to title or possession delivery may be made to his or her guardian.

[13 FR 7130, Nov. 27, 1948]

§ 12.13 Posting of notice of the provisions of Pub. L. No. 734, 75th Congress (38 U.S.C. 16–16j).

In order that all persons who bring property on premises of the Department of Veterans Affairs may be advised of the existence of the act of June 25, 1938 (38 U.S.C. 16–16j), and that it affects such property, notice thereof (Form 4–1182), shall be permanently posted in at least one prominent place on the premises of each field facility where persons are likely to see such notice.

[13 FR 7130, Nov. 27, 1948]

DISPOSITION OF PERSONAL FUNDS AND EFFECTS LEFT UPON PREMISES OF THE DEPARTMENT OF VETERANS AFFAIRS BY NON-VETERAN PATIENTS, EMPLOYEES AND OTHER PERSONS, KNOWN OR UNKNOWN

§ 12.15 Inventory of property.

Immediately upon the death at a Department of Veterans Affairs field facility of a person who was not admitted as a veteran, or immediately after it is ascertained that any such person has absented himself or herself from such field facility, a survey and inventory of the personal funds and effects of such deceased or absent person will be made in the manner prescribed in § 12.3(a).

[13 FR 7130, Nov. 27, 1948]

§ 12.16 Action on inventory and funds.

(a) The manager will dispose of the personal funds and effects as promptly as possible. No expense will be incurred by the Government for shipment of the effects.

(b) In making disposition of funds and effects the manager will release the funds to the owner if living and will release the effects to him or her or as directed by him or her, provided that if he or she is incompetent and has a guardian the funds and effects will be released to such guardian. If the owner is deceased, and left a last will and testament probated under the laws of the place of his or her last legal domicile or under the laws of the State, territory, insular possession, or dependency, within which the field facility may be, the personal property of such decedent situated upon such premises will be released to the executor. If such person left on said premises funds or effects not disposed of by a will probated in accordance with the provisions of this paragraph, such property shall be released to the administrator, if one has been appointed.

(c) In those cases where there is neither an administrator nor an executor the funds and effects will be released to the person entitled to inherit the personal property of the decedent under the intestacy laws of the State where the decedent was last domiciled.

(d) Where disposition of the funds and effects cannot be accomplished under the provisions of paragraphs (b) and (c)

of this section, the funds, at the expiration of 90 days will be deposited to the General Post Fund and the effects will be disposed of in accordance with the provisions of §§ 12.8, 12.9, and 12.10.

[13 FR 7131, Nov. 27, 1948, as amended at 14 FR 4726, July 28, 1949]

§ 12.17 Unclaimed effects to be sold.

(a) Personal effects of persons referred to in § 12.15 which remain unclaimed for 90 days after the death or departure of the owner shall be sold in the manner provided by § 12.8. The owner, his or her personal representative, or next of kin may reclaim any such property upon request therefor at any time prior to the sale.

(b) Any unclaimed funds and the proceeds of any effects sold as unclaimed will be deposited to the General Post Fund subject to be reclaimed within five years after notice of sale, by or on behalf of any person or persons who, if known, would have been entitled to the property prior to the sale.

[13 FR 7131, Nov. 27, 1948, as amended at 14 FR 4726, July 28, 1949]

§ 12.18 Disposition of funds and effects left by officers and enlisted men on the active list of the Army, Navy or Marine Corps of the United States.

(a) The manager will notify the commanding officer of the death or absence of such patient and will deliver to the commanding officer, without expense to the Department of Veterans Affairs, the funds and effects of the deceased or absent officer, or enlisted man procuring a receipt therefor.

(b) If the funds and effects are not delivered to the commanding officer within seven days after the death or absence without leave of an officer, or enlisted man, the funds will be deposited in the Personal Funds of Patients. If not disposed of at the expiration of 90 days after the date of death or absence, the funds will be transferred to the General Post Fund and the effects will be handled in accordance with regulations governing the disposition of unclaimed effects left by veterans. The funds and the proceeds derived from the sale of the personal effects will be paid to the person lawfully entitled thereto, providing claim is made within five years from the date of notice of sale, or in the case of legal disability within five years after termination of legal disability.

[13 FR 7131, Nov. 27, 1948, as amended at 14 FR 4726, July 28, 1949]

UNDER PUB. L. 382, 77TH CONGRESS, DECEMBER 26, 1941, AMENDING THE ACT OF JUNE 25, 1910 (24 U.S.C. 136)

§ 12.19 Provisions of Pub. L. 382 (38 U.S.C. 17–17j).

(a) Whenever any veteran (admitted as a veteran) shall die in any Department of Veterans Affairs hospital, center, or domiciliary activity or in any Federal, State, or private hospital or other institution, while being furnished care or treatment therein by the Department of Veterans Affairs, without leaving a will and without leaving any spouse, heirs, or next of kin entitled to his or her personal property, all such property, except funds on deposit in Personal Funds of Patients to the credit of an incompetent beneficiary, derived from payments of compensation, automatic or term insurance, emergency officers' retirement pay or pension, shall immediately vest in and become the property of the United States as trustee for the sole use and benefit of the General Post Fund, subject to claim as elsewhere provided. Funds to the credit of an incompetent beneficiary derived from payments of compensation, automatic or term insurance, emergency officers' retirement pay or pension will be deposited to the credit of the current appropriations provided for the payment of compensation, insurance or pension.

(b) *Personal property* as used in this section shall include cash, funds on deposit in Personal Funds of Patients, bank accounts, certificates of stock, bonds, and notes, the obligation of the United States or of others, money orders, checks, insurance policies the proceeds of which are payable to the veteran or his or her estate, postal savings certificates, money and choses in action, and all other papers of every character; also clothing, jewelry, and all other forms of personalty, or evidences of interest therein.

[19 FR 9330, Dec. 30, 1954]

§ 12.20 Posting of notice provisions of Pub. L. 382.

(a) VA Form 10–P–10, Application for Hospital Treatment or Domiciliary Care, includes notice to the applicant that the acceptance of care or treatment by any veteran shall constitute acceptance of the provisions of the act. Similar notice shall be given to each veteran receiving care as of March 26, 1942, by posting notice in a prominent place in each building wherein patients or members are housed. Such notices shall be posted immediately and kept posted.

(b) Since the provisions of the law are applicable to all veterans receiving care at the expense of the Department of Veterans Affairs (whether in contract, Federal, State or private hospital) it shall be the responsibility of the Department of Veterans Affairs officer authorizing admission of a veteran to other than a Department of Veterans Affairs hospital, center or home, to cause the chief officer of such institution to post in a conspicuous place, in all buildings where veterans are housed, the provisions of § 12.19(a), or if he or she declines to post such provisions, notify the patients individually and supply a statement from each acknowledging notice. Such provisions supersede in part the provisions of Form 10–P–10, executed prior to March 26, 1942.

[13 FR 7131, Nov. 27, 1948, as amended at 14 FR 243, Jan. 18, 1949]

§ 12.21 Action upon death of veteran.

Upon the death of a veteran at a Department of Veterans Affairs hospital, center or domiciliary activity while receiving care or treatment therein, and who it is believed leaves no will or heirs or next of kin entitled to his or her personal property, regardless of whether VA Form 10–P–10, executed by the veteran, names a designee, an inventory of the funds and effects, VA Form 10–2687, will be promptly prepared and supplemented by all information or evidence available as to personal property owned by the veteran in addition to that left at the place of death; similar action will be taken when the death of such a veteran hospitalized by the Department of Veterans Affairs occurs at a contract hospital, Army, Navy, Marine or other hospital. Such inventories and information together with any bank books, stocks, bonds, or other valuable paper as enumerated in § 12.19(b), left in the effects of the veteran, will be delivered to the manager of the Department of Veterans Affairs hospital, center, or domiciliary activity having jurisdiction, for disposition in accordance with existing regulations.

[14 FR 243, Jan. 18, 1949]

§ 12.22 Disposition of personal property.

Any assets heretofore or hereafter accruing to the benefit of the General Post Fund, including stocks, bonds, checks, bank deposits, savings certificates, money orders, and similar assets, will be sold or otherwise converted into cash, except that articles of personal adornment which are obviously of sentimental value shall, if unclaimed, be retained for 5 years from the date of death of the veteran, unless for sanitary or other reasons their retention is deemed unsafe. Possession of effects other than those located on the premises of the Department of Veterans Affairs will be obtained, except that if transportation, storage, etc., is involved, determination will be made as to whether expenditure therefor is warranted. Proceeds from the conversion or sale will be deposited to the credit of the General Post Fund. Funds on deposit in Personal Funds of Patients will be transferred to the General Post Fund. Any claims against the estate of the deceased veteran will be adjudicated and paid, if valid.

[33 FR 1073, Jan. 27, 1968]

§ 12.23 Recognition of valid claim against the General Post Fund.

Effective December 26, 1941, the assets of the estate of a veteran theretofore or thereafter deposited to the General Post Fund are subject to the valid claims of creditors presented to the Department of Veterans Affairs within 1 year from the date of death or otherwise as provided by any applicable law. Any heir, next of kin, legatee, or other person found to be legally entitled to the personal property of the veteran

may claim same within 5 years from the date of the veteran's death. If claimant is under any legal disability (as a minor, incompetent, etc.) at the date of the veteran's death, the 5-year period begins upon the termination of removal of legal disability. Such claims are for settlement by the field facility which had originally made the deposit. In the event of doubt as to entitlement or the necessity of legal proceedings to obtain assets for the benefit of the General Post Fund, the case will be referred to the Chief Attorney of jurisdiction for advice and/or appropriate action. Any necessary court costs or expenses will be paid from the appropriation, General Operating Expenses, Department of Veterans Affairs.

[33 FR 1073, Jan. 27, 1968]

OPERATION OF LOST AND FOUND SERVICE

§ 12.24 Operation of lost and found service.

Unless maintained by the Public Buildings Service, the lost and found service will be maintained by an employee designated by the Manager to be known as the lost and found custodian. VA Form 3771, Record of Lost or Found Article, will be used for recording articles of any personal property lost or found. Every effort will be made to determine rightful ownership of found articles and to recover items which have been reported lost. Currency, including readily negotiable instruments, found and delivered to the lost and found custodian will not be retained beyond the official closing hour. The currency or negotiable instruments will be delivered to the agent cashier before the close of business. Individuals claiming found articles will furnish complete identification and satisfy the facility authority of rightful ownership. Where more than one individual claims ownership the matter will be referred to the Manager for decision. All articles of personal property remaining unclaimed for 90 days or more will be disposed of in accordance with § 12.8.

[21 FR 3875, June 6, 1956]

PART 13—FIDUCIARY ACTIVITIES

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AUTHORITY: 38 U.S.C. 501, 5502, 5506–5510, 6101, 6106–6108, and as noted in specific sections.

SOURCE: 83 FR 32738, July 13, 2018, unless otherwise noted.

§ 13.10 Purpose and applicability of other regulations.

(a) *Purpose.* The regulations in this part implement the Department of Veterans Affairs' (VA) fiduciary program, which is authorized by 38 U.S.C. chapters 55 and 61. The purpose of the fiduciary program is to protect certain VA beneficiaries who, as a result of injury, disease, or infirmities of advanced age, or by reason of being less than the age of majority, cannot manage their VA benefits. Under this program, VA oversees these vulnerable beneficiaries to ensure their well-being, and appoints and oversees fiduciaries who manage these beneficiaries' benefits.

(b) *Applicability of other regulations.* Fiduciary matters arise after VA has determined that a beneficiary is entitled to benefits, and decisions on fiduciary matters are not decisions on claims for VA monetary benefits. Accordingly, VA's regulations governing

the adjudication of claims for benefits, *see* 38 CFR part 3, do not apply to fiduciary matters unless VA has prescribed applicability in this part.

(Authority: 38 U.S.C. 501)

§ 13.20 Definitions.

The following definitions apply to this part:

Dependent means a beneficiary's spouse as defined by this section, a beneficiary's child as defined by § 3.57 of this chapter, or a beneficiary's parent as defined by § 3.59 of this chapter, who does not have an income sufficient for reasonable maintenance and who obtains support for such maintenance from the beneficiary.

Fiduciary means an individual or entity appointed by VA to receive VA benefits on behalf of a beneficiary for the use and benefit of the beneficiary and the beneficiary's dependents.

Hub Manager means the individual who has authority to oversee the activities of a VA Fiduciary Hub or the Veterans Service Center Manager of the Manila, Philippines, VA Regional Office.

In the fiduciary program means, with respect to a beneficiary, that the beneficiary:

(1) Has been rated by VA as incapable of managing his or her own VA benefits as a result of injury, disease, or the infirmities of advanced age;

(2) Has been determined by a court with jurisdiction as being unable to manage his or her own financial affairs; or

(3) Is less than the age of majority.

Rating authority means VA employees who have authority under § 3.353 of this chapter to determine whether a beneficiary can manage his or her VA benefits.

Relative means a person who is an adopted child or is related to a beneficiary by blood or marriage, as defined by this chapter.

Restricted withdrawal agreement means a written contract between VA, a fiduciary, and a financial institution in which the fiduciary has VA benefit funds under management for a beneficiary, under which certain funds cannot be withdrawn without the consent of the Hub Manager.

Spouse means a husband or wife whose marriage, including common law marriage and same-sex marriage, meets the requirements of 38 U.S.C. 103(c).

VA benefit funds under management means the combined value of the VA funds maintained in a fiduciary account or accounts managed by a fiduciary for a beneficiary under § 13.200 and any VA funds invested by the fiduciary for the beneficiary under § 13.210, to include any interest income and return on investment derived from any account.

Written notice means that VA will provide to the beneficiary and the beneficiary's representative and legal guardian, if any, a written decision in a fiduciary matter that is appealable under § 13.600. Such notice will include:

(1) A clear statement of the decision,

(2) The reason(s) for the decision,

(3) A summary of the evidence considered in reaching the decision, and

(4) The necessary procedures and time limits to initiate an appeal of the decision.

(Authority: 38 U.S.C. 501)

§ 13.30 Beneficiary rights.

Except as prescribed in this part, a beneficiary in the fiduciary program is entitled to the same rights afforded any other VA beneficiary.

(a) *General policy*. Generally, a beneficiary has the right to manage his or her own VA benefits. However, due to a beneficiary's injury, disease, or infirmities of advanced age or by reason of being less than the age of majority, VA may determine that the beneficiary is unable to manage his or her benefits without VA supervision or the assistance of a fiduciary. Or a court with jurisdiction might determine that a beneficiary is unable to manage his or her financial affairs. Under any of these circumstances, VA will apply the provisions of this part to ensure that VA benefits are being used to maintain the well-being of the beneficiary and the beneficiary's dependents.

(b) *Specific rights*. The rights of beneficiaries in the fiduciary program include, but are not limited to, the right to:

(1) Receive direct payment of recurring monthly benefits until VA appoints a fiduciary if the beneficiary reaches the age of majority or older;

(2) Receive written notice regarding VA's appointment of a fiduciary or any other decision on a fiduciary matter that affects VA's provision of benefits to the beneficiary;

(3) Appeal to the Board of Veterans' Appeals VA's appointment of a fiduciary;

(4) Be informed of the fiduciary's name, telephone number, mailing address, and email address;

(5) Contact his or her fiduciary and request a disbursement of funds for current or foreseeable needs or consideration for payment of previously incurred expenses, account balance information, or other information or assistance consistent with the responsibilities of the fiduciary prescribed in § 13.140;

(6) Obtain from his or her fiduciary a copy of the fiduciary's VA-approved annual accounting;

(7) Have VA reissue benefits misused by a fiduciary if VA is negligent in appointing or overseeing the fiduciary or if the fiduciary who misused the benefits meets the criteria prescribed in § 13.410;

(8) Appeal to the Board of Veterans' Appeals VA's determination regarding its own negligence in misuse and reissuance of benefits matters;

(9) Submit to VA a reasonable request for appointment of a successor fiduciary. For purposes of this paragraph, *reasonable request* means a good faith effort to seek replacement of a fiduciary, if:

(i) The beneficiary's current fiduciary receives a fee deducted from the beneficiary's account under § 13.220 and the beneficiary requests an unpaid volunteer fiduciary who ranks higher in the order of preference under § 13.100(e);

(ii) The beneficiary requests removal of his or her fiduciary under § 13.500(a)(1)(iii) and supervised direct payment of benefits under § 13.110; or

(iii) The beneficiary provides credible information that the current fiduciary is not acting in the beneficiary's interest or is unable to effectively serve the beneficiary due to a personality conflict or disagreement and VA is not able to obtain resolution;

(10)(i) Be removed from the fiduciary program and receive direct payment of benefits without VA supervision provided that the beneficiary:

(A) Is rated by VA as able to manage his or her own benefits; or

(B) Is determined by a court with jurisdiction as able to manage his or her financial affairs if the beneficiary is in the fiduciary program as a result of a court order and not a decision by VA's rating agency; or

(C) Attains the age of majority;

(ii) Have a fiduciary removed and receive direct payment of benefits with VA supervision as prescribed in § 13.110 regarding supervised direct payment and § 13.500 regarding removal of fiduciaries generally, provided that the beneficiary establishes the ability to manage his or her own benefits with limited and temporary VA supervision; and

(11) Be represented by a VA-accredited attorney, claims agent, or representative of a VA-recognized veterans service organization. This includes the right to have a representative present during a field examination and the right to be represented in the appeal of a fiduciary matter under § 13.600.

(Authority: 38 U.S.C. 501)

(Approved by the Office of Management and Budget under control number 2900–0017)

§ 13.40 Representation of beneficiaries in the fiduciary program.

The provisions of 38 CFR 14.626 through 14.629 and 14.631 through 14.637 regarding accreditation and representation of VA claimants and beneficiaries in proceedings before VA are applicable to representation of beneficiaries before VA in fiduciary matters governed by this part.

(a) *Accreditation*. Only VA-accredited attorneys, claims agents, and accredited representatives of VA-recognized veterans service organizations who have complied with the power-of-attorney requirements in § 14.631 of this chapter may represent beneficiaries before VA in fiduciary matters.

(b) *Standards of conduct*. Accredited individuals who represent beneficiaries in fiduciary matters must comply with

the general and specific standards of conduct prescribed in §14.632(a) through (c) of this chapter, and attorneys must also comply with the standards prescribed in §14.632(d). For purposes of this section:

(1) A fiduciary matter is not a claim for VA benefits. However, the term *claimant* in §14.632 of this chapter includes VA beneficiaries who are in the fiduciary program, and the term *claim* in §14.632 includes a fiduciary matter that is pending before VA.

(2) The provisions of §14.632(c)(7) through (9) of this chapter mean that an accredited individual representing a beneficiary in a fiduciary matter may not:

(i) Delay or refuse to cooperate in the processing of a fiduciary appointment or any other fiduciary matter, including but not limited to a field examination prescribed by §13.120 and the investigation of a proposed fiduciary prescribed by §13.100;

(ii) Mislead, threaten, coerce, or deceive a beneficiary in the fiduciary program or a proposed or current fiduciary regarding payment of benefits or the rights of beneficiaries in the fiduciary program; or

(iii) Engage in, or counsel or advise a beneficiary or proposed or current fiduciary to engage in, acts or behavior prejudicial to the fair and orderly conduct of administrative proceedings before VA.

(3) The Hub Manager will submit a written report regarding an alleged violation of the standards of conduct prescribed in this section to the VA Chief Counsel who administers the accreditation program for a determination regarding further action, including suspension or cancellation of accreditation under §14.633 of this chapter, and notification to any agency, court, or bar to which the attorney, agent, or representative is admitted to practice.

(c) *Fees*. Except as prescribed in paragraphs (c)(1)(i) through (iii) of this section, an accredited attorney or claims agent may charge a reasonable fixed or hourly fee for representation services provided to a beneficiary in a fiduciary matter, provided that the fee meets the requirements of §14.636 of this chapter.

(1) The following provisions of §14.636 of this chapter do not apply in fiduciary matters:

(i) Fees under §14.636(e) of this chapter, to the extent that the regulation authorizes a fee based on a percentage of benefits recovered;

(ii) The presumptions prescribed by §14.636(f) of this chapter based upon a percentage of a past-due benefit amount. In fiduciary matters, the reasonableness of a fixed or hourly-rate fee will be determined based upon application of the reasonableness factors prescribed in §14.636(e); and

(iii) Direct payment of fees by VA out of past-due benefits under §14.636(g)(2) and (h) of this chapter.

(2) An accredited attorney or claims agent who wishes to charge a fee for representing a beneficiary in a fiduciary matter must comply with the fee agreement filing requirement prescribed in §14.636(g)(3) of this chapter.

(3) VA, the beneficiary, or the beneficiary's fiduciary may challenge the reasonableness of a fee charged by an accredited attorney or claims agent using the procedures prescribed in §14.636(i) of this chapter.

(Authority: 38 U.S.C. 501, 38 U.S.C. chapter 59)

§ 13.50 Suspension of benefits.

(a) Notwithstanding the beneficiary rights prescribed in §13.30, the Hub Manager will temporarily suspend payment of benefits and hold such benefits in the U.S. Treasury to the credit of the beneficiary or take other action that the Hub Manager deems appropriate to prevent exploitation of VA benefit funds or to ensure that the beneficiary's needs are being met, if:

(1) The beneficiary or the beneficiary's attorney, claims agent, or representative withholds cooperation in any of the appointment and oversight procedures prescribed in this part; or

(2) VA removes the beneficiary's fiduciary for any reason prescribed in §13.500(b) and is unable to appoint a successor fiduciary before the beneficiary has an immediate need for disbursement of funds.

(b) All or any part of the funds held in the U.S. Treasury to the beneficiary's credit under paragraph (a) of this section will be disbursed under the

order and in the discretion of the VA Regional Office Director who has jurisdiction over the fiduciary hub or regional office for the benefit of the beneficiary or the beneficiary's dependents.

(Authority: 38 U.S.C. 501, 512, 5502, 5504)

§ 13.100 Fiduciary appointments.

(a) *Authority*. Except as prescribed in paragraph (b) of this section, the Hub Manager will appoint a fiduciary for a beneficiary who:

(1) Has been rated by VA as being unable to manage his or her VA benefits,

(2) Has been determined by a court with jurisdiction as being unable to manage his or her financial affairs, or

(3) Has not reached age of majority.

(b) *Exceptions*. The Hub Manager will not appoint a fiduciary for a beneficiary who:

(1) Is eligible for supervised direct payment under § 13.110, or

(2) Is not a beneficiary described in paragraph (a)(1) or (a)(2) of this section and has not reached age of majority, but

(i) Is serving in the Armed Forces of the United States, or

(ii) Has been discharged from service in the Armed Forces of the United States, or

(iii) Qualifies for survivors' benefits as a surviving spouse.

(c) *Retroactive benefit payments*. The Hub Manager will withhold any retroactive, one-time, or other lump-sum benefit payment awarded to a beneficiary described in paragraph (a) of this section until the Hub Manager has appointed a fiduciary for the beneficiary and, if applicable, the fiduciary has obtained a surety bond under § 13.230.

(d) *Initial appointment*. In appointing a fiduciary, the Hub Manager will make every effort to appoint the person, agency, organization, or institution that will best serve the interest of the beneficiary. The Hub Manager will consider the results of a field examination, which will include a face-to-face meeting with the beneficiary and the beneficiary's dependents at their residence when practicable, and will conduct the investigation prescribed in paragraph (f) of this section. The Hub Manager will also consider whether:

(1) VA benefits can be paid directly to the beneficiary with limited and temporary supervision by VA, as prescribed in § 13.110;

(2) The circumstances require appointment of a temporary fiduciary under paragraph (h) of this section; and

(3) The proposed fiduciary is complying with the responsibilities of a fiduciary prescribed in § 13.140 with respect to all beneficiaries in the fiduciary program currently being served by the proposed fiduciary and whether the proposed fiduciary can handle an additional appointment without degrading service for any other beneficiary.

(e) *Order of preference in appointing a fiduciary*. The Hub Manager will consider individuals and entities for appointment in the following order of preference, provided that the proposed fiduciary is qualified and willing to serve and the appointment would serve the beneficiary's interest:

(1) The preference stated by the beneficiary in the fiduciary program, if the beneficiary has the capacity to state such a preference. If the beneficiary has a legal guardian appointed to handle his or her affairs, the Hub Manager will presume that the beneficiary does not have the capacity to state a preference and will consider individuals and entities in the order of preference prescribed in paragraphs (e)(2) through (10) of this section;

(2) The beneficiary's spouse;

(3) A relative who has care or custody of the beneficiary or his or her funds;

(4) Any other relative of the beneficiary;

(5) Any friend, acquaintance, or other person who is willing to serve as fiduciary for the beneficiary without a fee;

(6) The chief officer of a public or private institution in which the beneficiary receives care or which has custody of the beneficiary;

(7) The bonded officer of an Indian reservation, if applicable;

(8) An individual or entity who has been appointed by a court with jurisdiction to handle the beneficiary's affairs;

(9) An individual or entity who is not willing to serve without a fee; or

(10) A temporary fiduciary, if necessary.

(f) *Investigation of a proposed fiduciary*. Except as prescribed in paragraph (f)(3) of this section, before appointing a fiduciary for a beneficiary in the fiduciary program, the Hub Manager will conduct an investigation regarding the proposed fiduciary's qualifications.

(1) The investigation will include:

(i) To the extent practicable, a face-to-face interview of the proposed fiduciary;

(ii) A review of a credit report on the proposed fiduciary issued by a credit reporting agency no more than 30 days prior to the date of the proposed appointment;

(iii) A criminal background check to determine whether the proposed fiduciary has been convicted of any offense which would be a bar to serving as a fiduciary under § 13.130 or which the Hub Manager may consider and weigh under the totality of the circumstances regarding the proposed fiduciary's qualifications;

(iv) Obtaining proof of the proposed fiduciary's identity and relationship to the beneficiary, if any; and

(v) A determination regarding the need for surety bond under § 13.230 and the proposed fiduciary's ability to obtain such a bond.

(2) The Hub Manager may, at any time after the initial appointment or reappointment of the fiduciary for a beneficiary, repeat all or part of the investigation prescribed by paragraph (f)(1) of this section to ensure that the fiduciary continues to meet the qualifications for service and there is no current bar to service under § 13.130.

(3) The Hub Manager must conduct the requirements of paragraphs (f)(1)(i),(ii) and (iii) for every subsequent appointment of the fiduciary for each beneficiary.

(4) VA will not conduct the investigation prescribed by paragraph (f) of this section if the proposed fiduciary is an entity, such as the trust department of a bank that provides fiduciary services.

(g) *Expedited appointment*. The Hub Manager may waive the requirements of paragraphs (f)(1)(i) through (iii) of this section and expedite the appointment of a proposed fiduciary if the Hub Manager determines that an expedited appointment would be in the beneficiary's interest and:

(1) The proposed fiduciary is:

(i) The beneficiary's parent (natural, adopted, or step-parent) and the beneficiary is less than the age of majority, or

(ii) The beneficiary's spouse; or

(2) The annual amount of VA benefits the proposed fiduciary would manage for the beneficiary does not exceed the amount specified in 38 U.S.C. 5507(c)(2)(D), as adjusted by VA pursuant to 38 U.S.C. 5312.

(h) *Temporary fiduciary appointments*. (1) The Hub Manager may appoint a temporary fiduciary for a period not to exceed 120 days in any of the following circumstances:

(i) VA has removed a fiduciary for cause under § 13.500 and cannot expedite the appointment of a successor fiduciary, and the beneficiary has an immediate need for fiduciary services; or

(ii) The Hub Manager determines that the beneficiary has an immediate need for fiduciary services and it would not be in the beneficiary's or the beneficiary's dependents' interest to pay benefits to the beneficiary until a fiduciary is appointed.

(2) Any temporary fiduciary appointed under this paragraph (h) must be:

(i) An individual or entity that has already been subject to the procedures for appointment in paragraphs (d) and (f) of this section, and

(ii) Performing satisfactorily as a fiduciary for at least one other VA beneficiary for whom the fiduciary has submitted an annual accounting that VA has approved.

(i) *Authorization for disclosure of information*. The Hub Manager will:

(1) Obtain from every proposed fiduciary who is an individual a written authorization for VA to disclose to the beneficiary information regarding any fiduciary matter that may be appealed under § 13.600, including but not limited to the fiduciary's qualifications for appointment under § 13.100 or misuse of benefits under § 13.400. Such disclosures may occur in VA's correspondence with the beneficiary, in a VA fiduciary appointment or misuse of benefits decision, in a statement of the case for purposes of appeal under § 13.600, or upon

request by the beneficiary, the beneficiary's guardian, or the beneficiary's accredited attorney, claims agent, or representative;

(2) Notify the proposed fiduciary that the disclosed information may be used by the beneficiary in appealing a VA appointment or misuse decision to the Board of Veterans' Appeals under § 13.600; and

(3) Terminate consideration of a proposed fiduciary if the individual refuses to provide the authorization prescribed in paragraph (i)(1) of this section. Such refusal is a bar to serving as a fiduciary for a beneficiary under § 13.130(b).

(Authority: 38 U.S.C. 501, 5502, 5506, 5507)

§ 13.110 Supervised direct payment.

(a) *Authority*. The Hub Manager may authorize the payment of VA benefits directly to an adult beneficiary in the fiduciary program who has reached the age of majority if the Hub Manager determines, based upon a field examination, that the beneficiary can manage his or her VA benefits with limited and temporary VA supervision. In making this determination, the Hub Manager will consider:

(1) Whether the beneficiary is aware of his or her monthly income;

(2) Whether the beneficiary is aware of his or her fixed monthly expenses such as rent, mortgage, utilities, clothing, food, and medical bills;

(3) The beneficiary's ability to:

(i) Allocate appropriate funds to fixed monthly expenses and discretionary items;

(ii) Pay monthly bills in a timely manner; and

(iii) Conserve excess funds; and

(4) Any other information that demonstrates the beneficiary's actual ability to manage his or her VA benefits with limited VA supervision.

(b) *Supervision*. The limited and temporary supervision of beneficiaries receiving direct payment under paragraph (a) of this section will consist of:

(1) Assistance in the development of a budget regarding the beneficiary's income and expenses,

(2) Assistance with creating a fund usage report to aid the beneficiary in tracking his or her income and expenses, and

(3) Periodic reviews of the beneficiary's fund usage report, as required by the Hub Manager.

(c) *Reassessment*. The Hub Manager will reassess the beneficiary's ability to manage his or her VA benefits at or before the end of the first 12-month period of supervision. Based upon a field examination, an evaluation of the factors listed in paragraph (a) of this section, and the results of the supervision prescribed in paragraph (b) of this section, the Hub Manager will determine whether the beneficiary can manage his or her benefits without VA supervision.

(1) If the beneficiary demonstrates the ability to manage his or her VA benefits without supervision, the Hub Manager will prepare a report that summarizes the findings and refer the matter with a recommendation and supporting evidence to the rating authority for application of § 3.353(b)(3) of this chapter regarding reevaluation of ability to manage VA benefits and § 3.353(d) of this chapter regarding the presumption of ability to manage VA benefits without restriction.

(2) If the beneficiary does not demonstrate the ability to manage his or her VA benefits without VA supervision, the Hub Manager will:

(i) Appoint a fiduciary, or

(ii) Continue supervised direct payment for not longer than one additional 12-month period based upon evidence that additional supervision might assist the beneficiary in developing the ability to manage his or her own VA benefits. At the conclusion of the additional period of supervised direct payment, the Hub Manager will conduct the reassessment prescribed by paragraph (c) of this section and either recommend reevaluation under paragraph (c)(1) of this section or appoint a fiduciary under paragraph (c)(2)(i) of this section.

(Authority: 38 U.S.C. 501, 5502)

§ 13.120 Field examinations.

(a) *Authority*. The Hub Manager will order a field examination regarding fiduciary matters within the Hub Manager's jurisdiction for any of the reasons prescribed in paragraph (c) of this section. For purposes of this section,

field examination means the inquiry, investigation, or monitoring activity conducted by designated fiduciary hub or other qualified VA personnel who are authorized to:

(1) Interview beneficiaries, dependents, and other interested persons regarding fiduciary matters;

(2) Interview proposed fiduciaries and current fiduciaries regarding their qualifications, performance, or compliance with VA regulations;

(3) Conduct investigations and examine witnesses regarding any fiduciary matter;

(4) Take affidavits;

(5) Administer oaths and affirmations;

(6) Certify copies of public or private documents; and

(7) Aid claimants and beneficiaries in the preparation of claims for VA benefits or other fiduciary or claim-related material.

(b) *Scope of field examinations.* Field examinations may include, but are not limited to:

(1) Assessing a beneficiary's and the beneficiary's dependents' welfare and physical and mental well-being, environmental and social conditions, and overall financial situation, based upon visiting the beneficiary's current residence and conducting a face-to-face interview of the beneficiary and the beneficiary's dependents, when practicable;

(i) The Hub Manager will waive the requirements of paragraph (b)(1) of this section if the Veterans Health Administration (VHA) has approved the fiduciary as the beneficiary's family caregiver, and VHA's status report regarding the beneficiary indicates the beneficiary is in an excellent situation.

(ii) The provisions of paragraph (b)(1)(i) of this section do not apply when the Hub Manager has information that a fiduciary, who is also the beneficiary's VHA-designated family caregiver, is misusing a beneficiary's VA funds under management, is neglecting a beneficiary, or has failed to comply with the requirements of § 13.140, or there is insufficient evidence to determine the beneficiary's well-being.

(2) Assessing the beneficiary's ability to manage his or her own VA benefits with only limited VA supervision (*see* § 13.110 regarding supervised direct payment);

(3) Collecting and reviewing financial documentation, including income and expenditure information;

(4) Providing any necessary assistance to the beneficiary with issues affecting current or additional VA benefits, claims, and non-VA matters that may affect or conflict with VA benefits;

(5) Making appropriate referrals in cases of actual or suspected physical or mental abuse, neglect, or other harm to a beneficiary;

(6) Investigating, when necessary, allegations that a beneficiary's fiduciary has engaged in misconduct or misused VA benefits to include but not limited to allegations regarding:

(i) Theft or misappropriation of funds,

(ii) Failure to comply with the responsibilities of a fiduciary as prescribed in § 13.140,

(iii) Other allegations of inappropriate fund management by a fiduciary, and

(iv) Other special circumstances which require a visit with or onsite review of the fiduciary, such as a change in an award of benefits or benefit status, or non-fiduciary program matters.

(c) *Reasons for conducting field examinations.* A Hub Manager will order a field examination to:

(1) Determine whether benefits should be paid directly to a beneficiary under § 13.110 or to a fiduciary appointed for the beneficiary under § 13.100;

(2) Determine whether benefit payments should continue to be made directly to a beneficiary under § 13.110 or to a fiduciary on behalf of a beneficiary; or

(3) Ensure the well-being of a beneficiary in the fiduciary program or to protect a beneficiary's VA benefit funds.

(Authority: U.S.C. 501, 512, 5502, 5506, 5507, 5711)

(Approved by the Office of Management and Budget under control numbers 2900–0815 and 2900–0803)

§ 13.130 Bars to serving as a fiduciary.

(a) An individual or entity may not serve as a fiduciary for a VA beneficiary if the individual or entity:

(1) Misused or misappropriated a beneficiary's VA benefits while serving as the beneficiary's fiduciary;

(2) Has been convicted of a felony offense. For purposes of this paragraph, *felony offense* means a criminal offense for which the minimum period of imprisonment is 1 year or more, regardless of the actual sentence imposed or the actual time served. However, such conviction is not a bar to serving as a fiduciary for a beneficiary if all of the following conditions are met:

(i) The conviction occurred more than 10 years preceding the proposed date of appointment;

(ii) The conviction did not involve any of the following offenses:

(A) Fraud;

(B) Theft;

(C) Bribery;

(D) Embezzlement;

(E) Identity theft;

(F) Money laundering;

(G) Forgery;

(H) The abuse of or neglect of another person; or

(I) Any other financial crime;

(iii) There is no other person or entity who is willing and qualified to serve; and

(iv) The Hub Manager determines that the nature of the conviction is such that appointment of the individual poses no risk to the beneficiary and is in the beneficiary's interest.

(b) An individual may not serve as a fiduciary for a VA beneficiary if the individual:

(1) Refuses or neglects to provide the authorization for VA disclosure of information prescribed in § 13.100(i);

(2) Is unable to manage his or her own Federal or state benefits and is in a Federal or state agency's fiduciary, representative payment, or similar program;

(3) Has been adjudicated by a court with jurisdiction as being unable to manage his or her own financial affairs;

(4) Is incarcerated in a Federal, state, local, or other penal institution or correctional facility, sentenced to home confinement, released from incarceration to a half-way house, or on house arrest or in custody in any facility awaiting trial on pending criminal charges;

(5) Has felony charges pending;

(6) Has been removed as legal guardian by a state court for misconduct;

(7) Is under the age of majority; or

(8) Knowingly violates or refuses to comply with the regulations in this part.

(Authority: 38 U.S.C. 501, 5502, 5506, 5507, 6101, 6106)

§ 13.140 Responsibilities of fiduciaries.

Any individual or entity appointed by VA as a fiduciary to receive VA benefit payments on behalf of a beneficiary in the fiduciary program must fulfill certain responsibilities associated with the services of a fiduciary. These responsibilities include:

(a) *General.* (1) Fiduciaries appointed by VA to manage the VA funds of a beneficiary are also responsible for monitoring the beneficiary's well-being and using available funds to ensure that the beneficiary's needs are met. Fiduciaries owe VA and beneficiaries the duties of good faith and candor and must administer a beneficiary's funds under management in accordance with paragraph (b) of this section. In all cases, the fiduciary must disburse or otherwise manage funds according to the best interests of the beneficiary and the beneficiary's dependents and in light of the beneficiary's unique circumstances, needs, desires, beliefs, and values.

(2) The fiduciary must take all reasonable precautions to protect the beneficiary's private information contained in the fiduciary's paper and electronic records.

(i) For purposes of this section:

(A) *Reasonable precautions* means protecting against any unauthorized access to or use of the beneficiary's private information that may result in substantial harm or inconvenience to the beneficiary; and

(B) *Private information* means a beneficiary's first name and last name or first initial and last name in combination with any one or more of the following data elements that relate to such beneficiary: VA claim number, Social Security number, date of birth,

address, driver's license number or state-issued identification card number, or financial account number or credit card or debit card number, with or without any required security code, access code, personal identification number, or password, that would permit access to the beneficiary's account.

(ii) At a minimum, fiduciaries must place reasonable restrictions upon access to paper records containing the beneficiary's private information, including storage of such records in locked facilities, storage areas, or containers.

(iii) For electronic records containing the beneficiary's private information, the fiduciary must:

(A) Use unique identifications and passwords, which are not vendor-supplied default identifications and passwords, for computer, network, or online site access that are reasonably designed to maintain the security of the beneficiary's information and the fiduciary's financial transactions;

(B) Control access to data security passwords to ensure that such passwords are kept in a location and format that do not compromise the security of the beneficiary's private information; and

(C) For records containing private information on a computer system that is connected to the internet, keep reasonably up-to-date firewall and virus protection and operating system security patches to maintain the integrity of the beneficiary's private information and prevent unauthorized disclosure. For purposes of this section, a system is reasonably updated if the fiduciary installs software updates immediately upon release by the original equipment or software manufacturer, uses internet browser security settings suitable for transmission of private information, and maintains password-protected wireless connections or other networks.

(iv) The fiduciary must keep all paper and electronic records relating to the fiduciary's management of VA benefit funds for the beneficiary for the duration of service as fiduciary for the beneficiary and for a minimum of 2 years from the date that VA removes the fiduciary under § 13.500 or from the date that the fiduciary withdraws as fiduciary for the beneficiary under § 13.510.

(b) *Financial responsibilities.* The fiduciary's primary financial responsibilities include, but are not limited to:

(1) The use of the beneficiary's VA benefit funds under management only for the care, support, education, health, and welfare of the beneficiary and his or her dependents. Except as authorized under § 13.220 regarding fiduciary fees, a fiduciary may not derive a personal financial benefit from management or use of the beneficiary's funds;

(2) Protection of the beneficiary's VA benefits from loss or diversion;

(3) Except as prescribed in § 13.200 regarding fiduciary accounts, maintenance of separate financial accounts to prevent commingling of the beneficiary's funds with the fiduciary's own funds or the funds of any other beneficiary for whom the fiduciary has funds under management;

(4) Determination of the beneficiary's just debts. For purposes of this section, *just debts* mean the beneficiary's legitimate, legally enforceable debts;

(5) Timely payment of the beneficiary's just debts, provided that the fiduciary has VA benefit funds under management for the beneficiary to cover such debts;

(6) Providing the beneficiary with information regarding VA benefit funds under management for the beneficiary, including fund usage, upon request;

(7) Providing the beneficiary with a copy of the annual accounting approved by VA under § 13.280;

(8) Ensuring that any best-interest determination regarding the use of funds is consistent with VA policy, which recognizes that beneficiaries in the fiduciary program are entitled to the same standard of living as any other beneficiary with the same or similar financial resources, and that the fiduciary program is not primarily for the purpose of preserving funds for the beneficiary's heirs or disbursing funds according to the fiduciary's own beliefs, values, preferences, and interests; and

(9) Protecting the beneficiary's funds from the claims of creditors as described in § 13.270.

(c) *Non-financial responsibilities.* The fiduciary's primary non-financial responsibilities include, but are not limited to:

(1) Contacting social workers, mental health professionals, or the beneficiary's legal guardian regarding the beneficiary, when necessary;

(2) To the extent possible, ensuring the beneficiary receives appropriate medical care;

(3) Correcting any discord or uncomfortable living or other situations when possible;

(4) Acknowledging and addressing any complaints or concerns of the beneficiary to the best of the fiduciary's ability;

(5) Reporting to the appropriate authorities, including any legal guardian, any type of known or suspected abuse of the beneficiary;

(6) Maintaining contact with the beneficiary for purposes of assessing the beneficiary's capabilities, limitations, needs, and opportunities;

(7) Being responsive to the beneficiary and ensuring the beneficiary and his or her legal guardian have the fiduciary's current contact information.

(d) *The fiduciary's responsibilities to VA.* Any fiduciary who has VA benefit funds under management on behalf of a beneficiary in the fiduciary program must:

(1) If the fiduciary is also appointed by a court, annually provide to the fiduciary hub with jurisdiction a certified copy of the accounting(s) provided to the court or facilitate the hub's receipt of such accountings;

(2) Notify the fiduciary hub regarding any change in the beneficiary's circumstances, to include the beneficiary's relocation, the beneficiary's serious illness, or any other significant change in the beneficiary's circumstances which might adversely impact the beneficiary's well-being;

(3) Provide documentation or verification of any records concerning the beneficiary or matters relating to the fiduciary's responsibilities within 30 days of a VA request, unless otherwise directed by the Hub Manager;

(4) When necessary, appear before VA for face-to-face meetings; and

(5) Comply with the policies and procedures prescribed in this part.

(Authority: 38 U.S.C. 501, 512, 5502, 5507, 5509, 5711)

(Approved by the Office of Management and Budget under control numbers 2900–0017 and 2900–0085)

§ 13.200 Fiduciary accounts.

Except as prescribed in paragraph (b) of this section, any fiduciary appointed by VA to receive payments on behalf of a beneficiary must deposit the beneficiary's VA benefits in a fiduciary account that meets the requirements prescribed in paragraph (a) of this section.

(a) *Separate accounts.* Except as prescribed in paragraph (b) of this section, a fiduciary must establish and maintain a separate financial institution account for each VA beneficiary that the fiduciary serves. The fiduciary must not commingle a beneficiary's funds with the fiduciary's funds or any other beneficiary's funds, either upon or after receipt. The account must be:

(1) Established for direct deposit of VA benefits,

(2) Established in a Federally-insured financial institution, and in Federally-insured accounts when funds qualify for such deposit insurance, and

(3) Titled in the beneficiary's and fiduciary's names and note the existence of the fiduciary relationship.

(b) *Exceptions.* The general rule prescribed in paragraph (a) of this section regarding establishment and maintenance of separate accounts does not apply to the following fiduciaries:

(1) The beneficiary's spouse;

(2) State or local Government entities;

(3) Institutions, such as public or private medical care facilities, nursing homes, or other residential care facilities, when an annual accounting is not required. *See* § 13.280 regarding accounting requirements; or

(4) A trust company or a bank with trust powers organized under the laws of the United States or a state.

(Authority: U.S.C. 501, 5502, 5509, 5711)

§ 13.210 Fiduciary investments.

(a) *General.* A fiduciary must conserve or invest any VA benefits that the fiduciary receives on behalf of a

beneficiary, whether such benefits are in the form of recurring monthly payments or a one-time payment, if the beneficiary or the beneficiary's dependents do not need the benefits for current maintenance, reasonably foreseeable expenses, or reasonable improvements in the beneficiary's and the beneficiary's dependents' standard of living. Conservation of beneficiary funds is for the purpose of addressing unforeseen circumstances or planning for future care needs given the beneficiary's disabilities, circumstances, and eligibility for care furnished by the Government at Government expense. Fiduciaries should not conserve VA benefit funds under management for a beneficiary based primarily upon the interests of the beneficiary's heirs or according to the fiduciary's own values, preferences, and interests.

(b) *Types of investments*. An investment must be prudent and in the best interest of the beneficiary. Authorized investments include United States savings bonds or interest or dividend-paying accounts insured under Federal law. Any such investment must be clearly titled in the beneficiary's and fiduciary's names and identify the fiduciary relationship.

(c) *Exceptions*. The general rules regarding investment of VA benefits do not apply to the following fiduciaries:

(1) The beneficiary's spouse, and

(2) The chief officer of an institution in which the beneficiary is being furnished hospital treatment or institutional, nursing, or domiciliary care. VA benefits paid to the chief officer may not be invested.

(Authority: 38 U.S.C. 501, 5502)

§ 13.220 Fiduciary fees.

(a) *Authority*. The Hub Manager with jurisdiction over a fiduciary appointment may determine whether a fee is necessary to obtain the services of a fiduciary. A fee is necessary only if no other person or entity is qualified and willing to serve without a fee and the beneficiary's interests would be served by the appointment of a qualified paid fiduciary. The Hub Manager will not authorize a fee if the fiduciary:

(1) Is a spouse, dependent, or other relative of the beneficiary; or

(2) Will receive any other form of payment in connection with providing fiduciary services for the beneficiary.

(b) *Limitation on fees*. The Hub Manager will authorize a fiduciary to whom a fee is payable under paragraph (a) of this section to deduct from the beneficiary's account a reasonable monthly fee for fiduciary services rendered.

(1) For purposes of this section, *reasonable monthly fee* means a monetary amount that is authorized by the Hub Manager and does not exceed 4 percent of the monthly VA benefit paid to the fiduciary on behalf of the beneficiary for a month in which the fiduciary is eligible under paragraph (b)(2) of this section to collect a fee.

(2) A monthly fee may be collected for any month during which the fiduciary:

(i) Provides fiduciary services on behalf of the beneficiary,

(ii) Receives a recurring VA benefit payment for the beneficiary, and

(iii) Is authorized by the Hub Manager to receive a fee for fiduciary services.

(3) Fees may not be computed based upon:

(i) Any one-time, retroactive, or lump-sum payment made to the fiduciary on behalf of the beneficiary;

(ii) Any funds conserved by the fiduciary for the beneficiary in the beneficiary's account under § 13.200 or invested by the fiduciary for the beneficiary under § 13.210, to include any interest income and return on investment derived from any account; or

(iii) Any funds transferred to the fiduciary by a prior fiduciary for the beneficiary, or from the personal funds of patients or any other source.

(4) The Hub Manager will not authorize a fee for any month for which:

(i) VA or a court with jurisdiction determines that the fiduciary misused or misappropriated benefits, or

(ii) The beneficiary does not receive a VA benefit payment. However, the Hub Manager may authorize a fee for a month in which the beneficiary did not receive a benefit payment if VA later issues benefits for that month and the fiduciary:

(A) Receives VA approval to collect a fee for the month for which payment was made,

(B) Provided fiduciary services during the month for which payment was made, and

(C) Was the beneficiary's fiduciary when VA made the retroactive payment.

(Authority: 38 U.S.C. 501, 5502, 6101, 6106)

§ 13.230 Protection of beneficiary funds.

(a) *General*. Except as prescribed in paragraph (c) of this section, within 60 days of appointment, the fiduciary must furnish to the fiduciary hub with jurisdiction a corporate surety bond that is conditioned upon faithful discharge of all of the responsibilities of a fiduciary prescribed in § 13.140 and meets the requirements of paragraph (d) of this section, if the VA benefit funds that are due and to be paid for the beneficiary will exceed $25,000 at the time of appointment. The Hub Manager will not authorize the release of a retroactive, one-time, or other pending lump-sum benefit payment to the fiduciary until the fiduciary has furnished the bond prescribed by this section.

(b) *Accumulated funds*. The provisions of paragraph (a) of this section, which require a fiduciary to furnish a surety bond, apply in any case in which the accumulation over time of VA benefit funds under management by a fiduciary for a beneficiary exceeds $25,000. Except as prescribed in paragraph (c) of this section, within 60 days of accumulated funds exceeding the prescribed threshold, the fiduciary will furnish to the fiduciary hub a bond that meets the requirements of paragraph (d) of this section.

(c) *Exceptions*. (1) The provisions of paragraphs (a) and (b) of this section do not apply to:

(i) A fiduciary that is a trust company or a bank with trust powers organized under the laws of the United States or a state;

(ii) A fiduciary who is the beneficiary's spouse; or

(iii) A fiduciary in the Commonwealth of Puerto Rico, Guam, or another territory of the United States, or in the Republic of the Philippines, who has entered into a restricted withdrawal agreement in lieu of a surety bond.

(2) The Hub Manager may, at any time, require the fiduciary to obtain a bond described in paragraph (a) of this section and meeting the requirements of paragraph (d) of this section, without regard to the amount of VA benefit funds under management by the fiduciary for the beneficiary, if special circumstances indicate that obtaining a bond would be in the beneficiary's interest. Such special circumstances may include but are not limited to:

(i) A marginal credit report for the fiduciary; or

(ii) A fiduciary's misdemeanor criminal conviction either before or after appointment for any offense listed in § 13.130(a)(2)(ii);

(d) *Bond requirements*. A bond furnished by a fiduciary under paragraph (a) or (b) of this section must meet the following requirements:

(1) The bond must be a corporate surety bond in an amount sufficient to cover the value of the VA benefit funds under management by the fiduciary for the beneficiary.

(2) After furnishing the prescribed bond to the fiduciary hub, the fiduciary must:

(i) Adjust the bond amount to account for any increase or decrease of more than 20 percent in the VA benefit funds under management by the fiduciary for the beneficiary; and

(ii) Furnish proof of the adjustment to the fiduciary hub not later than 60 days after a change in circumstance described in paragraph (d)(2)(i) of this section.

(3) The bond furnished by the fiduciary must also:

(i) Identify the fiduciary, the beneficiary, and the bonding company; and

(ii) Contain a statement that the bond is payable to the Secretary of Veterans Affairs.

(e) *Periodic proof of bond*. A fiduciary must furnish proof of adequate bonding:

(1) With each annual accounting prescribed by § 13.280; and

(2) At any other time the Hub Manager with jurisdiction requests proof.

(f) *Liability*. (1) Except as otherwise provided by the terms of the bond, the surety and the fiduciary guaranteed by

the surety are jointly and severally liable for any misappropriation or misuse of VA benefits by the fiduciary.

(2) VA may collect on the bond regardless of any prior reissuance of benefits by VA under § 13.410 and until liability under the terms of the bond is exhausted.

(g) *Bond expenses*—(1) *Authority*. The fiduciary may deduct from the beneficiary's account any expense related to obtaining, maintaining, or adjusting a bond prescribed by this section.

(2) *Notice*. The Hub Manager will provide the beneficiary written notice regarding any bond furnished at the beneficiary's expense under paragraph (a), (b), or (c)(2) of this section or adjusted under paragraph (d)(2) of this section.

(Authority: 38 U.S.C. 501, 5502, 5507)

(Approved by the Office of Management and Budget under control numbers 2900–0017 and 2900–0804)

§ 13.240 Funds of beneficiaries less than the age of majority.

(a) *General*. Except as prescribed in paragraph (b) of this section, a fiduciary who receives VA benefits on behalf of a beneficiary who is less than the age of majority may use the benefits only for the use and benefit of that beneficiary and only if the fiduciary first determines that the person or persons who have custody of the beneficiary and are responsible for the beneficiary's needs are unable to provide for those needs.

(b) *Education benefits*. A fiduciary who receives VA education benefits on behalf of a beneficiary who is less than the age of majority may use the benefits for the beneficiary's education regardless of the ability of the person or persons who have custody of the beneficiary to pay for the beneficiary's education.

(Authority: 38 U.S.C. 501, 5502)

§ 13.250 Funds of deceased beneficiaries.

(a) *General*. When a beneficiary who has a fiduciary dies without leaving a valid will and without heirs, all VA benefit funds under management by the fiduciary for the deceased beneficiary on the date of death, less any deductions authorized by paragraph (c) of this section, must be returned to VA if such funds would escheat to a state.

(b) *Accountings*. Upon the death of a beneficiary described in paragraph (a) for whom the fiduciary must return to VA all benefit funds under management, less any deductions authorized under paragraph (c) of this section, or upon the death of any beneficiary for whom a fiduciary was required to submit an annual accounting to VA under § 13.280, the fiduciary must submit a final accounting to the fiduciary hub with jurisdiction within 90 days of the beneficiary's death.

(c) *Expenses*. The fiduciary may deduct a reasonable fee from the deceased beneficiary's account for purposes of determining whether the beneficiary's funds under management would escheat to a state under state law or whether the deceased beneficiary left a valid will or is survived by heirs. For the purpose of this section, *reasonable fee* means an amount customarily charged by attorneys or other professionals authorized to do such work in the state where the deceased beneficiary had his or her permanent place of residence.

(d) *Estate matters*. Upon the death of a beneficiary who has a valid will or heirs, the fiduciary must hold the remaining funds under management in trust for the deceased beneficiary's estate until the will is probated or heirs are ascertained, and disburse the funds according to applicable state law.

(Authority: U.S.C. 501, 5502)

§ 13.260 Personal funds of patients.

(a) *Distribution of funds*. Benefits deposited by VA in the personal funds of patients account for a veteran who was rated by VA as being unable to manage his or her VA benefits and who died leaving an account balance are payable to an eligible person. For purposes of this section, *eligible person* means an individual living at the time the account balance is distributed in the following order of preference:

(1) The deceased veteran's spouse, as defined by § 3.1000(d)(1) of this chapter;

(2) The veteran's children (in equal shares), as defined by § 3.57 of this chapter, but without regard to age or marital status; or

(3) The veteran's dependent parents (in equal shares) or surviving parent, as defined by § 3.59 of this chapter, provided that the parents were or parent was dependent within the meaning of § 3.250 of this chapter on the date of the veteran's death.

(4) Any balance remaining in the personal funds of patients account that cannot be distributed in accordance with paragraphs (a)(1) through (3) of this section will be used by VA to reimburse anyone who bore the expense of the veteran's last sickness or burial or will be deposited to the credit of the applicable current VA appropriation.

(b) *Application.* A person who seeks distribution of a deceased veteran's funds from the personal funds of patients account under paragraph (a) of this section must file an application with VA not later than 5 years after the veteran's death. If any person who seeks such distribution is under a legal disability that prevents him or her from filing an application at the time of the veteran's death, the 5-year period will run from the date of termination or removal of the legal disability.

(Authority: 38 U.S.C. 501, 5502)

§ 13.270 Creditors' claims.

Under 38 U.S.C. 5301(a)(1), VA benefit payments are exempt, both before and after receipt by the beneficiary, from the claims of creditors and taxation. The fiduciary should invoke this defense in applicable circumstances. If the fiduciary does not do so, the Hub Manager may refer the matter to the District Counsel for evaluation and appropriate legal action.

(Authority: 38 U.S.C. 501, 512, 5301)

§ 13.280 Accountings.

(a) *General.* Except as prescribed in paragraph (d) of this section, a fiduciary for a beneficiary must submit to the fiduciary hub with jurisdiction an annual accounting regarding the VA benefit funds under management by the fiduciary for the beneficiary if:

(1) The amount of VA benefit funds under management for the beneficiary exceeds $10,000;

(2) The fiduciary deducts a fee authorized under § 13.220 from the beneficiary's account;

(3) The beneficiary is being paid VA compensation benefits at a total disability rating (100 percent), whether schedular, extra-schedular, or based on individual unemployability; or

(4) The Hub Manager determines an accounting is necessary to ensure the fiduciary has properly managed the beneficiary's funds.

(b) *Scope of accounting.* For purposes of this section, *accounting* means the fiduciary's written report regarding the income and funds under management by the fiduciary for the beneficiary during the accounting period prescribed by the Hub Manager. The accounting prescribed by this section pertains to all activity in the beneficiary's accounts, regardless of the source of funds maintained in those accounts. An accounting consists of:

(1) A beginning inventory or account balance,

(2) An itemization of income,

(3) An itemization of expenses,

(4) An ending inventory or account balance,

(5) Copies of financial institution documents reflecting receipts, expenditures, and beginning and ending balances, and

(6) Receipts, when required by the Hub Manager.

(c) *Submission requirements.* Fiduciaries must submit annual accountings to the fiduciary hub as follows:

(1) The fiduciary must submit accountings on the appropriate VA form not later than 30 days after the end of the accounting period prescribed by the Hub Manager.

(2) The fiduciary must submit a corrected or supplemental accounting not later than 14 days after the date of VA notice of an accounting discrepancy.

(d) *Exceptions.* The provisions of this section that generally require the submission of an annual accounting do not apply to a fiduciary who is:

(1) The beneficiary's spouse;

(2) A chief officer of a Federal institution;

(3) A chief officer of a non-VA facility receiving benefits for a beneficiary institutionalized in the facility and:

(i) The beneficiary's monthly care, maintenance, and personal use expenses equal or exceed the amount of the beneficiary's monthly VA benefit; and

(ii) The amount of VA benefit funds under management by the fiduciary does not exceed $10,000; or

(4) A fiduciary who receives benefits on behalf of a beneficiary and both permanently resides outside of the United States or in the Commonwealth of Puerto Rico or the Republic of the Philippines, and the fiduciary was appointed outside of the United States or in the Commonwealth of Puerto Rico or the Republic of the Philippines.

(e) *Failure to comply with accounting requirements.* The Hub Manager will treat any willful neglect or refusal to file proper accountings as prima facie evidence of embezzlement or misappropriation of VA benefits. Such evidence is grounds for starting a misuse investigation under § 13.400.

(Authority: 38 U.S.C. 501, 5502, 5509, 6101)

(Approved by the Office of Management and Budget under control number 2900–0017)

§ 13.300 Onsite reviews.

(a) *Periodic onsite reviews.* (1) The Hub Manager will conduct a periodic, scheduled, onsite review of any fiduciary in the United States, whether the fiduciary is an individual or an entity, if:

(i) The fiduciary serves 20 or more beneficiaries, and

(ii) The total annual amount of recurring VA benefits paid to the fiduciary for such beneficiaries exceeds the threshold established in 38 U.S.C. 5508 as adjusted by VA under 38 U.S.C. 5312.

(2) The Hub Manager must complete at least one periodic onsite review triennially if the fiduciary meets the requirements of paragraph (a)(1) of this section.

(3) VA will provide the fiduciary with written notice of the periodic onsite review at least 30 days before the scheduled review date. The notice will:

(i) Inform the fiduciary of the pending review and the fiduciary's obligation under this part to cooperate in the onsite review process, and

(ii) Request that the fiduciary make available for review all relevant records, including but not limited to case files, bank statements, accountings, ledgers, check registers, receipts, bills, and any other items necessary to determine that the fiduciary has been acting in the best interest of VA beneficiaries and meeting the responsibilities of fiduciaries prescribed in § 13.140.

(b) *Unscheduled onsite reviews.* The Hub Manager may conduct unscheduled onsite reviews of any fiduciary, regardless of the number of beneficiaries served by the fiduciary or the total amount of VA benefit funds under management by the fiduciary, if:

(1) VA receives from any source credible information that the fiduciary has misused or is misusing VA benefits;

(2) The fiduciary's annual accounting is seriously delinquent. For purposes of this section, *seriously delinquent* means the fiduciary failed to submit the required accounting within 120 days after the ending date of the annual accounting period;

(3) VA receives from any source credible information that the fiduciary is not adequately performing the responsibilities of a fiduciary prescribed in § 13.140; or

(4) The Hub Manager determines that an unscheduled onsite review is necessary to ensure that the fiduciary is acting in the interest of the beneficiary or beneficiaries served by the fiduciary.

(c) *Procedures.* (1) Onsite reviews will consist of the following:

(i) A face-to-face meeting with the fiduciary. In the case of a fiduciary that is an entity, the face-to-face meeting will be with a representative of the entity;

(ii) A review of all relevant records maintained by the fiduciary, including but not limited to case files, bank statements, accountings, ledgers, check registers, receipts, bills, and any other items necessary to determine whether the fiduciary has been acting in the interest of VA beneficiaries; and

(iii) Interviews of beneficiaries, the fiduciary's employees, and other individuals as determined necessary by the Hub Manager.

(2) Not later than 30 days after completing a periodic or unscheduled onsite review, the Hub Manager will provide the fiduciary a written report of VA's findings, recommendations for correction of deficiencies, requests for

additional information, and notice of VA's intent regarding further action.

(3) Unless good cause for an extension is shown, not later than 30 days after the date that VA mails the report prescribed by paragraph (d)(2) of this section, the fiduciary must submit to the fiduciary hub a response to any VA request for additional information or recommendation for corrective action.

(4) The Hub Manager will remove the fiduciary for all VA beneficiaries whom the fiduciary serves if the fiduciary:

(i) Refuses to cooperate with VA during a periodic or unscheduled onsite review,

(ii) Is unable to produce necessary records,

(iii) Fails to respond to a VA request for additional information or recommendation for corrective action, or

(iv) Is found during an onsite review to have misused VA benefits.

(Authority: 38 U.S.C. 501, 5508)

§ 13.400 Misuse of benefits.

(a) *Definition of misuse.* Misuse of benefits by a fiduciary occurs in any case in which the fiduciary receives payment of benefits for the use and benefit of a beneficiary and the beneficiary's dependents, if any, and uses any part of such payment for a use other than the use and benefit of the beneficiary or the beneficiary's dependents. For the purpose of this section, *use and benefit* means any expenditure reasonably intended for the care, support, or maintenance of the beneficiary or the beneficiary's dependents. Such expenditures may include the fiduciary's efforts to improve the beneficiary's standard of living under rules prescribed in this part.

(b) *Misuse determinations.* Upon receipt of information from any source regarding possible misuse of VA benefits by a fiduciary, the Hub Manager may, upon his or her discretion, investigate the matter and issue a misuse determination in writing. This decision will:

(1) Identify the beneficiary,

(2) Identify the fiduciary,

(3) State whether the fiduciary is an individual fiduciary serving 10 or more beneficiaries or a corporation or other entity serving one or more beneficiaries,

(4) Identify the source of the information,

(5) Describe in detail the facts found as a result of the investigation,

(6) State the reasons for the Hub Manager's determination regarding whether the fiduciary misused any part of the beneficiary's benefit paid to the fiduciary, and

(7) If the Hub Manager determines that the fiduciary did misuse any part of the beneficiary's benefit, identify the months in which such misuse occurred.

(c) *Notice.* The Hub Manager will provide written notice of the misuse determination prescribed in paragraph (b) of this section, including a copy of the Hub Manager's written decision, an explanation regarding the reconsideration procedure prescribed in paragraph (d) of this section, and the beneficiary's right to appeal under § 13.600, to:

(1) The fiduciary;

(2) The beneficiary or the beneficiary's legal guardian, and the beneficiary's accredited representative, attorney, or claims agents;

(3) The court of jurisdiction if the fiduciary is also the beneficiary's court-appointed guardian and/or conservator; and

(4) The Director of the Pension and Fiduciary Service.

(d) *Finality and reconsideration of misuse determinations.* (1) The Hub Manager's misuse determination is a final decision, unless:

(i) The Hub Manager receives a written request for reconsideration from the fiduciary or the beneficiary not later than 30 days after the date that the Hub Manager mailed notice of his or her misuse determination; or

(ii) The Hub Manager receives a notice of disagreement from the beneficiary not later than 1 year after the date that the Hub Manager mailed notice of his or her misuse determination.

(2) The fiduciary or the beneficiary may submit additional information pertinent to reconsideration of the misuse determination and not previously considered by the Hub Manager, provided that the additional information is submitted with the written reconsideration request.

(3) The Hub Manager will close the record regarding reconsideration at the end of the 30-day period described in paragraph (d)(1)(i) of this section and furnish a timely request submitted by the fiduciary or the beneficiary, including any new information, to the Director of the VA Regional Office with jurisdiction over the fiduciary hub for a final decision.

(4) In making the misuse determination on reconsideration, the Regional Office Director's decision will be based upon a review of the information of record as of the date of the Hub Manager's misuse determination and any new information submitted with the request. The decision will:

(i) Identify the beneficiary,

(ii) Identify the fiduciary,

(iii) Identify if the fiduciary is also the beneficiary's court-appointed guardian or conservator,

(iv) Identify the date of the Hub Manager's prior decision,

(v) Describe in detail the facts found as a result of the Director's review of the Hub Manager's decision and any new information submitted with the reconsideration request, and

(vi) State the reasons for the Director's final decision, which may affirm, modify, or overturn the Hub Manager's decision.

(5) The Hub Manager will provide written notice of the Regional Office Director's final decision on reconsideration to:

(i) The fiduciary,

(ii) The beneficiary or the beneficiary's legal guardian, and the beneficiary's accredited representative, attorney, or claims agent;

(iii) The court, if the fiduciary is also the beneficiary's court-appointed guardian or conservator; and

(iv) The Director of the Pension and Fiduciary Service.

(e) *Reporting of misuse.* Except as prescribed in §1.204 of this chapter, which requires VA management officials to promptly report possible criminal matters involving felonies to the VA Office of Inspector General, reporting of misuse cases will occur as follows:

(1) Not later than 30 days after a final determination is made under paragraph (d) of this section that a fiduciary has misused VA benefits, the Director of the VA Regional Office who has jurisdiction over the fiduciary hub will notify the VA Office of Inspector General for purposes of any further action that the Inspector General deems appropriate under separate authority, and the court of jurisdiction if the fiduciary is also the beneficiary's court-appointed legal guardian and/or conservator.

(2) For purposes of application of §13.410 regarding reissuance and recoupment of benefits, the Office of Inspector General will advise the Director of the Pension and Fiduciary Service of any final decision regarding prosecution of a fiduciary who misused VA benefits and any final judgment of a court in such a prosecution not later than 30 days after the decision is made or judgment is entered.

(Authority: 38 U.S.C. 501, 5502, 6106)

§13.410 Reissuance and recoupment of misused benefits.

(a) *General.* (1) If the Hub Manager or the Regional Office Director upon reconsideration determines that a fiduciary described in paragraph (a)(2) of this section misused any part of a beneficiary's benefit paid to the fiduciary, the Regional Office Director will reissue benefits to the beneficiary's successor fiduciary in an amount equal to the amount of funds misused.

(2) This paragraph (a) applies to a fiduciary that is:

(i) An individual who served 10 or more beneficiaries during any month in which misuse occurred; or

(ii) A corporation or other entity serving one or more beneficiaries.

(b) *Negligence.* In any case in which the Hub Manager or the Regional Office Director upon reconsideration determines that an individual fiduciary who served fewer than 10 beneficiaries during any month in which misuse occurred misused a beneficiary's funds under management by the fiduciary, the Hub Manager will refer the matter to the Director, Pension and Fiduciary Service, for a determination of whether VA negligence caused the misuse. The Regional Office Director will reissue benefits to the beneficiary's successor fiduciary in an amount equal to the

amount of funds misused if the Director of the Pension and Fiduciary Service determines that VA negligence caused the misuse. The Pension and Fiduciary Service Director's negligence determination will be based upon a review of the VA information of record as of the date of the Hub Manager's or Regional Office Director's misuse determination. For purposes of this section, VA negligence causes misuse when:

(1) The Hub Manager failed to properly investigate or monitor the fiduciary; for example, when:

(i) The Hub Manager failed to review the fiduciary's accounting within 60 days after the date on which the accounting was scheduled for review. The date that an accounting is scheduled for review is the date the fiduciary hub receives the accounting;

(ii) The Hub Manager did not decide whether to investigate an allegation of misuse within 60 days of receipt of the allegation;

(iii) After deciding to investigate an allegation of misuse and finding misuse, the Hub Manager failed to initiate action within 60 days of receipt of the misuse allegation to terminate the fiduciary.

(2) Actual negligence by VA is shown. For purposes of this section, *actual negligence* means the Hub Manager's failure to exercise toward a beneficiary in the fiduciary program the care which a reasonable or prudent person would exercise in the circumstances, or the Hub Manager's taking action that a reasonable or prudent person would not take. The Regional Office Director shall reissue benefits based on actual negligence if the Director of the Pension and Fiduciary Service determines that:

(i) The Hub Manager owed a duty to the beneficiary under this part,

(ii) The Hub Manager's action or failure to act was negligent, and

(iii) The Hub Manager's negligence proximately caused the misuse of benefits by the fiduciary. For purposes of this section, *proximate cause* means that the misuse would not have occurred but for the Hub Manager's negligence.

(c) *Recoupment of misused benefits.* In all cases in which the Hub Manager or Regional Office Director upon reconsideration determines that a fiduciary misused benefits, VA will make a good faith effort to recoup the total amount of misused benefits from the fiduciary.

(1) For purposes of this section, *good faith effort* means that the Hub Manager will:

(i) Recover any misused benefits from the surety company, if a surety bond was in place regarding protection of beneficiary funds; or

(ii) In cases in which no surety bond was in place and the fiduciary does not repay all misused benefits within the time prescribed by the Hub Manager in consultation with the fiduciary:

(A) Request the creation of a debt to the United States in the amount of any misused benefits that remain unpaid; and

(B) Coordinate further recoupment action, including collection of any debt owed by the fiduciary to the United States as a result of the misuse, with the appropriate Federal and state agencies.

(2) VA will pay benefits recouped under paragraph (c) of this section to the beneficiary's successor fiduciary after deducting any amount reissued under paragraph (a) or (b) of this section.

(d) *Notice.* The Hub Manager, or in the case of a negligence determination, the Director of the Pension and Fiduciary Service, will provide the beneficiary or the beneficiary's legal guardian, and the beneficiary's accredited representative, attorney or claims agent written notice of any decision regarding reissuance or recoupment of benefits under this section.

(Authority: 38 U.S.C. 501, 6106, 6107)

§ 13.500 Removal of fiduciaries.

(a) The Hub Manager may remove a fiduciary if the Hub Manager determines that fiduciary services are no longer required for a beneficiary or removal is in the beneficiary's interest. Reasons for removal include, but are not limited to:

(1) *Beneficiary reasons.* (i) A VA rating authority determines that the beneficiary can manage his or her own VA benefits without VA supervision or appointment of a fiduciary;

(ii) The beneficiary requests appointment of a successor fiduciary under § 13.100;

(iii) The beneficiary requests supervised direct payment of benefits under § 13.110; or

(iv) The beneficiary dies.

(2) *Fiduciary reasons.* (i) The fiduciary's further service is barred under § 13.130;

(ii) The fiduciary fails to maintain his or her qualifications or does not adequately perform the responsibilities of a fiduciary prescribed in § 13.140;

(iii) The fiduciary fails to timely submit a complete accounting as prescribed in § 13.280;

(iv) VA or a court with jurisdiction determines that the fiduciary misused or misappropriated VA benefits;

(v) The fiduciary fails to respond to a VA request for information within 30 days after such request is made, unless the Hub Manager grants an extension based upon good cause shown by the fiduciary;

(vi) The fiduciary is unable or unwilling to provide the surety bond prescribed by § 13.230 or, if applicable, enter into a restricted withdrawal agreement;

(vii) The fiduciary no longer meets the requirements for appointment under § 13.100; or

(viii) The fiduciary is unable or unwilling to manage the beneficiary's benefit payments, accounts, or investments.

(b) *Procedures.* (1) If the Hub Manager determines that it is necessary to remove a fiduciary and appoint a successor fiduciary, the Hub Manager will:

(i) Provide the fiduciary and the beneficiary written notice of the removal; and

(ii) Instruct the fiduciary regarding the fiduciary's responsibilities prior to transfer of funds to a successor fiduciary or provide other instructions to the fiduciary.

(2) The fiduciary must:

(i) Continue as fiduciary for the beneficiary until the Hub Manager provides the fiduciary with the name and address of the successor fiduciary and instructions regarding the transfer of funds to the successor fiduciary; and

(ii) Not later than 30 days after transferring funds to the successor fiduciary or as otherwise instructed by the Hub Manager, provide the fiduciary hub a final accounting.

(Authority: 38 U.S.C. 501, 5502, 5507, 6106)

§ 13.510 Fiduciary withdrawals.

(a) *General.* A fiduciary may not withdraw as fiduciary for a beneficiary until the fiduciary receives notice from the Hub Manager regarding transfer of the beneficiary's funds to a successor fiduciary.

(b) *Voluntary withdrawal.* (1) Subject to the limitation prescribed in paragraph (a) of this section, a fiduciary who has VA benefit funds under management for a beneficiary may withdraw from the fiduciary relationship with the beneficiary at any time if the fiduciary:

(i) Provides the fiduciary hub with jurisdiction written notice of the fiduciary's intent to withdraw as fiduciary for the beneficiary;

(ii) Describes the reasons for withdrawal;

(iii) Continues as fiduciary for the beneficiary until the Hub Manager provides the fiduciary with the name and address of the successor fiduciary and instructions regarding the transfer of funds to the successor fiduciary; and

(iv) Not later than 30 days after transferring funds to the successor fiduciary or as otherwise instructed by the Hub Manager, provides the fiduciary hub with jurisdiction a final accounting.

(2) Upon receipt of the notice of intent to withdraw prescribed in paragraph (b)(1)(i) of this section, the Hub Manager will make a reasonable effort under the circumstances to expedite the appointment of a successor fiduciary. In determining the extent to which the fiduciary hub must expedite the appointment of a successor fiduciary, the Hub Manager will consider:

(i) The reasons for the withdrawal request provided under paragraph (b)(1)(ii) of this section;

(ii) The number of beneficiaries affected;

(iii) The relationship between the affected beneficiary or beneficiaries and the fiduciary; and

(iv) Whether expedited appointment of a successor fiduciary is necessary to protect the interests of the beneficiary or beneficiaries.

(c) *Notice*. If a fiduciary requests to withdraw from service for a beneficiary, the Hub Manager will provide the beneficiary or the beneficiary's legal guardian, and the beneficiary's accredited representative, attorney, or claims agent written notice of the withdrawal request and the procedures for appointment of a successor fiduciary.

(Authority: 38 U.S.C. 501, 5502)

§ 13.600 Appeals.

Except as prescribed in paragraph (a) of this section, VA decisions regarding fiduciary matters are committed to the Secretary of Veterans Affairs' discretion by law, as delegated to subordinate officials under this part, and cannot be appealed to the Board of Veterans' Appeals or any court.

(a) *Appealable decisions*. A beneficiary may appeal to the Board of Veterans' Appeals the following decisions:

(1) The Hub Manager's appointment of a fiduciary under § 13.100;

(2) The Hub Manager's removal of a fiduciary under § 13.500;

(3) The Hub Manager's misuse determination under § 13.400;

(4) The VA Regional Office Director's final decision upon reconsideration of a misuse determination under § 13.400(d); and

(5) The Director of the Pension and Fiduciary Service's negligence determination for purposes of reissuance of benefits under § 13.410.

(b) *Procedures*. (1) VA decisions regarding fiduciary matters are final, subject only to the right of appeal prescribed in this section.

(2) The initiation and processing of appeals under this section are governed by parts 19 and 20 of this chapter.

(Authority: 38 U.S.C. 501)

(Approved by the Office of Management and Budget under control number 2900–0085)

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AUTHORITY: 5 U.S.C. 301; 28 U.S.C. 2671–2680; 38 U.S.C. 501(a), 512, 515, 5502, 5901–5905; 28 CFR part 14, appendix to part 14, unless otherwise noted.

SOURCE: 19 FR 5552, Aug. 31, 1954, unless otherwise noted.

§ 14.500 Functions and responsibilities of General Counsel.

The General Counsel is responsible to the Secretary for the following:

(a) All litigation arising in, or out of, the activities of the Department of Veterans Affairs or involving any employee thereof in his or her official capacity.

(b) All interpretative legal advice involving construction or application of laws, including statutes, regulations, and decisional as well as common law.

(c) All legal services, advice and assistance required to implement any law administered by the Department of Veterans Affairs.

(d) All delegations of authority and professional guidance required to meet these responsibilities.

(e) Maintenance of a system of field offices capable of providing legal advice and assistance to all Department of Veterans Affairs field installations and acting for the General Counsel as provided by Department of Veterans Affairs Regulations and instructions, or as directed by the General Counsel in special cases. This includes cooperation with U.S. Attorneys in all civil and criminal cases pertaining to the Department of Veterans Affairs and reporting to the U.S. Attorneys, as authorized, or to the General Counsel, or both, criminal matters coming to the attention of the Regional Counsel.

(f) Other matters assigned.

[42 FR 41410, Aug. 17, 1977]

§ 14.501 Functions and responsibilities of Regional Counsels.

(a) Functions and responsibilities of the Regional Counsels are those set forth in this part and all other matters assigned by the General Counsel.

(b) In any matter within the jurisdiction of the General Counsel, delegated or otherwise assigned, the Regional Counsel and designated staff attorneys are authorized to conduct investigations, examine witnesses, take affadavits, administer oaths and affirmations and certify copies of public or private documents.

(c) The Regional Counsel is authorized to, and shall, under the guidance of the General Counsel, provide legal services, advice and assistance to Department of Veterans Affairs installations within the district assigned. In any area of regulatory, assigned or delegated responsibility, the Regional Counsel may delegate to staff members or other Department of Veterans Affairs attorneys authority to perform, to the extent specified, any legal function under the professional direction of the Regional Counsel. Conversely, the Regional Counsel may modify, suspend, or rescind any authority delegated hereunder.

(d) The Regional Counsel is authorized to cooperate with affiliated organizations, legislative committees, and with local and State bar associations to the end that any State law deficiencies relating to Department of Veterans Affairs operations may be removed. No commitment as to proposed legislation will be made without the approval of the General Counsel.

(e) In any case wherein the Regional Counsel is authorized to take legal action and payment of costs and necessary expenses incident thereto are involved, the administration requesting such action will pay such cost and expenses. Where it is impractical for the Regional Counsel to perform the legal service because of cost, distance, etc., the customary fee for the service rendered by a local attorney employed by the Regional Counsel will be borne by the administration requesting such action.

(f) The jurisdictions and addresses of Regional Counsels are as follows:

(1) *Region 1:* (JURISDICTION) Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island; (ADDRESS) VAMC, 200 Springs Road, Bldg. 61, Bedford, MA 01730.

(2) *Region 2:* (JURISDICTION) New Jersey, Metropolitan New York City; (ADDRESS) 800 Poly Place, Building 14, Brooklyn, NY 11209.

(3) *Region 3:* (JURISDICTION) District of Columbia; Fairfax, Virginia; Arlington, Virginia; Alexandria, Virginia; Martinsburg, West Virginia; and Maryland; (ADDRESS) 3900 Loch Raven Blvd., Bldg. 4, Baltimore, MD 21218.

(4) *Region 4:* (JURISDICTION) Pennsylvania, Delaware; (ADDRESS) University & Woodland Avenues, Philadelphia, PA 19104.

(5) *Region 5:* (JURISDICTION) Georgia, South Carolina; (ADDRESS) 1700 Clairmont Rd., Decatur, GA 30033–4032.

(6) *Region 6:* (JURISDICTION) Florida, Puerto Rico; (ADDRESS) P.O. Box 5005, Building 22, Room 333, Bay Pines, FL 33744.

(7) *Region 7:* (JURISDICTION) Ohio, West Virginia (excluding Martinsburg, West Virginia); (ADDRESS) 10000 Brecksville Rd., Bldg. 1, 5th Floor, Brecksville, OH 44141.

(8) *Region 8:* (JURISDICTION) Arkansas, Tennessee; (ADDRESS) 110 9th Ave., South Room A–201A, Nashville, TN 37203.

(9) *Region 9:* (JURISDICTION) Alabama, Mississippi; (ADDRESS) 1500 E. Woodrow Wilson Dr., Jackson, MS 39216.

(10) *Region 10:* (JURISDICTION) Illinois, Iowa; (ADDRESS) VA Medical Center, Bldg. 1, G Section 1st Floor, P. O. Box 1427, Hines, IL 60141.

(11) *Region 11:* (JURISDICTION) Michigan, Wisconsin; (ADDRESS) Patrick V. McNamara Federal Bldg., Suite 1460, 477 Michigan Ave., Detroit, MI 48226.

(12) *Region 12:* (JURISDICTION) Kansas, Missouri, Nebraska; (ADDRESS) 1 Jefferson Barracks Drive, St. Louis, MO 63125–4185.

(13) *Region 13:* (JURISDICTION) Oklahoma, Northern Texas; (ADDRESS) 4800 Memorial Drive, Bldg. 12, Waco, TX 76711.

(14) *Region 14:* (JURISDICTION) Louisiana, Southern Texas; (ADDRESS) 6900 Almeda Road, Houston, TX 77030.

(15) *Region 15:* (JURISDICTION) Minnesota, North Dakota, South Dakota; (ADDRESS) VA Medical Center, One Veterans Drive, Bldg. 73, Minneapolis, MN 55417.

(16) *Region 16:* (JURISDICTION) Colorado, Wyoming, Utah, Montana; (ADDRESS) Box 25126, 155 Van Gordon Street, Denver, CO 80225.

(17) *Region 18:* (JURISDICTION) California, Hawaii, and Philippine Islands; (ADDRESS) VA Medical Center, 4150 Clement Street, Bldg. 210, San Francisco, CA 94121.

(18) *Region 19:* (JURISDICTION) Arizona, Nevada, and New Mexico; (ADDRESS) 650 E. Indian School Rd., Bldg. 24, Phoenix AZ 85012.

(19) *Region 20:* (JURISDICTION) Idaho, Oregon, Washington, Alaska; (ADDRESS) 1220 S.W. Third Ave., Suite 1224, Portland, OR 97204.

(20) *Region 21:* (JURISDICTION) New York (except Metropolitan New York City), Vermont; (ADDRESS) 120 LeBrun, Buffalo, NY 14215.

(21) *Region 22:* (JURISDICTION) Indiana, Kentucky; (ADDRESS) 575 N. Pennsylvania Street, Room 309, Indianapolis, IN 46204.

(22) *Region 23:* (JURISDICTION) North Carolina, Virginia (excluding Fairfax, Arlington, and Alexandria); (ADDRESS) Hiram H. Ward Federal Bldg., 251 N. Main Street, Winston-Salem, NC 27155.

[42 FR 41411, Aug. 17, 1977, as amended at 61 FR 7216, Feb. 27, 1996; 70 FR 52015, Sept. 1, 2005]

§ 14.502 Requests for legal opinions from Central Office.

Requests for formal legal advice, including interpretation of law or regulations, shall be made only by the Secretary, the Deputy Secretary, the Assistant Secretaries, the Deputy Assistant Secretaries, and the administration head or top staff office official having jurisdiction over the particular subject matter, or by a subordinate acting for any such official.

[54 FR 34982, Aug. 23, 1989]

§ 14.503 Requests for legal advice and assistance in other than domestic relations matters.

(a) Requests from administrative officials in the field for legal advice or assistance will be addressed to the appropriate Regional Counsel and will be in writing if requested by the Regional Counsel. Questions regarding insurance activities at St. Paul and Philadelphia should be referred to the Regional Counsel at the respective station. Except as to matters referred to in § 14.504(b), the Regional Counsel's authority to render legal advice and assistance shall extend to the release (unless otherwise instructed by the General Counsel), without prior approval of the General Counsel, of opinions on all legal questions which are either:

(1) Wholly controlled by the interpretation or application of the laws of the State or States in the district office area, or

(2) Covered by Department of Veterans Affairs precedents and opinions of the General Counsel which the Regional Counsel knows to be currently authoritative on the issues involved.

In cases covered by § 14.504(b) and all others not included in paragraph (a)(1) or (2) or paragraph (b) of this section, the Regional Counsel will prepare a tentative opinion (including identification of the benefit sought) and forward it to the General Counsel for review. When it is returned, the Regional Counsel will conform the opinion (if necessary) to the views of the General Counsel, and release it to the requesting official. The Regional Counsel may release any modified opinion as the opinion of the General Counsel.

(b) The Regional Counsel may submit to the General Counsel any legal question, opinion, or question pertinent to legal functions, upon which the views or advice of the General Counsel are desired. This request should set forth the special circumstances, contain a statement of the legal implications involved (including any Department of Veterans Affairs benefits claimed), set forth the facts out of which they arise, and cite any statutes or court decisions readily available, regulations, related opinions of the General Counsel and other matters deemed pertinent, with

appropriate discussion. If any administration will be affected, a copy of the reply will be forwarded to that administration head.

[42 FR 41411, Aug. 17, 1977, as amended at 54 FR 34982, Aug. 23, 1989]

§ 14.504 Domestic relations questions, authority and exceptions.

(a) Regional Counsels have the same authority with respect to domestic relations questions as they do with respect to matters covered by § 14.503 except as specifically excluded by the provisions of paragraph (a) of that section.

(b) In the following instances the Regional Counsel, regardless of whether State law is wholly controlling or a Department of Veterans Affairs precedent is available, will prepare a tentative opinion, researched as completely as possible with reasonably available facilities, and forward two copies thereof directly to the General Counsel for review and disposition (as provided in § 14.503 respecting other than domestic relations matters):

(1) Where it is not clear under applicable State law: (i) Whether the marriage of a veteran's child or the remarriage of a veteran's widow was void without decree of annulment, or (ii) whether an annulment decree was rendered by a court with basic authority to render annulment decrees;

(2) When fraud or collusion by either party appears to have influenced the granting of an annulment decree;

(3) Cases in which there are contesting claims;

(4) Unusual situations, such as those involving proxy marriages, the law of two or more jurisdictions or of a foreign country;

(5) Cases involving difference of opinion between Regional Counsels or between a Regional Counsel and the official who submitted the question involved.

[42 FR 41411, Aug. 17, 1977]

§ 14.505 Submissions.

All submissions will set forth the question of law on which the opinion is desired, together with a complete and accurate summary of relevant facts. Files, correspondence, and other original papers will not be submitted unless pertinent portions thereof cannot practicably be summarized or copies made and attached as exhibits.

[42 FR 41411, Aug. 17, 1977]

§ 14.507 Opinions.

(a) A written legal opinion of the General Counsel involving veterans' benefits under laws administered by the Department of Veterans Affairs shall be conclusive as to all Department officials and employees with respect to the matter at issue, unless there has been a material change in controlling statute or regulation, a superseding written legal opinion by the General Counsel, or the designation on its face as ''advisory only'' by the General Counsel or the Deputy General Counsel acting as or for the General Counsel. Written legal opinions having conclusive effect under this section and not designated as precedent opinions pursuant to paragraph (b) of this section shall be considered by the Department of Veterans Affairs to be subject to the provisions of 5 U.S.C. 552(a)(2). Advice, recommendations, or conclusions on matters of Government or Department policy, contained within a written legal opinion, shall not be binding on Department officials and employees merely because of their being contained within a written legal opinion. Written legal opinions will be maintained in the Office of the General Counsel. Written legal opinions involving veterans' benefits under laws administered by the Department of Veterans Affairs, which pertain to a particular benefit matter, in addition to being maintained in the Office of the General Counsel, will be filed in the individual claim folder.

(b) A written legal opinion of the General Counsel involving veterans' benefits under laws administered by the Department of Veterans Affairs which, in the judgment of the General Counsel or the Deputy General Counsel acting as or for the General Counsel, necessitates regulatory change, interprets a statute or regulation as a matter of first impression, clarifies or modifies a prior opinion, or is otherwise of significance beyond the matter

at issue, may be designated a ''precedent opinion'' for purposes of such benefits. Written legal opinions designated as precedent opinions under this section shall be considered by Department of Veterans Affairs to be subject to the provisions of 5 U.S.C. 552(a)(1). An opinion designated as a precedent opinion is binding on Department officials and employees in subsequent matters involving a legal issue decided in the precedent opinion, unless there has been a material change in a controlling statute or regulation or the opinion has been overruled or modified by a subsequent precedent opinion or judicial decision.

(c) For purposes of this section, the term *written legal opinion of the General Counsel* means a typed or printed memorandum or letter signed by the General Counsel or by the Deputy General Counsel acting as or for the General Counsel, addressed to an official or officials of the Department of Veterans Affairs stating a conclusion on a legal issue pertaining to Department of Veterans Affairs activities.

(Authority: 38 U.S.C. 501)

[54 FR 5613, Feb. 6, 1989, as amended at 61 FR 68666, Dec. 30, 1996]

LITIGATION (OTHER THAN UNDER THE FEDERAL TORT CLAIMS ACT); INDEMNIFICATION

§ 14.514 Suits by or against United States or Department of Veterans Affairs officials; indemnification of Department of Veterans Affairs employees.

(a) *Suits against United States or Department of Veterans Affairs officials.* When a suit involving any activities of the Department of Veterans Affairs is filed against the United States or the Secretary or a suit is filed against any employee of the Department of Veterans Affairs in which is involved any official action of the employee, not covered by the provisions of §§ 14.600 through 14.617, a copy of the petition will be forwarded to the General Counsel who will take necessary action to obtain the pertinent facts, cooperate with or receive the cooperation of the Department of Justice and, where indicated, advise the Regional Counsel of any further action required.

(b) *Counsel and representation of employees.* The Department of Justice may afford counsel and representation to Government employees who are sued individually as a result of the performance of their official duties. A civil action commenced in a State court against an employee, as the result of an action under color of his or her office, may be removed to the applicable Federal District Court. If a suit is filed against an employee as the result of the performance of his or her official duties, where the provisions of either 28 U.S.C. 2679 or 38 U.S.C. 7316 are not applicable (see § 14.610), and the employee desires to be represented by the U.S. Attorney, the Regional Counsel will obtain a written request to this effect from the employee and will also obtain an affidavit of the facility Director describing the incident in sufficient detail to enable a determination to be made as to whether the employee was in the scope of his or her employment at the time. These statements, together with a copy of the petition and two copies of a summary of pertinent facts, will be sent to the General Counsel, who will transmit copies thereof to the Department of Justice for appropriate action.

(c) *Indemnification.* (1) The Department of Veterans Affairs may indemnify a Department of Veterans Affairs employee, who is personally named as a defendant in any civil suit in state or Federal court or an arbitration proceeding or other proceeding seeking damages against the employee personally, where either 28 U.S.C. 2679 or 38 U.S.C. 7316 is not applicable, for any verdict, judgment, or other monetary award which is rendered against such employee; provided that: the alleged conduct giving rise to the verdict, judgment, or award was taken within the scope of his or her employment and that such indemnification is in the interest of the Department of Veterans Affairs, as determined by the Secretary or his designee.

(2) The Department of Veterans Affairs may settle or compromise a personal damage claim against a Department of Veterans Affairs employee, in cases where the provisions of either 28 U.S.C. 2679 or 38 U.S.C. 7316 are not applicable, by the payment of available

funds, at any time; provided that: the alleged conduct giving rise to the personal damage claim was taken within the employee's scope of employment and that such settlement or compromise is in the interest of the Department of Veterans Affairs, as determined by the Secretary or his designee.

(3) Absent exceptional circumstances as determined by the Secretary or his designee, the Agency will not entertain a request either to agree to indemnify or to settle a personal damage claim before entry of an adverse verdict, judgment, or award.

(4) A Department of Veterans Affairs employee may request indemnification to satisfy a verdict, judgment, or award entered against that employee. The employee shall submit a written request, with appropriate documentation including copies of the verdict, judgment, award, or settlement proposal, in a timely manner to the Department of Veterans Affairs General Counsel, who shall make a recommended disposition of the request. Where the Department of Veterans Affairs determines it appropriate, the Agency shall seek the view of the Department of Justice. The General Counsel shall forward the employee request for indemnification, and the accompanying documentation, with the General Counsel's recommendation to the Secretary for decision.

(5) Any payment under this section either to indemnify a Department of Veterans Affairs employee or to settle or compromise a personal damage claim shall be contingent upon the availability of appropriated funds of the Department of Veterans Affairs.

(d) *Attorney-client privilege.* Attorneys employed by the Department of Veterans Affairs who participate in any process utilized for the purpose of determining whether the Agency should request the Department of Justice to provide representation to a Department employee sued, subpoenaed or charged in his individual capacity, or whether attorneys employed by the Department of Veterans Affairs should provide assistance in the representation of such a Department employee, undertake a full and traditional attorney-client relationship with the employee with respect to application of the attorney-client privilege. If representation is authorized, Department of Veterans Affairs attorneys who assist in the representation of an employee also undertake a full and traditional attorney-client relationship with the employee with respect to the attorney-client privilege. Any adverse information communicated by the client-employee to an attorney during the course of such attorney-client relationship shall not be disclosed to anyone, either inside or outside the Department of Veterans Affairs, other than attorneys responsible for representation of the employee, unless such disclosure is authorized by the employee.

(e) *Suits by the United States.* In any instance wherein direct submission to a U.S. Attorney for institution of civil action has been authorized by the Department of Justice, the Regional Counsel will furnish the U.S. Attorney a complete report of the facts and applicable law, documentary evidence, names and addresses of witnesses and, in cases wherein Department of Veterans Affairs action has been taken, a copy of any pertinent decision rendered. The Regional Counsel will forward two copies of such report and of any proposed pleading to the General Counsel, and will render any practicable assistance requested by the U.S. Attorney.

[42 FR 41411, Aug. 17, 1977, as amended at 54 FR 5614, Feb. 6, 1989]

§ 14.515 Suits involving loan guaranty matters.

(a) In actions for debt, possession or actions similar in substance (including title actions) in which § 36.4282 or § 36.4319 of this chapter has been complied with, the Regional Counsel is authorized to enter the appearance of and represent the Secretary of Veterans Affairs as the attorney of record and to file claims for debt in probate proceedings without prior reference to the General Counsel. Any such action will normally be taken within the time prescribed by law as though there had been valid service of process. In all other types of cases, the Regional Counsel will not enter an appearance or file any pleading on behalf of the Secretary except in imperative emergency until authorization is received

from the General Counsel after submission of all relevant facts. In doubtful cases, the Regional Counsel will request instructions from the General Counsel, submitting copy of so much of the pleadings or other papers, together with a sufficient recital of the facts as will make clear the background, the issues, and the relief sought. The submission also will include names and addresses of adverse parties and attorneys so that immediate action may be taken if injunctive relief seems proper. Where necessary in any case to preserve rights which might be lost by default if there had been proper service of process, appropriate action will be taken by a special appearance, or, in jurisdictions where a special appearance does not serve the purpose or under State statute or decisions will constitute a general appearance for a later date, by an appearance through amicus curiae, to obtain an extension of time, preferably 30 days or more, in which to appear and plead without prejudice. If not feasible to obtain an extension, the Regional Counsel will explain to adverse counsel by letter, and personally, if desirable, the necessity of deferring all action and will see that the proper judge receives a signed copy of the letter before default day. The letter will point out that there is no valid service of process on the Secretary of Veterans Affairs but will not base the delay on that alone.

(b) The General Counsel or each Regional Counsel representing the General Counsel is the attorney of the Secretary of Veterans Affairs for all purposes of 38 U.S.C. 3720 and, as such, is authorized to represent the Secretary in any court action or other legal matter arising under said statutory provisions. Said authorization is subject to any applicable statutes and Executive orders concerning claims of the United States. A Regional Counsel may enter appearance in such cases, subject to the provisions of §§ 36.4282 and 36.4319 of this chapter and paragraph (a) of this section. Each Regional Counsel is authorized to contract for the employment of attorneys on a fee basis for conducting any action arising under guaranty or insurance of loans or direct loans by the Department of Veterans Affairs; or for examination and other proper services with respect to title to and liens on real and personal property, material incident to such activities of the Department of Veterans Affairs, when, such employment is deemed by the Regional Counsel to be appropriate. the authority delegated to the Regional Counsel may be redelegated with the approval of the General Counsel.

(c) The General Counsel and each Regional Counsel, in carrying out their duties as authorized in paragraph (a) or (b) of this section, are authorized: (1) To contract for and execute, for and on behalf of the Secretary, any bond (and appropriate contract or application therefor) which is required in or preliminary to or in connection with any judicial proceeding in which the Regional Counsel is attorney for the Secretary, and to incur obligations for premiums for such bonds and (2) to do all other acts and incur all costs and expenses which are necessary or appropriate to further or protect the interests of the Secretary in or in connection with prosecuting or defending any cause in any court or tribunal within the United States, which cause arises out of or incident to the guaranty or insurance of loans, or the making or direct loans by the Department of Veterans Affairs, pursuant to 38 U.S.C. ch. 37.

(d) Except in an emergency, no Regional Counsel will initiate action for appellate review without prior approval by the General Counsel. These limitations do not preclude the filing of a motion for a new trial, appeal to intermediate court with hearing do novo, the giving of notice of appeal, reserving of bills of exception, or any other preliminary action in the trial court which may be necessary or appropriate to protect or facilitate, the exercise of the right of appellate review, nor do they preclude the taking of appropriate steps on behalf of the Secretary as appellee (respondent) without prior reference to the General Counsel. Upon the conclusion of the trial of a case, the Regional Counsel will report the result thereof to the General Counsel with recommendation as to seeking appellate review if the result reported is adverse to the position of the Department of Veterans Affairs

in the litigation. The reporting Regional Counsel who recommends appellate review will include as a part of the communication, or in exhibits attached: (1) A summary of the evidence; (2) a summary of the law points to be reviewed; (3) citations of statutes and cases; (4) statements of special reasons for recommending appellate review; (5) time limitations for the action recommended; (6) requirements, if any, respecting printing of the record and briefs; (7) the estimated total expenses to be incurred by reason of the appeal, reporting separately the estimated costs for printing the brief and record so that authority for printing may be granted in accordance with the prescribed procedure, MP–1, part II, chapter 9;[1] and (8) the recommendation or a statement as to nonrecommendation by the Loan Guaranty Officer.

[42 FR 41411, Aug. 17, 1977]

§ 14.516 Escheat and post fund cases.

In any case in which the Department of Veterans Affairs is entitled to possession of assets or property under the escheat provisions of 38 U.S.C. 5502(e), the gifts provisions of 38 U.S.C. ch. 83 or the General Post Fund provisions of 38 U.S.C. ch. 85, the Regional Counsel will endeavor to obtain possession of such assets or property in any manner appropriate under local procedure and practice, other than litigation. This procedure would include exploratory inquiry of the person having custody or possession of the assets or property for the purpose of determining whether the person would be willing to turn over the property to the Department of Veterans Affairs without litigation. If unsuccessful in this effort, a complete report will be submitted by the Regional Counsel to the General Counsel so that appropriate action may be taken to obtain the assistance of the Department of Justice in the matter.

[42 FR 41411, Aug. 17, 1977]

§ 14.517 Cases affecting the Department of Veterans Affairs generally.

Regional Counsels will establish and maintain such close liaison with the State and Federal courts as to insure that notice will be afforded the Department of Veterans Affairs on all cases affecting the Department of Veterans Affairs. Such information will be forwarded to the General Counsel promptly in every case.

[42 FR 41411, Aug. 17, 1977]

§ 14.518 Litigation involving beneficiaries in custody of Department of Veterans Affairs employees acting in official capacity.

(a) *Service of process generally*. An employee, at a field facility, served with a writ of habeas corpus involving a beneficiary of the Department of Veterans Affairs in the employee's custody will immediately notify the Regional Counsel of the region in addition to taking such steps as in his or her judgment are necessary for self protection.

(b) *Habeas corpus writs*. (1) If a Director of a Department of Veterans Affairs hospital concerned advises that, according, to current medical opinion, hospitalization is necessary for the veteran's safety or the safety of others, the Regional Counsel will vigorously oppose the writ at the trial court level. If the writ is granted, no further action will be taken unless so instructed by the General Counsel.

(2) If the medical opinion is that hospitalization is not required for the veteran's safety or the safety of others but continued treatment is clearly indicated in the veteran's interest, the Regional Counsel will assure that the court issuing the writ is so informed and will abide by the court's decision.

(3) If the medical opinion is that there is no danger of self injury to the veteran or others and the need for continued treatment is not clearly demonstrated, the Regional Counsel will advise the Director of the hospital concerned that the veteran should be released and will notify the veteran's attorney of the planned discharge. These cases will be handled informally to the extent practicable.

(4) Involuntary confinement of mentally ill patients in Department of Veterans Affairs installations is predicated upon the law of the State in which the installation is located. In the event the writ is filed in Federal

[1] Available in any Department of Veterans Affairs facility.

Court, the Regional Counsel will cooperate with the U.S. Attorney to the end that the case is removed to the appropriate State court.

[42 FR 41411, Aug. 17, 1977, as amended at 61 FR 7216, Feb. 27, 1996]

PROSECUTION

§ 14.560 Procedure where violation of penal statutes is involved including those offenses coming within the purview of the Assimilative Crime Act (18 U.S.C. 13).

The Department of Justice, or the U.S. Attorneys, are charged with the duty and responsibility of interpreting and enforcing criminal statutes, and the final determination as to whether the evidence in any case is sufficient to warrent prosecution is a matter solely for their determination. If the Department of Justice or U.S. Attorney decides to initiate action, the Regional Counsel will cooperate as may be requested. The Regional Counsel will promptly bring to the attention of the General Counsel any case wherein he or she is of the opinion that criminal or civil action should be initiated notwithstanding a decision by the U.S. Attorney not to bring such action; any case where action has been inordinately delayed; and any case which would cause significant publicity or notoriety.

(Authority: 38 U.S.C. 501)

[50 FR 24767, June 13, 1985, as amended at 68 FR 17551, Apr. 10, 2003]

§ 14.561 Administrative action prior to submission.

Before a submission is made to the U.S. Attorney in cases involving personnel or claims, the General Counsel, if the file is in Central Office, or the Regional Counsel at the regional office, hospital or center, if the file is in the regional office or other field facility, will first ascertain that necessary administrative or adjudicatory (forfeiture (see Pub. L. 86–222; 73 Stat. 452), etc.), action has been taken; except that in urgent cases such as breaches of the peace, disorderly conduct, trespass, robbery, or where the evidence may be lost by delay, or prosecution barred by the statute of limitations, submission to the U.S. Attorney will be made immediately.

[42 FR 41413, Aug. 17, 1977]

§ 14.562 Collections or adjustments.

When it is determined that a submission is to be made to the U.S. Attorney, no demand for payment or adjustment will be made without the advice of the U.S. Attorney. However, if, before or after submission, the potential defendant or other person tenders payment of the liability to the United States, payment will be accepted if the U.S. Attorney has no objection. If the U.S. Attorney determines that prosecution is not indicated, or when prosecution has ended, the file will be returned to the appropriate office with a report as to the action taken.

[42 FR 41413, Aug. 17, 1977]

FEDERAL TORT CLAIMS

§ 14.600 Federal Tort Claims Act—general.

(a) *Federal Tort Claims Act—overview.* The Federal Tort Claims Act (28 U.S.C. 1291, 1346, 1402, 2401, 2402, 2411, 2412, and 2671 through 2680) prescribes a uniform procedure for handling of claims against the United States, for money only, on account of damage to or loss of property, or on account of personal injury or death, caused by the negligent or wrongful act or omission of a Government employee while acting within the scope of his or her office or employment, under circumstances where the United States, if a private person, would be liable in accordance with the law of the place where the act or omission occurred.

(b) *Applicable regulations.* The regulations issued by the Department of Justice at 28 CFR part 14 are applicable to claims asserted under the Federal Tort Claims Act, including such claims that are filed with VA. The regulations in §§ 14.600 through 14.605 of this part supplement the regulations at 28 CFR part 14.

(c) *Delegations of authority concerning claims.* Subject to the limitations in 28 CFR 14.6(c), (d), and (e), authority to consider, ascertain, adjust, determine, compromise, and settle claims asserted

under the Federal Tort Claims Act (including the authority to execute an appropriate voucher and other necessary instruments in connection therewith) is delegated as follows:

(1) To the Under Secretary for Health, the Deputy Under Secretary for Health, Veterans Integrated Service Network (VISN) Directors, and VA Medical Facility Directors; with respect to any claim for $2,500 or less that arises out of the operations of the Veterans Health Administration.

(2) To the General Counsel, Deputy General Counsel, and Assistant General Counsel (Professional Staff Group I) or those authorized to act for them with respect to any claim; provided that any award, compromise, or settlement in excess of $300,000 shall be effected only with the prior written approval of the Attorney General or his or her designee; provided further that whenever a settlement is effected in an amount in excess of $100,000, a memorandum fully explaining the basis for the action taken shall be sent to the Department of Justice.

(3) To the Regional Counsels and the Deputy Assistant General Counsel (Professional Staff Group I) or those authorized to act for them with respect to any claim, provided that:

(i) Any award, compromise, or settlement in excess of $150,000 but not more than $300,000 shall be effected only with the prior written approval of the General Counsel, Deputy General Counsel, or Assistant General Counsel (Professional Staff Group I); provided further that whenever a settlement is effected in an amount in excess of $100,000, a memorandum fully explaining the basis for the action taken shall be sent to the Department of Justice; and

(ii) Any award where, for any reason, the compromise of a particular claim, as a practical matter, will, or may control the disposition of a related claim in which the amount to be paid may exceed $150,000 shall be effected only with the prior written approval of the General Counsel, Deputy General Counsel, or Assistant General Counsel (Professional Staff Group I); and

(iii) Any award, compromise, or settlement in excess of $300,000 shall be effected only with the prior written approval of the General Counsel, Deputy General Counsel, or Assistant General Counsel (Professional Staff Group I) and with the prior written approval of the Attorney General or his or her designee.

(d) *Delegations of authority to reconsider final denial of a claim.* Subject to the limitations in 28 CFR 14.6(c), (d), and (e), authority under 28 CFR 14.9 to reconsider final denials of claims under the Federal Tort Claims Act is delegated as follows:

(1) To the Regional Counsel with jurisdiction over the geographic area where the occurrence complained of arose, with respect to any claim for $2,500 or less that arises out of the operations of the Veterans Health Administration.

(2) To the General Counsel, Deputy General Counsel, and Assistant General Counsel (Professional Staff Group I) with respect to any claim; provided that any award, compromise, or settlement in excess of $300,000 shall be effected only with the prior written approval of the Attorney General or his or her designee; provided further that whenever a settlement is effected in an amount in excess of $100,000, a memorandum fully explaining the basis for the action taken shall be sent to the Department of Justice.

(Authority: 28 U.S.C. 1291, 1346, 1402, 2401, 2402, 2411, 2412, 2671–80; 38 U.S.C. 512, 515; 28 CFR part 14, appendix to part 14)

[64 FR 47112, Aug. 30, 1999, as amended at 74 FR 67076, Dec. 18, 2009]

§ 14.601 Investigation and development.

(a) *Development of untoward incidents.* (1) A report of any collision involving a Government-owned vehicle which results in property damage or personal injury or death will be made by the operator of the Government vehicle immediately following the accident, on SF 91, Operator's Report of Motor Vehicle Accident, and shall be submitted to the Director of the facility involved. A copy of said report, accompanied by an executed copy of VA Form 2162, Report of Accident, will be promptly submitted by the Director to the appropriate Regional Counsel, who will authorize such additional investigation as the circumstances of the case may warrant. Forms required by other

agencies will continue to be used in addition to VA Form 2162.

(2)(i) Any incident resulting in damage to, or loss of, property, other than personal effects of a patient in a Department of Veterans Affairs facility, or in personal injury or death, due apparently or allegedly to the negligent or wrongful act or omission of an employee of the Department of Veterans Affairs acting within the scope of his or her office or employment, or damage to or loss of Government-owned property caused by other than a Department of Veterans Affairs employee acting within the scope of his or her office or employment, will be immediately reported. The Director of the facility where such occurrence took place will promptly transmit a copy of the report to the appropriate Regional Counsel who will authorize such additional investigation as the circumstances of the case may warrant.

(ii) Where the incident involves the loss of personal effects of a patient in a Department of Veterans Affairs facility, the Director will assist the patient in completing an SF 95, Claim for Damage, Injury, or Death, and will advise the patient that it will be forwarded immediately to the appropriate Regional Counsel for consideration. The Director will forward along with the claim a brief summary of the facts, as well as his or her recommendation, to the Regional Counsel. The Regional Counsel will expedite the processing of claims of this nature.

(3) An employee will be designated at each facility to investigate motor vehicle collisions and other incidents involving damage to, or loss of privately owned property or personal injury or death, apparently or allegedly resulting from the negligent or wrongful act or omission of an employee of the Department of Veterans Affairs acting within the scope of his or her employment, other than investigation of alleged malpractice, or damage to or loss of Government-owned property caused by other than Department of Veterans Affairs employees. In Central Office, the designation will be made by the Director of Support Service, Office of the Assistant Secretary for Human Resources and Administration, and at all other facilities, by the Director.

(4) The Regional Counsel for the area in which a field facility is located will be responsible for processing claims involving motor vehicle collisions and other occurrences resulting in property damage, personal injury, or death, within such area. The Baltimore Regional Counsel will also have jurisdiction, except as otherwise provided in paragraph (a)(3) of this section over incidents occurring in Department of Veterans Affairs Central Office.

(b) *Development of medical malpractice claims.* In medical malpractice cases, the Regional Counsel may refer a claim to the Under Secretary for Health via the Director, Medical-Legal Affairs for review and for professional opinion or guidance. In the consideration of claims involving a medical question, the responsible Regional Counsel involved and the General Counsel will be guided by the views of the Under Secretary for Health as to the standard of medical care and treatment, the nature and extent of the injuries, the degree of temporary or permanent disability, the prognosis, the necessity for future treatment or physical rehabilitation, and any other pertinent medical aspects of a claim.

(Authority: 28 U.S.C. 2671–2680; 38 U.S.C. 512, 515; 28 CFR part 14, appendix to part 14)

[42 FR 41414, Aug. 17, 1977. Redesignated and amended at 61 FR 27784, June 3, 1996; 64 FR 47112, Aug. 30, 1999]

§ 14.602 Requests for medical information.

(a) Where there is indication that a tort claim will be filed, medical records or other information shall not be released without approval of the Regional Counsel.

(b) Request for medical records, documents, reports, or other information shall be handled in accordance with the provisions of § 1.511(a)(2) of this chapter.

[38 FR 5470, Mar. 1, 1973, as amended 42 FR 41415, Aug. 17, 1977. Redesignated at 61 FR 27784, June 3, 1996, as amended at 64 FR 47112, Aug. 30, 1999]

§ 14.603 Disposition of claims.

Setoff for cost of unauthorized medical treatment. In any tort claim administratively settled or compromised where the claimant owes the Department of

Veterans Affairs for unauthorized medical treatment, there will be included in the tort claim award the amount of the claimant's indebtedness to the Government. The amount of the indebtedness is for credit to the appropriation account from which the services were provided. The voucher prepared for settlement of the claim will specify the amount to be deposited to the credit of the designated account and that the balance of the award be paid to the claimant.

[42 FR 41416, Aug. 17, 1977, as amended at 43 FR 2722, Jan. 19, 1978. Redesignated and amended at 61 FR 27784, June 3, 1996]

§ 14.604 Filing a claim.

(a) Each person who inquires as to the procedure for filing a claim against the United States, predicated on a negligent or wrongful act or omission of an employee of the Department of Veterans Affairs acting within the scope of his or her employment, will be furnished a copy of SF 95, Claim for Damage, Injury, or Death. The claimant will be advised to submit the executed claim directly to the Regional Counsel having jurisdiction of the area wherein the occurrence complained of took place. He or she will also be advised to submit the information prescribed by 28 CFR 14.4 to the extent applicable. If a claim is presented to the Department of Veterans Affairs which involves the actions of employees or officers of other agencies, it will be forwarded to the Department of Veterans Affairs General Counsel, for appropriate action in accord with 28 CFR 14.2.

(b) A claim shall be deemed to have been presented when the Department of Veterans Affairs receives from a claimant, his or her duly authorized agent or legal representative, an executed SF 95, or other written notification of an incident, together with a claim for money damages, in a sum certain, for damage to or loss of property or personal injury or death: *Provided, however*, That before compromising or settling any claim, an executed SF 95 shall be obtained from the claimant.

(c) A claim presented in compliance with paragraphs (a) and (b) of this section may be amended by the claimant at any time prior to final Department of Veterans Affairs action or prior to the exercise of the claimant's option under 28 U.S.C. 2675(a). Amendments shall be submitted in writing and signed by the claimant or his or her duly authorized agent or legal representative. Upon the timely filing of an amendment to a pending claim, the Department of Veterans Affairs shall have 6 months in which to make a final disposition of the claim as amended and the claimant's option under 28 U.S.C. 2675(a) shall not accrue until 6 months after the filing of the amendment.

(Authority: 28 U.S.C. 1346(b)(1), 2401(b), 2671–2680; 38 U.S.C. 512, 515; 28 CFR part 14, appendix to part 14)

[42 FR 41414, Aug. 17, 1977, as amended at 61 FR 27784, June 3, 1996; 64 FR 47112, Aug. 30, 1999]

§ 14.605 Suits against Department of Veterans Affairs employees arising out of a wrongful act or omission or based upon medical care and treatment furnished in or for the Veterans Health Administration.

(a)(1) Section 2679 of title 28 U.S.C., provides that no suit will lie against a Federal employee, or the employee's estate, for damage to property, personal injury, or death resulting from his or her wrongful act or omission while acting within the scope of his or her office or employment with the Federal Government. An action against the United States under 28 U.S.C. 2671–2680 is the exclusive remedy under these circumstances.

(2) Section 7316 of title 38 U.S.C., provides that (i) where there is remedy against the United States under 28 U.S.C. 2671–2680, or (ii) where proceedings for compensation or other benefits from the United States are provided by law, and the availability of such benefits precludes a remedy under 28 U.S.C. 2671–2680 (as is the case, for example, in the Federal Employees' Compensation Act, 5 U.S.C. 8101, *et seq.*), such recourse is the exclusive remedy for property damage, personal injury, or death allegedly occurring as a result of malpractice or negligence committed by a physician, dentist, nurse, physician's assistant, dentist's assistant, pharmacist or paramedical

(for example, medical and dental technicians, nursing assistants, and therapists), or other supporting personnel, while furnishing medical care and treatment in the exercise of duties in or for the Veterans Health Administration. Accordingly, a malpractice or negligence suit for property damage, personal injury, or death will not lie against such personnel under the circumstances set forth in this subparagraph.

(b) The Department of Justice will defend any civil action or proceeding brought in any court against persons referred to in paragraph (a) (1) or (2) of this section under the circumstances set forth therein. Accordingly, when a suit is filed against any employee of the Department of Veterans Affairs as a result of a wrongful act or omission arising out of employment with the Government, or as a result of furnishing medical or dental care and treatment in or for the Veterans Health Administration, the employee shall immediately forward a copy of all papers served on him or her to the Regional Counsel having jurisdiction over the area in which the employee works. The employee will also promptly forward to the appropriate Regional Counsel a signed statement indicating whether he or she desires the Department of Justice to provide representation, and to otherwise protect his or her interests as provided for by law. Even though there may not have been service, if an employee learns that a suit arising from either of the above-described circumstances has been filed against him or her, the employee shall immediately so advise the appropriate Regional Counsel, provide the Regional Counsel with a brief description of the facts involved, and state whether he or she desires Federal intervention.

(c) Upon receipt of notice that suit has been filed against an employee of the Department of Veterans Affairs who is entitled to protection under 28 U.S.C. 2679 or 38 U.S.C. 7316, the Regional Counsel having jurisdiction over the place where the employee works will conduct a preliminary investigation, which will include an affidavit by the employee's supervisor as to whether the defendant-employee was acting in the scope of his or her employment at the time of the incident, and a request from the defendant-employee for representation. The affidavit will contain a factual description of the employee's duties and responsibilities at the time of the incident and should describe the incident in question. Upon receipt of such information, the Regional Counsel will make a preliminary determination as to whether such suit comes within the provisions of either 28 U.S.C. 2679 or 38 U.S.C. 7316. The Regional Counsel will refer the matter to the appropriate U.S. Attorney with a recommendation as to whether the employee is eligible for protection under 28 U.S.C. 2679 or 38 U.S.C. 7316. The U.S. Attorney will decide whether the Department of Veterans Affairs employee is eligible for the protection. The Regional Counsel will submit to the General Counsel a preliminary report in duplicate containing the information furnished the U.S. Attorney. In all such cases, the Regional Counsel will conduct a complete investigation of the facts and law. Two copies of the investigation report will be sent to the General Counsel and one copy will be sent to the appropriate U.S. Attorney. The General Counsel, through the Regional Counsel, will keep the employee advised of the action being taken concerning the suit. In the event that the U.S. Attorney or the Department of Justice determines that the employee is not eligible for immunization pursuant to one of the aformentioned provisions, the General Counsel's office, through the Regional Counsel, will advise the employee and will call to his or her attention the discretionary conditional indemnification provisions of section 7316(e) of title 38 U.S.C.

(d) Where a civil action is commenced in a State court against a Department of Veterans Affairs employee, and the matter is within the purview of either 28 U.S.C. 2679, or 38 U.S.C. 7316, the Department of Justice will be asked to remove such suit to the appropriate Federal District Court before trial, where it will be deemed an action against the United States. The defendant employee will be dismissed from the suit. After such removal, the United States has available all defenses to which it would have been entitled if the action had originally been

commenced against the United States in the proper Federal District Court. Should a Federal District Court determine that the Department of Veterans Affairs employee whose acts or omissions gave rise to the suit was not acting within the scope of his or her office or employment, and therefore not eligible for immunization as provided for in the aforementioned section, the case will be remanded to the State court from which it was removed, the employee will be reinstated as the defendant, and the United States will be dismissed from the suit. Where the employee has been reinstated as the defendant under such circumstances, in order to protect any rights which he or she may have under 38 U.S.C. 7316(e), he or she shall immediately notify the General Counsel, through the local Regional Counsel. Through the Regional Counsel, the General Counsel will call the employee's attention to the discretionary conditional indemnification provisions of section 7316(e).

(e) Under the authority of 38 U.S.C. 7316(e), the Secretary of Veterans Affairs may pay for monetary damages sustained by or assessed against an individual (or his or her estate) described in paragraph (a)(2) of this section, as the result of any suit instituted against such individual which is not congnizable under the provisions of 28 U.S.C. 2671–2680 because the individual was assigned to a foreign country, the said individual was detailed to a State or political division thereof, or the cause of action was specifically excluded under the provisions of 28 U.S.C. 2680(h); *Provided*, That the amount of damages sustained is reasonable when compared with similar cases, litigated or settled, and the United States was given a reasonable opportunity to defend such individual and to participate in settlement negotiations.

(Authority: 28 U.S.C 2671–2680; 38 U.S.C. 512, 515, 7316; 28 CFR part 14, appendix to part 14)

[42 FR 41417, Aug. 17, 1977. Redesignated and amended at 61 FR 27784, June 3, 1996; 64 FR 47112, Aug. 30, 1999]

ADMINISTRATIVE SETTLEMENT OF TORT CLAIMS ARISING IN FOREIGN COUNTRIES

§ 14.615 General.

(a) *Authority*. Section 515(b), title 38 U.S.C., provides that the Secretary of Veterans Affairs may pay tort claims, in the manner authorized in the first paragraph of section 2672 of title 28 U.S.C., when such claims arise in foreign countries in connection with Department of Veterans Affairs operations abroad.

(b) *Action by claimant*. Claims for property loss or damage may be filed by the owner of the property or his or her duly authorized agent or legal representative. If the property was insured and the insurer is subrogated, in whole or in part, and if both the owner and the insurer desire to file a claim for their respective losses they should join in one claim. Claims for personal injury may be filed by the injured person or his or her agent or legal representative. Claims for death may be filed by the personal representative of the decedent or any other legally qualified person. When filed by an agent or legal representative, the claim must show the title or capacity of the person representing the claimant and be accompanied by evidence of the appointment of such person as agent, legal representative, executor/executrix, administrator/administratrix, guardian, or other fiduciary.

(c) *Time for filing*. A claim may not be allowed under 38 U.S.C. 515(b) unless it is presented to the Secretary or his or her designee within 2 years after the claim accrues.

(Authority: 28 U.S.C 2671–2680; 38 U.S.C. 512, 515, 7316; 28 CFR part 14, appendix to part 14)

[38 FR 5473, Mar. 1, 1973, as amended at 42 FR 41417, Aug. 17, 1977; 64 FR 47112, Aug. 30, 1999]

§ 14.616 Form and place of filing claim.

(a) *Form of claim*. Claims arising under 38 U.S.C. 515(b) will be prepared in the form of a sworn statement and submitted in duplicate. The original copy of the claim will be sworn to or affirmed before an official with authority to administer oaths or affirmations and will contain the following information, at least:

(1) The name and address of claimant;

(2) The amount claimed for injury or death, and for property loss or damage;

(3) If property was lost or damaged, the amount paid or payable by the insurer together with the name of the insurer;

(4) A detailed statement of the facts and circumstances giving rise to the claim, including the time, place, and date of the accident or incident;

(5) If property was involved, a description of the property and the nature and extent of the damage and the cost of repair or replacement based upon at least two impartial estimates;

(6) If personal injury was involved, the nature of the injury, the cost of medical and/or hospital services, and time and income lost due to the injury;

(7) If death is involved, the names and ages of claimants and their relationship to decedent;

(8) The name and official position of the employee of the United States allegedly responsible for the accident or injury, or loss or damage of property;

(9) The names and addresses of any witnesses to accident or incident; and

(10) If desired, the law applicable to the claim.

(b) *Place of filing claim.* Claims arising in the Philippines under 38 U.S.C. 515(b) will be filed with the Director, Department of Veterans Affairs Regional Office, Manila, Republic of the Philippines. Claims arising in other foreign countries will be filed with the American Embassy or Consulate nearest the place where the incident giving rise to the claim took place.

(c) *Evidence to be submitted by claimant*—(1) *General.* The amount claimed on account of damage to or loss of property or on account of personal injury or death shall, so far as possible, be substantiated by competent evidence. Supporting statements, estimates and the like will, if possible, be obtained from disinterested parties. All evidence will be submitted in duplicate. Original evidence or certified copies shall be attached to the original copy of the claim, and simple copies shall be attached to the other copy of the claim. All documents in other than the English language will be accompanied by English translations.

(2) *Personal injury or death.* In support of claims for personal injury or death, the claimant will submit, as may be appropriate, itemized bills for medical, hospital, or burial expenses actually incurred; a statement from the claimant's or decedent's employer as to time and income lost from work; and a written report by the attending physician with respect to the nature and extent of the injury, the nature and extent of treatment, the degree of disability, the period of hospitalization or incapacitation, and the prognosis as to future treatment, hospitalization and the like.

(3) *Damage to personal property.* In support of claims for damage to personal property which has been repaired, the claimant will submit an itemized receipt, or, if not repaired, itemized estimates of the cost of repairs by two reliable parties who specialize in such work. If the property is not economically repairable, the claimant will submit corroborative statements of two reliable, qualified persons with respect to cost, age of the property and salvage value.

(4) *Damage to real property.* In support of claims for damage to land, trees, buildings, fences, or other improvements to real property, the claimant will submit an itemized receipt if repairs have been made, or, if repairs have not been made, itemized estimates of the cost of repairs by two reliable persons who specialize in such work. If the property is not economically repairable, the claimant will submit corroborative statements of two reliable, qualified persons with respect to the value of the improvements both before and after the accident or incident and the cost of replacements.

(5) *Damage to crops.* In support of claims for damage to crops, the claimant will submit an itemized signed statement showing the number of acres, or other unit measure of crop damaged, the probable yield per unit, the gross amount which would have been realized from such probable yield and an estimate of the costs of cultivating, harvesting and marketing the crop. If the crop is one which need not be planted each year, the diminution in value of the land beyond the damage to

the current year's crop will also be stated.

(Approved by the Office of Management and Budget under control number 2900–0437)

[38 FR 5474, Mar. 1, 1973, as amended at 42 FR 41418, Aug. 17, 1977; 49 FR 32848, Aug. 17, 1984]

§ 14.617 Disposition of claims.

(a) *Disposition of claims arising in Philippines.* All claims arising under 38 U.S.C. 515(b) in the Philippines, including a complete investigation report and a brief résumé of applicable law, will be forwarded directly by the Director to the General Counsel, together with a recommendation as to disposition.

(b) *Disposition of claims arising in foreign countries other than the Philippines.* When a claim is received in an American Embassy or Consulate, the Embassy or Consulate receiving such claim shall make such investigation as may be necessary or appropriate for a determination of the validity of the claim and thereafter shall forward the claim, together with all pertinent material, including a résumé of applicable law and a recommendation regarding allowance or disallowance of the claim, through regular channels of the Department of State to the General Counsel, Department of Veterans Affairs Central Office, Washington, DC.

(c) *Payment of claims.* Upon determining that there is liability on the part of the United States under 38 U.S.C. 515(b), the General Counsel, or such other personnel as may be designated by the Secretary, will take the necessary action to effect payment.

[38 FR 5474, Mar. 1, 1973, as amended at 42 FR 41418, Aug. 17, 1977]

CLAIMS FOR DAMAGE TO OR LOSS OF GOVERNMENT PROPERTY

§ 14.618 Collection action.

(a) In a case where the Regional Counsel determines that damage to or loss of Government property under the jurisdiction of the Department of Veterans Affairs resulted from the negligence or other legal wrong of a person other than an employee of the United States, while acting within the scope of his or her employment, the Regional Counsel will request payment in full of the amount of damage from the person liable therefor or such person's insurer.

(b) The Regional Counsel may collect, compromise, suspend, or terminate collection action on any such claim as is authorized under § 2.6(e)(4)(ii) of this chapter, in conformity with the standards in § 1.900 series of this chapter. Any such claim that has not been collected in full and which has not been compromised, suspended or terminated and does not exceed $100,000, will be referred by the Regional Counsel to the appropriate U.S. attorney along with the information required by §§ 1.951 through 1.953 of this chapter. Any claim in excess of $100,000 for which payment in full has not been made, will be transmitted along with the report required by § 14.601(a)(2)(i), a report on credit data (§ 1.952 of this chapter), and any other pertinent information, to the General Counsel for appropriate action.

(c) The General Counsel or those designated in § 2.6(e)(4) of this chapter will take action to collect in full on such claims and to compromise, suspend, or terminate any such claims not exceeding $100,000 in conformity with § 1.900 series of this chapter. Any such claims not compromised, or on which collection actions is not suspended or terminated and does not exceed $100,000, will be referred to the appropriate U.S. Attorney. Any such claims in excess of $100,000, which have not been collected in full, will be referred by the General Counsel to the Department of Justice for appropriate action.

(d) The provisions of paragraphs (a) through (c) of this section are not applicable to the collection of claims involving damage to General Services Administration Motor Pool System vehicles issued for Department of Veterans Affairs use. Whenever there is any indication that a party other than the operator of a motor pool system vehicle is at fault in an accident, all documents and data pertaining to the accident and its investigation will be submitted to the General Services Administration Regional Counsel of the region that issued the vehicle who has jurisdiction over such matters. Whenever a motor pool system vehicle is involved in an accident, resulting in damage to the property of, or injury to the person

of a third party, and the third party asserts a claim against the Department of Veterans Affairs based upon the alleged negligence of the vehicle operator, the claim will be considered under § 14.600 *et seq.*

[38 FR 5474, Mar. 1, 1973, as amended at 42 FR 41418, Aug. 17, 1977; 61 FR 27784, June 3, 1996]

CLAIMS FOR COST OF MEDICAL CARE AND SERVICES

§ 14.619 Collection action.

(a) In a case where the Regional Counsel determines that medical care and services were furnished as a result of the negligence of a third party, other than an employee of the United States while acting in the scope of his or her employment, the Regional Counsel will request payment in full of the amount of damage from the person liable therefor or such person's insurer.

(b) The Regional Counsel may collect, compromise, suspend, or terminate collection activity on any such claim as is authorized under § 2.6(e)(3) of this chapter. However, claims in excess of $100,000 may be compromised, settled, or waived only with the prior approval of the Department of Justice, which will be obtained through the General Counsel. Any such claim that has not been collected in full and which has not been compromised, suspended or terminated will be referred by the Regional Counsel to the appropriate U.S. Attorney along with appropriate information necessary to protect the interest of the Government. A copy of the referral to the U.S. Attorney will be sent to the General Counsel's office.

(c) In a case where the Regional Counsel determines that a claim is appropriate under the provisions of § 17.48(g) of this chapter or 38 U.S.C. 1729, for the cost of medical, hospital, or surgical care, the Regional Counsel may assert the claim and collect payment in full. The Regional Counsel may compromise, settle, waive, suspend or terminate collection activity on any claim not exceeding $100,000. Claims in excess of $100,000 may only be compromised, settled, or waived with the approval of the General Counsel. Any such claim not compromised, settled, or waived or where collection action is not suspended or terminated will be referred to the appropriate United States Attorney with sufficient data to enable that office to protect the interest of the Government. A copy of all materials referred to the United States Attorney will be furnished the General Counsel.

(Authority: 38 U.S.C. 1729(c)(1))

[42 FR 41418, Aug. 17, 1977, as amended at 43 FR 10560, Mar. 14, 1978; 51 FR 23227, June 26, 1986; 58 FR 39153, July 22, 1993; 61 FR 27785, June 3, 1996]

REPRESENTATION OF DEPARTMENT OF VETERANS AFFAIRS CLAIMANTS; RECOGNITION OF ORGANIZATIONS, ACCREDITED REPRESENTATIVES, ATTORNEYS, AGENTS; RULES OF PRACTICE AND INFORMATION CONCERNING FEES, 38 U.S.C. 5901–5905

§ 14.626 Purpose.

The purpose of the regulation of representatives, agents, attorneys, and other individuals is to ensure that claimants for Department of Veterans Affairs (VA) benefits have responsible, qualified representation in the preparation, presentation, and prosecution of claims for veterans' benefits.

[73 FR 29870, May 22, 2008]

§ 14.627 Definitions.

As used in regulations on representation of VA claimants:

(a) *Accreditation* means the authority granted by VA to representatives, agents, and attorneys to assist claimants in the preparation, presentation, and prosecution of claims for VA benefits.

(b) *Agency of original jurisdiction* means the VA activity or administration that made the initial determination on a claim or matter or that handles any subsequent adjudication of a claim or matter in the first instance, and includes the Office of the General Counsel with respect to proceedings under part 14 of this chapter to suspend or cancel accreditation or to review fee agreements.

(c) *Agent* means a person who has met the standards and qualifications outlined in § 14.629(b).

(d) *Attorney* means a member in good standing of a State bar who has met

the standards and qualifications in § 14.629(b).

(e) *Benefit* means any payment, service, commodity, function, or status, entitlement to which is determined under laws administered by VA pertaining to veterans, dependents, and survivors.

(f) *Cancellation* means termination of authority to represent claimants.

(g) *Chief Counsel* includes a designee of the Chief Counsel.

(h) *Claim* means application made under title 38 U.S.C., and implementing directives, for entitlement to VA benefits, reinstatement, continuation, or increase of benefits, or the defense of a proposed agency adverse action concerning benefits.

(i) *Claimant* means a person who has filed or has expressed to a representative, agent, or attorney an intention to file a written application for determination of entitlement to benefits provided under title 38, United States Code, and implementing directives.

(j) *Complete claims service* means representation of each claimant requesting assistance, from the initiation of a claim until the completion of any potential administrative appeal.

(k) *Cross-accreditation* means an accreditation based on the status of a representative as an accredited and functioning representative of another organization.

(l) *Deputy Chief Counsel* includes a designee of the Deputy Chief Counsel.

(m) *Facilities* means equipment and furnishings that promote the efficient operation of an office, and adjacent accommodations, which are needed to facilitate access to office space.

(n) *General Counsel* includes the Deputy General Counsel for Legal Policy if designated by the General Counsel. When so designated, references to ''the General Counsel or his or her designee'' may further include a designee of the Deputy General Counsel for Legal Policy.

(o) *Recognition* means certification by VA of organizations to assist claimants in the preparation, presentation, and prosecution of claims for VA benefits.

(p) *Representation* means the acts associated with representing a claimant in a proceeding before VA pursuant to a properly executed and filed VA Form 21–22, ''Appointment of Veterans Service Organization as Claimant's Representative,'' or VA Form 21–22a, ''Appointment of Individual as Claimant's Representative.''

(q) *Representative* means a person who has been recommended by a recognized organization and accredited by VA.

(r) *Service* means the delivery of a motion, response, or reply to a person or entity to which it is directed. Proof of service consists of a statement by the person who made service certifying the date and manner of service, the names of the persons served, and the addresses of the place of delivery. For service by mail, proof of service shall include the date and manner by which the document was mailed.

(s) *State* includes any State, possession, territory, or Commonwealth of the United States, and the District of Columbia.

(t) *Suspension* means temporary withholding of authority to represent claimants.

(u) *Tribal government* means the Federally recognized governing body of any Indian tribe, band, nation, or other organized group or community, including any Alaska Native village or Regional or Village Corporation as defined in or established pursuant to the Alaska Native Claims Settlement Act, which is recognized as eligible for the special programs and services provided by the United States to Indians because of their status as Indians.

(Authority: 38 U.S.C. 501(a), 5902, 5903, 5904)

[53 FR 52419, Dec. 28, 1988, as amended at 68 FR 8544, Feb. 24, 2003; 73 FR 29870, May 22, 2008; 82 FR 6272, Jan. 19, 2017; 82 FR 26753, June 9, 2017]

§ 14.628 Recognition of organizations.

Authorized officers of an organization may request recognition by letter to the Secretary of Veterans Affairs.

(a) *National organization*. An organization may be recognized as a national organization if:

(1) It was recognized by the Department of Veterans Affairs prior to October 10, 1978, and continues to satisfy the requirements of § 14.628(d) of this section, or

(2) It satisfies the following requirements:

(i) Requirements set forth in paragraph (d) of this section, including information required to be submitted under that paragraph;

(ii) In the case of a membership organization, membership of 2,000 or more persons, as certified by the head of the organization;

(iii) Capability and resources to provide representation to a sizable number of claimants;

(iv) Capability to represent claimants before the Board of Veterans' Appeals in Washington, D.C.; and

(v) Geographic diversification, *i.e.*, either one or more posts, chapters, or offices in at least ten states, or one or more members in at least twenty states.

(b)(1) *State organization*. An organization created and primarily funded by a State government for the purpose of serving the needs of veterans of that State may be recognized. Only one such organization may be recognized in each State.

(2) *Tribal organization*. For the purposes of 38 CFR 14.626 through 14.637, an organization that is a legally established organization that is primarily funded and controlled, sanctioned, or chartered by one or more tribal governments and that has a primary purpose of serving the needs of Native American veterans. Only one tribal organization may be recognized for each tribal government. If a tribal organization is created and funded by more than one tribal government, the approval of each tribal government must be obtained prior to applying for VA recognition. If one of the supporting tribal governments withdraws from the tribal organization, the tribal organization must notify VA of the withdrawal and certify that the tribal organization continues to meet the recognition requirements in paragraph (d) of this section.

(c) *Regional or local organization*. An organization other than a State or national organization as set forth in paragraphs (a) and (b) of this section may be recognized when the Department of Veterans Affairs has determined that it is a veterans' service organization primarily involved in delivering services connected with either title 38 U.S.C., benefits and programs or other Federal and State programs designed to assist veterans. The term *veteran* as used in this paragraph shall include veterans, former armed forces personnel, and the dependents or survivors of either. Further, the organization shall provide responsible, qualified representation in the preparation, presentation, and prosecution of claims for title 38 U.S.C., benefits.

(d) *Requirements for recognition*. (1) In order to be recognized under this section, an organization shall meet the following requirements:

(i) Have as a primary purpose serving veterans. In establishing that it meets this requirement, an organization requesting recognition shall submit a statement establishing the purpose of the organization and that veterans would benefit by recognition of the organization.

(ii) Demonstrate a substantial service commitment to veterans either by showing a sizable organizational membership or by showing performance of veterans' services to a sizable number of veterans. In establishing that it meets this requirement, an organization requesting recognition shall submit:

(A) The number of members and number of posts, chapters, or offices and their addresses;

(B) A copy of the articles of incorporation, constitution, charter, and bylaws of the organization, as appropriate;

(C) A description of the services performed or to be performed in connection with programs administered by the Department of Veterans Affairs, with an approximation of the number of veterans, survivors, and dependents served or to be served by the organization in each type of service designated; and

(D) A description of the type of services, if any, performed in connection with other Federal and State programs which are designed to assist former Armed Forces personnel and their dependents, with an approximation of the number of veterans, survivors, and dependents served by the organization under each program designated.

(iii) Commit a significant portion of its assets to veterans' services and

have adequate funding to properly perform those services. In establishing that it meets this requirement, an organization requesting recognition shall submit:

(A) A copy of the last financial statement of the organization indicating the amount of funds allocated for conducting particular veterans' services (VA may, in cases where it deems necessary, require an audited financial statement); and

(B) A statement indicating that use of the organization's funding is not subject to limitations imposed under any Federal grant or law which would prevent it from representing claimants before the Department of Veterans Affairs.

(iv) Maintain a policy and capability of providing complete claims service to each claimant requesting representation or give written notice of any limitation in its claims service with advice concerning the availability of alternative sources of claims service. Except as provided in paragraphs (d)(1)(iv)(A) and (B) of this section, in establishing that it meets this requirement, an organization requesting recognition shall submit evidence of its capability to represent claimants before Department of Veterans Affairs regional offices and before the Board of Veterans' Appeals.

(A) If an organization does not intend to represent claimants before the Board of Veterans' Appeals, the organization shall submit evidence of an association or agreement with a recognized service organization for the purpose of representation before the Board of Veterans' Appeals, or the proposed method of informing claimants of the limitations in service that can be provided, with advice concerning the availability of alternative sources of claims service.

(B) If an organization does not intend to represent each claimant requesting assistance, the organization shall submit a statement of its policy concerning the selection of claimants and the proposed method of informing claimants of this policy, with advice concerning the availability of alternative sources of claims service.

NOTE TO PARAGRAPH (d)(1)(iv): An organization may be considered to provide complete claims service notwithstanding the exercise of discretion to determine that provision of representation in a particular case is impracticable or inappropriate because, under the circumstances, the facts or law do not support the filing of a claim or appeal, an appropriate representative-claimant relationship cannot be maintained, or representation would give rise to a conflict of interest on the part of the organization.

(v) Take affirmative action, including training and monitoring of accredited representatives, to ensure proper handling of claims. In establishing that it meets this requirement, an organization requesting recognition shall submit:

(A) A statement of the skills, training, and other qualifications of current paid or volunteer staff personnel for handling veterans' claims; and

(B) A plan for recruiting and training qualified claim representatives, including the number of hours of formal classroom instruction, the subjects to be taught, the period of on-the-job training, a schedule or timetable for training, the projected number of trainees for the first year, and the name(s) and qualifications of the individual(s) primarily responsible for the training.

(2) In addition, the organization requesting recognition shall supply:

(i) A statement that neither the organization nor its accredited representatives will charge or accept a fee or gratuity for service to a claimant and that the organization will not represent to the public that Department of Veterans Affairs recognition of the organization is for any purpose other than claimant representation; and

(ii) The names, titles, and addresses of officers and the official(s) authorized to certify representatives.

(e) *Recognition or denial.* Only the Secretary is authorized to recognize organizations. Notice of the Secretary's determination on a request for recognition will be sent to an organization within 90 days of receipt of all information to be supplied.

(f) *Requests for further information.* The Secretary or the Secretary's designee may request further information

from any recognized organization, including progress reports, updates, or verifications.

(Authority: 38 U.S.C. 501(a), 5902)

(The Office of Management and Budget has approved the information collection requirements in this section under control number 2900–0850)

[53 FR 52419, Dec. 28, 1988, as amended at 57 FR 33878, July 31, 1992; 68 FR 8544, Feb. 24, 2003; 82 FR 6272, Jan. 19, 2017]

§ 14.629 Requirements for accreditation of service organization representatives; agents; and attorneys.

(a) *Service Organization Representatives.* A recognized organization shall file with the Office of the General Counsel VA Form 21 (Application for Accreditation as Service Organization Representative) for each person it desires accredited as a representative of that organization. The form must be signed by the prospective representative and the organization's certifying official. For each of its accredited representatives, a recognized organization's certifying official shall complete, sign and file with the Office of the General Counsel, not later than five years after initial accreditation through that organization or the most recent recertification by that organization, VA Form 21 to certify that the representative continues to meet the criteria for accreditation specified in paragraph (a)(1), (2) and (3) of this section. In recommending a person, the organization shall certify that the designee:

(1) Is of good character and reputation and has demonstrated an ability to represent claimants before the VA;

(2) Is either a member in good standing or a paid employee of such organization working for it not less than 1,000 hours annually; is accredited and functioning as a representative of another recognized organization; or, in the case of a county veterans' service officer or tribal veterans' service officer recommended by a recognized State organization, meets the following criteria:

(i) Is a paid employee of the county or tribal government working for it not less than 1,000 hours annually;

(ii) Has successfully completed a course of training and an examination which have been approved by the appropriate District Chief Counsel; and

(iii) Will receive either regular supervision and monitoring or annual training to assure continued qualification as a representative in the claim process; and

(3) Is not employed in any civil or military department or agency of the United States.

(Authority: 38 U.S.C. 501(a), 5902)

(b) *Accreditation of Agents and Attorneys.* (1) No individual may assist claimants in the preparation, presentation, and prosecution of claims for VA benefits as an agent or attorney unless he or she has first been accredited by VA for such purpose.

(i) For agents, the initial accreditation process consists of application to the Office of the General Counsel, self-certification of admission information concerning practice before any other court, bar, or State or Federal agency, an affirmative determination of character and fitness by VA, and a written examination.

(ii) For attorneys, the initial accreditation process consists of application to the Office of the General Counsel, self-certification of admission information concerning practice before any other court, bar, or State or Federal agency, and a determination of character and fitness. The Office of the General Counsel will presume an attorney's character and fitness to practice before VA based on State bar membership in good standing unless the Office of the General Counsel receives credible information to the contrary.

(iii) As a further condition of initial accreditation, both agents and attorneys are required to complete 3 hours of qualifying continuing legal education (CLE) during the first 12-month period following the date of initial accreditation by VA. To qualify under this subsection, a CLE course must be approved for a minimum of 3 hours of CLE credit by any State bar association and, at a minimum, must cover the following topics: representation before VA, claims procedures, basic eligibility for VA benefits, right to appeal, disability compensation (38 U.S.C. Chapter 11), dependency and indemnity compensation (38 U.S.C. Chapter 13),

and pension (38 U.S.C. Chapter 15). Upon completion of the initial CLE requirement, agents and attorneys shall certify to the Office of the General Counsel in writing that they have completed qualifying CLE. Such certification shall include the title of the CLE, date and time of the CLE, and identification of the CLE provider, and shall be submitted to VA as part of the annual certification prescribed by § 14.629(b)(4).

(iv) To maintain accreditation, agents and attorneys are required to complete an additional 3 hours of qualifying CLE on veterans benefits law and procedure not later than 3 years from the date of initial accreditation and every 2 years thereafter. To qualify under this subsection, a CLE course must be approved for a minimum of 3 hours of CLE credit by any State bar association. Agents and attorneys shall certify completion of the post-accreditation CLE requirement in the same manner as described in § 14.629(b)(1)(iii).

(2) An individual desiring accreditation as an agent or attorney must establish that he or she is of good character and reputation, is qualified to render valuable assistance to claimants, and is otherwise competent to advise and assist claimants in the preparation, presentation, and prosecution of their claim(s) before the Department. An individual desiring accreditation as an agent or attorney must file a completed application (VA Form 21a) with the Office of the General Counsel (022D), 810 Vermont Avenue, NW., Washington, DC 20420, on which the applicant submits the following:

(i) His or her full name and home and business addresses;

(ii) Information concerning the applicant's military and civilian employment history (including character of military discharge, if applicable);

(iii) Information concerning representation provided by the applicant before any department, agency, or bureau of the Federal government;

(iv) Information concerning any criminal background of the applicant;

(v) Information concerning whether the applicant has ever been determined mentally incompetent or hospitalized as a result of a mental disease or disability, or is currently under treatment for a mental disease or disability;

(vi) Information concerning whether the applicant was previously accredited as a representative of a veterans service organization and, if so, whether that accreditation was terminated or suspended by or at the request of that organization;

(vii) Information concerning the applicant's level of education and academic history;

(viii) The names, addresses, and phone numbers of three character references; and

(ix) Information relevant to whether the applicant for accreditation as an agent has any physical limitations that would interfere with the completion of a comprehensive written examination administered under the supervision of the appropriate District Chief Counsel (agents only); and

(x) Certification that the applicant has satisfied the qualifications and standards required for accreditation as prescribed by VA in this section, and that the applicant will abide by the standards of conduct prescribed by VA in § 14.632 of this part.

(3) Evidence showing lack of good character and reputation includes, but is not limited to, one or more of the following: Conviction of a felony, conviction of a misdemeanor involving fraud, bribery, deceit, theft, or misappropriation; suspension or disbarment from a court, bar, or Federal or State agency on ethical grounds; or resignation from admission to a court, bar, or Federal or State agency while under investigation to avoid sanction.

(4) As a further condition of initial accreditation and annually thereafter, each person seeking accreditation as an agent or attorney shall submit to VA information about any court, bar, or Federal or State agency to which the agent or attorney is admitted to practice or otherwise authorized to appear. Applicants shall provide identification numbers and membership information for each jurisdiction in which the applicant is admitted and a certification that the agent or attorney is in good standing in every jurisdiction in which admitted. After accreditation, agents and attorneys must notify VA within 30 days of any change

in their status in any jurisdiction in which they are admitted to appear.

(5) VA will not accredit an individual as an agent or attorney if the individual has been suspended by any court, bar, or Federal or State agency in which the individual was previously admitted and not subsequently reinstated. However, if an individual remains suspended in a jurisdiction on grounds solely derivative of suspension or disbarment in another jurisdiction to which he or she has been subsequently reinstated, the Chief Counsel with subject-matter jurisdiction may evaluate the facts and grant or reinstate accreditation as appropriate.

(6) After an affirmative determination of character and fitness for practice before the Department, applicants for accreditation as a claims agent must achieve a score of 75 percent or more on a written examination administered by VA as a prerequisite to accreditation. No applicant shall be allowed to sit for the examination more than twice in any 6-month period.

(c) *Representation by Attorneys, Law Firms, Law Students and Paralegals.* (1) After accreditation by the Office of the General Counsel, an attorney may represent a claimant upon submission of a VA Form 21–22a, ''Appointment of Attorney or Agent as Claimant's Representative.''

(2) If the claimant consents in writing, an attorney associated or affiliated with the claimant's attorney of record or employed by the same legal services office as the attorney of record may assist in the representation of the claimant.

(3) A legal intern, law student, or paralegal may not be independently accredited to represent claimants under this paragraph. A legal intern, law student, or certified paralegal may assist in the preparation, presentation, or prosecution of a claim, under the direct supervision of an attorney of record designated under §14.631(a), if the claimant's written consent is furnished to VA. Such consent must specifically state that participation in all aspects of the claim by a legal intern, law student, or paralegal furnishing written authorization from the attorney of record is authorized. In addition, suitable authorization for access to the claimant's records must be provided in order for such an individual to participate. The supervising attorney must be present at any hearing in which a legal intern, law student, or paralegal participates. The written consent must include the name of the veteran, or the name of the appellant if other than the veteran (e.g., a veteran's survivor, a guardian, or a fiduciary appointed to receive VA benefits on an individual's behalf); the applicable VA file number; the name of the attorney-at-law; the consent of the appellant for the use of the services of legal interns, law students, or paralegals and for such individuals to have access to applicable VA records; and the names of the legal interns, law students, or paralegals who will be assisting in the case. The signed consent must be submitted to the agency of original jurisdiction and maintained in the claimant's file.In the case of appeals before the Board in Washington, DC, the signed consent must be submitted to: Director, Office of Management, Planning and Analysis (014), Board of Veterans' Appeals, P.O. Box 27063, Washington, DC 20038. In the case of hearings before a Member or Members of the Board at VA field facilities, the consent must be presented to the presiding Member of the hearing.

(4) Unless revoked by the claimant, consent provided under paragraph (c)(2) or paragraph (c)(3) of this section shall remain effective in the event the claimant's original attorney is replaced as attorney of record by another member of the same law firm or an attorney employed by the same legal services office.

(d) *Decisions on applications for accreditation.* The Chief Counsel with subject-matter jurisdiction will conduct an inquiry and make an initial determination regarding any question relating to the qualifications of a prospective service organization representative, agent, or attorney.

(1) If the Chief Counsel determines that the prospective service organization representative, agent, or attorney meets the requirements for accreditation in paragraph (a) or (b) of this section, notification of accreditation will be issued by the Chief Counsel and will constitute authority to prepare, present, and prosecute claims before an

agency of original jurisdiction or the Board of Veterans' Appeals.

(2)(i) If the Chief Counsel determines that the prospective representative, agent, or attorney does not meet the requirements for accreditation, notification will be issued by the Chief Counsel concerning the reasons for disapproval, an opportunity to submit additional information, and any restrictions on further application for accreditation. If an applicant submits additional evidence, the Chief Counsel will consider such evidence and provide further notice concerning his or her final decision.

(ii) The determination of the Chief Counsel regarding the qualifications of a prospective service organization representative, agent, or attorney is a final adjudicative determination of an agency of original jurisdiction that may only be appealed to the Board of Veterans' Appeals.

NOTE TO §14.629: A legal intern, law student, paralegal, or veterans service organization support-staff person, working under the supervision of an individual designated under §14.631(a) as the claimant's representative, attorney, or agent, may qualify for read-only access to pertinent Veterans Benefits Administration automated claims records as described in §§1.600 through 1.603 in part 1 of this chapter.

(Authority: 38 U.S.C. 501(a), 5904)

(The Office of Management and Budget has approved the information collection requirements in this section under control numbers 2900–0018 and 2900–0605)

[53 FR 52421, Dec. 28, 1988, as amended at 55 FR 38057, Sept. 17, 1990; 68 FR 8545, Feb. 24, 2003; 71 FR 28586, May 17, 2006; 72 FR 58012, Oct. 12, 2007; 73 FR 29871, May 22, 2008; 73 FR 29871, May 22, 2008; 81 FR 32649, May 24, 2016; 82 FR 6272, Jan. 19, 2017; 82 FR 26753, June 9, 2017; 84 FR 174, Jan. 18, 2019]

§14.630 Authorization for a particular claim.

(a) Any person may be authorized to prepare, present, and prosecute one claim. A power of attorney executed on VA Form 21–22a, ''Appointment of Attorney or Agent as Claimant's Representative,'' and a statement signed by the person and the claimant that no compensation will be charged or paid for the services, shall be filed with the agency of original jurisdiction where the claim is presented. The power of attorney identifies to VA the claimant's appointment of representation and authorizes VA's disclosure of information to the person representing the claimant.

(b) Representation may be provided by an individual pursuant to this section one time only. An exception to this limitation may be granted by the General Counsel in unusual circumstances. Among the factors which may be considered in determining whether an exception will be granted are:

(1) The number of accredited representatives, agents, and attorneys operating in the claimant's geographic region;

(2) Whether the claimant has unsuccessfully sought representation from other sources;

(3) The nature and status of the claim; and

(4) Whether there exists unique circumstances which would render alternative representation inadequate.

(c) Persons providing representation under this section must comply with the laws administered by VA and with the regulations governing practice before VA including the rules of conduct in §14.632 of this part.

(d) Persons providing representation under this section are subject to suspension and or exclusion from representation of claimants before VA on the same grounds as apply to representatives, agents, and attorneys in §14.633 of this part.

(e) With respect to the limitation in paragraph (b) of this section, a person who had been authorized under paragraph (a) of this section to represent a claimant who later dies and is replaced by a substitute pursuant to 38 CFR 3.1010 for purposes of processing the claim to completion will be permitted to represent the substitute if the procedures of §14.631(g) are followed.

(Authority: 38 U.S.C. 501(a), 5121A, 5903)

[68 FR 8546, Feb. 24, 2003, as amended at 73 FR 29872, May 22, 2008; 79 FR 52983, Sept. 5, 2014]

§14.631 Powers of attorney; disclosure of claimant information.

(a) A power of attorney, executed on either VA Form 21–22, ''Appointment of Veterans Service Organization as

Claimant's Representative,'' or VA Form 21–22a, ''Appointment of Attorney or Agent as Claimant's Representative,'' is required to represent a claimant before VA and to authorize VA's disclosure of information to any person or organization representing a claimant before the Department. Without the signature of a person providing representation for a particular claim under §14.630 of this part or an accredited veterans service organization representative, agent, or attorney, the appointment is invalid, and the person appointed to provide representation is under no obligation to do so. The power of attorney shall meet the following requirements:

(1) Contain signature by:

(i) The claimant, or

(ii) The claimant's guardian, or

(iii) In the case of an incompetent, minor, or otherwise incapacitated person without a guardian, the following in the order named—spouse, parent, other relative or friend (if interests are not adverse), or the director of the hospital in which the claimant is maintained; and

(iv) An individual providing representation on a particular claim under §14.630 of this part or an accredited veterans service organization representative, agent, or attorney; and

(2) Shall be presented to the appropriate VA office for filing in the veteran's claims folder.

(b) VA may, for any purpose, treat a power of attorney naming as a claimant's representative an organization recognized under §14.628, a particular office of such an organization, or an individual representative of such an organization as an appointment of the entire organization as the claimant's representative, unless the claimant specifically indicates in the power of attorney a desire to appoint only the individual representative. Such specific indication must be made in the space on the power-of-attorney form for designation of the representative and must use the word ''only'' with reference to the individual representative.

(c) An organization, individual providing representation on a particular claim under §14.630, representative, agent, or attorney named in a power of attorney executed pursuant to paragraph (a) of this section may withdraw from representation provided before a VA agency of original jurisdiction if such withdrawal would not adversely impact the claimant's interests. This section is applicable unless 38 CFR 20.6 governs withdrawal from the representation. Withdrawal is also permissible if a claimant persists in a course of action that the organization or individual providing representation reasonably believes is fraudulent or criminal and is furthered through the representation of the organization or individual; the claimant fails to uphold an obligation to the organization or individual providing representation regarding the services of the organization or individual; or other good cause for withdrawal exists. An organization or individual providing representation withdraws from representation by notifying the claimant, the VA organization in possession of the claims file, and the agency of original jurisdiction in writing prior to taking any action to withdraw and takes steps necessary to protect the claimant's interests including, but not limited to, giving advance notice to the claimant, allowing time for appointment of alternative representation, and returning any documents provided by VA in the course of the representation to the agency of original jurisdiction or pursuant to the claimant's instructions, to the organization or individual substituted as the representative, agent, or attorney of record. Upon withdrawing from representation, all property of the claimant must be returned to the claimant. If the claimant is unavailable, all documents provided by VA for purposes of representation must be returned to the VA organization in possession of the claims file. Any other property of the claimant must be maintained by the organization or individual according to applicable law.

(d) Questions concerning the validity or effect of powers of attorney shall be referred to the appropriate District Chief Counsel for initial determination. This determination may be appealed to the General Counsel.

(e)(1) Only one organization, representative, agent, or attorney will be recognized at one time in the prosecution of a particular claim. Except as

provided in §14.629(c) and paragraph (f)(2) of this section, all transactions concerning the claim will be conducted exclusively with the recognized organization, representative, agent, or attorney of record until notice of a change, if any, is received by the appropriate office of VA.

(2) An organization named in a power of attorney executed in accordance with paragraph (a) of this section may employ an attorney to represent a claimant in a particular claim. Unless the attorney is an accredited representative of the organization, the written consent of the claimant shall be required.

(f)(1) A power of attorney may be revoked at any time, and an agent or attorney may be discharged at any time. Unless a claimant specifically indicates otherwise, the receipt of a new power of attorney executed by the claimant and the organization or individual providing representation shall constitute a revocation of an existing power of attorney.

(2) If an agent or attorney limits the scope of his or her representation regarding a particular claim by so indicating on VA Form 21–22a, or a claimant authorizes a person to provide representation in a particular claim under §14.630, such specific authority shall constitute a revocation of an existing general power of attorney filed under paragraph (a) of this section only as it pertains to, and during the pendency of, that particular claim. Following the final determination of such claim, the general power of attorney shall remain in effect as to any new or reopened claim.

(g) If a request to substitute is granted pursuant to 38 CFR 3.1010, then a new VA Form 21–22, ''Appointment of Veterans Service Organization as Claimant's Representative,'' or VA Form 21–22a, ''Appointment of Individual as Claimant's Representative,'' under paragraph (a) of this section is required in order to represent the substitute before VA. If the substitute desires representation on a one-time basis pursuant to §14.630(a), a statement signed by the person providing representation and the substitute that no compensation will be charged or paid for the services is also required.

(Authority: 38 U.S.C. 501(a), 5121A, 5902, 5903, 5904)

(The Office of Management and Budget has approved the information collection requirements in this section under control number 2900–0321)

[43 FR 46535, Oct. 10, 1978, as amended at 53 FR 52421, Dec. 28, 1988; 68 FR 8546, Feb. 24, 2003; 73 FR 29873, May 22, 2008; 79 FR 52983, Sept. 5, 2014; 82 FR 26754, June 9, 2017; 84 FR 174, Jan. 18, 2019]

§14.632 Standards of conduct for persons providing representation before the Department

(a)(1) All persons acting on behalf of a claimant shall faithfully execute their duties as individuals providing representation on a particular claim under §14.630, representatives, agents, or attorneys.

(2) All individuals providing representation are required to be truthful in their dealings with claimants and VA.

(b) An individual providing representation on a particular claim under §14.630, representative, agent, or attorney shall:

(1) Provide claimants with competent representation before VA. Competent representation requires the knowledge, skill, thoroughness, and preparation necessary for the representation. This includes understanding the issues of fact and law relevant to the claim as well as the applicable provisions of title 38, United States Code, and title 38, Code of Federal Regulations;

(2) Act with reasonable diligence and promptness in representing claimants. This includes responding promptly to VA requests for information or assisting a claimant in responding promptly to VA requests for information.

(c) An individual providing representation on a particular claim under §14.630, representative, agent, or attorney shall not:

(1) Violate the standards of conduct as described in this section;

(2) Circumvent a rule of conduct through the actions of another;

(3) Engage in conduct involving fraud, deceit, misrepresentation, or dishonesty;

(4) Violate any of the provisions of title 38, United States Code, or title 38, Code of Federal Regulations;

(5) Enter into an agreement for, charge, solicit, or receive a fee that is clearly unreasonable or otherwise prohibited by law or regulation;

(6) Solicit, receive, or enter into agreements for gifts related to services for which a fee could not lawfully be charged;

(7) Delay, without good cause, the processing of a claim at any stage of the administrative process;

(8) Mislead, threaten, coerce, or deceive a claimant regarding benefits or other rights under programs administered by VA;

(9) Engage in, or counsel or advise a claimant to engage in acts or behavior prejudicial to the fair and orderly conduct of administrative proceedings before VA;

(10) Disclose, without the claimant's authorization, any information provided by VA for purposes of representation; or

(11) Engage in any other unlawful or unethical conduct.

(d) In addition to complying with standards of conduct for practice before VA in paragraphs (a) through (c) of this section, an attorney shall not, in providing representation to a claimant before VA, engage in behavior or activities prohibited by the rules of professional conduct of any jurisdiction in which the attorney is licensed to practice law.

(Authority: 38 U.S.C. 501(a), 5902, 5904)

[73 FR 29873, May 22, 2008, as amended at 84 FR 174, Jan. 18, 2019]

§ 14.633 Termination of accreditation or authority to provide representation under § 14.630.

(a) Accreditation or authority to provide representation on a particular claim under § 14.630 may be suspended or canceled at the request of an organization, individual providing representation under § 14.630, representative, agent, or attorney. When an organization requests suspension or cancellation of the accreditation of a representative due to misconduct or lack of competence on the part of the representative or because the representative resigned to avoid suspension or cancellation of accreditation for misconduct or lack of competence, the organization shall inform VA of the reason for the request for suspension or cancellation and the facts and circumstances surrounding any incident that led to the request.

(b) Accreditation shall be canceled at such time as a determination is made by the General Counsel that any requirement of § 14.629 is no longer met by a representative, agent, or attorney.

(c) Accreditation or authority to provide representation on a particular claim shall be canceled when the General Counsel finds, by clear and convincing evidence, one or more of the following:

(1) Violation of or refusal to comply with the laws administered by VA or with the regulations governing practice before VA including the standards of conduct in § 14.632;

(2) Knowingly presenting or prosecuting a fraudulent claim against the United States, or knowingly providing false information to the United States;

(3) Demanding or accepting unlawful compensation for preparing, presenting, prosecuting, or advising or consulting, concerning a claim;

(4) Knowingly presenting to VA a frivolous claim, issue, or argument. A claim, issue, or argument is frivolous if the individual providing representation under § 14.630, representative, agent, or attorney is unable to make a good faith argument on the merits of the position taken or to support the position taken by a good faith argument for an extension, modification, or reversal of existing law;

(5) Suspension or disbarment by any court, bar, or Federal or State agency to which such individual providing representation under § 14.630, representative, agent, or attorney was previously admitted to practice, or disqualification from participating in or appearing before any court, bar, or Federal or State agency and lack of subsequent reinstatement;

(6) Charging excessive or unreasonable fees for representation as determined by VA, the Court of Appeals for Veterans Claims, or the United States Court of Appeals for the Federal Circuit; or

(7) Any other unlawful or unethical practice adversely affecting an individual's fitness for practice before VA.

(d) Accreditation or authority to provide representation on a particular claim shall be canceled when the General Counsel finds that the performance of an individual providing representation under §14.630, representative, agent, or attorney before VA demonstrates a lack of the degree of competence necessary to adequately prepare, present, and prosecute claims for veteran's benefits. A determination that the performance of an individual providing representation under §14.630, representative, agent, or attorney before VA demonstrates a lack of the degree of competence required to represent claimants before VA will be based upon consideration of the following factors:

(1) The relative complexity and specialized nature of the matter;

(2) The individual's general experience;

(3) The individual's training and experience; and

(4) The preparation and study the individual is able to give veterans benefits matters and whether it is feasible to refer such matters to, or associate or consult with, an individual of established competence in the field of practice.

(e) As to cancellation of accreditation under paragraphs (c) or (d) of this section, upon receipt of credible written information from any source indicating improper conduct, or incompetence, the Chief Counsel with subject-matter jurisdiction shall inform the subject of the allegations about the specific law, regulation, or policy alleged to have been violated or the nature of the alleged incompetence and the source of the complaint, and shall provide the subject with the opportunity to respond. If the matter involves an accredited representative of a recognized organization, the notice shall include contact with the representative's organization. When appropriate, including situations where no harm results to the claimant or VA, the Chief Counsel will provide the subject with an opportunity to correct the offending behavior before deciding whether to proceed with a formal inquiry. If the subject refuses to comply and the matter remains unresolved, or the behavior subsequently results in harm to a claimant or VA, the Chief Counsel shall immediately initiate a formal inquiry into the matter.

(1) If the result of the inquiry does not justify further action, the Chief Counsel will close the inquiry and maintain the record for 3 years.

(2) If the result of the inquiry justifies further action, the Chief Counsel shall:

(i) Inform the General Counsel of the result of the inquiry and notify the individual providing representation under §14.630, representative, agent or attorney of an intent to cancel accreditation or authority to provide representation on a particular claim. The notice will be sent to individuals providing representation on a particular claim by certified or registered mail to the individual's last known address of record as indicated on the VA Form 21–22a on file with the agency of original jurisdiction. The notice will be sent to accredited individuals by certified or registered mail to the individual's last known address of record as indicated in VA's accreditation records. The notice will state the reason(s) for the cancellation proceeding and advise the individual to file an answer, in oath or affidavit form or the form specified for unsworn declarations under penalty of perjury in 28 U.S.C. 1746, within 30 days from the date the notice was mailed, responding to the stated reasons for cancellation and explaining why he or she should not be suspended or excluded from practice before VA. The notice will also advise the individual of the right to submit additional evidence and the right to request a hearing on the matter. Requests for hearings must be made in the answer. If the individual does not file an answer with the Office of the General Counsel within 30 days of the date that the Chief Counsel mailed the notice, the Chief Counsel shall close the record before the Office of the General Counsel and forward it with a recommendation to the General Counsel for a final decision.

(ii) In the event that a hearing is not requested, the Chief Counsel shall close

the record before the Office of the General Counsel and forward it with a recommendation to the General Counsel for a final decision.

(iii) The Chief Counsel may extend the time to file an answer or request a hearing for a reasonable period upon a showing of sufficient cause.

(iv) For purposes of computing time for responses to notices of intent to cancel accreditation, *days* means calendar days. In computing the time for filing this response, the date on which the notice was mailed by the Chief Counsel shall be excluded. A response postmarked prior to the expiration of the 30th day shall be accepted as timely filed. If the 30th day falls on a weekend or legal holiday, the first business day thereafter shall be included in the computation. As used in this section, *legal holiday* means New Year's Day, Birthday of Martin Luther King, Jr., Washington's Birthday, Memorial Day, Independence Day, Labor Day, Columbus Day, Veterans Day, Thanksgiving Day, Christmas Day, and any other day appointed as a holiday by the President or the Congress of the United States, or by the State in which the individual resides.

(f) If a hearing is requested, it will be held at the VA Regional Office nearest the individual's principal place of business. If the individual's principal place of business is Washington, DC, the hearing will be held at the VA Central Office or other VA facility in Washington, DC. For hearings conducted at either location, the Chief Counsel with subject-matter jurisdiction shall present the evidence. The hearing officer shall not report, directly or indirectly to, or be employed by the General Counsel or the head of the VA agency of original jurisdiction before which the individual provided representation. The hearing officer shall provide notice of the hearing to the individual providing representation under § 14.630, representative, agent, or attorney by certified or registered mail at least 21 days before the date of the hearing. Hearings shall not be scheduled before the completion of the 30-day period for filing an answer to the notice of intent to cancel accreditation. The hearing officer will have authority to administer oaths. The party requesting the hearing will have a right to counsel, to present evidence, and to cross-examine witnesses. Upon request of the individual requesting the hearing, an appropriate VA official designated in § 2.1 of this chapter may issue subpoenas to compel the attendance of witnesses and the production of documents necessary for a fair hearing. The hearing shall be conducted in an informal manner and court rules of evidence shall not apply. Testimony shall be recorded verbatim. The evidentiary record shall be closed 10 days after the completion of the hearing. The hearing officer shall submit the entire hearing transcript, any pertinent records or information, and a recommended finding to the Chief Counsel within 30 days of closing the record. The Chief Counsel shall immediately forward the record and the hearing officer's recommendation to the General Counsel for a final decision.

(g) The General Counsel may suspend the accreditation of a representative, agent, or attorney, under paragraphs (b), (c), or (d) of this section, for a definite period or until the conditions for reinstatement specified by the General Counsel are satisfied. The General Counsel shall reinstate an individual's accreditation at the end of the suspension period or upon verification that the individual has satisfied the conditions for reinstatement.

(h) The decision of the General Counsel is a final adjudicative determination of an agency of original jurisdiction that may only be appealed to the Board of Veterans' Appeals.

(1) *Decisions issued before the effective date of the modernized review system.* Notwithstanding provisions in this section for closing the record before the Office of the General Counsel at the end of the 30-day period for filing an answer or 10 days after a hearing, appeals of decisions issued before the effective date of the modernized review system as provided in § 19.2(a) of this chapter shall be initiated and processed using the procedures in 38 CFR parts 19 and 20 applicable to legacy appeals. Nothing in this section shall be construed to limit the Board's authority to remand a matter to which this paragraph (h)(1) applies to the General

Counsel under 38 CFR 20.904 for any action that is essential for a proper appellate decision or the General Counsel's ability to issue a Supplemental Statement of the Case under 38 CFR 19.31.

(2) *Decisions issued on or after the effective date of the modernized review system.* Notwithstanding provisions in this section for closing the record before the Office of the General Counsel at the end of the 30-day period for filing an answer or 10 days after a hearing, appeals of decisions issued on or after the effective date of the modernized review system as provided in §19.2(a) of this chapter shall be initiated and processed using the procedures in 38 CFR part 20 applicable to appeals under the modernized system.

(i) In cases where the accreditation of an agent or attorney is suspended or cancelled, the Office of the General Counsel may notify all agencies, courts, and bars to which the agent or attorney is admitted to practice.

(j) The effective date for suspension or cancellation of accreditation or authority to provide representation on a particular claim shall be the date upon which the General Counsel's final decision is rendered.

(Authority: 38 U.S.C. 501, 5902, 5904)

(The Office of Management and Budget has approved the information collections requirements in this section control number 2900–0018)

[53 FR 52422, Dec. 28, 1988, as amended at 72 FR 58012, Oct. 12, 2007; 73 FR 29874, May 22, 2008; 82 FR 26754, June 9, 2017; 84 FR 174, Jan. 18, 2019]

§ 14.634 Banks or trust companies acting as guardians.

Banks or trust companies, corporate entities, acting as guardians for claimants, may be represented before adjudicating agencies as authorized representatives of claimants by an officer or employee, including a regularly employed attorney, if the employee or attorney represents the corporation in its fiduciary capacity.

(Authority: 38 U.S.C. 5903, 5904)

[43 FR 46535, Oct. 10, 1978. Redesignated and amended at 57 FR 4104, Feb. 3, 1992; 68 FR 8547, Feb. 24, 2003]

§ 14.635 Office space and facilities.

The Secretary may furnish office space and facilities, if available, in buildings owned or occupied by the Department of Veterans Affairs, for the use of paid full-time representatives of recognized national organizations, and for employees of recognized State or tribal organizations who are accredited to national organizations, for purposes of assisting claimants in the preparation, presentation, and prosecution of claims for Department of Veterans Affairs benefits.

(a) Request for office space should be made by an appropriate official of the organization to the Director of the Department of Veterans Affairs facility in which space is desired and should set forth:

(1) The number of full-time paid representatives who will be permanently assigned to the office;

(2) The number of secretarial or other support staff who will be assigned to the office;

(3) The number of claimants for whom the organization holds powers of attorney whose claims are within the jurisdiction of the facility or who reside in the area served by the facility, the number of such claimants whose claims are pending, and the number of claims prosecuted during the previous three years; and

(4) Any other information the organization deems relevant to the allocation of office space.

(b) When in the judgment of the Director office space and facilities previously granted could be better used by the Department of Veterans Affairs, or would receive more effective use or serve more claimants if allocated to another recognized national organization, the Director may withdraw such space or reassign such space to another organization. In the case of a facility under the control of the Veterans Benefits Administration or the Veterans Health Administration, the final decision on such matters will be made by the Under Secretary for Benefits or the

Under Secretary for Health, respectively.

(Authority: 38 U.S.C. 501(a), 5902)

[53 FR 52423, Dec. 28, 1988. Redesignated and amended at 57 FR 4104, Feb. 3, 1992; 68 FR 8547, Feb. 24, 2003; 82 FR 6272, Jan. 19, 2017]

§ 14.636 Payment of fees for representation by agents and attorneys in proceedings before Agencies of Original Jurisdiction and before the Board of Veterans' Appeals.

(a) *Applicability of rule.* The provisions of this section apply to the services of accredited agents and attorneys with respect to benefits under laws administered by VA in all proceedings before the agency of original jurisdiction or before the Board of Veterans' Appeals regardless of whether an appeal has been initiated.

(b) *Who may charge fees for representation.* Only accredited agents and attorneys may receive fees from claimants or appellants for their services provided in connection with representation. Recognized organizations (including their accredited representatives when acting as such) and individuals recognized under § 14.630 of this part are not permitted to receive fees. An agent or attorney who may also be an accredited representative of a recognized organization may not receive such fees unless he or she has been properly designated as an agent or attorney in accordance with § 14.631 of this part in his or her individual capacity as an accredited agent or attorney.

(c) *Circumstances under which fees may be charged.* Except as noted in paragraph (d) of this section, agents and attorneys may only charge fees as follows:

(1)(i) Agents and attorneys may charge claimants or appellants for representation provided after an agency of original jurisdiction has issued notice of an initial decision on the claim or claims if the notice of the initial decision was issued on or after the effective date of the modernized review system as provided in § 19.2(a) of this chapter, and the agent or attorney has complied with the power of attorney requirements in § 14.631 and the fee agreement requirements in paragraph (g) of this section. For purposes of this paragraph (c)(1)(i), an initial decision on a claim would include an initial decision on an initial claim for an increase in rate of benefit, an initial decision on a request to revise a prior decision based on clear and unmistakable error (unless fees are permitted at an earlier point pursuant to paragraph (c)(1)(ii) or paragraph (c)(2)(ii) of this section), and an initial decision on a supplemental claim that was presented after the final adjudication of an earlier claim. However, a supplemental claim will be considered part of the earlier claim if the claimant has continuously pursued the earlier claim by filing any of the following, either alone or in succession: A request for higher-level review, on or before one year after the date on which the agency of original jurisdiction issued a decision; a supplemental claim, on or before one year after the date on which the agency of original jurisdiction issued a decision; a Notice of Disagreement, on or before one year after the date on which the agency of original jurisdiction issued a decision; a supplemental claim, on or before one year after the date on which the Board of Veterans' Appeals issued a decision; or a supplemental claim, on or before one year after the date on which the Court of Appeals for Veterans Claims issued a decision.

(ii) Agents and attorneys may charge fees for representation provided with respect to a request for revision of a decision of an agency of original jurisdiction under 38 U.S.C. 5109A or the Board of Veterans' Appeals under 38 U.S.C. 7111 based on clear and unmistakable error if notice of the challenged decision on a claim or claims was issued on or after the effective date of the modernized review system as provided in § 19.2(a), and the agent or attorney has complied with the power of attorney requirements in § 14.631 and the fee agreement requirements in paragraph (g) of this section.

(2)(i) Agents and attorneys may charge claimants or appellants for representation provided: After an agency of original jurisdiction has issued a decision on a claim or claims, including any claim to reopen under 38 CFR 3.156(a) or for an increase in rate of a

benefit; the agency of original jurisdiction issued notice of that decision before the effective date of the modernized review system as provided in § 19.2(a) of this chapter; a Notice of Disagreement has been filed with respect to that decision on or after June 20, 2007; and the agent or attorney has complied with the power of attorney requirements in § 14.631 and the fee agreement requirements in paragraph (g) of this section.

(ii) Agents and attorneys may charge fees for representation provided with respect to a request for revision of a decision of an agency of original jurisdiction under 38 U.S.C. 5109A or the Board of Veterans' Appeals under 38 U.S.C. 7111 based on clear and unmistakable error if notice of the challenged decision was issued before the effective date of the modernized review system as provided in § 19.2(a); a Notice of Disagreement was filed with respect to the challenged decision on or after June 20, 2007; and the agent or attorney has complied with the power of attorney requirements in § 14.631 and the fee agreement requirements in paragraph (g) of this section.

(3) In cases in which a Notice of Disagreement was filed on or before June 19, 2007, agents and attorneys may charge fees only for services provided after both of the following conditions have been met:

(i) A final decision was promulgated by the Board with respect to the issue, or issues, involved in the appeal; and

(ii) The agent or attorney was retained not later than 1 year following the date that the decision by the Board was promulgated. (This condition will be considered to have been met with respect to all successor agents or attorneys acting in the continuous prosecution of the same matter if a predecessor was retained within the required time period.)

(4) Except as noted in paragraph (i) of this section and § 14.637(d), the agency of original jurisdiction that issued the decision referenced in paragraph (c)(1) or (2) of this section shall determine whether an agent or attorney is eligible for fees under this section. The agency of original jurisdiction's eligibility determination is a final adjudicative action that may only be appealed to the Board.

(d) *Exceptions*—(1) *Chapter 37 loans.* With respect to services of agents and attorneys provided after October 9, 1992, a reasonable fee may be charged or paid in connection with any proceeding in a case arising out of a loan made, guaranteed, or insured under chapter 37, United States Code, even though the conditions set forth in paragraph (c) of this section are not met.

(2) *Payment of fee by disinterested third party.* (i) An agent or attorney may receive a fee or salary from an organization, governmental entity, or other disinterested third party for representation of a claimant or appellant even though the conditions set forth in paragraph (c) of this section have not been met. An organization, governmental entity, or other third party is considered disinterested only if the entity or individual does not stand to benefit financially from the successful outcome of the claim. In no such case may the attorney or agent charge a fee which is contingent, in whole or in part, on whether the matter is resolved in a manner favorable to the claimant or appellant.

(ii) For purposes of this part, a person shall be presumed not to be disinterested if that person is the spouse, child, or parent of the claimant or appellant, or if that person resides with the claimant or appellant. This presumption may be rebutted by clear and convincing evidence that the person in question has no financial interest in the success of the claim.

(iii) The provisions of paragraph (g) of this section (relating to fee agreements) shall apply to all payments or agreements to pay involving disinterested third parties. In addition, the agreement shall include or be accompanied by the following statement, signed by the attorney or agent: ''I certify that no agreement, oral or otherwise, exists under which the claimant or appellant will provide anything of value to the third-party payer in this case in return for payment of my fee or salary, including, but not limited to, reimbursement of any fees paid.''

(e) *Fees permitted.* Fees permitted for services of an agent or attorney admitted to practice before VA must be reasonable. They may be based on a fixed fee, hourly rate, a percentage of benefits recovered, or a combination of such bases. Factors considered in determining whether fees are reasonable include:

(1) The extent and type of services the representative performed;

(2) The complexity of the case;

(3) The level of skill and competence required of the representative in giving the services;

(4) The amount of time the representative spent on the case;

(5) The results the representative achieved, including the amount of any benefits recovered;

(6) The level of review to which the claim was taken and the level of the review at which the representative was retained;

(7) Rates charged by other representatives for similar services;

(8) Whether, and to what extent, the payment of fees is contingent upon the results achieved; and

(9) If applicable, the reasons why an agent or attorney was discharged or withdrew from representation before the date of the decision awarding benefits.

(f) *Presumptions and discharge.* (1) Fees which do not exceed 20 percent of any past-due benefits awarded as defined in paragraph (h)(3) of this section shall be presumed to be reasonable if the agent or attorney provided representation that continued through the date of the decision awarding benefits. Fees which exceed 33⅓ percent of any past-due benefits awarded shall be presumed to be unreasonable. These presumptions may be rebutted through an examination of the factors in paragraph (e) of this section establishing that there is clear and convincing evidence that a fee which does not exceed 20 percent of any past-due benefits awarded is not reasonable or that a fee which exceeds 33⅓ percent is reasonable in a specific circumstance.

(2) With regard to a fee agreement in which the amount of the fee is contingent on the claimant receiving an award of benefits, a reasonable fee for an agent or attorney who is discharged by the claimant or withdraws from representation before the date of the decision awarding benefits is one that fairly and accurately reflects his or her contribution to and responsibility for the benefits awarded. The amount of the fee is informed by an examination of the factors in paragraph (e) of this section.

(g) *Fee agreements.* All agreements for the payment of fees for services of agents and attorneys (including agreements involving fees or salary paid by an organization, governmental entity or other disinterested third party) must be in writing and signed by both the claimant or appellant and the agent or attorney.

(1) To be valid, a fee agreement must include the following:

(i) The name of the veteran,

(ii) The name of the claimant or appellant if other than the veteran,

(iii) The name of any disinterested third-party payer (see paragraph (d)(2) of this section) and the relationship between the third-party payer and the veteran, claimant, or appellant,

(iv) The applicable VA file number, and

(v) The specific terms under which the amount to be paid for the services of the attorney or agent will be determined.

(2) Fee agreements must also clearly specify if VA is to pay the agent or attorney directly out of past due benefits. A direct-pay fee agreement is a fee agreement between the claimant or appellant and an agent or attorney providing for payment of fees out of past-due benefits awarded directly to an agent or attorney. A fee agreement that does not clearly specify that VA is to pay the agent or attorney out of past-due benefits or that specifies a fee greater than 20 percent of past-due benefits awarded by VA shall be considered to be an agreement in which the agent or attorney is responsible for collecting any fees for representation from the claimant without assistance from VA.

(3) A copy of a direct-pay fee agreement, as defined in paragraph (g)(2) of this section, must be filed with the agency of original jurisdiction within 30 days of its execution. A copy of any fee agreement that is not a direct-pay fee agreement must be filed with the

Office of the General Counsel within 30 days of its execution by mailing the copy to the following address: Office of the General Counsel (022D), Department of Veterans Affairs, 810 Vermont Avenue NW., Washington, DC 20420. Only fee agreements that do not provide for the direct payment of fees, documents related to review of fees under paragraph (i) of this section, and documents related to review of expenses under § 14.637, may be filed with the Office of the General Counsel. All documents relating to the adjudication of a claim for VA benefits, including any correspondence, evidence, or argument, must be filed with the agency of original jurisdiction, Board of Veterans' Appeals, or other VA office as appropriate.

(h) *Payment of fees by Department of Veterans Affairs directly to an agent or attorney from past-due benefits.* (1) Subject to the requirements of the other paragraphs of this section, including paragraphs (c) and (e), the claimant or appellant and an agent or attorney may enter into a fee agreement providing that payment for the services of the agent or attorney will be made directly to the agent or attorney by VA out of any past-due benefits awarded in any proceeding before VA or the United States Court of Appeals for Veterans Claims. VA will charge and collect an assessment out of the fees paid directly to agents or attorneys from past-due benefits awarded. The amount of such assessment shall be equal to five percent of the amount of the fee required to be paid to the agent or attorney, but in no event shall the assessment exceed $100. Such an agreement will be honored by VA only if the following conditions are met:

(i) The total fee payable (excluding expenses) does not exceed 20 percent of the total amount of the past-due benefits awarded,

(ii) The amount of the fee is contingent on whether or not the claim is resolved in a manner favorable to the claimant or appellant, and

(iii) The award of past-due benefits results in a cash payment to a claimant or an appellant from which the fee may be deducted. (An award of past-due benefits will not always result in a cash payment to a claimant or an appellant. For example, no cash payment will be made to military retirees unless there is a corresponding waiver of retirement pay. (*See* 38 U.S.C. 5304(a) and 38 CFR 3.750)

(2) For purposes of this paragraph (h), a claim will be considered to have been resolved in a manner favorable to the claimant or appellant if all or any part of the relief sought is granted.

(3) For purposes of this paragraph (h), ''past-due benefits'' means a nonrecurring payment resulting from a benefit, or benefits, granted on appeal or awarded on the basis of a claim readjudicated after a denial by a VA agency of original jurisdiction or the Board of Veterans' Appeals or the lump sum payment that represents the total amount of recurring cash payments that accrued between the effective date of the award, as determined by applicable laws and regulations, and the date of the grant of the benefit by the agency of original jurisdiction, the Board of Veterans' Appeals, or an appellate court.

(i) When the benefit granted on appeal, or as the result of the readjudicated claim, is service connection for a disability, the ''past-due benefits'' will be based on the initial disability rating assigned by the agency of original jurisdiction following the award of service connection. The sum will equal the payments accruing from the effective date of the award to the date of the initial disability rating decision. If an increased evaluation is subsequently granted as the result of an appeal of the disability evaluation initially assigned by the agency of original jurisdiction, and if the agent or attorney represents the claimant or appellant in that phase of the claim, the agent or attorney will be paid a supplemental payment based upon the increase granted on appeal, to the extent that the increased amount of disability is found to have existed between the initial effective date of the award following the grant of service connection and the date of the rating action implementing the appellate decision granting the increase.

(ii) Unless otherwise provided in the fee agreement between the claimant or appellant and the agent or attorney, the agent's or attorney's fees will be

determined on the basis of the total amount of the past-due benefits even though a portion of those benefits may have been apportioned to the claimant's or appellant's dependents.

(iii) If an award is made as the result of favorable action with respect to several issues, the past-due benefits will be calculated only on the basis of that portion of the award which results from action taken on issues concerning which the criteria in paragraph (c) of this section have been met.

(4) As required by paragraph (g)(3) of this section, the agent or attorney must file with the agency of original jurisdiction within 30 days of the date of execution a copy of the agreement providing for the direct payment of fees out of any benefits subsequently determined to be past due.

(i) *Motion for review of fee agreement.* Before the expiration of 120 days from the date of the final VA action, the Office of the General Counsel may review a fee agreement between a claimant or appellant and an agent or attorney upon its own motion or upon the motion of the claimant or appellant. The Office of the General Counsel may order a reduction in the fee called for in the agreement if it finds by a preponderance of the evidence, or by clear and convincing evidence in the case of a fee presumed reasonable under paragraph (f) of this section, that the fee is unreasonable. The Office of the General Counsel may approve a fee presumed unreasonable under paragraph (f) of this section if it finds by clear and convincing evidence that the fee is reasonable. The Office of the General Counsel's review of the agreement under this paragraph will address the issues of eligibility under paragraph (c) of this section and reasonableness under paragraph (e) of this section. The Office of the General Counsel will limit its review and decision under this paragraph to the issue of reasonableness if another agency of original jurisdiction has reviewed the agreement and made an eligibility determination under paragraph (c) of this section. Motions for review of fee agreements must be in writing and must include the name of the veteran, the name of the claimant or appellant if other than the veteran, and the applicable VA file number. Such motions must set forth the reason, or reasons, why the fee called for in the agreement is unreasonable and must be accompanied by all evidence the moving party desires to submit.

(1) A claimant's or appellant's motion for review of a fee agreement must be served on the agent or attorney and must be filed at the following address: Office of the General Counsel (022D), 810 Vermont Avenue, NW., Washington, DC 20420. The agent or attorney may file a response to the motion, with any relevant evidence, with the Office of the General Counsel not later than 30 days from the date on which the claimant or appellant served the motion on the agent or attorney. Such responses must be served on the claimant or appellant. The claimant or appellant then has 15 days from the date on which the agent or attorney served a response to file a reply with the Office of the General Counsel. Such replies must be served on the agent or attorney.

(2) The Deputy Chief Counsel with subject-matter jurisdiction shall initiate the Office of the General Counsel's review of a fee agreement on its own motion by serving the motion on the agent or attorney and the claimant or appellant. The agent or attorney may file a response to the motion, with any relevant evidence, with the Office of the General Counsel (022D), 810 Vermont Avenue, NW., Washington, DC 20420, not later than 30 days from the date on which the Office of the General Counsel served the motion on the agent or attorney. Such responses must be served on the claimant or appellant.

(3) The Office of the General Counsel shall close the record before the Office of the General Counsel in proceedings to review fee agreements 15 days after the date on which the agent or attorney served a response on the claimant or appellant, or 30 days after the claimant, appellant, or the Office of the General Counsel served the motion on the agent or attorney if there is no response. The Deputy Chief Counsel with subject-matter jurisdiction may, for a reasonable period upon a showing of sufficient cause, extend the time for an agent or attorney to serve an answer or for a claimant or appellant to serve a reply. The Deputy Chief Counsel shall

forward the record and a recommendation to the General Counsel or his or her designee for a final decision. Unless either party files a Notice of Disagreement, the agent or attorney must refund any excess payment to the claimant or appellant not later than the expiration of the time within which the Office of the General Counsel's decision may be appealed to the Board of Veterans' Appeals.

(j) In addition to whatever other penalties may be prescribed by law or regulation, failure to comply with the requirements of this section may result in proceedings under §14.633 of this chapter to terminate the agent's or attorney's accreditation to practice before VA.

(k)(1) *Decisions issued before the effective date of the modernized review system.* Notwithstanding provisions in this section for closing the record before the Office of the General Counsel at the end of the 30-day period for serving a response or 15 days after the date on which the agent or attorney served a response, appeals of decisions issued before the effective date of the modernized review system as provided in §19.2(a) of this chapter, shall be initiated and processed using the procedures in 38 CFR parts 19 and 20 applicable to legacy appeals. Nothing in this section shall be construed to limit the Board's authority to remand a matter to the General Counsel under 38 CFR 20.904 for any action that is essential for a proper appellate decision or the General Counsel's ability to issue a Supplemental Statement of the Case under 38 CFR 19.31.

(2) *Decisions issued on or after the effective date of the modernized review system.* Notwithstanding provisions in this section for closing the record before the Office of the General Counsel at the end of the 30-day period for serving a response or 15 days after the date on which the agent or attorney served a response, appeals of decisions issued on or after the effective date of the modernized review system as provided in §19.2(a) of this chapter, shall be initiated and processed using the procedures in 38 CFR part 20 applicable to appeals under the modernized system.

(Authority: 38 U.S.C. 5902, 5904, 5905)

(The Office of Management and Budget has approved the information collection requirements in this section under control number 2900–0605.)

[73 FR 29875, May 22, 2008, as amended at 80 FR 81193, Dec. 29, 2015; 82 FR 26754, June 9, 2017; 84 FR 175, Jan. 18, 2019]

§14.637 Payment of the expenses of agents and attorneys in proceedings before Agencies of Original Jurisdiction and before the Board of Veterans' Appeals.

(a) *Applicability of rule.* The provisions of this section apply to the services of accredited agents and attorneys with respect to benefits under laws administered by VA in all proceedings before the agency of original jurisdiction or before the Board of Veterans' Appeals regardless of whether an appeal has been initiated.

(b) *General.* Any agent or attorney may be reimbursed for expenses incurred on behalf of a veteran or a veteran's dependents or survivors in the prosecution of a claim for benefits pending before VA. Whether such an agent or attorney will be reimbursed for expenses and the method of such reimbursement is a matter to be determined by the agent or attorney and the claimant or appellant in the fee agreement filed with the Office of the General Counsel or the agency of original jurisdiction under §14.636 of this part. Expenses are not payable directly to the agent or attorney by VA out of benefits determined to be due to a claimant or appellant.

(c) *Nature of expenses subject to reimbursement.* ''Expenses'' include nonrecurring expenses incurred directly in the prosecution of a claim for benefits on behalf of a claimant or appellant. Examples of such expenses include expenses for travel specifically to attend a hearing with respect to a particular claim, the cost of copies of medical records or other documents obtained from an outside source, and the cost of obtaining the services of an expert witness or an expert opinion. ''Expenses'' do not include normal overhead costs of the agent or attorney such as office rent, utilities, the cost of obtaining or

operating office equipment or a legal library, salaries of the representative and his or her support staff, and the cost of office supplies.

(d) *Expense charges permitted; motion for review of expenses.* Reimbursement for the expenses of an agent or attorney may be obtained only if the expenses are reasonable. The Office of the General Counsel may review the expenses charged by an agent or attorney upon its own motion or the motion of the claimant or appellant and may order a reduction in the expenses charged if it finds that they are excessive or unreasonable. The Office of the General Counsel's review of expenses under this paragraph will address the issues of eligibility under § 14.636(c) and reasonableness. The Office of the General Counsel will limit its review and decision under this paragraph to the issue of reasonableness if another agency of original jurisdiction has reviewed the fee agreement between the claimant and the agent or attorney and determined that the agent or attorney is eligible for reimbursement of expenses. Motions for review of expenses must be in writing and must include the name of the veteran, the name of the claimant or appellant if other than the veteran, and the applicable VA file number. Such motions must specifically identify which expenses charged are unreasonable; must set forth the reason, or reasons, why such expenses are excessive or unreasonable and must be accompanied by all evidence the claimant or appellant desires to submit. Factors considered in determining whether expenses are excessive or unreasonable include the complexity of the case, the potential extent of benefits recoverable, and whether travel expenses are in keeping with expenses normally incurred by other representatives.

(1) A claimant's or appellant's motion for review of expenses must be served on the agent or attorney and must be filed at the following address: Office of the General Counsel (022D), 810 Vermont Avenue, NW., Washington, DC 20420. The agent or attorney may file a response to the motion, with any accompanying evidence, with the Office of the General Counsel not later than 30 days from the date on which the claimant or appellant served the motion on the agent or attorney. Such responses must be served on the claimant or appellant. The claimant or appellant then has 15 days from the date on which the agent or attorney served a response to file a reply with the Office of the General Counsel. Such replies must be served on the agent or attorney.

(2) The Deputy Chief Counsel with subject-matter jurisdiction shall initiate the Office of the General Counsel's review of expenses on its own motion by serving the motion on the agent or attorney and the claimant or appellant. The agent or attorney may file a response to the motion, with any accompanying evidence, with the Office of the General Counsel (022D), 810 Vermont Avenue, NW., Washington, DC 20420, not later than 30 days from the date on which the Office of the General Counsel served the motion on the agent or attorney. Such responses must be served on the claimant or appellant.

(3) The Office of the General Counsel shall close the record before the Office of the General Counsel in proceedings to review expenses 15 days after the date on which the agent or attorney served a response on the claimant or appellant, or 30 days after the claimant, appellant, or the Office of the General Counsel served the motion on the agent or attorney if there is no response. The Deputy Chief Counsel with subject-matter jurisdiction may, for a reasonable period upon a showing of sufficient cause, extend the time for an agent or attorney to serve an answer or for a claimant or appellant to serve a reply. The Deputy Chief Counsel shall forward the record and a recommendation to the General Counsel or his or her designee for a final decision. Unless either party files a Notice of Disagreement, the agent or attorney must refund any excess payment to the claimant or appellant not later than the expiration of the time within which the Office of the General Counsel's decision may be appealed to the Board of Veterans' Appeals.

(e) In addition to whatever other penalties may be prescribed by law or regulation, failure to comply with the requirements of this section may result in proceedings under § 14.633 of this

part to terminate the agent's or attorney's accreditation to practice before VA.

(f)(1) *Decisions issued before the effective date of the modernized review system.* Notwithstanding provisions in this section for closing the record before the Office of the General Counsel at the end of the 30-day period for serving a response or 15 days after the date on which the agent or attorney served a response, appeals of decisions issued before the effective date of the modernized review system as provided in § 19.2(a) of this chapter, shall be initiated and processed using the procedures in 38 CFR parts 19 and 20 applicable to legacy appeals. Nothing in this section shall be construed to limit the Board's authority to remand a matter to the General Counsel under 38 CFR 20.904 for any action that is essential for a proper appellate decision or the General Counsel's ability to issue a Supplemental Statement of the Case under 38 CFR 19.31.

(2) *Decisions issued on or after the effective date of the modernized review system.* Notwithstanding provisions in this section for closing the record before the Office of the General Counsel at the end of the 30-day period for serving a response or 15 days after the date on which the agent or attorney served a response, appeals of decisions issued on or after the effective date of the modernized review system as provided in § 19.2(a) of this chapter, shall be initiated and processed using the procedures in 38 CFR part 20 applicable to appeals under the modernized system.

(Authority: 38 U.S.C. 5904)

(The Office of Management and Budget has approved the information collection requirements in this section under control number 2900–0085)

[73 FR 29878, May 22, 2008, as amended at 80 FR 81194, Dec. 29, 2015; 82 FR 26754, June 9, 2017; 84 FR 176, Jan. 18, 2019]

PERSONNEL CLAIMS

§ 14.664 Scope of authority and effective date.

Pub. L. 88–558 (78 Stat. 767), approved August 31, 1964, as amended, authorizes the Secretary or the Secretary's designee to settle and pay a claim for not more than $40,000 made by a civilian officer or employee of the Department of Veterans Affairs for damage to, or loss of personal property incident to such person's service. Authority is delegated by § 2.6(e)(5) of this chapter to the General Counsel, Deputy General Counsel, Assistant General Counsel (Professional Staff Group III), and the Deputy Assistant General Counsel, of said staff group and the Regional Counsel and those acting for them to settle and pay such claims on behalf of the Secretary, and such settlement shall be final and conclusive.

(Authority: 31 U.S.C. 3721(b))

[42 FR 41421, Aug. 17, 1977, as amended at 49 FR 47005, Nov. 30, 1984; 55 FR 48841, Nov. 23, 1990]

§ 14.665 Claims.

(a) The claim must be presented in writing on VA Form 2–4760, Employee's Claim for Reimbursement for Personal Property Damaged or Lost Incident to Employment. It will be submitted to the personnel office where the claim originates within 2 years after it accrues except that if the claim accrues in time of war or in time of armed conflict in which any Armed Force of the United States is engaged or if such war or armed conflict intervenes within 2 years after it accrues, and if good cause is shown, the claim may be presented not later than 2 years after that cause ceases to exist. The claim must be executed and certified by the officer or the employee suffering the loss or damage, or in the event of his or her death, by the surviving spouse, children, father or mother or both, or brothers or sisters or both. Claims of survivors shall be settled and paid in the order named. All claims must contain the following:

(1) The date, time, and place the loss or damage occurred and the circumstances surrounding such loss or damage, together with the supporting statements of any witnesses who can verify such facts.

(2) In the event of damage, the date of acquisition, original cost, condition before damage, and at least two estimates of the cost of repair or replacement. In the event of loss, the date of acquisition, the original cost, the condition, and an estimate of the reasonable market value of the article or articles.

(3) A statement as to any claims or potential claim he or she may have for indemnification of the loss or damage against other than the United States and whether he or she will assign such to the United States and cooperate in its prosecution. Where such claim or potential claim is against a carrier or insurer, evidence that a timely claim has been properly made. Where a recovery from the carrier or his or her insurer has been obtained or offered, such information shall be included.

(4) In cases involving damage or destruction of personal property by patients or domiciliary members, a statement as to whether a claim was filed pursuant to 38 U.S.C. 703(a)(5) and whether such claim has been finally denied.

(b) The Personnel Officer receiving the claim will forward same to the person designated to investigate accidents at the station pursuant to § 14.605 within 5 days after receipt.

(c) The employee designated pursuant to § 14.605 will ascertain if such claim is complete in all respects and conduct such investigation as is necessary to establish all facts required to properly evaluate the claim both as to merit and the reasonable amount payable for the loss or damage. Where it is indicated that the claimant may have a potential claim against other than the United States, the employee designated will secure a suitable assignment of all right and title to such claim, to the extent the United States makes reimbursement, and the agreement of the claimant to furnish such evidence as may be necessary to pursue such claim. If the potential claim is against a carrier or insurer, the employee designated will ascertain that the claimant has filed a timely proper claim and procure evidence thereof. The employee designated will also include information concerning any offer of settlement the carrier may have made. The completed investigation, original claim and supporting evidence will be forwarded to the appropriate Regional Counsel.

[38 FR 5475, Mar. 1, 1973, as amended at 42 FR 41421, Aug. 17, 1977]

§ 14.666 Regional Counsel responsibility.

(a) The Regional Counsel having jurisdiction will conduct such additional investigation as is deemed necessary to establish all facts required. If the claimant has a potential claim for indemnification against other than the United States, the Regional Counsel will ascertain that a suitable assignment, legally enforceable, of all right and title to such claim, to the extent the United States makes reimbursement, and the agreement of the claimant to furnish such evidence as may be necessary to pursue such claim is of record. If such potential claim is against a carrier or insurer, the Regional Counsel will ascertain that claimant has filed a timely proper claim against the carrier or insurer and review same for legal sufficiency.

(b) The Regional Counsel having jurisdiction over a claim will not authorize payment thereon unless the requirement of §§ 14.664 through 14.667 are met. In determining the equitable value of a claim, the depreciation schedule issued by the General Counsel will be used as a guide.

[42 FR 41422, Aug. 17, 1977]

§ 14.667 Claims payable.

(a) No claim shall be paid unless timely filed in proper form as provided in § 14.665 and the preponderance of the evidence establishes that the loss or damage:

(1) Actually occurred and the amount claimed is reasonable,

(2) Was incident to the employee's service and his or her possession of the property was reasonable, useful, or proper under the circumstances,

(3) Did not occur at quarters occupied within the 50 States or the District of Columbia that were not assigned to the claimant or otherwise provided in kind by the United States.

(4) Was not caused wholly or partly by the negligent act of claimant, the claimant's agent, or employee, and that the claimant has no right to indemnification for the loss or damage from other than the United States, except to the extent that the claimant assigns such right to the United States and agrees to furnish evidence required

to enable the United States to enforce such right. In the event there is a right to recovery for the loss or damage from a carrier or insurer the claimant will be required to file a timely claim for such recovery before consideration of the claim against the United States.

(b) No claim for the cost of repair or replacement of personal property of employees damaged or destroyed by patients or domiciliary members while such employees are engaged in the performance of official duties shall be entertained under §§14.664 through 14.667, unless claim filed pursuant to 38 U.S.C. 703(a)(5) (§17.78 of this chapter) has been finally denied for the reason that such claim did not meet the criteria established by that law.

[38 FR 5475, Mar. 1, 1973, as amended at 42 FR 41422, Aug. 17, 1977]

§ 14.668 Disposition of claims.

(a) *Disallowed claims*. Claimants will be promptly notified of the disallowance of a claim and the reasons therefor.

(b) *Allowed claims*—(1) *Reimbursement in kind*. Where a claim is allowed and it is determined to be to the advantage of the Government, reimbursement will be made in kind. The official authorizing settlement will request the Director, Supply Service, Veterans Health Services and Research Administration, to procure the necessary article or articles and deliver same to the claimant.

(2) *Reimbursement by check*. The official authorizing settlement will forward allowed claims, other than those requiring reimbursement in kind, to the Finance activity at the Department of Veterans Affairs installation where the claim arose. That activity will audit the claim, which if found proper for payment, will be scheduled on SF 1166, Voucher and Schedule of Payments, and forwarded to the appropriate Regional Disbursing Office for payment.

[38 FR 5475, Mar. 1, 1973, as amended at 42 FR 41422, Aug. 17, 1977]

§ 14.669 Fees of agents or attorneys; penalty.

The Military Personnel and Civilian Employees' Claims Act of 1964 (Pub. L. 88–558; 78 Stat. 767) was amended by Pub. L. 89–185 (79 Stat. 789), on September 15, 1965, by adding a new section which provided that no more than 10 percent of the amount paid in settlement of each individual claim submitted and settled under the authority of the Act shall be paid or delivered to or received by any agent or attorney on account of services rendered in connection with that claim. Any person violating the provisions of this Act is deemed to be guilty of a misdemeanor and upon conviction thereof shall be fined in any sum not exceeding $1,000.

[38 FR 5475, Mar. 1, 1973]

COMMITMENTS—FIDUCIARIES

SOURCE: 42 FR 41422, Aug. 17, 1977, unless otherwise noted.

§ 14.700 Court cost and expenses; commitment, restoration, fiduciary appointments.

It is the responsibility of the Regional Counsel to assure the protection of the veteran, his or her beneficiaries, and their estates in State court proceedings involving commitment and restoration, and the appointment of fiduciaries. To this end certain expenses such as court costs, publication fees, recording fees, transportation expenses and fees for medical testimony may be authorized by the Regional Counsel. Payment of these costs will be borne by the administration concerned. However, every effort will be made by the Regional Counsel to avoid having these costs imposed on the Department of Veterans Affairs. The travel and per diem cost of the Regional Counsel personnel will be borne by the Regional Counsel.

§ 14.701 Commitment and restoration proceedings.

(a) *State institutions*. Regional Counsels are authorized to cooperate with State courts, including the production of required records in the commitment of veterans to State hospitals or in their restoration to full civil rights.

(b) *Department of Veterans Affairs institutions*—(1) *Assistance to courts in commitment proceedings*. The Regional Counsel will render assistance to the

courts in cases involving the commitment of mentally ill veterans to the Department of Veterans Affairs. To this end, the Regional Counsel may:

(i) Produce Department of Veterans Affairs records.

(ii) Appear in court and present material facts.

(iii) When authorized to institute commitment proceedings under paragraph (b)(2) of this section, prepare and present all necessary legal papers, and arrange and authorize transportation costs of veterans and attendants at Department of Veterans Affairs expense (§§ 14.703 and 14.704).

(2) *Commitment proceedings.* If a mentally ill veteran will accept hospitalization voluntarily, no action will be initiated by any Department of Veterans Affairs employee to commit such veteran. If the veteran will not accept hospitalization, or after being voluntarily hospitalized by the Department of Veterans Affairs demands his or her release, and hospitalization is necessary for the veteran's safety or the safety of others, the Regional Counsel (if a relative of the veteran or other interested person has not done so) may institute proceedings to commit the veteran to the Department of Veterans Affairs subject to the following conditions:

(i) That the written consent of the veteran's nearest relative has been obtained. If the nearest relative cannot be readily contacted or refuses to consent, coupled with inability or refusal to offer adequate alternative care, the Regional Counsel may initiate the action if the petition is signed by another relative, a civil official or representative of a cooperating agency or other person authorized by State law.

(ii) If timely action cannot be taken under paragraph (b)(2)(i) of this section, the Hospital or Clinic Director, or designee, may sign the petition if permissible under State law, and the Regional Counsel will then take any action necessary to bring the matter before the appropriate court.

(3) *Illegal commitment.* When a hospitalized veteran, previously committed to the Department of Veterans Affairs, demands release and continued hospitalization is necessary for the veteran's safety or the safety of others, and the Regional Counsel determines the commitment to be illegal, immediate action will be taken to obtain a legal commitment.

(4) *Restoration proceedings.* When a veteran has been a committed patient in a Department of Veterans Affairs hospital and is subsequently rated competent by the Department of Veterans Affairs, the Regional Counsel upon request, may institute proceedings necessary to restore the veteran to full civil rights.

§ 14.702 Medical testimony in commitment or restoration proceedings.

(a) *Commitment.* When permissable under State law, Department of Veterans Affairs physicans, upon request of the Regional Counsel, will sign interrogatories or certificates of mental illness or insanity and, unless unavailable, as provided in paragraph (c) of this section, will testify in proceedings which the Regional Counsel is authorized to institute under § 14.701 to commit eligible veterans to the Department of Veterans Affairs.

(b) *Restoration.* (1) When permissible under State law, Department of Veterans Affairs physicans, upon the request of the Regional Counsel, will testify in proceedings brought for the purpose of restoring a committed veteran to full civil rights when the veteran is a committed patient in a Department of Veterans Affairs hospital.

(2) The Director of a Department of Veterans Affairs hospital or the Regional Counsel upon discharge of the veteran, may furnish a certificate of sanity or such similar certificate to the proper civil authorities.

(c) *Employment of private physicians.* When testimony of Department of Veterans Affairs physicians is prohibited or is unavailable because of a duty assignment, comparative expense or other valid reason, the Director of the Department of Veterans Affairs hospital, upon recommendation of the Regional Counsel, may employ any qualified physician for preliminary examination of the veteran and for testimony in any commitment or restoration proceeding which the Regional Counsel is authorized to institute

under §14.701, and authorize the payment of a fee not to exceed the prescribed fee, or in the absence thereof, the customary fee charged for the service rendered.

§14.703 Costs in commitment or restoration proceedings.

(a) When authorized to institute a proceeding under §14.701, the Regional Counsel may authorize in advance or thereafter the payment or reimbursement of costs and other expenses for which the veteran is legally liable, including publication of notice necessary to accomplish the commitment.

(b) The Regional Counsel also may authorize the payment of necessary costs and expenses for which the veteran is legally liable incident to his or her restoration to full civil rights in any case in which the Regional Counsel ia authorized to institute restoration proceedings under §14.701(b)(4).

§14.704 Authorization of transportation necessary for commitment of a veteran beneficiary.

When a mentally ill veteran who should be committed is hospitalized by the Department of Veterans Affairs and under the law of the State wherein the hospital is located, a commitment may not be had locally, the veteran may be returned temporarily to the jurisdiction of the appropriate court in order that the commitment can be accomplished. If the veteran is in a Department of Veterans Affairs hospital, the Hospital Director may authorize travel of the veteran and an attendant or attendants, if necessary, upon request of the Regional Counsel. If the veteran is being maintained in a non-Department of Veterans Affairs hospital, the Director of the facility authorizing and paying for the care may authorize such travel upon request of the Regional Counsel.

§14.705 Authority to file petitions for appointment of fiduciaries in State courts.

(a) *Adult beneficiary*. The Regional Counsel is authorized to file or cause to be filed on behalf of a petitioner in a case coming within §14.706(a) a petition for the appointment of a fiduciary and all necessary legal papers for an adult beneficiary only if it has been determined that alternative methods of payment would not be to the best interests of the beneficiary and when the Regional Counsel has obtained the written consent of:

(1) The beneficiary's spouse.

(2) The beneficiary's adult child, parent, adult brother or sister if the beneficiary is unmarried, or consent of the spouse is immaterial because of estrangement or mental incapacity, or refusal to consent coupled with failure to offer adequate alternative means for providing for the beneficiary's needs.

(3) A civil official or representative of a cooperating agency when none of the relative listed in paragraph (a) (1) and (2) of this section can be located after reasonable inquiry or those located are not mentally competent to consent or refuse without offering adequate alternative means for providing for the needs of the beneficiary.

(b) *Minor beneficiaries*. The Regional Counsel is authorized to file or cause to be filed on behalf of a petitioner in a case coming within §14.706(a) a petition for the appointment of a fiduciary for a minor. If permissible under the law of the jurisdiction concerned and if it has been determined that protection of the minor's rights under laws administered by the Department of Veterans Affairs requires the appointment, provided: the written consent of the minor's natural or adoptive parent or parents or the person or persons occupying the relationship of ''in loco parentis'' as defined, by the law of the jurisdiction, in which they reside has been obtained. The Regional Counsel will not institute a court proceeding for the appointment of a fiduciary over the objections of such parent or parents if they are sui juris unless the parent or parents have abandoned the minor or have otherwise refused to meet their parental obligations toward the minor or they have previously been appointed or recognized as the minor's fiduciary and failed to properly execute the duties of their trust. If the minor has no parent or the parent or parents are not sui juris, the Regional Counsel may file the petition without the consent of any relative.

(c) *Court-appointed fiduciaries*. In court-appointed fiduciary cases, the

Regional Counsel may appear in the court of appointment or in any court having original, concurrent, or appellate jurisdiction, and make proper presentation relating to the foregoing matters. The Regional Counsel's authority includes by is not limited to:

(1) Petitioning the court to cite a fiduciary to account;

(2) Filing exceptions to accountings;

(3) Requiring fiduciaries to file bonds or make any necessary adjustments;

(4) Requiring investments;

(5) Filing petitions to vacate or modify court orders;

(6) Appearing or intervening in any State court as attorney for the Secretary of Veterans Affairs in litigation instituted by the Secretary or otherwise affecting money paid to such fiduciary by the Department of Veterans Affairs;

(7) Incurring necessary court costs and other expenses, including witness fees, appeal bonds, advertising in any newspaper or other publication, preparing briefs or transcripts, purchase of records of trial or other records;

(8) Instituting any other action necessary to secure proper administration of the estate of a Department of Veterans Affairs beneficiary, such as filing petitions for the removal of a fiduciary and appointment of a successor;

(9) Taking appropriate action to recover funds improperly disbursed.

(d) *Appeal*. Unless a trial is de novo, no appeal shall be taken to an appellate court and no costs incurred in connection therewith without the prior approval of the General Counsel and the Under Secretary for Benefits or their designees.

§ 14.706 Legal services in behalf of beneficiaries.

(a) The Regional Counsel may furnish legal services in behalf of minor and incompetent beneficiaries of the Department of Veterans Affairs in fiduciary appointment and estate administration matters involving Department of Veterans Affairs benefits or property derived therefrom when the beneficiary's estate or income is not sufficient to justify the employment of an attorney.

(b) The Regional Counsel may also furnish legal services in hardship situations when restoration from legal disability is a condition of precedent to direct payment of Department of Veterans Affairs benefits.

(c) Where the fiduciary does not in due course institute the necessary action to terminate the trust relationship and the beneficiary requests representation by the Regional Counsel or in any such case where there is in question the proper administration of the estate, the Regional Counsel may file the necessary action and supply legal services. Costs, unless assessed against the fiduciary, should be charged to the estate of the beneficiary.

§ 14.707 Authorization of transportation of a veteran beneficiary for appointment of a fiduciary.

When the appointment of a fiduciary is required for an incompetent veteran hospitalized by the Department of Veterans Affairs and, under the law of the State wherein the hospital is located, the appointment cannot be had locally, the veteran may be returned temporarily to the jurisdiction of the appropriate court in order that the appointment can be accomplished. If the veteran is in a Department of Veterans Affairs hospital, the Hospital Director, upon request of the Regional Counsel, may authorize travel of the veteran and an attendant or attendants, if necessary. If the veteran is being maintained in a non-Department of Veterans Affairs hospital, the Director of the facility authorizing and paying for the care may authorize such travel upon request of the Regional Counsel.

§ 14.708 Costs and other expenses incident to appointment of fiduciary.

(a) The Regional Counsel may authorize the payment of costs and other necessary expenses incident to the appointment of an initial or successor fiduciary for a Department of Veterans Affairs beneficiary when:

(1) Authorized to render legal services under § 14.706.

(2) Appointment was caused by the Department of Veterans Affairs and it develops that no benefits are payable and there is no estate from which costs may be paid.

(3) Costs must be advanced when there is no immediate estate from which same may be paid. These costs

are to be recovered from benefits payable unless the case falls within paragraph (a)(1) of this section.

(b) Costs and necessary expenses include:

(1) All those chargeable by statute or rule of court and certified by the clerk of court.

(2) Certified copies of court records required by the Department of Veterans Affairs.

(3) Fees for guardian ad litem when chargeable as court costs and required by State law.

§ 14.709 Surety bonds; court-appointed fiduciary.

(a) It is the policy of the Department of Veterans Affairs to require, where possible under State laws and rules of the court, corporate surety bonds in all court-appointed fiduciary cases where the fiduciary is an individual and the estate is sufficient to justify the expense of procuring a corporate surety bond. Corporate bonds may be required of corporate fiduciaries in accordance with State laws. In cases wherein fiduciaries neglect or refuse to furnish corporate bonds, as requested by the Regional Counsel, the Regional Counsel should take appropriate court action and notify the Veterans Service Center Manager.

(b) When it is not practical or feasible to require a fiduciary to furnish a corporate surety bond, the Regional Counsel is authorized to accept bonds with such number of personal sureties as is permissible under State law, but in no event less than one. To be acceptable for Department of Veterans Affairs purposes, each personal surety must be worth at least the penal sum named in the bond over and above all debts, liabilities and exemptions and qualify in accordance with the requirements of State law. The Regional Counsel will request suitable evidence of financial responsibility whenever there is any question as to the ability of a personal surety to meet any probable liability. When suitable evidence is not furnished as requested, or financial responsibility is found to be insufficient to meet the penal sum of the bond, the Regional Counsel should take appropriate court action and notify the Veterans Service Center Manager.

(c) It is the policy of the Department of Veterans Affairs to require surety bonds in an amount commensurate with value of the personal estate derived from Department of Veterans Affairs benefits plus the anticipated net income from Department of Veterans Affairs benefits received during the ensuing accounting period. In cases where the fiduciaries neglect or refuse to furnish surety bonds in the amount requested by the Regional Counsel, the Regional Counsel should take appropriate court action and notify the Veterans Service Center Manager. When permissible under State law, the Regional Counsel may accept, without objection, a lesser degree of protection approved by the court when it is determined that such action will adequately protect the beneficiary's estate.

[42 FR 41422, Aug. 17, 1977, as amended at 71 FR 28586, May 17, 2006]

TESTIMONY OF DEPARTMENT PERSONNEL AND PRODUCTION OF DEPARTMENT RECORDS IN LEGAL PROCEEDINGS

SOURCE: 59 FR 6566, Feb. 11, 1994, unless otherwise noted.

§ 14.800 Purpose.

Sections 14.800 through 14.810 establish policy, assign responsibilities and prescribe procedures with respect to:

(a) The production or disclosure of official information or records of the Department of Veterans Affairs (VA); and

(b) The testimony of present or former VA personnel relating to any official information acquired by any individual as part of that individual's performance of official duties, or by virtue of that individual's official status, in federal, state or other legal proceedings covered by these regulations.

(Authority: 38 U.S.C. 501(a) and (b); 5 U.S.C. 301)

§ 14.801 Applicability.

(a) Sections 14.800 through 14.810 apply to:

(1) Contractors and subcontractors which undertake a VA activity or maintain VA records when the contract covering their actions provides that these regulations apply, as well as the personnel of contractors and subcontractors.

(2) All components of the Department, including Canteen Service, the Office of Inspector General, and all staff offices, services and administrations, and their personnel.

(b) Sections 14.800 through 14.810 do not apply to:

(1) Testimony or records provided in accordance with Office of Personnel Management regulations implementing 5 U.S.C. 6322.

(2)(i) Legal proceedings in which the Department of Veterans Affairs, the Secretary of Veterans Affairs or the United States is a party, is represented or has a direct and substantial interest; or

(ii) Legal proceedings in which an individual or entity is a party for whom the United States is providing representation.

(3) Legal proceedings in which VA personnel are to testify while in leave or off-duty status as to matters which are purely personal and that do not arise out of, or relate in any way to, the personnel's official duties or to the functions and activities of the VA or the United States.

(4) Official comments on matters in legal proceedings, where appropriate.

(5) Disclosures, in the absence of a request or demand, of information or records by VA components, particularly the Office of Inspector General, to federal, state, local and foreign law enforcement or regulatory agencies.

(6) Congressional demands or requests for testimony or documents.

(7) Requests for, and release of, records under the Freedom of Information Act, 5 U.S.C. 552, and the Privacy Act, 5 U.S.C. 552a.

(8) Disclosures in child support and alimony proceedings under the authority of 42 U.S.C. 659 and regulations promulgated by the Office of Personnel Management implementing that section.

(9) Legal proceedings before or involving the VA concerning a claim or dispute as to the rights of a beneficiary or obligations or liabilities of the United States under any law or program administered by the Department of Veterans Affairs.

(10) Requests by a veteran or that veteran's representative for access to the veteran's records for use in an administrative or judicial claim for benefits administered by the Department of Veterans Affairs.

(11) Foreign legal proceedings covered by Department of State procedures governing the production of records or witnesses in response to requests or demands in connection with foreign legal proceedings.

(c) Sections 14.800 through 14.810 are not intended to, and do not:

(1) Waive the sovereign immunity of the United States;

(2) Infringe upon or displace the responsibilities committed to the Department of Justice in conducting litigation on behalf of the United States in appropriate cases;

(3) Remove the need for the Department to comply with any applicable legal confidentiality provisions, such as the Privacy Act, before having the legal authority to make any disclosure or providing any testimony under these regulations. (Sections 14.800 through 14.810 do not give VA disclosure authority under applicable confidentiality statutes; absent disclosure authority granted by those statutes, information and records subject to those laws may not be disclosed, or testimony given as to them under the procedures established in these regulations); or

(4) Preclude treating any written request for agency records that is not in the nature of a request or demand related to legal proceedings as a request under the Freedom of Information or Privacy Acts.

(Authority: 38 U.S.C. 501(a) and (b); 5 U.S.C. 301)

§ 14.802 Definitions.

(a) *Demand.* Order, subpoena, or other demand of a court of competent jurisdiction, or other specific authority or under color of law, for the production, disclosure, or release of VA information or records or for the appearance and testimony of VA personnel as witnesses.

(b) *Request.* Any informal request, by whatever method, from a party, a party's attorney, or any person acting on behalf of a party, for the production of VA records or information or for the testimony of VA personnel as witnesses, which has not been ordered by a court of competent jurisdiction or

other specific authority or under color of law.

(c) *VA personnel*. All present and former officers and employees of the VA and any other individuals who are or have been appointed by, or subject to the supervision, jurisdiction, or control of the Secretary of Veterans Affairs or another official of the VA, including nonappropriated fund activity employees, and other individuals hired through contractual agreements by or on behalf of the VA, or performing services under such agreements for VA, such as consultants, contractors, subcontractors, their employees and personnel. This phrase also includes individuals who served or are serving on any advisory committee or in any advisory capacity, whether formal or informal.

(d) *Legal proceedings*. All pretrial, trial, and post-trial stages of all existing or reasonably anticipated judicial or administrative actions, hearings, investigations, or similar proceedings before courts, commissions, boards, or other tribunals, foreign or domestic that are not specified in § 14.801(b). This phrase includes depositions and other pretrial proceedings, as well as responses to formal or informal requests by attorneys or others in situations involving legal proceedings not specified in § 14.801(b).

(e) *Official VA information*. All information of any kind, however stored, that is in the custody and control of VA or was acquired by VA personnel as part of their official duties or because of their official status.

(f) *Testimony*. Testimony in any form, including personal appearances in court, depositions, recorded interviews, telephonic, televised or videotaped testimony or any response during discovery or similar proceedings, which response would involve more than the production of records.

(g) *VA records*. All documents which are records of the Department of Veterans Affairs for purposes of the Freedom of Information Act, 5 U.S.C. 552, regardless of storage media, including the term ''record'' as defined in 44 U.S.C. 3301, and implementing regulations.

(Authority: 38 U.S.C. 501(a) and (b); 5 U.S.C. 301)

§ 14.803 Policy.

(a) VA personnel may provide testimony or produce VA records in legal proceedings covered by §§ 14.800 through 14.810 only as authorized in accordance with these regulations. In determining whether to authorize testimony or the production of records, the determining official will consider the effect in this case, as well as in future cases generally, based on the factors set forth in § 14.804, which testifying or producing records not available for public disclosure will have on the ability of the agency or VA personnel to perform their official duties.

(b) The Department of Veterans Affairs does not seek to deny its employees access to the courts as citizens, or in the employees' private capacities on off-duty time.

(c) The Department of Veterans Affairs does not seek to deny the Nation's veterans access to the courts.

(Authority: 38 U.S.C. 501 (a) and (b); 5 U.S.C. 301)

§ 14.804 Factors to consider.

In deciding whether to authorize the disclosure of VA records or information or the testimony of VA personnel, VA personnel responsible for making the decision should consider the following types of factors:

(a) The need to avoid spending the time and money of the United States for private purposes and to conserve the time of VA personnel for conducting their official duties concerning servicing the Nation's veteran population;

(b) How the testimony or production of records would assist VA in performing its statutory duties;

(c) Whether the disclosure of the records or presentation of testimony is necessary to prevent the perpetration of fraud or other injustice in the matter in question;

(d) Whether the demand or request is unduly burdensome or otherwise inappropriate under the applicable court or administrative rules;

(e) Whether the testimony or production of records, including release in camera, is appropriate or necessary under the rules of procedure governing

the case or matter in which the demand or request arose, or under the relevant substantive law concerning privilege;

(f) Whether the testimony or production of records would violate a statute, executive order, regulation or directive. (Where the production of a record or testimony as to the content of a record or about information contained in a record would violate a confidentiality statute's prohibition against disclosure, disclosure will not be made. Examples of such statutes are the Privacy Act, 5 U.S.C. 552a, and sections 5701, 5705 and 7332 of title 38, United States Code.);

(g) Whether the testimony or production of records, except when *in camera* and necessary to assert a claim of privilege, would reveal information properly classified pursuant to applicable statutes or Executive Orders;

(h) Whether the testimony would interfere with ongoing law enforcement proceedings, compromise constitutional rights, compromise national security interests, hamper VA or private health care research activities, reveal sensitive patient or beneficiary information, interfere with patient care, disclose trade secrets or similarly confidential commercial or financial information or otherwise be inappropriate under the circumstances.

(i) Whether such release or testimony reasonably could be expected to result in the appearance of VA or the Federal government favoring one litigant over another;

(j) Whether such release or testimony reasonably could be expected to result in the appearance of VA or the Federal government endorsing or supporting a position advocated by a party to the proceeding;

(k) The need to prevent the public's possible misconstruction of variances between personal opinions of VA personnel and VA or Federal policy.

(l) The need to minimize VA's possible involvement in issues unrelated to its mission;

(m) Whether the demand or request is within the authority of the party making it;

(n) Whether the demand or request is sufficiently specific to be answered;

(o) Other matters or concerns presented for consideration in making the decision.

(Authority: 38 U.S.C. 501 (a) and (b); 5 U.S.C. 301)

§ 14.805 Contents of a demand or request.

The request or demand for testimony or production of documents shall set forth in, or be accompanied by, an affidavit, or if that is not feasible, in, or accompanied by, a written statement by the party seeking the testimony or records or by the party's attorney, a summary of the nature and relevance of the testimony or records sought in the legal proceedings containing sufficient information for the responsible VA official to determine whether VA personnel should be allowed to testify or records should be produced. Where the materials are considered insufficient to make the determination as described in § 14.807, the responsible VA official may ask the requester to provide additional information.

(Authority: 38 U.S.C. 501 (a) and (b); 5 U.S.C. 301)

§ 14.806 Scope of testimony or production.

VA personnel shall not, in response to a request or demand for testimony or production of records in legal proceedings, comment or testify or produce records without the prior written approval of the responsible VA official designated in § 14.807(b). VA personnel may only testify concerning or comment upon official VA information, subjects or activities, or produce records, that were specified in writing, submitted to and properly approved by the responsible VA official.

(Authority: 38 U.S.C. 501 (a) and (b); 5 U.S.C. 301)

§ 14.807 Procedure when demand or request is made.

(a) VA personnel upon whom a demand or request for testimony or the production of records in connection with legal proceedings as defined in § 14.802(d) is made shall notify the head of his or her field station, or if in Central Office, the head of the component for which he or she works. The field

station or Central Office component shall notify the responsible VA official designated in § 14.807(b).

(b) In response to a demand or request for the production of records or the testimony of VA personnel, other than personnel in the Office of the Inspector General (OIG), as witnesses in legal proceedings covered by these regulations, the General Counsel, the Regional Counsel, an attorney in the Office of General Counsel designated by the General Counsel, or an attorney in the Regional Counsel office designated by the Regional Counsel is the responsible VA official authorized to determine whether VA personnel may be interviewed, contacted or used as witnesses, including used as expert witnesses, and whether VA records may be produced; and what, if any, conditions will be imposed upon such interview, contact, testimony or production of records. For personnel in the OIG, the Counselor to the Inspector General or an attorney designated by the Counselor to the Inspector General, is the responsible VA official authorized to make the determinations provided in § 14.807, and that official will keep the General Counsel informed of such determinations for purposes of litigation or claims of privilege.

(c) In appropriate cases, the responsible VA official shall promptly notify the Department of Justice of the demand or request. After consultation and coordination with the Department of Justice, as required, and after any necessary consultation with the VA component which employs or employed the VA personnel whose testimony is sought or which is responsible for the maintenance of the records sought, the VA official shall determine in writing whether the individual is required to comply with the demand or request and shall notify the requester or the court or other authority of the determination reached where the determination is that VA will not comply fully with the request or demand. The responsible VA official shall give notice of the decision to other persons as circumstances may warrant. Oral approval may be granted, and a record of such approval made and retained in accordance with the procedures in § 14.807(f) concerning oral requests or demands.

(d) If, after VA personnel have received a request or demand in a legal proceeding and have notified the responsible VA official in accordance with this section, a response to the request or demand is required before instructions from the responsible official are received, the responsible official designated in paragraph (b) of this section shall furnish the requester or the court or other authority with a copy of §§ 14.800 through 14.810 and any other relevant documentation, inform the requester or the court or other authority that the request or demand is being reviewed, and seek a stay of the request or demand pending a final determination by the VA official concerned.

(e) If a court of competent jurisdiction or other appropriate authority declines to stay the effect of the demand or request in response to action taken pursuant to § 14.807(d), or if such court or other authority orders that the demand or request be complied with notwithstanding the final decision of the appropriate VA official, the VA personnel upon whom the demand or request was made shall notify the responsible VA official of such ruling or order. If the responsible VA official determines that no further legal review of or challenge to the ruling or order will be sought, the affected VA personnel shall comply with the demand, order or request. If directed by the appropriate VA official after consultation with the appropriate United States Attorney's office, however, the affected VA personnel shall respectfully decline to comply with the demand, request or order. See *United States ex rel. Touhy* v. *Ragen*, 340 U.S. 462 (1951).

(f) Normally, written demands or requests allowing reasonable lead time for evaluation and processing are required. However, in emergency situations where response time is limited and a written demand or request is impractical, the following procedures should be followed:

(1) The responsible VA official has the authority to waive the requirement of a written demand or request and may expedite a response in the event of an emergency under conditions which could not be anticipated in the course

of proper planning or which demonstrate a good faith attempt to comply with these regulations. Determinations on oral demands or requests should be reserved for instances where insistence on compliance with the requirements of a proper written request would result in the effective denial of the request and cause an injustice in the outcome of the legal proceeding for which the testimony or records are sought. No requester has a right to make an oral demand or request and receive a determination, however. Whether to permit such an exceptional procedure is a decision within the sole discretion of the responsible VA official.

(2) If the responsible VA official concludes that the demand or request, or any portion of it, should be granted (after considering the factors listed in §14.804), the responsible VA official will then orally advise the requester of the determination in accordance with the procedures provided in §14.807(c), including any limitations on such testimony or production of records, and seek a written confirmation of the oral demand or request. The responsible VA official will make a written record of the determination made concerning the oral demand or request, including the grant or denial, the circumstances requiring the procedure, and the conditions to which the requester agreed.

(Authority: 38 U.S.C. 501 (a) and (b); 5 U.S.C. 301)

§14.808 Expert or opinion testimony.

(a) VA personnel shall not provide, with or without compensation, opinion or expert testimony in any legal proceedings concerning official VA information, subjects or activities, except on behalf of the United States or a party represented by the United States Department of Justice. Upon a showing by the requester or court or other appropriate authority that, in light of the factors listed in §14.804, there are exceptional circumstances and that the anticipated testimony will not be adverse to the interests of the Department of Veterans Affairs or to the United States, the responsible VA official designated in §14.807(b) may, in writing, grant special authorization for VA personnel to appear and testify. If, despite the final determination of the responsible VA official, a court of competent jurisdiction or other appropriate authority, orders the expert or opinion testimony of VA personnel, the personnel shall notify the responsible VA official of such order. If the responsible VA official determines that no further legal review of or challenge to the order will be sought, the affected VA personnel shall comply with the order. If directed by the appropriate VA official after consultation with the appropriate United States Attorney's office, however, the affected VA personnel shall respectfully decline to comply with the demand, request or order. See *United States ex rel. Touhy* v. *Ragen*, 340 U.S. 462 (1951).

(b)(1) If, while testifying in any legal proceeding, VA personnel are asked for expert or opinion testimony concerning official VA information, subjects or activities, which testimony has not been approved in advance in accordance with these regulations, the witness shall:

(i) Respectfully decline to answer on the grounds that such expert or opinion testimony is forbidden by these regulations;

(ii) Request an opportunity to consult with the responsible VA official mentioned in §14.807(b) before giving such testimony;

(iii) Explain that, upon such consultation, approval for such testimony may be provided; and

(iv) Explain that providing such testimony absent such approval may expose the individual to criminal liability under 18 U.S.C. 201–209 and to disciplinary or other adverse personnel action.

(2) If the witness is then ordered by the body conducting the proceeding to provide expert or opinion testimony concerning official VA information, subjects or activities without the opportunity to consult with the appropriate VA official, the witness respectfully shall refuse to do so. See *United States ex rel. Touhy* v. *Ragen*, 340 U.S. 462 (1951).

(c) Upon notification by the witness of a request for opinion or expert testimony concerning official VA information, subjects or activities during

§ 14.802(d) legal proceedings, the responsible VA official shall follow the procedures contained in this section to determine whether such testimony shall be approved.

(d) If VA personnel who are unaware of these regulations provide expert or opinion testimony concerning official VA information, subjects or activities in any legal proceeding, including one mentioned in § 14.802(d) in which the United States is not already represented, without consulting with the responsible VA official, the witness, as soon after testifying as possible, shall inform the responsible VA official of the fact that such testimony was given and provide a summary of the expert or opinion testimony given.

(Authority: 38 U.S.C. 501 (a) and (b); 5 U.S.C. 301)

§ 14.809 Demands or requests in legal proceedings for records protected by confidentiality statutes.

In addition to complying with the requirements of §§ 14.800 through 14.810, requests or demands in legal proceedings for the production of records, or for testimony of VA employees concerning information, protected by the Privacy Act, 5 U.S.C. 552a, or other confidentiality statutes, such as 38 U.S.C. 5701, 5705 and 7332, must satisfy the requirements for disclosure imposed by those statutes, and implementing regulations, such as 38 CFR 1.511, before the records may be provided or testimony given. Accordingly, the responsible VA official may first determine whether there is legal authority to provide the testimony or records sought under applicable confidentiality statutes before applying §§ 14.800 through 14.810. Where an applicable confidentiality statute mandates disclosure, §§ 14.800 through 14.810 will not apply.

(Authority: 38 U.S.C. 501 (a) and (b); 5 U.S.C. 301)

§ 14.810 Fees.

(a) The testimony of VA personnel as witnesses, particularly as expert witnesses, and the production of VA records in legal proceedings subject to §§ 14.800 through 14.810 are services which convey special benefits to the individuals or entities seeking such testimony or production of records above and beyond those accruing to the general public. These services are not regularly received by or available without charge to the public at large. Consequently, these are the sort of services for which the VA may establish a charge for providing under 31 U.S.C. 9701. The responsible VA official will determine all fees associated with §§ 14.800 through 14.810, and shall timely notify the requester of the fees, particularly those which are to be paid in advance.

(b)(1) When a request is granted under § 14.808 to permit VA personnel to testify in whole or in part as to expert, opinion or policy matters, the requester shall pay to the government a fee calculated to reimburse the cost of providing the witness. The fee shall include:

(i) Costs of the time expended by VA personnel to process and respond to the demand or request;

(ii) Costs of attorney time expended in reviewing the demand or request and any information located in connection with the demand or request;

(iii) Expenses generated by materials and equipment used to search for, produce, and copy the responsive information;

(iv) The cost of the time expended by the witness to prepare to testify; and

(v) Costs of travel by the witness and attendance at trial.

(2) All costs for documents necessary for such expert testimony shall be calculated as provided in VA regulations implementing the fee provisions of the Freedom of Information Act, 5 U.S.C. 552.

(c) When an individual testifies in legal proceedings covered by these regulations in any capacity other than as an expert witness, the requester shall pay to the witness the fee and expenses prescribed for attendance by the applicable rule of court. If no such fee is prescribed, the applicable Federal rule, such as a local Federal district court rule, will apply. No additional fee will be prescribed for the time spent while testifying or in attendance to do so.

(d) When a requester wishes to interview VA personnel as part of legal proceedings covered by these regulations, and such interview has been approved

in accordance with these regulations, the requester shall pay a fee calculated upon the total hourly pay of the individual interviewed.

(e) When VA produces records in legal proceedings pursuant to §§14.800 through 14.810, the fees to be charged and paid prior to production of the records shall be the fees charged by VA under its regulations implementing the fee provisions of the Freedom of Information Act, 5 U.S.C. 552.

(f) Fees shall be paid as follows:

(1) Fees for copies of documents, blueprints, electronic tapes, or other VA records will be paid to the VA office or station providing the records, and covered to the General Fund of the Department of the Treasury.

(2) Witness fees for testimony shall be paid to the witness, who shall endorse the check ''pay to the United States,'' and surrender it to his or her supervisor. It shall thereafter be deposited in the General Fund.

(3) The private party requesting a VA witness shall forward in advance necessary round trip tickets and all requisite travel and per diem funds.

(g) A waiver of any fees in connection with the testimony of an expert witness may be granted by the appropriate VA official at the official's discretion provided that the waiver is in the interest of the United States. Fee waivers shall not be routinely granted, nor shall they be granted under circumstances which might create the appearance that the VA or the United States favors one party or a position advocated by a party to the legal proceeding.

(Authority: 38 U.S.C. 501 (a) and (b); 5 U.S.C. 301)

PART 15—ENFORCEMENT OF NONDISCRIMINATION ON THE BASIS OF HANDICAP IN PROGRAMS OR ACTIVITIES CONDUCTED BY THE DEPARTMENT OF VETERANS AFFAIRS

Sec.

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AUTHORITY: 29 U.S.C. 794.

SOURCE: 53 FR 25885, July 8, 1988, unless otherwise noted.

§ 15.101 Purpose.

The purpose of this regulation is to effectuate section 119 of the Rehabilitation, Comprehensive Services, and Developmental Disabilities Amendments of 1978, which amended section 504 of the Rehabilitation Act of 1973 to prohibit discrimination on the basis of handicap in programs or activities conducted by Executive agencies or the United States Postal Service.

§ 15.102 Application.

This regulation (§§15.101–15.170) applies to all programs or activities conducted by the agency, except for programs or activities conducted outside the United States that do not involve individuals with handicaps in the United States.

§ 15.103 Definitions.

For purposes of this regulation, the term—

Assistant Attorney General means the Assistant Attorney General, Civil Rights Division, United States Department of Justice.

Auxiliary aids means services or devices that enable persons with impaired sensory, manual, or speaking skills to have an equal opportunity to participate in, and enjoy the benefits of, programs or activities conducted by the agency. For example, auxiliary aids useful for persons with impaired vision include readers, Brailled materials, audio recordings, and other similar services and devices. Auxiliary aids

useful for persons with impaired hearing include telephone handset amplifiers, telephones compatible with hearing aids, telecommunication devices for deaf persons (TDD's), interpreters, notetakers, written materials, and other similar services and devices.

Complete complaint means a written statement that contains the complainant's name and address and describes the agency's alleged discriminatory action in sufficient detail to inform the agency of the nature and date of the alleged violation of section 504. It shall be signed by the complainant or by someone authorized to do so on his or her behalf. Complaints filed on behalf of classes or third parties shall describe or identify (by name, if possible) the alleged victims of discrimination.

Facility means all or any portion of buildings, structures, equipment, roads, walks, parking lots, rolling stock or other conveyances, or other real or personal property.

Historic preservation programs means programs conducted by the agency that have preservation of historic properties as a primary purpose.

Historic properties means those properties that are listed or eligible for listing in the National Register of Historic Places or properties designated as historic under a statute of the appropriate State or local government body.

Individual with handicaps means any person who has a physical or mental impairment that substantially limits one or more major life activities, has a record of such an impairment, or is regarded as having such an impairment.

As used in this definition, the phrase:

(1) *Physical or mental impairment* includes—

(i) Any physiological disorder or condition, cosmetic disfigurement, or anatomical loss affecting one or more of the following body systems: Neurological; musculoskeletal; special sense organs; respiratory, including speech organs; cardiovascular; reproductive; digestive; genitourinary; hemic and lymphatic; skin; and endocrine; or

(ii) Any mental or psychological disorder, such as mental retardation, organic brain syndrome, emotional or mental illness, and specific learning disabilities. The term *physical or mental impairment* includes, but is not limited to, such diseases and conditions as orthopedic, visual, speech, and hearing impairments, cerebral palsy, epilepsy, muscular dystrophy, multiple sclerosis, cancer, heart disease, diabetes, mental retardation, emotional illness, and drug addiction and alcoholism.

(2) *Major life activities* includes functions such as caring for one's self, performing manual tasks, walking, seeing, hearing, speaking, breathing, learning, and working.

(3) *Has a record of such an impairment* means has a history of, or has been misclassified as having, a mental or physical impairment that substantially limits one or more major life activities.

(4) *Is regarded as having an impairment* means—

(i) Has a physical or mental impairment that does not substantially limit major life activities but is treated by the agency as constituting such a limitation;

(ii) Has a physical or mental impairment that substantially limits major life activities only as a result of the attitudes of others toward such impairment; or

(iii) Has none of the impairments defined in paragraph (1) of this definition but is treated by the agency as having such an impairment.

Qualified individual with handicaps means—

(1) With respect to preschool, elementary, or secondary education services provided by the agency, an individual with handicaps who is a member of a class of persons otherwise entitled by statute, regulation, or agency policy to receive education services from the agency;

(2) With respect to any other agency program or activity under which a person is required to perform services or to achieve a level of accomplishment, an individual with handicaps who meets the essential eligibility requirements and who can achieve the purpose of the program or activity without modifications in the program or activity that the agency can demonstrate would result in a fundamental alteration in its nature;

(3) With respect to any other program or activity, an individual with

handicaps who meets the essential eligibility requirements for participation in, or receipt of benefits from, that program or activity; and

(4) *Qualified handicapped person* as that term is defined for purposes of employment in 29 CFR 1613.702(f), which is made applicable to this regulation by § 15.140.

Section 504 means section 504 of the Rehabilitation Act of 1973 (Pub. L. 93–112, 87 Stat. 394 (29 U.S.C. 794)), as amended by the Rehabilitation Act Amendments of 1974 (Pub. L. 93–516, 88 Stat. 1617); the Rehabilitation, Comprehensive Services, and Developmental Disabilities Amendments of 1978 (Pub. L. 95–602, 92 Stat. 2955); and the Rehabilitation Act Amendments of 1986 (Pub. L. 99–506, 100 Stat. 1810). As used in this regulation, section 504 applies only to programs or activities conducted by Executive agencies and not to federally assisted programs.

Substantial impairment means a significant loss of the integrity of finished materials, design quality, or special character resulting from a permanent alteration.

§§ 15.104–15.109 [Reserved]

§ 15.110 Self-evaluation.

(a) The agency shall, by September 6, 1989, evaluate its current policies and practices, and the effects thereof, that do not or may not meet the requirements of this regulation and, to the extent modification of any such policies and practices is required, the agency shall proceed to make the necessary modifications.

(b) The agency shall provide an opportunity to interested persons, including individuals with handicaps or organizations representing individuals with handicaps, to participate in the self-evaluation process by submitting comments (both oral and written).

(c) The agency shall, for at least three years following completion of the self-evaluation, maintain on file and make available for public inspection:

(1) A description of areas examined and any problems identified; and

(2) A description of any modifications made.

§ 15.111 Notice.

The agency shall make available to employees, applicants, participants, beneficiaries, and other interested persons such information regarding the provisions of this regulation and its applicability to the programs or activities conducted by the agency, and make such information available to them in such manner as the head of the agency finds necessary to apprise such persons of the protections against discrimination assured them by section 504 and this regulation.

§§ 15.112–15.129 [Reserved]

§ 15.130 General prohibitions against discrimination.

(a) No qualified individual with handicaps shall, on the basis of handicap, be excluded from participation in, be denied the benefits of, or otherwise be subjected to discrimination under any program or activity conducted by the agency.

(b)(1) The agency, in providing any aid, benefit, or service, may not, directly or through contractual, licensing, or other arrangements, on the basis of handicap—

(i) Deny a qualified individual with handicaps the opportunity to participate in or benefit from the aid, benefit, or service;

(ii) Afford a qualified individual with handicaps an opportunity to participate in or benefit from the aid, benefit, or service that is not equal to that afforded others;

(iii) Provide a qualified individual with handicaps with an aid, benefit, or service that is not as effective in affording equal opportunity to obtain the same result, to gain the same benefit, or to reach the same level of achievement as that provided to others;

(iv) Provide different or separate aid, benefits, or services to individuals with handicaps or to any class of individuals with handicaps than is provided to others unless such action is necessary to provide qualified individuals with handicaps with aid, benefits, or services that are as effective as those provided to others;

(v) Deny a qualified individual with handicaps the opportunity to participate as a member of planning or advisory boards;

(vi) Otherwise limit a qualified individual with handicaps in the enjoyment of any right, privilege, advantage, or opportunity enjoyed by others receiving the aid, benefit, or service.

(2) The agency may not deny a qualified individual with handicaps the opportunity to participate in programs or activities that are not separate or different, despite the existence of permissibly separate or different programs or activities.

(3) The agency may not, directly or through contractual or other arrangements, utilize criteria or methods of administration the purpose or effect of which would—

(i) Subject qualified individuals with handicaps to discrimination on the basis of handicap; or

(ii) Defeat or substantially impair accomplishment of the objectives of a program or activity with respect to individuals with handicaps.

(4) The agency may not, in determining the site or location of a facility, make selections the purpose or effect of which would—

(i) Exclude individuals with handicaps from, deny them the benefits of, or otherwise subject them to discrimination under any program or activity conducted by the agency; or

(ii) Defeat or substantially impair the accomplishment of the objectives of a program or activity with respect to individuals with handicaps.

(5) The agency, in the selection of procurement contractors, may not use criteria that subject qualified individuals with handicaps to discrimination on the basis of handicap.

(6) The agency may not administer a licensing or certification program in a manner that subjects qualified individuals with handicaps to discrimination on the basis of handicap, nor may the agency establish requirements for the programs or activities of licensees or certified entities that subject qualified individuals with handicaps to discrimination on the basis of handicap. However, the programs or activities of entities that are licensed or certified by the agency are not, themselves, covered by this regulation.

(c) The exclusion of nonhandicapped persons from the benefits of a program limited by Federal statute or Executive order to individuals with handicaps or the exclusion of a specific class of individuals with handicaps from a program limited by Federal statute or Executive order to a different class of individuals with handicaps is not prohibited by this regulation.

(d) The agency shall administer programs and activities in the most integrated setting appropriate to the needs of qualified individuals with handicaps.

§§ 15.131–15.139 [Reserved]

§ 15.140 Employment.

No qualified individual with handicaps shall, on the basis of handicap, be subject to discrimination in employment under any program or activity conducted by the agency. The definitions, requirements, and procedures of section 501 of the Rehabilitation Act of 1973 (29 U.S.C. 791), as established by the Equal Employment Opportunity Commission in 29 CFR part 1613, shall apply to employment in federally conducted programs or activities.

§§ 15.141–15.148 [Reserved]

§ 15.149 Program accessibility: Discrimination prohibited.

Except as otherwise provided in § 15.150, no qualified individual with handicaps shall, because the agency's facilities are inaccessible to or unusable by individuals with handicaps, be denied the benefits of, be excluded from participation in, or otherwise be subjected to discrimination under any program or activity conducted by the agency.

§ 15.150 Program accessibility: Existing facilities.

(a) *General.* The agency shall operate each program or activity so that the program or activity, when viewed in its entirety, is readily accessible to and usable by individuals with handicaps. This paragraph does not—

(1) Necessarily require the agency to make each of its existing facilities accessible to and usable by individuals with handicaps;

(2) In the case of historic preservation programs, require the agency to take any action that would result in a substantial impairment of significant historic features of an historic property; or

(3) Require the agency to take any action that it can demonstrate would result in a fundamental alteration in the nature of a program or activity or in undue financial and administrative burdens. In those circumstances where agency personnel believe that the proposed action would fundamentally alter the program or activity or would result in undue financial and administrative burdens, the agency has the burden of proving that compliance with § 15.150(a) would result in such alteration or burdens. The decision that compliance would result in such alteration or burdens must be made by the agency head or his or her designee after considering all agency resources available for use in the funding and operation of the conducted program or activity, and must be accompanied by a written statement of the reasons for reaching that conclusion. If an action would result in such an alteration or such burdens, the agency shall take any other action that would not result in such an alteration or such burdens but would nevertheless ensure that individuals with handicaps receive the benefits and services of the program or activity.

(b) *Methods*—(1) *General*. The agency may comply with the requirements of this section through such means as redesign of equipment, reassignment of services to accessible buildings, assignment of aides to beneficiaries, home visits, delivery of services at alternate accessible sites, alteration of existing facilities and construction of new facilities, use of accessible rolling stock, or any other methods that result in making its programs or activities readily accessible to and usable by individuals with handicaps. The agency is not required to make structural changes in existing facilities where other methods are effective in achieving compliance with this section. The agency, in making alterations to existing buildings, shall meet accessibility requirements to the extent compelled by the Architectural Barriers Act of 1968, as amended (42 U.S.C. 4151–4157), and any regulations implementing it. In choosing among available methods for meeting the requirements of this section, the agency shall give priority to those methods that offer programs and activities to qualified individuals with handicaps in the most integrated setting appropriate.

(2) *Historic preservation programs*. In meeting the requirements of § 15.150(a) in historic preservation programs, the agency shall give priority to methods that provide physical access to individuals with handicaps. In cases where a physical alteration to an historic property is not required because of § 15.150(a)(2) or (3), alternative methods of achieving program accessibility include—

(i) Using audio-visual materials and devices to depict those portions of an historic property that cannot otherwise be made accessible;

(ii) Assigning persons to guide individuals with handicaps into or through portions of historic properties that cannot otherwise be made accessible; or

(iii) Adopting other innovative methods.

(c) *Time period for compliance*. The agency shall comply with the obligations established under this section by November 7, 1988, except that where structural changes in facilities are undertaken, such changes shall be made by September 6, 1991, but in any event as expeditiously as possible.

(d) *Transition plan*. In the event that structural changes to facilities will be undertaken to achieve program accessibility, the agency shall develop, by March 6, 1989, a transition plan setting forth the steps necessary to complete such changes. The agency shall provide an opportunity to interested persons, including individuals with handicaps or organizations representing individuals with handicaps, to participate in the development of the transition plan by submitting comments (both oral and written). A copy of the transition plan shall be made available for public inspection. The plan shall, at a minimum—

(1) Identify physical obstacles in the agency's facilities that limit the accessibility of its programs or activities to individuals with handicaps;

(2) Describe in detail the methods that will be used to make the facilities accessible;

(3) Specify the schedule for taking the steps necessary to achieve compliance with this section and, if the time period of the transition plan is longer than one year, identify steps that will be taken during each year of the transition period; and

(4) Indicate the official responsible for implementation of the plan.

§ 15.151 Program accessibility: New construction and alterations.

Each building or part of a building that is constructed or altered by, on behalf of, or for the use of the agency shall be designed, constructed, or altered so as to be readily accessible to and usable by individuals with handicaps. The definitions, requirements, and standards of the Architectural Barriers Act (42 U.S.C. 4151–4157), as established in 41 CFR 101–19.600 to 101–19.607, apply to buildings covered by this section.

§§ 15.152–15.159 [Reserved]

§ 15.160 Communications.

(a) The agency shall take appropriate steps to ensure effective communication with applicants, participants, personnel of other Federal entities, and members of the public.

(1) The agency shall furnish appropriate auxiliary aids where necessary to afford an individual with handicaps an equal opportunity to participate in, and enjoy the benefits of, a program or activity conducted by the agency.

(i) In determining what type of auxiliary aid is necessary, the agency shall give primary consideration to the requests of the individual with handicaps.

(ii) The agency need not provide individually prescribed devices, readers for personal use or study, or other devices of a personal nature.

(2) Where the agency communicates with applicants and beneficiaries by telephone, telecommunication devices for deaf persons (TDD's) or equally effective telecommunication systems shall be used to communicate with persons with impaired hearing.

(b) The agency shall ensure that interested persons, including persons with impaired vision or hearing, can obtain information as to the existence and location of accessible services, activities, and facilities.

(c) The agency shall provide signage at a primary entrance to each of its inaccessible facilities, directing users to a location at which they can obtain information about accessible facilities. The international symbol for accessibility shall be used at each primary entrance of an accessible facility.

(d) This section does not require the agency to take any action that it can demonstrate would result in a fundamental alteration in the nature of a program or activity or in undue financial and administrative burdens. In those circumstances where agency personnel believe that the proposed action would fundamentally alter the program or activity or would result in undue financial and administrative burdens, the agency has the burden of proving that compliance with § 15.160 would result in such alteration or burdens. The decision that compliance would result in such alteration or burdens must be made by the agency head or his or her designee after considering all agency resources available for use in the funding and operation of the conducted program or activity and must be accompanied by a written statement of the reasons for reaching that conclusion. If an action required to comply with this section would result in such an alteration or such burdens, the agency shall take any other action that would not result in such an alteration or such burdens but would nevertheless ensure that, to the maximum extent possible, individuals with handicaps receive the benefits and services of the program or activity.

§§ 15.161–15.169 [Reserved]

§ 15.170 Compliance procedures.

(a) Except as provided in paragraph (b) of this section, this section applies to all allegations of discrimination on the basis of handicap in programs and activities conducted by the agency.

(b) The agency shall process complaints alleging violations of section 504 with respect to employment according to the procedures established by the Equal Employment Opportunity Commission in 29 CFR part 1613 pursuant to section 501 of the Rehabilitation Act of 1973 (29 U.S.C. 791).

(c) The Deputy Assistant Secretary for Resolution Management shall be responsible for coordinating implementation of this section. Complaints may be sent to the Secretary of Veterans Affairs or the Deputy Assistant Secretary for Resolution Management at the following address: Department of Veterans Affairs, 810 Vermont Avenue NW., Washington, DC 20420.

(d) The agency shall accept and investigate all complete complaints for which it has jurisdiction. All complete complaints must be filed within 180 days of the alleged act of discrimination. The agency may extend this time period for good cause.

(e) If the agency receives a complaint over which it does not have jurisdiction, it shall promptly notify the complainant and shall make reasonable efforts to refer the complaint to the appropriate Government entity.

(f) The agency shall notify the Architectural and Transportation Barriers Compliance Board upon receipt of any complaint alleging that a building or facility that is subject to the Architectural Barriers Act of 1968, as amended (42 U.S.C. 4151–4157), is not readily accessible to and usable by individuals with handicaps.

(g) Within 180 days of the receipt of a complete complaint for which it has jurisdiction, the agency shall notify the complainant of the results of the investigation in a letter containing—

(1) Findings of fact and conclusions of law;

(2) A description of a remedy for each violation found; and

(3) A notice of the right to appeal.

(h) Appeals of the findings of fact and conclusions of law or remedies must be filed by the complainant within 90 days of receipt from the agency of the letter required by §15.170(g). The agency may extend this time for good cause.

(i) Timely appeals shall be accepted and processed by the head of the agency.

(j) The head of the agency shall notify the complainant of the results of the appeal within 60 days of the receipt of the request. If the head of the agency determines that additional information is needed from the complainant, he or she shall have 60 days from the date of receipt of the additional information to make his or her determination on the appeal.

(k) The time limits cited in paragraphs (g) and (j) of this section may be extended with the permission of the Assistant Attorney General.

(l) The agency may delegate its authority for conducting complaint investigations to other Federal agencies, except that the authority for making the final determination may not be delegated to another agency.

[53 FR 25885, July 8, 1988, as amended at 53 FR 25885, July 8, 1988; 54 FR 34982, Aug. 23, 1989; 67 FR 3435, Jan. 24, 2002]

§§ 15.171–15.999 [Reserved]

PART 16—PROTECTION OF HUMAN SUBJECTS

Sec.

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AUTHORITY: 5 U.S.C. 301; 38 U.S.C. 501, 7331, 7334; 42 U.S.C. 300v–1(b).

SOURCE: 82 FR 7272, Jan. 19, 2017, unless otherwise noted.

§ 16.101 To what does this policy apply?

(a) Except as detailed in § 16.104, this policy applies to all research involving human subjects conducted, supported, or otherwise subject to regulation by any Federal department or agency that takes appropriate administrative action to make the policy applicable to such research. This includes research conducted by Federal civilian employees or military personnel, except that each department or agency head may adopt such procedural modifications as may be appropriate from an administrative standpoint. It also includes research conducted, supported, or otherwise subject to regulation by the Federal Government outside the United States. Institutions that are engaged in research described in this paragraph and institutional review boards (IRBs) reviewing research that is subject to this policy must comply with this policy.

(b) [Reserved]

(c) Department or agency heads retain final judgment as to whether a particular activity is covered by this policy and this judgment shall be exercised consistent with the ethical principles of the Belmont Report.[62]

(d) Department or agency heads may require that specific research activities or classes of research activities conducted, supported, or otherwise subject to regulation by the Federal department or agency but not otherwise covered by this policy comply with some or all of the requirements of this policy.

(e) Compliance with this policy requires compliance with pertinent federal laws or regulations that provide additional protections for human subjects.

(f) This policy does not affect any state or local laws or regulations (including tribal law passed by the official governing body of an American Indian or Alaska Native tribe) that may otherwise be applicable and that provide additional protections for human subjects.

(g) This policy does not affect any foreign laws or regulations that may otherwise be applicable and that provide additional protections to human subjects of research.

(h) When research covered by this policy takes place in foreign countries, procedures normally followed in the foreign countries to protect human subjects may differ from those set forth in this policy. In these circumstances, if a department or agency head determines that the procedures prescribed by the institution afford protections that are at least equivalent to those provided in this policy, the department or agency head may approve the substitution of the foreign procedures in lieu of the procedural requirements provided in this policy. Except when otherwise required by statute, Executive Order, or the department or agency head, notices of these actions as they occur will be published in the FEDERAL REGISTER or will be otherwise published as provided in department or agency procedures.

(i) Unless otherwise required by law, department or agency heads may waive the applicability of some or all of the provisions of this policy to specific research activities or classes of research activities otherwise covered by this policy, provided the alternative procedures to be followed are consistent with the principles of the Belmont Report.[63] Except when otherwise required by statute or Executive Order, the department or agency head shall forward advance notices of these actions to the Office for Human Research Protections, Department of Health and Human Services (HHS), or any successor office, or to the equivalent office

[62] The National Commission for the Protection of Human Subjects of Biomedical and Behavioral Research.– Belmont Report. Washington, DC: U.S. Department of Health and Human Services. 1979.

[63] *Id.*

within the appropriate Federal department or agency, and shall also publish them in the FEDERAL REGISTER or in such other manner as provided in department or agency procedures. The waiver notice must include a statement that identifies the conditions under which the waiver will be applied and a justification as to why the waiver is appropriate for the research, including how the decision is consistent with the principles of the Belmont Report.

(j) Federal guidance on the requirements of this policy shall be issued only after consultation, for the purpose of harmonization (to the extent appropriate), with other Federal departments and agencies that have adopted this policy, unless such consultation is not feasible.

(k) [Reserved]

(l) Compliance dates and transition provisions:

(1) *Pre-2018 Requirements*. For purposes of this section, the *pre-2018 Requirements* means this subpart as published in the 2016 edition of the Code of Federal Regulations.

(2) *2018 Requirements*. For purposes of this section, the *2018 Requirements* means the Federal Policy for the Protection of Human Subjects requirements contained in this part. The general compliance date for the 2018 Requirements is January 21, 2019. The compliance date for §16.114(b) (cooperative research) of the 2018 Requirements is January 20, 2020.

(3) *Research subject to pre-2018 requirements*. The pre-2018 Requirements shall apply to the following research, unless the research is transitioning to comply with the 2018 Requirements in accordance with paragraph (l)(4) of this section:

(i) Research initially approved by an IRB under the pre-2018 Requirements before January 21, 2019;

(ii) Research for which IRB review was waived pursuant to §16.101(i) of the pre-2018 Requirements before January 21, 2019; and

(iii) Research for which a determination was made that the research was exempt under §16.101(b) of the pre-2018 Requirements before January 21, 2019.

(4) *Transitioning research*. If, on or after July 19, 2018, an institution planning or engaged in research otherwise covered by paragraph (l)(3) of this section determines that such research instead will transition to comply with the 2018 Requirements, the institution or an IRB must document and date such determination.

(i) If the determination to transition is documented between July 19, 2018, and January 20, 2019, the research shall:

(A) Beginning on the date of such documentation through January 20, 2019, comply with the pre-2018 Requirements, except that the research shall comply with the following:

(*1*) Section 16.102(l) of the 2018 Requirements (definition of research) (instead of §16.102(d) of the pre-2018 Requirements);

(*2*) Section 16.103(d) of the 2018 Requirements (revised certification requirement that eliminates IRB review of application or proposal) (instead of §16.103(f) of the pre-2018 Requirements); and

(*3*) Section 16.109(f)(1)(i) and (iii) of the 2018 Requirements (exceptions to mandated continuing review) (instead of §16.103(b), as related to the requirement for continuing review, and in addition to §16.109, of the pre-2018 Requirements); and

(B) Beginning on January 21, 2019, comply with the 2018 Requirements.

(ii) If the determination to transition is documented on or after January 21, 2019, the research shall, beginning on the date of such documentation, comply with the 2018 Requirements.

(5) *Research subject to 2018 Requirements*. The 2018 Requirements shall apply to the following research:

(i) Research initially approved by an IRB on or after January 21, 2019;

(ii) Research for which IRB review is waived pursuant to paragraph (i) of this section on or after January 21, 2019; and

(iii) Research for which a determination is made that the research is exempt on or after January 21, 2019.

(m) Severability: Any provision of this part held to be invalid or unenforceable by its terms, or as applied to any person or circumstance, shall be construed so as to continue to give maximum effect to the provision permitted by law, unless such holding

shall be one of utter invalidity or unenforceability, in which event the provision shall be severable from this part and shall not affect the remainder thereof or the application of the provision to other persons not similarly situated or to other dissimilar circumstances.

[82 FR 7272, Jan. 19, 2017, as amended at 83 FR 28517, June 19, 2018]

§ 16.102 Definitions for purposes of this policy.

(a) *Certification* means the official notification by the institution to the supporting Federal department or agency component, in accordance with the requirements of this policy, that a research project or activity involving human subjects has been reviewed and approved by an IRB in accordance with an approved assurance.

(b) *Clinical trial* means a research study in which one or more human subjects are prospectively assigned to one or more interventions (which may include placebo or other control) to evaluate the effects of the interventions on biomedical or behavioral health-related outcomes.

(c) *Department or agency head* means the head of any Federal department or agency, for example, the Secretary of HHS, and any other officer or employee of any Federal department or agency to whom the authority provided by these regulations to the department or agency head has been delegated.

(d) *Federal department or agency* refers to a federal department or agency (the department or agency itself rather than its bureaus, offices or divisions) that takes appropriate administrative action to make this policy applicable to the research involving human subjects it conducts, supports, or otherwise regulates (*e.g.*, the U.S. Department of Health and Human Services, the U.S. Department of Defense, or the Central Intelligence Agency).

(e)(1) *Human subject* means a living individual about whom an investigator (whether professional or student) conducting research:

(i) Obtains information or biospecimens through intervention or interaction with the individual, and uses, studies, or analyzes the information or biospecimens; or (ii) Obtains, uses, studies, analyzes, or generates identifiable private information or identifiable biospecimens.

(2) *Intervention* includes both physical procedures by which information or biospecimens are gathered (*e.g.*, venipuncture) and manipulations of the subject or the subject's environment that are performed for research purposes.

(3) *Interaction* includes communication or interpersonal contact between investigator and subject.

(4) *Private information* includes information about behavior that occurs in a context in which an individual can reasonably expect that no observation or recording is taking place, and information that has been provided for specific purposes by an individual and that the individual can reasonably expect will not be made public (*e.g.*, a medical record).

(5) *Identifiable private information* is private information for which the identity of the subject is or may readily be ascertained by the investigator or associated with the information.

(6) *An identifiable biospecimen* is a biospecimen for which the identity of the subject is or may readily be ascertained by the investigator or associated with the biospecimen.

(7) Federal departments or agencies implementing this policy shall:

(i) Upon consultation with appropriate experts (including experts in data matching and re-identification), reexamine the meaning of ''identifiable private information,'' as defined in paragraph (e)(5) of this section, and ''identifiable biospecimen,'' as defined in paragraph (e)(6) of this section. This reexamination shall take place within 1 year and regularly thereafter (at least every 4 years). This process will be conducted by collaboration among the Federal departments and agencies implementing this policy. If appropriate and permitted by law, such Federal departments and agencies may alter the interpretation of these terms, including through the use of guidance.

(ii) Upon consultation with appropriate experts, assess whether there are analytic technologies or techniques that should be considered by investigators to generate ''identifiable private information,'' as defined in paragraph

(e)(5) of this section, or an ''identifiable biospecimen,'' as defined in paragraph (e)(6) of this section. This assessment shall take place within 1 year and regularly thereafter (at least every 4 years). This process will be conducted by collaboration among the Federal departments and agencies implementing this policy. Any such technologies or techniques will be included on a list of technologies or techniques that produce identifiable private information or identifiable biospecimens. This list will be published in the FEDERAL REGISTER after notice and an opportunity for public comment. The Secretary, HHS, shall maintain the list on a publicly accessible Web site.

(f) *Institution* means any public or private entity, or department or agency (including federal, state, and other agencies).

(g) *IRB* means an institutional review board established in accord with and for the purposes expressed in this policy.

(h) *IRB approval* means the determination of the IRB that the research has been reviewed and may be conducted at an institution within the constraints set forth by the IRB and by other institutional and federal requirements.

(i) *Legally authorized representative* means an individual or judicial or other body authorized under applicable law to consent on behalf of a prospective subject to the subject's participation in the procedure(s) involved in the research. If there is no applicable law addressing this issue, *legally authorized representative* means an individual recognized by institutional policy as acceptable for providing consent in the nonresearch context on behalf of the prospective subject to the subject's participation in the procedure(s) involved in the research.

(j) *Minimal risk* means that the probability and magnitude of harm or discomfort anticipated in the research are not greater in and of themselves than those ordinarily encountered in daily life or during the performance of routine physical or psychological examinations or tests.

(k) *Public health authority* means an agency or authority of the United States, a state, a territory, a political subdivision of a state or territory, an Indian tribe, or a foreign government, or a person or entity acting under a grant of authority from or contract with such public agency, including the employees or agents of such public agency or its contractors or persons or entities to whom it has granted authority, that is responsible for public health matters as part of its official mandate.

(l) *Research* means a systematic investigation, including research development, testing, and evaluation, designed to develop or contribute to generalizable knowledge. Activities that meet this definition constitute research for purposes of this policy, whether or not they are conducted or supported under a program that is considered research for other purposes. For example, some demonstration and service programs may include research activities. For purposes of this part, the following activities are deemed not to be research:

(1) Scholarly and journalistic activities (*e.g.*, oral history, journalism, biography, literary criticism, legal research, and historical scholarship), including the collection and use of information, that focus directly on the specific individuals about whom the information is collected.

(2) Public health surveillance activities, including the collection and testing of information or biospecimens, conducted, supported, requested, ordered, required, or authorized by a public health authority. Such activities are limited to those necessary to allow a public health authority to identify, monitor, assess, or investigate potential public health signals, onsets of disease outbreaks, or conditions of public health importance (including trends, signals, risk factors, patterns in diseases, or increases in injuries from using consumer products). Such activities include those associated with providing timely situational awareness and priority setting during the course of an event or crisis that threatens public health (including natural or man-made disasters).

(3) Collection and analysis of information, biospecimens, or records by or for a criminal justice agency for activities authorized by law or court order

solely for criminal justice or criminal investigative purposes.

(4) Authorized operational activities (as determined by each agency) in support of intelligence, homeland security, defense, or other national security missions.

(m) *Written*, or *in writing*, for purposes of this part, refers to writing on a tangible medium (*e.g.*, paper) or in an electronic format.

§ 16.103 Assuring compliance with this policy—research conducted or supported by any Federal department or agency.

(a) Each institution engaged in research that is covered by this policy, with the exception of research eligible for exemption under § 16.104, and that is conducted or supported by a Federal department or agency, shall provide written assurance satisfactory to the department or agency head that it will comply with the requirements of this policy. In lieu of requiring submission of an assurance, individual department or agency heads shall accept the existence of a current assurance, appropriate for the research in question, on file with the Office for Human Research Protections, HHS, or any successor office, and approved for Federal-wide use by that office. When the existence of an HHS-approved assurance is accepted in lieu of requiring submission of an assurance, reports (except certification) required by this policy to be made to department and agency heads shall also be made to the Office for Human Research Protections, HHS, or any successor office. Federal departments and agencies will conduct or support research covered by this policy only if the institution has provided an assurance that it will comply with the requirements of this policy, as provided in this section, and only if the institution has certified to the department or agency head that the research has been reviewed and approved by an IRB (if such certification is required by § 16.103(d)).

(b) The assurance shall be executed by an individual authorized to act for the institution and to assume on behalf of the institution the obligations imposed by this policy and shall be filed in such form and manner as the department or agency head prescribes.

(c) The department or agency head may limit the period during which any assurance shall remain effective or otherwise condition or restrict the assurance.

(d) Certification is required when the research is supported by a Federal department or agency and not otherwise waived under § 16.101(i) or exempted under § 16.104. For such research, institutions shall certify that each proposed research study covered by the assurance and this section has been reviewed and approved by the IRB. Such certification must be submitted as prescribed by the Federal department or agency component supporting the research. Under no condition shall research covered by this section be initiated prior to receipt of the certification that the research has been reviewed and approved by the IRB.

(e) For nonexempt research involving human subjects covered by this policy (or exempt research for which limited IRB review takes place pursuant to § 16.104(d)(2)(iii), (d)(3)(i)(C), or (d)(7) or (8)) that takes place at an institution in which IRB oversight is conducted by an IRB that is not operated by the institution, the institution and the organization operating the IRB shall document the institution's reliance on the IRB for oversight of the research and the responsibilities that each entity will undertake to ensure compliance with the requirements of this policy (*e.g.*, in a written agreement between the institution and the IRB, by implementation of an institution-wide policy directive providing the allocation of responsibilities between the institution and an IRB that is not affiliated with the institution, or as set forth in a research protocol).

(Approved by the Office of Management and Budget under Control Number 0990–0260)

§ 16.104 Exempt research.

(a) Unless otherwise required by law or by department or agency heads, research activities in which the only involvement of human subjects will be in one or more of the categories in paragraph (d) of this section are exempt from the requirements of this policy,

except that such activities must comply with the requirements of this section and as specified in each category.

(b) Use of the exemption categories for research subject to the requirements of subparts B, C, and D: Application of the exemption categories to research subject to the requirements of 45 CFR part 46, subparts B, C, and D, is as follows:

(1) *Subpart B*. Each of the exemptions at this section may be applied to research subject to subpart B if the conditions of the exemption are met.

(2) *Subpart C*. The exemptions at this section do not apply to research subject to subpart C, except for research aimed at involving a broader subject population that only incidentally includes prisoners.

(3) *Subpart D*. The exemptions at paragraphs (d)(1), (4), (5), (6), (7), and (8) of this section may be applied to research subject to subpart D if the conditions of the exemption are met. Paragraphs (d)(2)(i) and (ii) of this section only may apply to research subject to subpart D involving educational tests or the observation of public behavior when the investigator(s) do not participate in the activities being observed. Paragraph (d)(2)(iii) of this section may not be applied to research subject to subpart D.

(c) [Reserved]

(d) Except as described in paragraph (a) of this section, the following categories of human subjects research are exempt from this policy:

(1) Research, conducted in established or commonly accepted educational settings, that specifically involves normal educational practices that are not likely to adversely impact students' opportunity to learn required educational content or the assessment of educators who provide instruction. This includes most research on regular and special education instructional strategies, and research on the effectiveness of or the comparison among instructional techniques, curricula, or classroom management methods.

(2) Research that only includes interactions involving educational tests (cognitive, diagnostic, aptitude, achievement), survey procedures, interview procedures, or observation of public behavior (including visual or auditory recording) if at least one of the following criteria is met:

(i) The information obtained is recorded by the investigator in such a manner that the identity of the human subjects cannot readily be ascertained, directly or through identifiers linked to the subjects;

(ii) Any disclosure of the human subjects' responses outside the research would not reasonably place the subjects at risk of criminal or civil liability or be damaging to the subjects' financial standing, employability, educational advancement, or reputation; or

(iii) The information obtained is recorded by the investigator in such a manner that the identity of the human subjects can readily be ascertained, directly or through identifiers linked to the subjects, and an IRB conducts a limited IRB review to make the determination required by § 16.111(a)(7).

(3)(i) Research involving benign behavioral interventions in conjunction with the collection of information from an adult subject through verbal or written responses (including data entry) or audiovisual recording if the subject prospectively agrees to the intervention and information collection and at least one of the following criteria is met:

(A) The information obtained is recorded by the investigator in such a manner that the identity of the human subjects cannot readily be ascertained, directly or through identifiers linked to the subjects;

(B) Any disclosure of the human subjects' responses outside the research would not reasonably place the subjects at risk of criminal or civil liability or be damaging to the subjects' financial standing, employability, educational advancement, or reputation; or

(C) The information obtained is recorded by the investigator in such a manner that the identity of the human subjects can readily be ascertained, directly or through identifiers linked to the subjects, and an IRB conducts a limited IRB review to make the determination required by § 16.111(a)(7).

(ii) For the purpose of this provision, benign behavioral interventions are brief in duration, harmless, painless,

not physically invasive, not likely to have a significant adverse lasting impact on the subjects, and the investigator has no reason to think the subjects will find the interventions offensive or embarrassing. Provided all such criteria are met, examples of such benign behavioral interventions would include having the subjects play an online game, having them solve puzzles under various noise conditions, or having them decide how to allocate a nominal amount of received cash between themselves and someone else.

(iii) If the research involves deceiving the subjects regarding the nature or purposes of the research, this exemption is not applicable unless the subject authorizes the deception through a prospective agreement to participate in research in circumstances in which the subject is informed that he or she will be unaware of or misled regarding the nature or purposes of the research.

(4) Secondary research for which consent is not required: Secondary research uses of identifiable private information or identifiable biospecimens, if at least one of the following criteria is met:

(i) The identifiable private information or identifiable biospecimens are publicly available;

(ii) Information, which may include information about biospecimens, is recorded by the investigator in such a manner that the identity of the human subjects cannot readily be ascertained directly or through identifiers linked to the subjects, the investigator does not contact the subjects, and the investigator will not re-identify subjects;

(iii) The research involves only information collection and analysis involving the investigator's use of identifiable health information when that use is regulated under 45 CFR parts 160 and 164, subparts A and E, for the purposes of ''health care operations'' or ''research'' as those terms are defined at 45 CFR 164.501 or for ''public health activities and purposes'' as described under 45 CFR 164.512(b); or

(iv) The research is conducted by, or on behalf of, a Federal department or agency using government-generated or government-collected information obtained for nonresearch activities, if the research generates identifiable private information that is or will be maintained on information technology that is subject to and in compliance with section 208(b) of the E-Government Act of 2002, 44 U.S.C. 3501 note, if all of the identifiable private information collected, used, or generated as part of the activity will be maintained in systems of records subject to the Privacy Act of 1974, 5 U.S.C. 552a, and, if applicable, the information used in the research was collected subject to the Paperwork Reduction Act of 1995, 44 U.S.C. 3501 *et seq*.

(5) Research and demonstration projects that are conducted or supported by a Federal department or agency, or otherwise subject to the approval of department or agency heads (or the approval of the heads of bureaus or other subordinate agencies that have been delegated authority to conduct the research and demonstration projects), and that are designed to study, evaluate, improve, or otherwise examine public benefit or service programs, including procedures for obtaining benefits or services under those programs, possible changes in or alternatives to those programs or procedures, or possible changes in methods or levels of payment for benefits or services under those programs. Such projects include, but are not limited to, internal studies by Federal employees, and studies under contracts or consulting arrangements, cooperative agreements, or grants. Exempt projects also include waivers of otherwise mandatory requirements using authorities such as sections 1115 and 1115A of the Social Security Act, as amended.

(i) Each Federal department or agency conducting or supporting the research and demonstration projects must establish, on a publicly accessible Federal Web site or in such other manner as the department or agency head may determine, a list of the research and demonstration projects that the Federal department or agency conducts or supports under this provision. The research or demonstration project must be published on this list prior to commencing the research involving human subjects.

(ii) [Reserved]

(6) Taste and food quality evaluation and consumer acceptance studies:

(i) If wholesome foods without additives are consumed, or

(ii) If a food is consumed that contains a food ingredient at or below the level and for a use found to be safe, or agricultural chemical or environmental contaminant at or below the level found to be safe, by the Food and Drug Administration or approved by the Environmental Protection Agency or the Food Safety and Inspection Service of the U.S. Department of Agriculture.

(7) Storage or maintenance for secondary research for which broad consent is required: Storage or maintenance of identifiable private information or identifiable biospecimens for potential secondary research use if an IRB conducts a limited IRB review and makes the determinations required by § 16.111(a)(8).

(8) Secondary research for which broad consent is required: Research involving the use of identifiable private information or identifiable biospecimens for secondary research use, if the following criteria are met:

(i) Broad consent for the storage, maintenance, and secondary research use of the identifiable private information or identifiable biospecimens was obtained in accordance with § 16.116(a)(1) through (4), (a)(6), and (d);

(ii) Documentation of informed consent or waiver of documentation of consent was obtained in accordance with § 16.117;

(iii) An IRB conducts a limited IRB review and makes the determination required by § 16.111(a)(7) and makes the determination that the research to be conducted is within the scope of the broad consent referenced in paragraph (d)(8)(i) of this section; and (iv) The investigator does not include returning individual research results to subjects as part of the study plan. This provision does not prevent an investigator from abiding by any legal requirements to return individual research results.

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§§ 16.105–16.106 [Reserved]

§ 16.107 IRB membership.

(a) Each IRB shall have at least five members, with varying backgrounds to promote complete and adequate review of research activities commonly conducted by the institution. The IRB shall be sufficiently qualified through the experience and expertise of its members (professional competence), and the diversity of its members, including race, gender, and cultural backgrounds and sensitivity to such issues as community attitudes, to promote respect for its advice and counsel in safeguarding the rights and welfare of human subjects. The IRB shall be able to ascertain the acceptability of proposed research in terms of institutional commitments (including policies and resources) and regulations, applicable law, and standards of professional conduct and practice. The IRB shall therefore include persons knowledgeable in these areas. If an IRB regularly reviews research that involves a category of subjects that is vulnerable to coercion or undue influence, such as children, prisoners, individuals with impaired decision-making capacity, or economically or educationally disadvantaged persons, consideration shall be given to the inclusion of one or more individuals who are knowledgeable about and experienced in working with these categories of subjects.

(b) Each IRB shall include at least one member whose primary concerns are in scientific areas and at least one member whose primary concerns are in nonscientific areas.

(c) Each IRB shall include at least one member who is not otherwise affiliated with the institution and who is not part of the immediate family of a person who is affiliated with the institution.

(d) No IRB may have a member participate in the IRB's initial or continuing review of any project in which the member has a conflicting interest, except to provide information requested by the IRB.

(e) An IRB may, in its discretion, invite individuals with competence in special areas to assist in the review of issues that require expertise beyond or in addition to that available on the

IRB. These individuals may not vote with the IRB.

§ 16.108 IRB functions and operations.

(a) In order to fulfill the requirements of this policy each IRB shall:

(1) Have access to meeting space and sufficient staff to support the IRB's review and recordkeeping duties;

(2) Prepare and maintain a current list of the IRB members identified by name; earned degrees; representative capacity; indications of experience such as board certifications or licenses sufficient to describe each member's chief anticipated contributions to IRB deliberations; and any employment or other relationship between each member and the institution, for example, full-time employee, part-time employee, member of governing panel or board, stockholder, paid or unpaid consultant;

(3) Establish and follow written procedures for:

(i) Conducting its initial and continuing review of research and for reporting its findings and actions to the investigator and the institution;

(ii) Determining which projects require review more often than annually and which projects need verification from sources other than the investigators that no material changes have occurred since previous IRB review; and

(iii) Ensuring prompt reporting to the IRB of proposed changes in a research activity, and for ensuring that investigators will conduct the research activity in accordance with the terms of the IRB approval until any proposed changes have been reviewed and approved by the IRB, except when necessary to eliminate apparent immediate hazards to the subject.

(4) Establish and follow written procedures for ensuring prompt reporting to the IRB; appropriate institutional officials; the department or agency head; and the Office for Human Research Protections, HHS, or any successor office, or the equivalent office within the appropriate Federal department or agency of

(i) Any unanticipated problems involving risks to subjects or others or any serious or continuing noncompliance with this policy or the requirements or determinations of the IRB; and

(ii) Any suspension or termination of IRB approval.

(b) Except when an expedited review procedure is used (as described in § 16.110), an IRB must review proposed research at convened meetings at which a majority of the members of the IRB are present, including at least one member whose primary concerns are in nonscientific areas. In order for the research to be approved, it shall receive the approval of a majority of those members present at the meeting.

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§ 16.109 IRB review of research.

(a) An IRB shall review and have authority to approve, require modifications in (to secure approval), or disapprove all research activities covered by this policy, including exempt research activities under § 16.104 for which limited IRB review is a condition of exemption (under § 16.104(d)(2)(iii), (d)(3)(i)(C), and (d)(7), and (8)).

(b) An IRB shall require that information given to subjects (or legally authorized representatives, when appropriate) as part of informed consent is in accordance with § 16.116. The IRB may require that information, in addition to that specifically mentioned in § 16.116, be given to the subjects when in the IRB's judgment the information would meaningfully add to the protection of the rights and welfare of subjects.

(c) An IRB shall require documentation of informed consent or may waive documentation in accordance with § 16.117.

(d) An IRB shall notify investigators and the institution in writing of its decision to approve or disapprove the proposed research activity, or of modifications required to secure IRB approval of the research activity. If the IRB decides to disapprove a research activity, it shall include in its written notification a statement of the reasons for its decision and give the investigator an opportunity to respond in person or in writing.

(e) An IRB shall conduct continuing review of research requiring review by

the convened IRB at intervals appropriate to the degree of risk, not less than once per year, except as described in § 16.109(f).

(f)(1) Unless an IRB determines otherwise, continuing review of research is not required in the following circumstances:

(i) Research eligible for expedited review in accordance with § 16.110;

(ii) Research reviewed by the IRB in accordance with the limited IRB review described in § 16.104(d)(2)(iii), (d)(3)(i)(C), or (d)(7) or (8);

(iii) Research that has progressed to the point that it involves only one or both of the following, which are part of the IRB-approved study:

(A) Data analysis, including analysis of identifiable private information or identifiable biospecimens, or

(B) Accessing follow-up clinical data from procedures that subjects would undergo as part of clinical care.

(2) [Reserved.]

(g) An IRB shall have authority to observe or have a third party observe the consent process and the research.

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§ 16.110 Expedited review procedures for certain kinds of research involving no more than minimal risk, and for minor changes in approved research.

(a) The Secretary of HHS has established, and published as a Notice in the FEDERAL REGISTER, a list of categories of research that may be reviewed by the IRB through an expedited review procedure. The Secretary will evaluate the list at least every 8 years and amend it, as appropriate, after consultation with other federal departments and agencies and after publication in the FEDERAL REGISTER for public comment. A copy of the list is available from the Office for Human Research Protections, HHS, or any successor office.

(b)(1) An IRB may use the expedited review procedure to review the following:

(i) Some or all of the research appearing on the list described in paragraph (a) of this section, unless the reviewer determines that the study involves more than minimal risk;

(ii) Minor changes in previously approved research during the period for which approval is authorized; or

(iii) Research for which limited IRB review is a condition of exemption under § 16.104(d)(2)(iii), (d)(3)(i)(C), and (d)(7) and (8).

(2) Under an expedited review procedure, the review may be carried out by the IRB chairperson or by one or more experienced reviewers designated by the chairperson from among members of the IRB. In reviewing the research, the reviewers may exercise all of the authorities of the IRB except that the reviewers may not disapprove the research. A research activity may be disapproved only after review in accordance with the nonexpedited procedure set forth in § 16.108(b).

(c) Each IRB that uses an expedited review procedure shall adopt a method for keeping all members advised of research proposals that have been approved under the procedure.

(d) The department or agency head may restrict, suspend, terminate, or choose not to authorize an institution's or IRB's use of the expedited review procedure.

§ 16.111 Criteria for IRB approval of research.

(a) In order to approve research covered by this policy the IRB shall determine that all of the following requirements are satisfied:

(1) Risks to subjects are minimized:

(i) By using procedures that are consistent with sound research design and that do not unnecessarily expose subjects to risk, and

(ii) Whenever appropriate, by using procedures already being performed on the subjects for diagnostic or treatment purposes.

(2) Risks to subjects are reasonable in relation to anticipated benefits, if any, to subjects, and the importance of the knowledge that may reasonably be expected to result. In evaluating risks and benefits, the IRB should consider only those risks and benefits that may result from the research (as distinguished from risks and benefits of therapies subjects would receive even if not participating in the research). The IRB should not consider possible long-range effects of applying knowledge

gained in the research (*e.g.*, the possible effects of the research on public policy) as among those research risks that fall within the purview of its responsibility.

(3) Selection of subjects is equitable. In making this assessment the IRB should take into account the purposes of the research and the setting in which the research will be conducted. The IRB should be particularly cognizant of the special problems of research that involves a category of subjects who are vulnerable to coercion or undue influence, such as children, prisoners, individuals with impaired decision-making capacity, or economically or educationally disadvantaged persons.

(4) Informed consent will be sought from each prospective subject or the subject's legally authorized representative, in accordance with, and to the extent required by, § 16.116.

(5) Informed consent will be appropriately documented or appropriately waived in accordance with § 16.117.

(6) When appropriate, the research plan makes adequate provision for monitoring the data collected to ensure the safety of subjects.

(7) When appropriate, there are adequate provisions to protect the privacy of subjects and to maintain the confidentiality of data.

(i) The Secretary of HHS will, after consultation with the Office of Management and Budget's privacy office and other Federal departments and agencies that have adopted this policy, issue guidance to assist IRBs in assessing what provisions are adequate to protect the privacy of subjects and to maintain the confidentiality of data.

(ii) [Reserved]

(8) For purposes of conducting the limited IRB review required by § 16.104(d)(7)), the IRB need not make the determinations at paragraphs (a)(1) through (7) of this section, and shall make the following determinations:

(i) Broad consent for storage, maintenance, and secondary research use of identifiable private information or identifiable biospecimens is obtained in accordance with the requirements of § 16.116(a)(1)–(4), (a)(6), and (d);

(ii) Broad consent is appropriately documented or waiver of documentation is appropriate, in accordance with § 16.117; and

(iii) If there is a change made for research purposes in the way the identifiable private information or identifiable biospecimens are stored or maintained, there are adequate provisions to protect the privacy of subjects and to maintain the confidentiality of data.

(b) When some or all of the subjects are likely to be vulnerable to coercion or undue influence, such as children, prisoners, individuals with impaired decision-making capacity, or economically or educationally disadvantaged persons, additional safeguards have been included in the study to protect the rights and welfare of these subjects.

§ 16.112 Review by Institution

Research covered by this policy that has been approved by an IRB may be subject to further appropriate review and approval or disapproval by officials of the institution. However, those officials may not approve the research if it has not been approved by an IRB.

§ 16.113 Suspension or Termination of IRB Approval of Research.

An IRB shall have authority to suspend or terminate approval of research that is not being conducted in accordance with the IRB's requirements or that has been associated with unexpected serious harm to subjects. Any suspension or termination of approval shall include a statement of the reasons for the IRB's action and shall be reported promptly to the investigator, appropriate institutional officials, and the department or agency head.

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§ 16.114 Cooperative Research.

(a) Cooperative research projects are those projects covered by this policy that involve more than one institution. In the conduct of cooperative research projects, each institution is responsible for safeguarding the rights and welfare of human subjects and for complying with this policy.

(b)(1) Any institution located in the United States that is engaged in cooperative research must rely upon approval by a single IRB for that portion

of the research that is conducted in the United States. The reviewing IRB will be identified by the Federal department or agency supporting or conducting the research or proposed by the lead institution subject to the acceptance of the Federal department or agency supporting the research.

(2) The following research is not subject to this provision:

(i) Cooperative research for which more than single IRB review is required by law (including tribal law passed by the official governing body of an American Indian or Alaska Native tribe); or

(ii) Research for which any Federal department or agency supporting or conducting the research determines and documents that the use of a single IRB is not appropriate for the particular context.

(c) For research not subject to paragraph (b) of this section, an institution participating in a cooperative project may enter into a joint review arrangement, rely on the review of another IRB, or make similar arrangements for avoiding duplication of effort.

§ 16.115 IRB Records.

(a) An institution, or when appropriate an IRB, shall prepare and maintain adequate documentation of IRB activities, including the following:

(1) Copies of all research proposals reviewed, scientific evaluations, if any, that accompany the proposals, approved sample consent forms, progress reports submitted by investigators, and reports of injuries to subjects.

(2) Minutes of IRB meetings, which shall be in sufficient detail to show attendance at the meetings; actions taken by the IRB; the vote on these actions including the number of members voting for, against, and abstaining; the basis for requiring changes in or disapproving research; and a written summary of the discussion of controverted issues and their resolution.

(3) Records of continuing review activities, including the rationale for conducting continuing review of research that otherwise would not require continuing review as described in § 16.109(f)(1).

(4) Copies of all correspondence between the IRB and the investigators.

(5) A list of IRB members in the same detail as described in § 16.108(a)(2).

(6) Written procedures for the IRB in the same detail as described in § 16.108(a)(3) and (4).

(7) Statements of significant new findings provided to subjects, as required by § 16.116(c)(5).

(8) The rationale for an expedited reviewer's determination under § 16.110(b)(1)(i) that research appearing on the expedited review list described in § 16.110(a) is more than minimal risk.

(9) Documentation specifying the responsibilities that an institution and an organization operating an IRB each will undertake to ensure compliance with the requirements of this policy, as described in § 16.103(e).

(b) The records required by this policy shall be retained for at least 3 years, and records relating to research that is conducted shall be retained for at least 3 years after completion of the research. The institution or IRB may maintain the records in printed form, or electronically. All records shall be accessible for inspection and copying by authorized representatives of the Federal department or agency at reasonable times and in a reasonable manner.

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§ 16.116 General Requirements for Informed Consent.

(a) *General.* General requirements for informed consent, whether written or oral, are set forth in this paragraph and apply to consent obtained in accordance with the requirements set forth in paragraphs (b) through (d) of this section. Broad consent may be obtained in lieu of informed consent obtained in accordance with paragraphs (b) and (c) of this section only with respect to the storage, maintenance, and secondary research uses of identifiable private information and identifiable biospecimens. Waiver or alteration of consent in research involving public benefit and service programs conducted by or subject to the approval of state or local officials is described in paragraph (e) of this section. General waiver or alteration of informed consent is

described in paragraph (f) of this section. Except as provided elsewhere in this policy:

(1) Before involving a human subject in research covered by this policy, an investigator shall obtain the legally effective informed consent of the subject or the subject's legally authorized representative.

(2) An investigator shall seek informed consent only under circumstances that provide the prospective subject or the legally authorized representative sufficient opportunity to discuss and consider whether or not to participate and that minimize the possibility of coercion or undue influence.

(3) The information that is given to the subject or the legally authorized representative shall be in language understandable to the subject or the legally authorized representative.

(4) The prospective subject or the legally authorized representative must be provided with the information that a reasonable person would want to have in order to make an informed decision about whether to participate, and an opportunity to discuss that information.

(5) Except for broad consent obtained in accordance with paragraph (d) of this section:

(i) Informed consent must begin with a concise and focused presentation of the key information that is most likely to assist a prospective subject or legally authorized representative in understanding the reasons why one might or might not want to participate in the research. This part of the informed consent must be organized and presented in a way that facilitates comprehension.

(ii) Informed consent as a whole must present information in sufficient detail relating to the research, and must be organized and presented in a way that does not merely provide lists of isolated facts, but rather facilitates the prospective subject's or legally authorized representative's understanding of the reasons why one might or might not want to participate.

(6) No informed consent may include any exculpatory language through which the subject or the legally authorized representative is made to waive or appear to waive any of the subject's legal rights, or releases or appears to release the investigator, the sponsor, the institution, or its agents from liability for negligence.

(b) *Basic elements of informed consent.* Except as provided in paragraph (d), (e), or (f) of this section, in seeking informed consent the following information shall be provided to each subject or the legally authorized representative:

(1) A statement that the study involves research, an explanation of the purposes of the research and the expected duration of the subject's participation, a description of the procedures to be followed, and identification of any procedures that are experimental;

(2) A description of any reasonably foreseeable risks or discomforts to the subject;

(3) A description of any benefits to the subject or to others that may reasonably be expected from the research;

(4) A disclosure of appropriate alternative procedures or courses of treatment, if any, that might be advantageous to the subject;

(5) A statement describing the extent, if any, to which confidentiality of records identifying the subject will be maintained;

(6) For research involving more than minimal risk, an explanation as to whether any compensation and an explanation as to whether any medical treatments are available if injury occurs and, if so, what they consist of, or where further information may be obtained;

(7) An explanation of whom to contact for answers to pertinent questions about the research and research subjects' rights, and whom to contact in the event of a research-related injury to the subject;

(8) A statement that participation is voluntary, refusal to participate will involve no penalty or loss of benefits to which the subject is otherwise entitled, and the subject may discontinue participation at any time without penalty or loss of benefits to which the subject is otherwise entitled; and

(9) One of the following statements about any research that involves the collection of identifiable private information or identifiable biospecimens:

(i) A statement that identifiers might be removed from the identifiable private information or identifiable biospecimens and that, after such removal, the information or biospecimens could be used for future research studies or distributed to another investigator for future research studies without additional informed consent from the subject or the legally authorized representative, if this might be a possibility; or

(ii) A statement that the subject's information or biospecimens collected as part of the research, even if identifiers are removed, will not be used or distributed for future research studies.

(c) *Additional elements of informed consent.* Except as provided in paragraph (d), (e), or (f) of this section, one or more of the following elements of information, when appropriate, shall also be provided to each subject or the legally authorized representative:

(1) A statement that the particular treatment or procedure may involve risks to the subject (or to the embryo or fetus, if the subject is or may become pregnant) that are currently unforeseeable;

(2) Anticipated circumstances under which the subject's participation may be terminated by the investigator without regard to the subject's or the legally authorized representative's consent;

(3) Any additional costs to the subject that may result from participation in the research;

(4) The consequences of a subject's decision to withdraw from the research and procedures for orderly termination of participation by the subject;

(5) A statement that significant new findings developed during the course of the research that may relate to the subject's willingness to continue participation will be provided to the subject;

(6) The approximate number of subjects involved in the study;

(7) A statement that the subject's biospecimens (even if identifiers are removed) may be used for commercial profit and whether the subject will or will not share in this commercial profit;

(8) A statement regarding whether clinically relevant research results, including individual research results, will be disclosed to subjects, and if so, under what conditions; and

(9) For research involving biospecimens, whether the research will (if known) or might include whole genome sequencing (*i.e.*, sequencing of a human germline or somatic specimen with the intent to generate the genome or exome sequence of that specimen).

(d) *Elements of broad consent for the storage, maintenance, and secondary research use of identifiable private information or identifiable biospecimens.* Broad consent for the storage, maintenance, and secondary research use of identifiable private information or identifiable biospecimens (collected for either research studies other than the proposed research or nonresearch purposes) is permitted as an alternative to the informed consent requirements in paragraphs (b) and (c) of this section. If the subject or the legally authorized representative is asked to provide broad consent, the following shall be provided to each subject or the subject's legally authorized representative:

(1) The information required in paragraphs (b)(2), (b)(3), (b)(5), and (b)(8) and, when appropriate, (c)(7) and (9) of this section;

(2) A general description of the types of research that may be conducted with the identifiable private information or identifiable biospecimens. This description must include sufficient information such that a reasonable person would expect that the broad consent would permit the types of research conducted;

(3) A description of the identifiable private information or identifiable biospecimens that might be used in research, whether sharing of identifiable private information or identifiable biospecimens might occur, and the types of institutions or researchers that might conduct research with the identifiable private information or identifiable biospecimens;

(4) A description of the period of time that the identifiable private information or identifiable biospecimens may be stored and maintained (which period of time could be indefinite), and a description of the period of time that the identifiable private information or identifiable biospecimens may be used

for research purposes (which period of time could be indefinite);

(5) Unless the subject or legally authorized representative will be provided details about specific research studies, a statement that they will not be informed of the details of any specific research studies that might be conducted using the subject's identifiable private information or identifiable biospecimens, including the purposes of the research, and that they might have chosen not to consent to some of those specific research studies;

(6) Unless it is known that clinically relevant research results, including individual research results, will be disclosed to the subject in all circumstances, a statement that such results may not be disclosed to the subject; and

(7) An explanation of whom to contact for answers to questions about the subject's rights and about storage and use of the subject's identifiable private information or identifiable biospecimens, and whom to contact in the event of a research-related harm.

(e) *Waiver or alteration of consent in research involving public benefit and service programs conducted by or subject to the approval of state or local officials*—(1) *Waiver*. An IRB may waive the requirement to obtain informed consent for research under paragraphs (a) through (c) of this section, provided the IRB satisfies the requirements of paragraph (e)(3) of this section. If an individual was asked to provide broad consent for the storage, maintenance, and secondary research use of identifiable private information or identifiable biospecimens in accordance with the requirements at paragraph (d) of this section, and refused to consent, an IRB cannot waive consent for the storage, maintenance, or secondary research use of the identifiable private information or identifiable biospecimens.

(2) *Alteration*. An IRB may approve a consent procedure that omits some, or alters some or all, of the elements of informed consent set forth in paragraphs (b) and (c) of this section provided the IRB satisfies the requirements of paragraph (e)(3) of this section. An IRB may not omit or alter any of the requirements described in paragraph (a) of this section. If a broad consent procedure is used, an IRB may not omit or alter any of the elements required under paragraph (d) of this section.

(3) *Requirements for waiver and alteration*. In order for an IRB to waive or alter consent as described in this subsection, the IRB must find and document that:

(i) The research or demonstration project is to be conducted by or subject to the approval of state or local government officials and is designed to study, evaluate, or otherwise examine:

(A) Public benefit or service programs;

(B) Procedures for obtaining benefits or services under those programs;

(C) Possible changes in or alternatives to those programs or procedures; or

(D) Possible changes in methods or levels of payment for benefits or services under those programs; and

(ii) The research could not practicably be carried out without the waiver or alteration.

(f) *General waiver or alteration of consent*—(1) *Waiver*. An IRB may waive the requirement to obtain informed consent for research under paragraphs (a) through (c) of this section, provided the IRB satisfies the requirements of paragraph (f)(3) of this section. If an individual was asked to provide broad consent for the storage, maintenance, and secondary research use of identifiable private information or identifiable biospecimens in accordance with the requirements at paragraph (d) of this section, and refused to consent, an IRB cannot waive consent for the storage, maintenance, or secondary research use of the identifiable private information or identifiable biospecimens.

(2) *Alteration*. An IRB may approve a consent procedure that omits some, or alters some or all, of the elements of informed consent set forth in paragraphs (b) and (c) of this section provided the IRB satisfies the requirements of paragraph (f)(3) of this section. An IRB may not omit or alter any of the requirements described in paragraph (a) of this section. If a broad consent procedure is used, an IRB may not omit or alter any of the elements required under paragraph (d) of this section.

(3) *Requirements for waiver and alteration.* In order for an IRB to waive or alter consent as described in this subsection, the IRB must find and document that:

(i) The research involves no more than minimal risk to the subjects;

(ii) The research could not practicably be carried out without the requested waiver or alteration;

(iii) If the research involves using identifiable private information or identifiable biospecimens, the research could not practicably be carried out without using such information or biospecimens in an identifiable format;

(iv) The waiver or alteration will not adversely affect the rights and welfare of the subjects; and

(v) Whenever appropriate, the subjects or legally authorized representatives will be provided with additional pertinent information after participation.

(g) *Screening, recruiting, or determining eligibility.* An IRB may approve a research proposal in which an investigator will obtain information or biospecimens for the purpose of screening, recruiting, or determining the eligibility of prospective subjects without the informed consent of the prospective subject or the subject's legally authorized representative, if either of the following conditions are met:

(1) The investigator will obtain information through oral or written communication with the prospective subject or legally authorized representative, or

(2) The investigator will obtain identifiable private information or identifiable biospecimens by accessing records or stored identifiable biospecimens.

(h) *Posting of clinical trial consent form.* (1) For each clinical trial conducted or supported by a Federal department or agency, one IRB-approved informed consent form used to enroll subjects must be posted by the awardee or the Federal department or agency component conducting the trial on a publicly available Federal Web site that will be established as a repository for such informed consent forms.

(2) If the Federal department or agency supporting or conducting the clinical trial determines that certain information should not be made publicly available on a Federal Web site (*e.g.* confidential commercial information), such Federal department or agency may permit or require redactions to the information posted.

(3) The informed consent form must be posted on the Federal Web site after the clinical trial is closed to recruitment, and no later than 60 days after the last study visit by any subject, as required by the protocol.

(i) *Preemption.* The informed consent requirements in this policy are not intended to preempt any applicable Federal, state, or local laws (including tribal laws passed by the official governing body of an American Indian or Alaska Native tribe) that require additional information to be disclosed in order for informed consent to be legally effective.

(j) *Emergency medical care.* Nothing in this policy is intended to limit the authority of a physician to provide emergency medical care, to the extent the physician is permitted to do so under applicable Federal, state, or local law (including tribal law passed by the official governing body of an American Indian or Alaska Native tribe).

(Approved by the Office of Management and Budget under Control Number 0990–0260)

§ 16.117 Documentation of informed consent.

(a) Except as provided in paragraph (c) of this section, informed consent shall be documented by the use of a written informed consent form approved by the IRB and signed (including in an electronic format) by the subject or the subject's legally authorized representative. A written copy shall be given to the person signing the informed consent form.

(b) Except as provided in paragraph (c) of this section, the informed consent form may be either of the following:

(1) A written informed consent form that meets the requirements of § 16.116. The investigator shall give either the subject or the subject's legally authorized representative adequate opportunity to read the informed consent form before it is signed; alternatively, this form may be read to the subject or the subject's legally authorized representative.

(2) A short form written informed consent form stating that the elements of informed consent required by § 16.116 have been presented orally to the subject or the subject's legally authorized representative, and that the key information required by § 16.116(a)(5)(i) was presented first to the subject, before other information, if any, was provided. The IRB shall approve a written summary of what is to be said to the subject or the legally authorized representative. When this method is used, there shall be a witness to the oral presentation. Only the short form itself is to be signed by the subject or the subject's legally authorized representative. However, the witness shall sign both the short form and a copy of the summary, and the person actually obtaining consent shall sign a copy of the summary. A copy of the summary shall be given to the subject or the subject's legally authorized representative, in addition to a copy of the short form.

(c)(1) An IRB may waive the requirement for the investigator to obtain a signed informed consent form for some or all subjects if it finds any of the following:

(i) That the only record linking the subject and the research would be the informed consent form and the principal risk would be potential harm resulting from a breach of confidentiality. Each subject (or legally authorized representative) will be asked whether the subject wants documentation linking the subject with the research, and the subject's wishes will govern;

(ii) That the research presents no more than minimal risk of harm to subjects and involves no procedures for which written consent is normally required outside of the research context; or

(iii) If the subjects or legally authorized representatives are members of a distinct cultural group or community in which signing forms is not the norm, that the research presents no more than minimal risk of harm to subjects and provided there is an appropriate alternative mechanism for documenting that informed consent was obtained.

(2) In cases in which the documentation requirement is waived, the IRB may require the investigator to provide subjects or legally authorized representatives with a written statement regarding the research.

(Approved by the Office of Management and Budget under Control Number 0990–0260)

§ 16.118 Applications and proposals lacking definite plans for involvement of human subjects.

Certain types of applications for grants, cooperative agreements, or contracts are submitted to Federal departments or agencies with the knowledge that subjects may be involved within the period of support, but definite plans would not normally be set forth in the application or proposal. These include activities such as institutional type grants when selection of specific projects is the institution's responsibility; research training grants in which the activities involving subjects remain to be selected; and projects in which human subjects' involvement will depend upon completion of instruments, prior animal studies, or purification of compounds. Except for research waived under § 16.101(i) or exempted under § 16.104, no human subjects may be involved in any project supported by these awards until the project has been reviewed and approved by the IRB, as provided in this policy, and certification submitted, by the institution, to the Federal department or agency component supporting the research.

§ 16.119 Research undertaken without the intention of involving human subjects.

Except for research waived under § 16.101(i) or exempted under § 16.104, in the event research is undertaken without the intention of involving human subjects, but it is later proposed to involve human subjects in the research, the research shall first be reviewed and approved by an IRB, as provided in this policy, a certification submitted by the institution to the Federal department or agency component supporting the research, and final approval given to the proposed change by the Federal department or agency component.

§ 16.120 Evaluation and disposition of applications and proposals for research to be conducted or supported by a Federal department or agency.

(a) The department or agency head will evaluate all applications and proposals involving human subjects submitted to the Federal department or agency through such officers and employees of the Federal department or agency and such experts and consultants as the department or agency head determines to be appropriate. This evaluation will take into consideration the risks to the subjects, the adequacy of protection against these risks, the potential benefits of the research to the subjects and others, and the importance of the knowledge gained or to be gained.

(b) On the basis of this evaluation, the department or agency head may approve or disapprove the application or proposal, or enter into negotiations to develop an approvable one.

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§ 16.122 Use of Federal funds.

Federal funds administered by a Federal department or agency may not be expended for research involving human subjects unless the requirements of this policy have been satisfied.

§ 16.123 Early termination of research support: Evaluation of applications and proposals.

(a) The department or agency head may require that Federal department or agency support for any project be terminated or suspended in the manner prescribed in applicable program requirements, when the department or agency head finds an institution has materially failed to comply with the terms of this policy.

(b) In making decisions about supporting or approving applications or proposals covered by this policy the department or agency head may take into account, in addition to all other eligibility requirements and program criteria, factors such as whether the applicant has been subject to a termination or suspension under paragraph (a) of this section and whether the applicant or the person or persons who would direct or has/have directed the scientific and technical aspects of an activity has/have, in the judgment of the department or agency head, materially failed to discharge responsibility for the protection of the rights and welfare of human subjects (whether or not the research was subject to federal regulation).

§ 16.124 Conditions.

With respect to any research project or any class of research projects the department or agency head of either the conducting or the supporting Federal department or agency may impose additional conditions prior to or at the time of approval when in the judgment of the department or agency head additional conditions are necessary for the protection of human subjects.

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

Section 17.35 is also issued under 38 U.S.C. 1724.

Section 17.38 is also issued under 38 U.S.C. 1703.

Section 17.46 is also issued under 38 U.S.C. 1710.

Section 17.52 is also issued under 38 U.S.C. 1701, 1703, 1710, 1712, and 3104.

Section 17.55 is also issued under 38 U.S.C. 513, 1703, and 1728.

Section 17.56 is also issued under 38 U.S.C. 1703 and 1728.

Section 17.105 is also issued under 38 U.S.C. 501, 1721, 1722A, 1724, and 1725A.

Section 17.108 is also issued under 38 U.S.C. 501, 1703, 1710, 1725A, and 1730A.

Section 17.110 is also issued under 38 U.S.C. 501, 1703, 1710, 1720D, 1722A, and 1730A.

Section 17.111 is also issued under 38 U.S.C. 101(28), 501, 1701(7), 1703, 1710, 1710B, 1720B, 1720D, and 1722A.

Section 17.125 is also issued under 38 U.S.C. 7304.

Section 17.169 is also issued under 38 U.S.C. 1712C.

Sections 17.380, 17.390 and 17.412 are also issued under sec. 260, Pub. L. 114–223, 130 Stat. 857, and sec. 236, div. J, Pub. L 115–141, 132 Stat. 348.

Section 17.410 is also issued under 38 U.S.C. 1787.

Section 17.415 is also issued under 38 U.S.C. 7301, 7304, 7402, and 7403.

Section 17.417 also issued under 38 U.S.C. 1701 (note), 1709A, 1712A (note), 1722B, 7301, 7330A, 7401–7403, 7406 (note).

Sections 17.640 and 17.647 are also issued under sec. 4, Pub. L. 114–2, 129 Stat. 30.

Sections 17.641 through 17.646 are also issued under 38 U.S.C. 501(a) and sec. 4, Pub. L. 114–2, 129 Stat. 30.

Section 17.655 also issued under 38 U.S.C. 501(a), 7304, 7405.

Sections 17.4000 through 17.4040 also issued under 38 U.S.C. 1703, 1703B, and 1703C.

Section 17.4100 *et seq.* is also issued under 38 U.S.C. 1703A.

Section 17.4600 is also issued under 38 U.S.C. 1725A.

DEFINITIONS AND ACTIVE DUTY

§ 17.1 Incorporation by reference.

(a) Certain materials are incorporated by reference into this part with the approval of the Director of the Federal Register under 5 U.S.C. 552(a) and 1 CFR part 51. To enforce an edition of a publication other than that specified in this section, VA will provide notice of the change in a rule in the FEDERAL REGISTER and the material will be made available to the public. All approved materials are available for inspection at the Department of Veterans Affairs, Office of Regulation Policy and Management (02REG), 810 Vermont Avenue NW., Room 1068, Washington, DC 20420, call 202–461–4902, or at the National Archives and Records Administration (NARA). For information on the availability of approved materials at NARA, call (202) 741–6030, or go to: *http://www.archives.gov/federal_register/code_of_federal_regulations/ibr_locations.html.*

(b) National Fire Protection Association, 1 Batterymarch Park, Quincy, MA 02269. (For ordering information, call toll-free 1–800–344–3555).

(1) NFPA 10, Standard for Portable Fire Extinguishers (2010 edition), Incorporation by Reference (IBR) approved for §§ 17.63, 17.74, and 17.81.

(2) NFPA 13, Standard for the Installation of Sprinkler Systems (2010 edition), IBR approved for § 17.74.

(3) NFPA 13D, Standard for the Installation of Sprinkler Systems in One- and Two-Family Dwellings and Manufactured Homes (2010 edition), IBR approved for § 17.74.

(4) NFPA 13R, Standard for the Installation of Sprinkler Systems in Residential Occupancies Up To and Including Four Stories in Height (2010 edition), IBR approved for § 17.74.

(5) NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems (2011 edition), IBR approved for § 17.74.

(6) NFPA 30, Flammable and Combustible Liquids Code (2012 edition), IBR approved for § 17.74.

(7) NFPA 72, National Fire Alarm and Signaling Code (2010 edition), IBR approved for § 17.74.

(8) NFPA 101, Life Safety Code (2012 edition), IBR approved for §§ 17.63, 17.74 (chapters 1 through 11, 24, and section 33.7), 17.81, and 17.82.

(9) NFPA 101A, Guide on Alternative Approaches to Life Safety (2010 edition), IBR approved for § 17.63.

(10) NFPA 720, Standard for the Installation of Carbon Monoxide (CO) Detection and Warning Equipment (2012 edition), IBR approved for § 17.74.

(Authority: 5 U.S.C. 552(a), 38 U.S.C. 501, 1721.)

[80 FR 44861, July 28, 2015]

§ 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—

(1) Means the furnishing of:

(i) A temporary home to a veteran, embracing the furnishing of shelter, food, clothing and other comforts of home, including necessary medical services; or

(ii) A day hospital program consisting of intensive supervised rehabilitation and treatment provided in a therapeutic residential setting for residents with mental health or substance use disorders, and co-occurring medical or psychosocial needs such as homelessness and unemployment.

(2) Includes travel and incidental expenses pursuant to § 70.10.

(Authority: 38 U.S.C. 1701(4))

[23 FR 6498, Aug. 22, 1958]

EDITORIAL NOTE: For FEDERAL REGISTER citations affecting § 17.30, see the List of CFR Sections Affected, which appears in the Finding Aids section of the printed volume and at *www.fdsys.gov*.

§ 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.

(5) Service in Women's Army Auxiliary Corps (WAAC). Recognized effective March 18, 1980.

(6) Service of any person in a group the members of which rendered service to the Armed Forces of the United States in a capacity considered civilian employment or contractual service at the time such service was rendered, if the Secretary of Defense:

(i) Determines that the service of such group constituted active military service; and

(ii) Issues to each member of such group a discharge from such service under honorable conditions where the nature and duration of the service of such member so warrants.

(7) Service in American Merchant Marine in Oceangoing Service any time during the period December 7, 1941, to August 15, 1945. Recognized effective January 19, 1988.

(8) Service by the approximately 50 Chamorro and Carolinian former native policemen who received military training in the Donnal area of central Saipan and were placed under the command of Lt. Casino of the 6th Provisional Military Police Battalion to accompany U.S. Marines on active, combat-patrol activity any time during the period August 19, 1945, to September 2, 1945. Recognized effective September 30, 1999.

(9) Service by Civilian Crewmen of the U.S. Coast and Geodetic Survey (USCGS) vessels, who performed their service in areas of immediate military hazard while conducting cooperative operations with and for the U.S. Armed Forces any time during the period December 7, 1941, to August 15, 1945. Qualifying USCGS vessels specified by the Secretary of the Air Force are the Derickson, Explorer, Gilbert, Hilgard, E. Lester Jones, Lydonia, Patton, Surveyor, Wainwright, Westdahl, Oceanographer, Hydrographer, or Pathfinder. Recognized effective April 8, 1991.

(10) Service by Civilian Employees of Pacific Naval Air Bases who actively participated in Defense of Wake Island during World War II. Recognized effective January 22, 1981.

(11) Service by Civilian Navy Identification Friend or Foe (IFF) Technicians who served in the Combat Areas of the Pacific any time during the period December 7, 1941, to August 15, 1945. Recognized effective August 2, 1988.

(12) Service by Civilian personnel assigned to the Secret Intelligence Element of the Office of Strategic Services (OSS). Recognized effective December 27, 1982.

(13) Service by Engineer Field Clerks (World War I). Recognized effective August 31, 1979.

(14) Service by Guam Combat Patrol. Recognized effective May 10, 1983.

(15) Service by Honorably discharged members of the American Volunteer Group (Flying Tigers) who served any time during the period December 7, 1941, to July 18, 1942. Recognized effective May 3, 1991.

(16) Service by Honorably discharged members of the American Volunteer Guard, Eritrea Service Command who served any time during the period June 21, 1942, to March 31, 1943. Recognized effective June 29, 1992.

(17) Service by Male Civilian Ferry Pilots. Recognized effective July 17, 1981.

(18) Service with the Operational Analysis Group of the Office of Scientific Research and Development, Office of Emergency Management, which served overseas with the U.S. Army Air Corps any time during the period December 7, 1941, to August 15, 1945. Recognized effective August 27, 1999.

(19) Service by Quartermaster Corps Female Clerical Employees serving with the American Expeditionary Forces in World War II. Recognized effective January 22, 1981.

(20) Service by Quartermaster Corps Keswick Crew on Corregidor (World War II). Recognized effective February 7, 1984.

(21) Service by Reconstruction Aides and Dietitians in World War I. Recognized effective July 6, 1981.

(22) Service by Signal Corps Female Telephone Operators Unit of World War I. Recognized effective May 15, 1979.

(23) Service by three scouts/guides, Miguel Tenorio, Penedicto Taisacan, and Cristino Dela Cruz, who assisted

the U.S. Marines in the offensive operations against the Japanese on the Northern Mariana Islands from June 19, 1944, through September 2, 1945. Recognized effective September 30, 1999.

(24) Service by U.S. civilian employees of American Airlines who served overseas as a result of American Airlines' Contract with the Air Transport Command any time during the period December 14, 1941, to August 14, 1945. Recognized effective October 5, 1990.

(25) Service by U.S. civilian female employees of the U.S. Army Nurse Corps while serving in the Defense of Bataan and Corregidor any time during the period January 2, 1942, to February 3, 1945. Recognized effective December 13, 1993.

(26) Service by U.S. Civilian Flight Crew and Aviation Ground Support Employees of Braniff Airways, who served overseas in the North Atlantic or under the jurisdiction of the North Atlantic Wing, Air Transport Command (ATC), as a result of a Contract with the ATC any time during the period February 26, 1942, to August 14, 1945. Recognized effective June 2, 1997.

(27) Service by U.S. Civilian Flight Crew and Aviation Ground Support Employees of Consolidated Vultree Aircraft Corporation (Consairway Division), who served overseas as a result of a Contract with the Air Transport Command any time during the period December 14, 1941, to August 14, 1945. Recognized effective June 29, 1992.

(28) Service by U.S. Flight Crew and Aviation Ground Support Employees of Northeast Airlines Atlantic Division, who served overseas as a result of Northeast Airlines' Contract with the Air Transport Command any time during the period December 7, 1941, to August 14, 1945. Recognized effective June 2, 1997.

(29) Service by U.S. Civilian Flight Crew and Aviation Ground Support Employees of Northwest Airlines, who served overseas as a result of Northwest Airlines' Contract with the Air Transport Command any time during the period December 14, 1941, to August 14, 1945. Recognized effective December 13, 1993.

(30) Service by U.S. Civilian Flight Crew and Aviation Ground Support Employees of Pan American World Airways and its Subsidiaries and Affiliates, who served overseas as a result of Pan American's Contract with the Air Transport Command and Naval Air Transport Service any time during the period December 14, 1941, to August 14, 1945. Recognized effective July 16, 1992.

(31) Service by U.S. Civilian Flight Crew and Aviation Ground Support Employees of Transcontinental and Western Air (TWA), Inc., who served overseas as a result of TWA's Contract with the Air Transport Command any time during the period December 14, 1941, to August 14, 1945. The ''Flight Crew'' includes pursers. Recognized effective May 13, 1992.

(32) Service by U.S. Civilian Flight Crew and Aviation Ground Support Employees of United Air Lines (UAL), who served overseas as a result of UAL's Contract with the Air Transport Command any time during the period December 14, 1941, to August 14, 1945. Recognized effective May 13, 1992.

(33) Service by U.S. civilian volunteers who actively participated in the Defense of Bataan. Recognized effective February 7, 1984.

(34) Service by U.S. civilians of the American Field Service (AFS) who served overseas operationally in World War I any time during the period August 31, 1917, to January 1, 1918. Recognized effective August 30, 1990.

(35) Service by U.S. civilians of the American Field Service (AFS) who served overseas under U.S. Armies and U.S. Army Groups in World War II any time during the period December 7, 1941, to May 8, 1945. Recognized effective August 30, 1990.

(36) Service by U.S. Merchant Seamen who served on blockships in support of Operation Mulberry. Recognized effective October 18, 1985.

(37) Service by Wake Island Defenders from Guam. Recognized effective April 7, 1982.

(38) Service by Women's Air Forces Service Pilots (WASP). Recognized effective November 23, 1977.

(39) Service by persons who were injured while providing aerial transportation of mail and serving under conditions set forth in Public Law 73–140.

(40) Service in the Alaska Territorial Guard during World War II, for any

person who the Secretary of Defense determines was honorably discharged.

(41) Service by Army field clerks.

(42) Service by Army Nurse Corps, Navy Nurse Corps, and female dietetic and physical therapy personnel as follows:

(i) Female Army and Navy nurses on active service under order of the service department; or

(ii) Female dietetic and physical therapy personnel, excluding students and apprentices, appointed with relative rank after December 21, 1942, or commissioned after June 21, 1944.

(43) Service by students who were enlisted men in Aviation camps during World War I.

(44) Active service in the Coast Guard after January 28, 1915, while under the jurisdiction of the Treasury Department, the Navy Department, the Department of Transportation, or the Department of Homeland Security. This does not include temporary members of the Coast Guard Reserves.

(45) Service by contract surgeons if the disability was the result of injury or disease contracted in the line of duty during a period of war while actually performing the duties of assistant surgeon or acting assistant surgeon with any military force in the field, or in transit, or in a hospital.

(46) Service by field clerks of the Quartermaster Corps.

(47) Service by lighthouse service personnel who were transferred to the service and jurisdiction of the War or Navy Departments by Executive Order under the Act of August 29, 1916. Effective July 1, 1939, service was consolidated with the Coast Guard.

(48) Service by male nurses who were enlisted in a Medical Corps.

(49) Service by persons having a pensionable or compensable status before January 1, 1959.

(50) Service by a Commonwealth Army veteran or new Philippine Scout, as defined in 38 U.S.C. 1735, who resides in the United States and is a citizen of the United States or an alien lawfully admitted to the United States for permanent residence; service by Regular Philippine Scouts and service in the Insular Force of the Navy, Samoan Native Guard, or Samoan Native Band of the Navy.

(51) Service with the Revenue Cutter Service while serving under direction of the Secretary of the Navy in cooperation with the Navy. Effective January 28, 1915, the Revenue Cutter Service was merged into the Coast Guard.

(52) Service during World War I in the Russian Railway Service Corps as certified by the Secretary of the Army.

(53) Service by members of training camps authorized by section 54 of the National Defense Act (Pub. L. 64–85, 39 Stat. 166), except for members of Student Army Training Corps Camps at the Presidio of San Francisco; Plattsburg, New York; Fort Sheridan, Illinois; Howard University, Washington, DC; Camp Perry, Ohio; and Camp Hancock, Georgia, from July 18, 1918, to September 16, 1918.

(54) Service in the Women's Army Corps (WAC) after June 30, 1943.

(55) Service in the Women's Reserve of the Navy, Marine Corps, and Coast Guard.

(56) Effective July 28, 1959, service by a veteran who was discharged for alienage during a period of hostilities unless evidence affirmatively shows the veteran was discharged at his or her own request. A veteran who was discharged for alienage after a period of hostilities and whose service was honest and faithful is not barred from benefits if he or she is otherwise entitled. A discharge changed prior to January 7, 1957, to honorable by a board established under 10 U.S.C. 1552 and 1553 will be considered as evidence that the discharge was not at the alien's request.

(57) Attendance at the preparatory schools of the United States Air Force Academy, the United States Military Academy, or the United States Naval Academy for enlisted active duty members who are reassigned to a preparatory school without a release from active duty, and for other individuals who have a commitment to active duty in the Armed Forces that would be binding upon disenrollment from the preparatory school.

(58) For purposes of providing medical care under chapter 17 for a service-connected disability, service by any person who has suffered an injury or contracted a disease in line of duty

while en route to or from, or at, a place for final acceptance or entry upon active duty and:

(i) Who has applied for enlistment or enrollment in the active military, naval, or air service and has been provisionally accepted and directed or ordered to report to a place for final acceptance into such service;

(ii) Who has been selected or drafted for service in the Armed Forces and has reported pursuant to the call of the person's local draft board and before rejection; or

(iii) Who has been called into the Federal service as a member of the National Guard, but has not been enrolled for the Federal service.

Note to paragraph (b)(58): The injury or disease must be due to some factor relating to compliance with proper orders. Draftees and selectees are included when reporting for preinduction examination or for final induction on active duty. Such persons are not included for injury or disease suffered during the period of inactive duty, or period of waiting, after a final physical examination and prior to beginning the trip to report for induction. Members of the National Guard are included when reporting to a designated rendezvous.

(59) Authorized travel to or from such duty or service, as described in this section.

(60) The period of time immediately following the date an individual is discharged or released from a period of active duty, as determined by the Secretary concerned to have been required for that individual to proceed to that individual's home by the most direct route, and in any event until midnight of the date of such discharge or release.

(c) *Active duty for training* means:

(1) Full-time duty in the Armed Forces performed by Reserves for training purposes.

(2) Full-time duty for training purposes performed as a commissioned officer of the Reserve Corps of the Public Health service during the period covered in paragraph (b)(2) of this section.

(3) In the case of members of the Army National Guard or Air National Guard of any State, full-time duty under sections 316, 502, 503, 504, or 505 of title 32 U.S.C., or the prior corresponding provisions of law.

(4) Duty performed by a member of a Senior Reserve Officers' Training Corps program when ordered to such duty for the purpose of training or a practice cruise under chapter 103 of title 10 U.S.C. for a period of not less than four weeks and which must be completed by the member before the member is commissioned.

(5) Attendance at the preparatory schools of the United States Air Force Academy, the United States Military Academy, or the United States Naval Academy by an individual who enters the preparatory school directly from the Reserves, National Guard or civilian life, unless the individual has a commitment to service on active duty which would be binding upon disenrollment from the preparatory school.

(6) Authorized travel to or from such duty as described in paragraph (c) of this section if an individual, when authorized or required by competent authority, assumes an obligation to perform active duty for training and is disabled from an injury, acute myocardial infarction, a cardiac arrest, or a cerebrovascular accident incurred while proceeding directly to or returning directly from such active duty for training. Authorized travel should take into account:

(i) The hour on which such individual began so to proceed or to return;

(ii) The hour on which such individual was scheduled to arrive for, or on which such individual ceased to perform, such duty;

(iii) The method of travel employed;

(iv) The itinerary;

(v) The manner in which the travel was performed; and

(vi) The immediate cause of disability.

(NOTE TO PARAGRAPH (C)(6): Active duty for training does not include duty performed as a temporary member of the Coast Guard Reserve.)

(d) *Inactive duty training* means:

(1) Duty (other than full-time duty) prescribed for Reserves (including commissioned officers of the Reserve Corps of the Public Health Service) by the Secretary concerned under section 206,

title 37 U.S.C., or any other provision of law;

(2) Special additional duties authorized for Reserves (including commissioned officers of the Reserve Corps of the Public Health Service) by an authority designated by the Secretary concerned and performed by them on a voluntary basis in connection with the prescribed training or maintenance activities of the units to which they are assigned.

(3) Duty (other than full-time duty) for members of the National Guard or Air National Guard of any State under the provisions of law stated in paragraph (c)(3) of this section.

(4) Training (other than active duty for training) by a member of, or applicant for membership (as defined in 5 U.S.C. 8140(g)) in, the Senior Reserve Officers' Training Corps prescribed under chapter 103 of title 10 U.S.C.

(5) Inactive duty for training does not include work or study performed in connection with correspondence courses, or attendance at an educational institution in an inactive status, or duty performed as a temporary member of the Coast Guard Reserve.

(6) Travel to or from such duty as described in this paragraph (d) if an individual, when authorized or required by competent authority, assumes an obligation to perform inactive duty training and is disabled from an injury, acute myocardial infarction, a cardiac arrest, or a cerebrovascular accident incurred while proceeding directly to or returning directly from such inactive duty training. Authorized travel should take into account:

(i) The hour on which such individual began so to proceed or to return;

(ii) The hour on which such individual was scheduled to arrive for, or on which such individual ceased to perform, such duty;

(iii) The method of travel employed;

(iv) The itinerary;

(v) The manner in which the travel was performed; and

(vi) The immediate cause of disability.

(Authority: 38 U.S.C. 101, 106, 501, 1734 and 1735.)

[34 FR 9339, June 13, 1969, as amended at 45 FR 6934, Jan. 31, 1980; 45 FR 43169, June 26, 1980; 48 FR 56580, Dec. 22, 1983; 61 FR 21965, May 13, 1996; 75 FR 54497, Sept. 8, 2010; 78 FR 78260, Dec. 26, 2013]

PROTECTION OF PATIENT RIGHTS

§ 17.32 Informed consent and advance care planning.

(a) *Definitions*:

Advance Directive. Specific written statements made by a patient who has decision-making capacity regarding future health care decisions in any of the following:

(i) *VA Living Will*. A written statement made by a patient on an authorized VA form which sets forth the patient's wishes regarding the patient's health care treatment preferences including the withholding and withdrawal of life-sustaining treatment.

(ii) *VA Durable Power of Attorney for Health Care*. A written instruction on a VA form which designates the patient's choice of health care agent.

(iii) *State-Authorized Advance Directive*. A non-VA living will, durable power of attorney for health care, or other advance health care planning document, the validity of which is determined pursuant to applicable State law. For the purposes of this paragraph and paragraph (h) of this section, ''applicable State law'' means the law of the State where the advance directive was signed, the State where the patient resided when the advance directive was signed, the State where the patient now resides, or the State where the patient is receiving treatment. VA will resolve any conflict between those State laws regarding the validity of the advance directive by following the law of the State that gives effect to the expressed wishes in the advance directive.

Close friend. Any person eighteen years or older who has shown care and concern for the patient's welfare, who is familiar with the patient's activities, health, religious beliefs and values, and who has presented a signed written statement for the record that

describes that person's relationship to and familiarity with the patient.

Decision-making capacity. The ability to understand and appreciate the nature and consequences of health care treatment decisions.

Health care agent. An individual named by the patient in a Durable Power of Attorney for Health Care.

Legal guardian. A person appointed by a court of appropriate jurisdiction to make decisions for an individual who has been judicially determined to be incompetent.

Practitioner. Any physician, dentist, or health care professional who has been granted specific clinical privileges to perform the treatment or procedure. For the purpose of obtaining informed consent for medical treatment, the term practitioner includes medical and dental residents and other appropriately trained health care professionals designated by VA regardless of whether they have been granted clinical privileges.

Signature consent. The patient's or surrogate's signature on a VA-authorized consent form.

Special guardian. A person appointed by a court of appropriate jurisdiction for the specific purpose of making health care decisions.

Surrogate. An individual, organization or other body authorized under this section to give informed consent on behalf of a patient who lacks decision-making capacity.

(b) *Policy*. Except as otherwise provided in this section, all patient care furnished under title 38 U.S.C. shall be carried out only with the full and informed consent of the patient or, in appropriate cases, a representative thereof. In order to give informed consent, the patient must have decision-making capacity and be able to communicate decisions concerning health care. If the patient lacks decision-making capacity or has been declared incompetent, consent must be obtained from the patient's surrogate. Practitioners may provide necessary medical care in emergency situations without the patient's or surrogate's express consent when immediate medical care is necessary to preserve life or prevent serious impairment of the health of the patient or others and the patient is unable to consent and the practitioner determines that the patient has no surrogate or that waiting to obtain consent from the patient's surrogate would increase the hazard to the life or health of the patient or others. In such circumstances consent is implied.

(c) *General requirements for informed consent*. Informed consent is the freely given consent that follows a careful explanation by the practitioner to the patient or the patient's surrogate of the proposed diagnostic or therapeutic procedure or course of treatment. The practitioner, who has primary responsibility for the patient or who will perform the particular procedure or provide the treatment, must explain in language understandable to the patient or surrogate the nature of a proposed procedure or treatment; the expected benefits; reasonably foreseeable associated risks, complications or side effects; reasonable and available alternatives; and anticipated results if nothing is done. The patient or surrogate must be given the opportunity to ask questions, to indicate comprehension of the information provided, and to grant permission freely without coercion. The practitioner must advise the patient or surrogate if the proposed treatment is novel or unorthodox. The patient or surrogate may withhold or revoke his or her consent at any time.

(d) *Documentation of informed consent*. (1) The informed consent process must be appropriately documented in the health record. In addition, signature consent is required for all diagnostic and therapeutic treatments or procedures that:

(i) Require the use of sedation;

(ii) Require anesthesia or narcotic analgesia;

(iii) Are considered to produce significant discomfort to the patient;

(iv) Have a significant risk of complication or morbidity; or

(v) Require injections of any substance into a joint space or body cavity.

(2) A patient or surrogate will sign with an ''X'' when the patient or surrogate has a debilitating illness or disability, *i.e.*, significant physical impairment and/or difficulty in executing a signature due to an underlying health condition(s), or is unable to read

and write. When the patient's or surrogate's signature is indicated by an ''X,'' two adults must witness the act of signing. By signing, the witnesses are attesting only to the fact that they saw the patient or surrogate and the practitioner sign the form. The signed form must be filed in the patient's health record. A properly executed VA-authorized consent form is valid for a period of 60 calendar days. If, however, the treatment plan involves multiple treatments or procedures, it will not be necessary to repeat the informed consent discussion and documentation so long as the course of treatment proceeds as planned, even if treatment extends beyond the 60-day period. If there is a change in the patient's condition that might alter the diagnostic or therapeutic decision, the consent is automatically rescinded.

(3) If it is impractical to consult with the surrogate in person, informed consent may be obtained by mail, facsimile, or telephone. A facsimile copy of a signed consent form is adequate to proceed with treatment. However, the surrogate must agree to submit a signed consent form to the practitioner. If consent is obtained by telephone, the conversation must be audiotaped or witnessed by a second VA employee. The name of the person giving consent and his or her authority to act as surrogate must be adequately identified for the record.

(e) *Surrogate consent.* If the practitioner who has primary responsibility for the patient determines that the patient lacks decision-making capacity and is unlikely to regain it within a reasonable period of time, informed consent must be obtained from the patient's surrogate. Patients who are incapable of giving consent as a matter of law, *i.e.*, persons judicially determined to be incompetent and minors not otherwise able to provide informed consent, will be deemed to lack decision-making capacity for the purposes of this section. If the patient is considered a minor in the state where the VA facility is located and cannot consent to medical treatment, consent must be obtained from the patient's parent or legal guardian. The surrogate generally assumes the same rights and responsibilities as the patient in the informed consent process. The surrogate's decision must be based on his or her knowledge of what the patient would have wanted, *i.e.*, substituted judgment. If the patient's wishes are unknown, the decision must be based on the patient's best interest. The following persons are authorized to consent on behalf of patients who lack decision-making capacity in the following order of priority:

(1) Health care agent;

(2) Legal guardian or special guardian;

(3) Next-of-kin: a close relative of the patient eighteen years of age or older, in the following priority: spouse, child, parent, sibling, grandparent, or grandchild; or

(4) Close friend.

(f) *Consent for patients without surrogates.* (1) If none of the surrogates listed in paragraph (e) of this section are available, the practitioner may request Regional Counsel assistance to obtain a special guardian for health care or follow the procedures outlined in this paragraph (f).

(2) Facilities may use the following process to make treatment decisions for patients who lack decision-making capacity and have no surrogate. For treatments or procedures that involve minimal risk, the practitioner must verify that no authorized surrogate can be located. The practitioner must attempt to explain the nature and purpose of the proposed treatment to the patient and enter this information in the health record. For procedures that require signature consent, the practitioner must certify that the patient has no surrogate. The attending physician and the Chief of Service (or his or her designee) must indicate their approval of the treatment decision in writing. Any decision to withhold or withdraw life-sustaining treatment for such patients must be reviewed by a multi-disciplinary committee appointed by the facility Director. The committee functions as the patient's advocate and may not include members of the treatment team. The committee must submit its findings and recommendations in a written report to the Chief of Staff who must note his or her approval of the report in writing. After reviewing the record, the facility Director may concur with the decision

to withhold or withdraw life support or request further review by Regional Counsel.

(g) *Special consent situations.* In addition to the other requirements of this section, additional protections are required in the following situations.

(1) No patient will undergo any unusual or extremely hazardous treatment or procedure, e.g., that which might result in irreversible brain damage or sterilization, except as provided in this paragraph (g). Before treatment is initiated, the patient or surrogate must be given adequate opportunity to consult with independent specialists, legal counsel or other interested parties of his or her choosing. The patient's or surrogate's signature on a VA authorized consent form must be witnessed by someone who is not affiliated with the VA health care facility, e.g., spouse, legal guardian, or patient advocate. If a surrogate makes the treatment decision, a multi-disciplinary committee, appointed by the facility Director, must review that decision to ensure it is consistent with the patient's wishes or in his or her best interest. The committee functions as the patient's advocate and may not include members of the treatment team. The committee must submit its findings and recommendations in a written report to the facility Director. The Director may authorize treatment consistent with the surrogate's decision or request that a special guardian for health care be appointed to make the treatment decision.

(2) Administration of psychotropic medication to an involuntarily committed patient against his or her will must meet the following requirements. The patient or surrogate must be allowed to consult with independent specialists, legal counsel or other interested parties concerning the treatment with psychotropic medication. Any recommendation to administer or continue medication against the patient's or surrogate's will must be reviewed by a multi-disciplinary committee appointed by the facility Director for this purpose. This committee must include a psychiatrist or a physician who has psychopharmacology privileges. The facility Director must concur with the committee's recommendation to administer psychotropic medications contrary to the patient's or surrogate's wishes. Continued therapy with psychotropic medication must be reviewed every 30 days. The patient (or a representative on the patient's behalf) may appeal the treatment decision to a court of appropriate jurisdiction.

(3) If a proposed course of treatment or procedure involves approved medical research in whole or in part, the patient or representative shall be advised of this. Informed consent shall be obtained specifically for the administration or performance of that aspect of the treatment or procedure that involves research. Such consent shall be in addition to that obtained for the administration or performance of the nonresearch aspect of the treatment or procedure and must meet the requirements for informed consent set forth in 38 CFR Part 16, *Protection of Human Subjects*.

(h) *Advance health care planning.* Subject to the provisions of paragraphs (h)(1) through (h)(4) of this section, VA will follow the wishes of a patient expressed in an Advance Directive when the attending physician determines and documents in the patient's health record that the patient lacks decision-making capacity and is not expected to regain it. An advance directive that is valid in one or more States under applicable State law, as defined in paragraph (a) of this section, will be recognized throughout the VA health care system.

(1) *Witnesses.* A VA Advance Directive: Living Will and Durable Power of Attorney for Health Care must be signed by the patient in the presence of two witnesses. Neither witness may to the witness' knowledge be named in the patient's will, appointed as health care agent in the advance directive, or financially responsible for the patient's care. VA employees of the Chaplain Service, Psychology Service, Social Work Service, or nonclinical employees (e.g., Medical Administration Service, Voluntary Service, or Environmental Management Service) may serve as witnesses. Other individuals employed by the VA facility in which the patient is being treated may not sign as witnesses to the advance directive. Witnesses are attesting only to the fact

that they saw the patient sign the form.

(2) *Instructions in critical situations.* VA will follow the unambiguous verbal or non-verbal instructions regarding future health care decisions of a patient who has decision-making capacity when the patient is admitted to care when critically ill and loss of capacity may be imminent and the patient is not physically able to sign an advance directive form, or the appropriate form is not readily available. The patient's instructions must have been expressed to at least two members of the health care team. The substance of the patient's instructions must be recorded in a progress note in the patient's health record and must be cosigned by at least two members of the health care team who were present and can attest to the wishes expressed by the patient. These instructions will be given effect only if the patient loses decision-making capacity during the presenting situation.

(3) *Revocation.* A patient who has decision-making capacity may revoke an advance directive or instructions in a critical situation at any time by using any means expressing the intent to revoke.

(4) *VA policy and disputes.* Neither the treatment team nor surrogate may override a patient's clear instructions in an Advance Directive or in instructions in critical situations, except that those portions of an Advance Directive or instructions given in a critical situation that are not consistent with VA policy will not be given effect.

(Authority: 38 U.S.C. 7331–7334)

(The information collection requirements in this section have been approved by the Office of Management and Budget under control number 2900–0583)

[62 FR 53961, Oct. 17, 1997, as amended at 70 FR 71774, Nov. 30, 2005; 71 FR 68740, Nov. 28, 2006; 72 FR 10366, Mar. 8, 2007; 74 FR 34503, July 16, 2009]

§ 17.33 Patients' rights.

(a) *General.* (1) Patients have a right to be treated with dignity in a humane environment that affords them both reasonable protection from harm and appropriate privacy with regard to their personal needs.

(2) Patients have a right to receive, to the extent of eligibility therefor under the law, prompt and appropriate treatment for any physical or emotional disability.

(3) Patients have the right to the least restrictive conditions necessary to achieve treatment purposes.

(4) No patient in the Department of Veterans Affairs medical care system, except as otherwise provided by the applicable State law, shall be denied legal rights solely by virtue of being voluntarily admitted or involuntarily committed. Such legal rights include, but are not limited to, the following:

(i) The right to hold and to dispose of property except as may be limited in accordance with paragraph (c)(2) of this section;

(ii) The right to execute legal instruments (e.g., will);

(iii) The right to enter into contractual relationships;

(iv) The right to register and vote;

(v) The right to marry and to obtain a separation, divorce, or annulment;

(vi) The right to hold a professional, occupational, or vehicle operator's license.

(b) *Residents and inpatients.* Subject to paragraphs (c) and (d) of this section, patients admitted on a residential or inpatient care basis to the Department of Veterans Affairs medical care system have the following rights:

(1) *Visitations and communications.* Each patient has the right to communicate freely and privately with persons outside the facility, including government officials, attorneys, and clergymen. To facilitate these communications each patient shall be provided the opportunity to meet with visitors during regularly scheduled visiting hours, convenient and reasonable access to public telephones for making and receiving phone calls, and the opportunity to send and receive unopened mail.

(i) Communications with attorneys, law enforcement agencies, or government officials and representatives of recognized service organizations when the latter are acting as agents for the patient in a matter concerning Department of Veterans Affairs benefits, shall not be reviewed.

(ii) A patient may refuse visitors.

(iii) If a patient's right to receive unopened mail is restricted pursuant to paragraph (c) of this section, the patient shall be required to open the sealed mail while in the presence of an appropriate person for the sole purpose of ascertaining whether the mail contains contraband material, *i.e.*, implements which pose significant risk of bodily harm to the patient or others or any drugs or medication. Any such material will be held for the patient or disposed of in accordance with instructions concerning patients' mail published by the Veterans Health Administration, Department of Veterans Affairs, and/or the local health care facility.

(iv) Each patient shall be afforded the opportunity to purchase, at the patient's expense, letter writing material including stamps. In the event a patient needs assistance in purchasing writing material, or in writing, reading or sending mail, the medical facility will attempt, at the patient's request, to provide such assistance by means of volunteers, sufficient to mail at least one (1) letter each week.

(v) All information gained by staff personnel of a medical facility during the course of assisting a patient in writing, reading, or sending mail is to be kept strictly confidential except for any disclosure required by law.

(2) *Clothing*. Each patient has the right to wear his or her own clothing.

(3) *Personal Possessions*. Each patient has the right to keep and use his or her own personal possessions consistent with available space, governing fire safety regulations, restrictions on noise, and restrictions on possession of contraband material, drugs and medications.

(4) *Money*. Each patient has the right to keep and spend his or her own money and to have access to funds in his or her account in accordance with instructions concerning personal funds of patients published by the Veterans Health Administration.

(5) *Social Interaction*. Each patient has the right to social interaction with others.

(6) *Exercise*. Each patient has the right to regular physical exercise and to be outdoors at regular and frequent intervals. Facilities and equipment for such exercise shall be provided.

(7) *Worship*. The opportunity for religious worship shall be made available to each patient who desires such opportunity. No patient will be coerced into engaging in any religious activities against his or her desires.

(c) *Restrictions*. (1) A right set forth in paragraph (b) of this section may be restricted within the patient's treatment plan by written order signed by the appropriate health care professional if—

(i) It is determined pursuant to paragraph (c)(2) of this section that a valid and sufficient reason exists for a restriction, and

(ii) The order imposing the restriction and a progress note detailing the indications therefor are both entered into the patient's permanent medical record.

(2) For the purpose of paragraph (c) of this section, a valid and sufficient reason exists when, after consideration of pertinent facts, including the patient's history, current condition and prognosis, a health care professional reasonably believes that the full exercise of the specific right would—

(i) Adversely affect the patient's physical or mental health,

(ii) Under prevailing community standards, likely stigmatize the patient's reputation to a degree that would adversely affect the patient's return to independent living,

(iii) Significantly infringe upon the rights of or jeopardize the health or safety of others, or

(iv) Have a significant adverse impact on the operation of the medical facility, to such an extent that the patient's exercise of the specific right should be restricted. In determining whether a patient's specific right should be restricted, the health care professional concerned must determine that the likelihood and seriousness of the consequences that are expected to result from the full exercise of the right are so compelling as to warrant the restriction. The Chief of Service or Chief of Staff, as designated by local policy, should concur with the decision to impose such restriction. In this connection, it should be noted that there is no intention to imply that each of the reasons specified in paragraphs

(c)(2)(i) through (iv) of this section are logically relevant to each of the rights set forth in paragraph (b)(1) of this section.

(3) If it has been determined under paragraph (c)(2) of this section that a valid and sufficient reason exists for restricting any of the patient's rights set forth in paragraph (b) of this section, the least restrictive method for protecting the interest or interests specified in paragraphs (c)(2)(i) through (iv) of this section that are involved shall be employed.

(4) The patient must be promptly notified of any restriction imposed under paragraph (c) of this section and the reasons therefor.

(5) All restricting orders under paragraph (c) of this section must be reviewed at least once every 30 days by the practitioner and must be concurred in by the Chief of Service or Chief of Staff.

(d) *Restraint and seclusion of patients.* (1) Each patient has the right to be free from physical restraint or seclusion except in situations in which there is a substantial risk of imminent harm by the patient to himself, herself, or others and less restrictive means of preventing such harm have been determined to be inappropriate or insufficient. Patients will be physically restrained or placed in seclusion only on the written order of an appropriate licensed health care professional. The reason for any restraint order will be clearly documented in the progress notes of the patient's medical record. The written order may be entered on the basis of telephonic authority, but in such an event, an appropriate licensed health care professional must examine the patient and sign a written order within an appropriate timeframe that is in compliance with current community and/or accreditation standards. In emergency situations, where inability to contact an appropriate licensed health care professional prior to restraint is likely to result in immediate harm to the patient or others, the patient may be temporarily restrained by a member of the staff until appropriate authorization can be received from an appropriate licensed health care professional . Use of restraints or seclusion may continue for a period of time that does not exceed current community and/or accreditation standards, within which time an appropriate licensed health care professional shall again be consulted to determine if continuance of such restraint or seclusion is required. Restraint or seclusion may not be used as a punishment, for the convenience of staff, or as a substitute for treatment programs.

(2) While in restraint or seclusion, the patient must be seen within appropriate timeframes in compliance with current community and/or accreditation standards:

(i) By an appropriate health care professional who will monitor and chart the patient's physical and mental condition; and

(ii) By other ward personnel as frequently as is reasonable under existing circumstances.

(3) Each patient in restraint or seclusion shall have bathroom privileges according to his or her needs.

(4) Each patient in restraint or seclusion shall have the opportunity to bathe at least every twenty-four (24) hours.

(5) Each patient in restraint or seclusion shall be provided nutrition and fluid appropriately.

(e) *Medication.* Patients have a right to be free from unnecessary or excessive medication. Except in an emergency, medication will be administered only on a written order of an appropriate health care professional in that patient's medical record. The written order may be entered on the basis of telephonic authority received from an appropriate health care professional, but in such event, the written order must be countersigned by an appropriate health care professional within 24 hours of the ordering of the medication. An appropriate health care professional will be responsible for all medication given or administered to a patient. A review by an appropriate health care professional of the drug regimen of each inpatient shall take place at least every thirty (30) days. It is recognized that administration of certain medications will be reviewed more frequently. Medication shall not be used as punishment, for the convenience of the staff, or in quantities

which interfere with the patient's treatment program.

(f) *Confidentiality*. Information gained by staff from the patient or the patient's medical record will be kept confidential and will not be disclosed except in accordance with applicable law.

(g) *Patient grievances*. Each patient has the right to present grievances with respect to perceived infringement of the rights described in this section or concerning any other matter on behalf of himself, herself or others, to staff members at the facility in which the patient is receiving care, other Department of Veterans Affairs officials, government officials, members of Congress or any other person without fear or reprisal.

(h) *Notice of patient's rights*. Upon the admission of any patient, the patient or his/her representative shall be informed of the rights described in this section, shall be given a copy of a statement of those rights and shall be informed of the fact that the statement of rights is posted at each nursing station. All staff members assigned to work with patients will be given a copy of the statement of rights and these rights will be discussed with them by their immediate supervisor.

(i) *Other rights*. The rights described in this section are in addition to and not in derogation of any statutory, constitutional or other legal rights.

(Authority: 38 U.S.C. 501, 1721)

[47 FR 55486, Dec. 10, 1982. Redesignated at 61 FR 21965, May 13, 1996, as amended at 70 FR 67094, Nov. 4, 2005]

TENTATIVE ELIGIBILITY DETERMINATIONS

§ 17.34 Tentative eligibility determinations.

Subject to the provisions of §§ 17.36 through 17.38, when an application for hospital care or other medical services, except outpatient dental care, has been filed which requires an adjudication as to service connection or a determination as to any other eligibility prerequisite which cannot immediately be established, the service (including transportation) may be authorized without further delay if it is determined that eligibility for care probably will be established. Tentative eligibility determinations under this section, however, will only be made if:

(a) *In emergencies*. The applicant needs hospital care or other medical services in emergency circumstances, or

(b) *Based on discharge*. The application is filed within 6 months after date of discharge under conditions other than dishonorable, and for a veteran who seeks eligibility based on a period of service that began after September 7, 1980, the veteran must meet the applicable minimum service requirements under 38 U.S.C. 5303A.

(Authority: 38 U.S.C. 501, 5303A)

[35 FR 6586, Apr. 24, 1970. Redesignated at 61 FR 21965, May 13, 1996, as amended at 64 FR 54212, Oct. 6, 1999; 78 FR 28142, May 14, 2013]

HOSPITAL OR NURSING HOME CARE AND MEDICAL SERVICES IN FOREIGN COUNTRIES

§ 17.35 Hospital care and outpatient services in foreign countries.

(a) Under the VA Foreign Medical Program, VA may furnish hospital care and outpatient services to any veteran outside of the United States, without regard to the veteran's citizenship:

(1) If necessary for treatment of a service-connected disability, or any disability associated with and held to be aggravating a service-connected disability;

(2) If the care and services are furnished to a veteran participating in a rehabilitation program under 38 U.S.C. chapter 31 who requires care and services for the reasons enumerated in § 17.47(i)(2).

(b) Under the Foreign Medical Program, the care and services authorized under paragraph (a) of this section are available in the Republic of the Philippines to a veteran who meets the requirements of paragraph (a) of this section. VA may also provide outpatient services to a veteran referenced in paragraph (a)(1) in the VA outpatient clinic in Manila for the treatment of such veteran's service-connected conditions within the limits of the clinic. Non-service connected conditions of a veteran who has a service-connected disability may be treated within the limits of the VA outpatient clinic in Manila.

(c) Claims for payment or reimbursement for services not previously authorized by VA under this section are governed by §§ 17.123–17.127 and 17.129–17.132.

[83 FR 29448, June 25, 2018]

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; and veterans awarded the Medal of Honor.

(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 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 who wishes to be enrolled must apply by submitting a VA Form 10–10EZ:

(i) To a VA medical facility or by mail it to the U.S. Postal address on the form; or

(ii) Online at the designated World Wide Web internet address; or

(iii) By calling a designated telephone number and submitting application information verbally. To complete a telephone application, the veteran seeking enrollment must attest to the accuracy and authenticity of their verbal application for enrollment and consent to VA's copayment requirements and third-party billing procedures.

(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) Interthoracoscapular (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/*.

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

(Authority: 38 U.S.C 101, 501, 1521, 1701, 1705, 1710, 1721, 1722)

[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; 79 FR 72578, Dec. 3, 2013; 79 FR 57414, Sept. 24, 2014; 81 FR 13997, Mar. 16, 2016; 84 FR 7815, Mar. 5, 2019]

§ 17.37 Enrollment not required—provision of hospital and outpatient care to veterans.

Even if not enrolled in the VA healthcare system:

(a) A veteran rated for service-connected disabilities at 50 percent or greater will receive VA care provided for in the ''medical benefits package'' set forth in § 17.38.

(b) A veteran who has a service-connected disability will receive VA care provided for in the ''medical benefits package'' set forth in § 17.38 for that service-connected disability.

(c) A veteran who was discharged or released from active military service for a disability incurred or aggravated in the line of duty will receive VA care provided for in the ''medical benefits package'' set forth in § 17.38 for that disability for the 12-month period following discharge or release.

(d) When there is a compelling medical need to complete a course of VA treatment started when the veteran was enrolled in the VA healthcare system, a veteran will receive that treatment.

(e) Subject to the provisions of § 21.240, a veteran participating in VA's vocational rehabilitation program described in §§ 21.1 through 21.430 will receive VA care provided for in the ''medical benefits package'' set forth in § 17.38.

(f) A veteran may receive care provided for in the 'medical benefits package' based on factors other than veteran status (e.g., a veteran who is a private-hospital patient and is referred to VA for a diagnostic test by that hospital under a sharing contract; a veteran who is a VA employee and is examined to determine physical or mental fitness to perform official duties; a Department of Defense retiree under a sharing agreement).

(g) For care not provided within a State, a veteran may receive VA care provided for in the ''medical benefits package'' set forth in § 17.38 if authorized under the provisions of 38 U.S.C. 1724 and 38 CFR 17.35.

(h) Commonwealth Army veterans and new Philippine Scouts may receive

care provided for in the ''medical benefits package'' set forth in § 17.38 if authorized under the provisions of 38 U.S.C. 1724 and 38 CFR 17.35.

(i) A veteran may receive certain types of VA care not included in the ''medical benefits package'' set forth in § 17.38 if authorized by statute or other sections of 38 CFR (e.g., humanitarian emergency care for which the individual will be billed, compensation and pension examinations, dental care, domiciliary care, nursing home care, readjustment counseling, care as part of a VA-approved research project, seeing-eye or guide dogs, sexual trauma counseling and treatment, special registry examinations).

(j) A veteran may receive an examination to determine whether the veteran is catastrophically disabled and therefore eligible for inclusion in priority category 4.

(k) A veteran may receive care for psychosis or mental illness other than psychosis pursuant to 38 CFR 17.109.

(Authority: 38 U.S.C. 101, 501, 1701, 1705, 1710, 1721, 1722)

[64 FR 54217, Oct. 6, 1999, as amended at 67 FR 35039, May 17, 2002; 78 FR 28142, May 14, 2013]

§ 17.38 Medical benefits package.

(a) Subject to paragraphs (b) and (c) of this section, the following hospital, outpatient, and extended care services constitute the ''medical benefits package'' (basic care and preventive care):

(1) Basic care.

(i) Outpatient medical, surgical, and mental healthcare, including care for substance abuse.

(ii) Inpatient hospital, medical, surgical, and mental healthcare, including care for substance abuse.

(iii) Prescription drugs, including over-the-counter drugs and medical and surgical supplies available under the VA national formulary system.

(iv) Emergency care in VA facilities; and emergency care in non-VA facilities in accordance with sharing contracts or if authorized by § 17.52(a)(3), § 17.53, § 17.54, §§ 17.120 through 17.132, or §§ 17.4000 through 17.4040.

(v) Bereavement counseling as authorized in § 17.98.

(vi) Comprehensive rehabilitative services other than vocational services provided under 38 U.S.C. chapter 31.

(vii) 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 and appropriate, in connection with the veteran's treatment as authorized under 38 CFR 71.50.

(viii) Durable medical equipment and prosthetic and orthotic devices, including eyeglasses and hearing aids as authorized under § 17.149.

(ix) Home health services authorized under 38 U.S.C. 1717 and 1720C.

(x) Reconstructive (plastic) surgery required as a result of disease or trauma, but not including cosmetic surgery that is not medically necessary.

(xi)(A) Hospice care, palliative care, and institutional respite care; and

(B) Noninstitutional extended care services, including but not limited to noninstitutional geriatric evaluation, noninstitutional adult day health care, and noninstitutional respite care.

(xii) Payment of beneficiary travel as authorized under 38 CFR part 70.

(xiii) Pregnancy and delivery services, to the extent authorized by law.

(xiv) Newborn care, post delivery, for a newborn child for the date of birth plus seven calendar days after the birth of the child when the birth mother is a woman veteran enrolled in VA health care and receiving maternity care furnished by VA or under authorization from VA and the child is delivered either in a VA facility, or in another facility pursuant to a VA authorization for maternity care at VA expense.

(xv) Completion of forms (e.g., Family Medical Leave forms, life insurance applications, Department of Education forms for loan repayment exemptions based on disability, non-VA disability program forms) by healthcare professionals based on an examination or knowledge of the veteran's condition, but not including the completion of forms for examinations if a third party customarily will pay health care practitioners for the examination but will not pay VA.

(2) Preventive care, as defined in 38 U.S.C. 1701(9), which includes:

(i) Periodic medical exams.

(ii) Health education, including nutrition education.

(iii) Maintenance of drug-use profiles, drug monitoring, and drug use education.

(iv) Mental health and substance abuse preventive services.

(v) Immunizations against infectious disease.

(vi) Prevention of musculoskeletal deformity or other gradually developing disabilities of a metabolic or degenerative nature.

(vii) Genetic counseling concerning inheritance of genetically determined diseases.

(viii) Routine vision testing and eyecare services.

(ix) Periodic reexamination of members of high-risk groups for selected diseases and for functional decline of sensory organs, and the services to treat these diseases and functional declines.

(b) *Provision of the ''medical benefits package''*. Care referred to in the ''medical benefits package'' will be provided to individuals only if it is determined by appropriate healthcare professionals that the care is needed to promote, preserve, or restore the health of the individual and is in accord with generally accepted standards of medical practice.

(1) *Promote health*. Care is deemed to promote health if the care will enhance the quality of life or daily functional level of the veteran, identify a predisposition for development of a condition or early onset of disease which can be partly or totally ameliorated by monitoring or early diagnosis and treatment, and prevent future disease.

(2) *Preserve health*. Care is deemed to preserve health if the care will maintain the current quality of life or daily functional level of the veteran, prevent the progression of disease, cure disease, or extend life span.

(3) *Restoring health*. Care is deemed to restore health if the care will restore the quality of life or daily functional level that has been lost due to illness or injury.

(c) In addition to the care specifically excluded from the ''medical benefits package'' under paragraphs (a) and (b) of this section, the ''medical benefits package'' does not include the following:

(1) Abortions and abortion counseling.

(2) In vitro fertilization. Note: See § 17.380.

(3) Drugs, biologicals, and medical devices not approved by the Food and Drug Administration unless the treating medical facility is conducting formal clinical trials under an Investigational Device Exemption (IDE) or an Investigational New Drug (IND) application, or the drugs, biologicals, or medical devices are prescribed under a compassionate use exemption.

(4) Gender alterations.

(5) Hospital and outpatient care for a veteran who is either a patient or inmate in an institution of another government agency if that agency has a duty to give the care or services. This exclusion does not apply to veterans who are released from incarceration in a prison or jail into a temporary housing program (such as a community residential re-entry center or halfway house).

(6) Membership in spas and health clubs.

[64 FR 54217, Oct. 6, 1999, as amended at 67 FR 35039, May 17, 2002; 73 FR 36798, June 30, 2008; 75 FR 54030, Sept. 3, 2010; 76 FR 11339, Mar. 2, 1011; 76 FR 26172, May 5, 2011; 76 FR 78571, Dec. 19, 2011; 82 FR 6275, Jan. 19, 2017; 84 FR 26306, June 5, 2019]

§ 17.39 Certain Filipino veterans.

(a) Any Filipino Commonwealth Army veteran, including one who was recognized by authority of the U.S. Army as belonging to organized Filipino guerilla forces, or any new Philippine Scout is eligible for hospital care, nursing home care, and outpatient medical services within the United States in the same manner and subject to the same terms and conditions as apply to U.S. veterans, if such veteran or scout resides in the United States and is a citizen or lawfully admitted to the United States for permanent residence. For purposes of these VA health care benefits, the standards described in 38 CFR 3.42(c) will be accepted as proof of U.S. citizenship or lawful permanent residence.

(b) Commonwealth Army Veterans, including those who were recognized by

authority of the U.S. Army as belonging to organized Filipino guerilla forces, and new Philippine Scouts are not eligible for VA health care benefits if they do not meet the residency and citizenship requirements described in § 3.42(c).

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

(Authority: 38 U.S.C. 501, 1734)

[71 FR 6680, Feb. 9, 2006]

§ 17.40 Additional services for indigents.

In addition to the usual medical services agreed upon between the governments of the United States and the Republic of the Philippines to be made available to patients for whom the Department of Veterans Affairs has authorized care at the Veterans Memorial Medical Center, any such patient determined by the U.S. Department of Veterans Affairs to be indigent or without funds may be furnished toilet articles and barber services, including haircutting and shaving necessary for hygienic reasons.

[33 FR 5299, Apr. 3, 1968, as amended at 47 FR 58247, Dec. 30, 1982. Redesignated at 61 FR 21965, May 13, 1996]

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; 64 FR 54218, Oct. 6, 1999; 79 FR 54615, Sept. 12, 2014]

§ 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, Sept. 12, 2014]

§ 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 on or before June 6, 2019, 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.

(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.

[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; 84 FR 26306, June 5, 2019]

§ 17.47 Considerations applicable in determining eligibility for hospital care, medical services, nursing home care, 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 or medical services. 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 or medical services 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 or medical services , will govern the facility Director's disapproval or approval of such care or services,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 hospital care or medical services, 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 hospital care or medical services, 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(b), except to the extent continuing eligibility for such treatment is provided for in the judgment for settlement described in §3.362(b) 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 medical services; or any condition which does not require hospital care or medical services for an acute or chronic condition but requires domiciliary care. Domiciliary care, as the term implies, is the provision of a temporary 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 care, medical services, 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 care, medical services, 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) 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 and medical services 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 and/or receiving medical services 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 and/or receiving medical services 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]

EDITORIAL NOTE: For FEDERAL REGISTER citations affecting § 17.47, see the List of CFR Sections Affected, which appears in the Finding Aids section of the printed volume and at *www.fdsys.gov*.

§ 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)

[70 FR 29627, May 24, 2005, as amended at 79 FR 54615, Sept. 12, 2014]

§ 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 58529, Sept. 17, 2002]

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 VA patients pursuant to agreements between VA and the department or agency operating the facility. When such an agreement has been entered into and a bed allocation for VA 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 § 17.44. Care in a Federal facility not operated by VA, however, shall not be authorized for any military retiree whose sole basis for eligibility is under § 17.44, or, except in Alaska and Hawaii, for any retiree of the uniformed services suffering from a chronic disability whose entitlement is under § 17.44 or § 17.46(a)(2) regardless of whether he or she may have dual eligibility under other provisions of § 17.46.

[79 FR 54615, Sept. 12, 2014]

§ 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 § 17.48(i).

(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;

(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;

(4) Hospital care for women veterans;

(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.

(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.

(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 that 181 days.

(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.

(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.

(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.

(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.

(c) The provisions of this section shall not apply to care furnished by VA after June 6, 2019.

[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, Sept. 12, 2014; 84 FR 26306, June 5, 2019]

§ 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 [Reserved]

§ 17.55 Payment for authorized public or private hospital care.

Except as otherwise provided in this section, payment for public or private hospital care furnished on or before June 6, 2019, under 38 U.S.C. 1703 and § 17.52, or at any time under 38 U.S.C. 1728 and §§ 17.120 and 17.128 or under 38 U.S.C. 1787 and § 17.410, 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 Centers for Medicare & Medicaid Services (CMS) 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.

[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; 84 FR 26306, June 5, 2019]

§ 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), 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 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.

(e) Except for payments for care furnished under 38 U.S.C. 1725 and § 17.1005, under 38 U.S.C. 1728 and §§ 17.120 and 17.128, or under 38 U.S.C. 1787 and § 17.410, the provisions of this section shall not apply to care furnished by VA after June 6, 2019, or care furnished pursuant to an agreement authorized by 38 U.S.C. 1703A.

[75 FR 78915, Dec. 17, 2010, as amended at 78 FR 26251, May 6, 2013; 78 FR 68364, Nov. 14, 2013; 79 FR 16200, Mar. 25, 2014; 84 FR 26306, June 5, 2019]

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: 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. Redesignated and amended at 61 FR 21965, 21966, May 13, 1996 and further redesignated at 63 FR 39515, July 23, 1998; 79 FR 54615, Sept. 12, 2014]

§ 17.58 Evacuation of community nursing homes.

When veterans are evacuated from a community nursing home as the result of an emergency, they may be relocated to another facility that meets certain minimum standards, as set forth in 38 CFR 51.59(c)(1).

(Authority: 38 U.S.C. 501, 1720)

[76 FR 55571, Sept. 8, 2011]

§ 17.60 Extensions of community nursing home care beyond six months.

Directors of health care facilities may authorize, for any veteran whose hospitalization was not primarily for a service-connected disability, an extension of nursing care in a public or private nursing home care facility at VA expense beyond six months when the need for nursing home care continues to exist and

(a) Arrangements for payment of such care through a public assistance program (such as Medicaid) for which the veteran has applied, have been delayed due to unforeseen eligibility problems which can reasonably be expected to be resolved within the extension period, or

(b) The veteran has made specific arrangements for private payment for such care, and

(1) Such arrangements cannot be effectuated as planned because of unforseen, unavoidable difficulties, such as a temporary obstacle to liquidation of property, and

(2) Such difficulties can reasonably be expected to be resolved within the extension period; or

(c) The veteran is terminally ill and life expectancy has been medically determined to be less than six months.

(d) In no case may an extension under paragraph (a) or (b) of this section exceed 45 days.

(Authority: 38 U.S.C. 501, 1720(a))

[53 FR 13121, Apr. 21, 1988. Redesignated at 61 FR 21965, May 13, 1996]

COMMUNITY RESIDENTIAL CARE

SOURCE: 54 FR 20842, May 15, 1989, unless otherwise noted.

§ 17.61 Eligibility.

VA health care personnel may assist a veteran by referring such veteran for placement in a privately or publicly-owned community residential care facility if:

(a) At the time of initiating the assistance:

(1) The veteran is receiving VA medical services on an outpatient basis or VA medical center, domiciliary, or nursing home care; or

(2) Such care or services were furnished the veteran within the preceding 12 months;

(b) The veteran does not need hospital or nursing home care but is unable to live independently because of medical (including psychiatric) conditions and has no suitable family resources to provide needed monitoring, supervision, and any necessary assistance in the veteran's daily living activities; and

(c) The facility has been approved in accordance with § 17.63 of this part.

(Authority: 38 U.S.C. 1730)

[54 FR 20842, May 15, 1989. Redesignated and amended at 61 FR 21965, 21966, May 13, 1996]

§ 17.62 Definitions.

For the purpose of §§ 17.61 through 17.72:

(a) The term *community residential care* means the monitoring, supervision, and assistance, in accordance with a statement of needed care, of the daily living activities of referred veterans in an approved home in the community by the facility's provider.

(b) The term *daily living activities* includes:

(1) Walking;

(2) Bathing, shaving, brushing teeth, combing hair;

(3) Dressing;

(4) Eating;

(5) Getting in or getting out of bed;

(6) Laundry;

(7) Cleaning room;

(8) Managing money;

(9) Shopping;

(10) Using public transportation;

(11) Writing letters;

(12) Making telephone calls;

(13) Obtaining appointments;

(14) Self-administration of medications;

(15) Recreational and leisure activities; and

(16) Other similar activities.

(c) The term *paper hearing* means a review of the written evidence of record by the hearing official.

(d) The term *oral hearing* means the in person testimony of representatives of a community residential care facility and of VA before the hearing official and the review of the written evidence of record by that official.

(e) The term *approving official* means the Director or, if designated by the Director, the Associate Director or Chief of Staff of a Department of Veterans Affairs Medical Center or Outpatient Clinic which has jurisdiction to approve a community residential care facility.

(f) The term *hearing official* means the Director or, if designated by the Director, the Associate Director or

Chief of Staff of a Department of Veterans Affairs Medical Center or Outpatient Clinic which has jurisdiction to approve a community residential care facility.

(Authority: 38 U.S.C. 1730)

[54 FR 20842, May 15, 1989. Redesignated and amended at 61 FR 21965, 21966, May 13, 1996; 74 FR 63308, Dec. 3, 2009]

§ 17.63 Approval of community residential care facilities.

The approving official may approve a community residential care facility, based on the report of a VA inspection and on any findings of necessary interim monitoring of the facility, if that facility meets the following standards:

(a) *Health and safety standards.* The facility must:

(1) Meet all State and local regulations including construction, maintenance, and sanitation regulations;

(2) Meet the requirements in the applicable provisions of NFPA 101 and NFPA 101A (incorporated by reference, *see* § 17.1) and the other publications referenced in those provisions. The institution shall provide sufficient staff to assist patients in the event of fire or other emergency. Any equivalencies or variances to VA requirements must be approved by the appropriate Veterans Health Administration Veterans Integrated Service Network (VISN) Director;

(3) Have safe and functioning systems for heating and/or cooling, as needed (a heating or cooling system is deemed to be needed if VA determines that, in the county, parish, or similar jurisdiction where the facility is located, a majority of community residential care facilities or other extended care facilities have one), hot and cold water, electricity, plumbing, sewage, cooking, laundry, artificial and natural light, and ventilation.

(4) Meet the following additional requirements, if the provisions for One and Two-Family Dwellings, as defined in NFPA 101, are applicable to the facility:

(i) Portable fire extinguishers must be installed, inspected, and maintained in accordance with NFPA 10 (incorporated by reference, *see* § 17.1); and

(ii) The facility must meet the requirements in section 33.7 of NFPA 101.

(b) [Reserved]

(c) *Interior plan.* The facility must:

(1) Have comfortable dining areas, adequate in size for the number of residents;

(2) Have confortable living room areas, adequate in size to accommodate a reasonable proportion of residents; and

(3) Maintain at least one functional toilet and lavatory, and bathing or shower facility for every six people living in the facility, including provider and staff.

(d) *Laundry service.* The facility must provide or arrange for laundry service.

(e) *Residents' bedrooms.* Residents' bedrooms must:

(1) Contain no more than four beds;

(i) Facilities approved before August 24, 2017 may not establish any new resident bedrooms with more than two beds per room;

(ii) Facilities approved after August 24, 2017 may not provide resident bedrooms containing more than two beds per room.

(2) Measure, exclusive of closet space, at least 100 square feet for a single-resident room, or 80 square feet for each resident in a multiresident room; and

(3) Contain a suitable bed for each resident and appropriate furniture and furnishings.

(f) *Nutrition.* The facility must:

(1) Provide a safe and sanitary food service that meets individual nutritional requirements and residents' preferences;

(2) Plan menus to meet currently recommended dietary allowances;

(g) *Activities.* The facility must plan and facilitate appropriate recreational and leisure activities to meet individual needs.

(h) *Residents' rights.* The facility must have written policies and procedures that ensure the following rights for each resident:

(1) Each resident has the right to:

(i) Be informed of the rights described in this section;

(ii) The confidentiality and nondisclosure of information obtained by community residential care facility staff on the residents and the residents' records subject to the requirements of applicable law;

(iii) Be able to inspect the residents' own records kept by the community residential care facility;

(iv) Exercise rights as a citizen; and

(v) Voice grievances and make recommendations concerning the policies and procedures of the facility.

(2) *Financial affairs*. Residents must be allowed to manage their own personal financial affairs, except when the resident has been restricted in this right by law. If a resident requests assistance from the facility in managing personal financial affairs the request must be documented.

(3) *Privacy*. Residents must:

(i) Be treated with respect, consideration, and dignity;

(ii) Have access, in reasonable privacy, to a telephone within the facility;

(iii) Be able to send and receive mail unopened and uncensored; and

(iv) Have privacy of self and possessions.

(4) *Work*. No resident will perform household duties, other than personal housekeeping tasks, unless the resident receives compensation for these duties or is told in advance they are voluntary and the patient agrees to do them.

(5) *Freedom of association*. Residents have the right to:

(i) Receive visitors and associate freely with persons and groups of their own choosing both within and outside the facility;

(ii) Make contacts in the community and achieve the highest level of independence, autonomy, and interaction in the community of which the resident is capable;

(iii) Leave and return freely to the facility, and

(iv) Practice the religion of their own choosing or choose to abstain from religious practice.

(6) *Transfer*. Residents have the right to transfer to another facility or to an independent living situation.

(i) *Records*. (1) The facility must maintain records on each resident in a secure place. Resident records must include a copy of all signed agreements with the resident. Resident records may be disclosed only with the permission of the resident; an authorized agent, fiduciary, or personal representative if the resident is not competent; or when required by law.

(2) The facility must maintain and make available, upon request of the approving VA official, records establishing compliance with paragraphs (j)(1) and (2) of this section; written policies and procedures required under paragraph (j)(3) of this section; and, emergency notification procedures.

(j) *Staff requirements*. (1) Sufficient, qualified staff must be on duty and available to care for the resident and ensure the health and safety of each resident.

(2) The community residential care provider and staff must have the following qualifications: Adequate education, training, or experience to maintain the facility.

(3) The community residential care provider must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.

(4) Except as provided in paragraph (j)(5)(ii) of this section, the community residential care provider must not employ individuals who—

(i) Have been convicted within 7 years by a court of law of any of the following offenses or their equivalent in a state or territory:

(A) Murder, attempted murder, or manslaughter;

(B) Arson;

(C) Assault, battery, assault and battery, assault with a dangerous weapon, mayhem or threats to do bodily harm;

(D) Burglary;

(E) Robbery;

(F) Kidnapping;

(G) Theft, fraud, forgery, extortion or blackmail;

(H) Illegal use or possession of a firearm;

(I) Rape, sexual assault, sexual battery, or sexual abuse;

(J) Child or elder abuse, or cruelty to children or elders; or

(K) Unlawful distribution or possession with intent to distribute a controlled substance; or

(ii) Have had a finding entered within 6 months into an applicable State registry or with the applicable licensing authority concerning abuse, neglect,

mistreatment of individuals or misappropriation of property.

(5)(i) If the conviction by a court of law of a crime enumerated in paragraph (j)(4)(i) of this section occurred greater than 7 years in the past, or a finding was entered into an applicable State registry as specified in paragraph (j)(4)(ii) of this section more than 6 months in the past, the community residential care provider must perform an individual assessment of the applicant or employee to determine suitability for employment. The individual assessment must include consideration of the following factors:

(A) The nature of the job held or sought;

(B) The nature and gravity of the offense or offenses;

(C) The time that has passed since the conviction and/or completion of the sentence;

(D) The facts or circumstances surrounding the offense or conduct;

(E) The number of offenses for which the individual was convicted;

(F) The employee or applicant's age at the time of conviction, or release from prison;

(G) The nexus between the criminal conduct of the person and the job duties of the position;

(H) Evidence that the individual performed the same type of work, post-conviction, with the same or a different employer, with no known incidents of criminal conduct;

(I) The length and consistency of employment history before and after the offense or conduct; rehabilitation efforts, including education or training; and,

(J) Employment or character references and any other information regarding fitness for the particular position.

(ii) An individual assessment must be performed to determine suitability for employment for any conviction defined in paragraph (j)(8)(iv), regardless of the age of the conviction.

(6)(i) The community residential care provider must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source, and misappropriation of resident property are reported to the approving official immediately, which means no more than 24 hours after the provider becomes aware of the alleged violation; and to other officials in accordance with State law. The report, at a minimum, must include—

(A) The facility name, address, telephone number, and owner;

(B) The date and time of the alleged violation;

(C) A summary of the alleged violation;

(D) The name of any public or private officials or VHA program offices that have been notified of the alleged violations, if any;

(E) Whether additional investigation is necessary to provide VHA with more information about the alleged violation;

(F) The name of the alleged victim;

(G) Contact information for the resident's next of kin or other designated family member, agent, personal representative, or fiduciary; and

(H) Contact information for a person who can provide additional details at the community residential care provider, including a name, position, location, and phone number.

(ii) The community residential care provider must notify the resident's next of kin, caregiver, other designated family member, agent, personal representative, or fiduciary of the alleged incident concurrently with submission of the incident report to the approving official.

(iii) The community residential care provider must have evidence that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source, and misappropriation of resident property are documented and thoroughly investigated, and must prevent further abuse while the investigation is in progress. The results of all investigations must be reported to the approving official within 5 working days of the incident and to other officials in accordance with all other applicable law, and appropriate corrective action must be taken if the alleged violation is verified. Any corrective action taken by the community residential care provider as a result of such investigation must be reported to the approving official, and to other officials as required under all other applicable law.

(iv) The community residential care provider must remove all duties requiring direct resident contact with veteran residents from any employee alleged to have violated this paragraph (j) during the investigation of such employee.

(7) For purposes of this paragraph (j), the term ''employee'' includes a:

(i) Non-VA health care provider at the community residential care facility;

(ii) Staff member of the community residential care facility who is not a health care provider, including a contractor; and

(iii) Person with direct resident access. The term ''person with direct resident access'' means an individual living in the facility who is not receiving services from the facility, who may have access to a resident or a resident's property, or may have one-on-one contact with a resident.

(8) For purposes of this paragraph (j), an employee is considered ''convicted'' of a criminal offense—

(i) When a judgment of conviction has been entered against the individual by a Federal, State, or local court, regardless of whether there is an appeal pending;

(ii) When there has been a finding of guilt against the individual by a Federal, State, or local court;

(iii) When a plea of guilty or nolo contendere by the individual has been accepted by a Federal, State, or local court; or

(iv) When the individual has entered into participation in a first offender, deferred adjudication, or other arrangement or program where judgment of conviction has been withheld.

(9) For purposes of this paragraph (j), the terms ''abuse'' and ''neglect'' have the same meaning set forth in 38 CFR 51.90(b).

(k) *Cost of community residential care.* (1) Payment for the charges of community residential care is not the responsibility of the United States Government or VA.

(2) The resident or an authorized personal representative and a representative of the community residential care facility must agree upon the charge and payment procedures for community residential care.

(3) The charges for community residential care must be reasonable:

(i) For residents in a community residential care facility as of June 14, 1989, the rates charged for care are pegged to the facility's basic rate for care as of July 31, 1987. Increases in the pegged rate during any calendar year cannot exceed the annual percentage increase in the National Consumer Price Index (CPI) for that year;

(ii) For community residential care facilities approved after July 31, 1987, the rates for care shall not exceed 110 percent of the average rate for approved facilities in that State as of March 31, 1987. Increases in this rate during any calendar year cannot exceed the annual percentage increase in the National Consumer Price Index (CPI) for that year.

(iii) The approving official may approve a deviation from the requirements of paragraphs (k)(3)(i) through (ii) of this section upon request from a community residential care facility representative, a resident in the facility, or an applicant for residency, if the approving official determines that the cost of care for the resident will be greater than the average cost of care for other residents, or if the resident chooses to pay more for the care provided at a facility which exceeds VA standards.

(Authority: 38 U.S.C. 1730)

(The information collection requirements in this section have been approved by the Office of Management and Budget under control number 2900–0844.)

[54 FR 20842, May 15, 1989, as amended at 54 FR 22754, May 26, 1989. Redesignated at 61 FR 21965, May 13, 1996, as amended at 61 FR 63720, Dec. 2, 1996; 69 FR 18803, Apr. 9, 2004; 74 FR 63308, Dec. 3, 2009; 76 FR 10248, Feb. 24, 2011; 82 FR 34415, July 25, 2017; 82 FR 35451, July 31, 2017]

§ 17.64 [Reserved]

§ 17.65 Approvals and provisional approvals of community residential care facilities.

(a) An approval of a facility meeting all of the standards in 38 CFR 17.63 based on the report of a VA inspection and any findings of necessary interim monitoring of the facility shall be for a 12-month period.

(b) The approving official, based on the report of a VA inspection and on any findings of necessary interim monitoring of the facility, may provide a community residential care facility with a provisional approval if that facility does not meet one or more of the standards in 38 CFR 17.63, provided that the deficiencies do not jeopardize the health or safety of the residents, and that the facility management and VA agree to a plan of correcting the deficiencies in a specified amount of time. A provisional approval shall not be for more than 12 months and shall not be for more time than VA determines is reasonable for correcting the specific deficiencies.

(c) An approval may be changed to a provisional approval or terminated under the provisions of §§ 17.66 through 17.71 because of a subsequent failure to meet the standards of § 17.63 and a provisional approval may be terminated under the provisions of §§ 17.66 through 17.71 based on failure to meet the plan of correction or failure otherwise to meet the standards of § 17.63.

(d)(1) VA may waive one or more of the standards in 38 CFR 17.63 for the approval of a particular community residential care facility, provided that a VA safety expert certifies that the deficiency does not endanger the life or safety of the residents; the deficiency cannot be corrected as provided in paragraph (b) of this section for provisional approval of the community residential care facility; and granting the waiver is in the best interests of the veteran in the facility and VA's community residential care program. In order to reach the above determinations, the VA safety expert may request supporting documentation from the community residential care facility.

(2) In those instances where a waiver is granted, the subject standard is deemed to have been met for purposes of approval of the community residential care facility under paragraphs (a) or (b) of this section. The waiver and date of issuance will be noted on each annual survey of the facility as long as the waiver remains valid and in place.

(3) A waiver issued under this section remains valid so long as the community residential care facility operates continuously under this program without a break. VA may, on the recommendation of an approving official, rescind a waiver issued under this section if a VA inspector determines that there has been a change in circumstances and that the deficiency can now be corrected, or a VA safety expert finds that the deficiency jeopardizes the health and safety of residents.

(Authority: 38 U.S.C. 1730)

[74 FR 63308, Dec. 3, 2009, as amended at 78 FR 32126, May 29, 2013]

§ 17.66 Notice of noncompliance with VA standards.

If the hearing official determines that an approved community residential care facility does not comply with the standards set forth in § 17.63 of this part, the hearing official shall notify the community residential care facility in writing of:

(a) The standards which have not been met;

(b) The date by which the standards must be met in order to avoid revocation of VA approval;

(c) The community residential care facility's opportunity to request an oral or paper hearing under § 17.67 of this part before VA approval is revoked; and

(d) The date by which the hearing official must receive the community residential care facility's request for a hearing, which shall not be less than 10 calendar days and not more than 20 calendar days after the date of VA notice of noncompliance, unless the hearing official determines that noncompliance with the standards threatens the lives of community residential care residents in which case the hearing official must receive the community residential care facility's request for an oral or paper hearing within 36 hours of receipt of VA notice.

(Authority: 38 U.S.C. 1730)

[54 FR 20842, May 15, 1989. Redesignated and amended at 61 FR 21965, 21967, May 13, 1996; 78 FR 32126, May 29, 2013]

§ 17.67 Request for a hearing.

The community residential care facility operator must specify in writing whether an oral or paper hearing is requested. The request for the hearing

must be sent to the hearing official. Timely receipt of a request for a hearing will stay the revocation of VA approval until the hearing official issues a written decision on the community residential care facility's compliance with VA standards. The hearing official may accept a request for a hearing received after the time limit, if the community residential care facility shows that the failure of the request to be received by the hearing official's office by the required date was due to circumstances beyond its control.

(Authority: 38 U.S.C. 1730)

[54 FR 20842, May 15, 1989. Redesignated at 61 FR 21965, May 13, 1996]

§ 17.68 Notice and conduct of hearing.

(a) Upon receipt of a request for an oral hearing, the hearing official shall:

(1) Notify the community residential care facility operator of the date, time, and location for the hearing; and

(2) Notify the community residential care facility operator that written statements and other evidence for the record may be submitted to the hearing official before the date of the hearing. An oral hearing shall be informal. The rules of evidence shall not be followed. Witnesses shall testify under oath or affirmation. A recording or transcript of every oral hearing shall be made. The hearing official may exclude irrelevant, immaterial, or unduly repetitious testimony.

(b) Upon the receipt of a community residential care facility's request for a paper hearing, the hearing official shall notify the community residential care facility operator that written statements and other evidence must be submitted to the hearing official by a specified date in order to be considered as part of the record.

(c) In all hearings, the community residential care facility operator and VA may be represented by counsel.

(Authority: 38 U.S.C. 1730)

[54 FR 20842, May 15, 1989. Redesignated at 61 FR 21965, May 13, 1996]

§ 17.69 Waiver of opportunity for hearing.

If representatives of a community residential care facility which receive a notice of noncompliance under § 17.66 of this part fail to appear at an oral hearing of which they have been notified or fail to submit written statements for a paper hearing in accordance with § 17.68 of this part, unless the hearing official determines that their failure was due to circumstances beyond their control, the hearing official shall:

(a) Consider the representatives of the community residential care facility to have waived their opportunity for a hearing; and,

(b) Revoke VA approval of the community residential care facility and notify the community residential care facility of this revocation.

(Authority: 38 U.S.C. 1730)

[54 FR 20842, May 15, 1989. Redesignated and amended at 61 FR 21965, 21967, May 13, 1996]

§ 17.70 Written decision following a hearing.

(a) The hearing official shall issue a written decision within 20 days of the completion of the hearing. An oral hearing shall be considered completed when the hearing ceases to receive in person testimony. A paper hearing shall be considered complete on the date by which written statements must be submitted to the hearing official in order to be considered as part of the record.

(b) The hearing official's determination of a community residential care facility's noncompliance with VA standards shall be based on the preponderance of the evidence.

(c) The written decision shall include:

(1) A statement of the facts;

(2) A determination whether the community residential care facility complies with the standards set forth in § 17.63 of this part; and

(3) A determination of the time period, if any, the community residential care facility shall have to remedy any noncompliance with VA standards before revocation of VA approval occurs.

(d) The hearing official's determination of any time period under paragraph (c)(3) of this section shall consider the safety and health of the residents of the community residential care facility and the length of time since the community residential care

facility received notice of the noncompliance.

(Authority: 38 U.S.C. 1730)

[54 FR 20842, May 15, 1989. Redesignated and amended at 61 FR 21965, 21967, May 13, 1996]

§ 17.71 Revocation of VA approval.

(a) If a hearing official determines under § 17.70 of this part that a community residential care facility does not comply with the standards set forth in § 17.63 of this part and determines that the community residential care facility shall not have further time to remedy the noncompliance, the hearing official shall revoke approval of the community residential care facility and notify the community residential care facility of this revocation.

(b) Upon revocation of VA approval, VA health care personnel shall:

(1) Cease referring veterans to the community residential care facility; and,

(2) Notify any veteran residing in the community residential care facility of the facility's disapproval and request permission to assist in the veteran's removal from the facility. If a veteran has a person or entity authorized by law to give permission on behalf of the veteran, VA health care personnel shall notify that person or entity of the community residential care facility's disapproval and request permission to assist in removing the veteran from the community residential care facility.

(c) If the hearing official determines that a community residential care facility fails to comply with the standards set forth in § 17.63 of this part and determines that the community residential care facility shall have an additional time period to remedy the noncompliance, the hearing official shall review at the end of the time period the evidence of the community residential care facility's compliance with the standards which were to have been met by the end of that time period and determine if the community residential care facility complies with the standards. If the community residential care facility fails to comply with these or any other standards, the procedures set forth in §§ 17.66–17.71 of this part shall be followed.

(Authority: 38 U.S.C. 1730)

[54 FR 20842, May 15, 1989. Redesignated and amended at 61 FR 21965, 21967, May 13, 1996]

§ 17.72 Availability of information.

VA standards will be made available to other Federal, State and local agencies charged with the responsibility of licensing, or otherwise regulating or inspecting community residential care facilities.

(Authority: 38 U.S.C. 1730)

[54 FR 20842, May 15, 1989. Redesignated at 61 FR 21965, May 13, 1996]

§ 17.73 Medical foster homes—general.

(a) *Purpose*. Through the medical foster home program, VA recognizes and approves certain medical foster homes for the placement of veterans. The choice to become a resident of a medical foster home is a voluntary one on the part of each veteran. VA's role is limited to referring veterans to approved medical foster homes. When a veteran is placed in an approved home, VA will provide inspections to ensure that the home continues to meet the requirements of this part, as well as oversight and medical foster home caregiver training. If a medical foster home does not meet VA's criteria for approval, VA will not refer any veteran to the home or provide any of these services. VA may also provide certain medical benefits to veterans placed in medical foster homes, consistent with the VA program in which the veteran is enrolled.

(b) *Definitions*. For the purposes of this section and § 17.74:

Labeled means that the equipment or materials have attached to them a label, symbol, or other identifying mark of an organization recognized as having jurisdiction over the evaluation and periodic inspection of such equipment or materials, and by whose labeling the manufacturer indicates compliance with appropriate standards or performance.

Medical foster home means a private home in which a medical foster home caregiver provides care to a veteran resident and:

(i) The medical foster home caregiver lives in the medical foster home;

(ii) The medical foster home caregiver owns or rents the medical foster home; and

(iii) There are not more than three residents receiving care (including veteran and non-veteran residents).

Medical foster home caregiver means the primary person who provides care to a veteran resident in a medical foster home.

Placement refers to the voluntary decision by a veteran to become a resident in an approved medical foster home.

Veteran resident means a veteran residing in an approved medical foster home who meets the eligibility criteria in paragraph (c) of this section.

(c) *Eligibility*. VA health care personnel may assist a veteran by referring such veteran for placement in a medical foster home if:

(1) The veteran is unable to live independently safely or is in need of nursing home level care;

(2) The veteran must be enrolled in, or agree to be enrolled in, either a VA Home Based Primary Care or VA Spinal Cord Injury Homecare program, or a similar VA interdisciplinary program designed to assist medically complex veterans living in the home; and

(3) The medical foster home has been approved in accordance with paragraph (d) of this section.

(d) *Approval of medical foster homes*. Medical foster homes will be approved by a VA Medical Foster Homes Coordinator based on the report of a VA inspection and on any findings of necessary interim monitoring of the medical foster home, if that home meets the standards established in § 17.74. The approval process is governed by the process for approving community residential care facilities under §§ 17.65 through 17.72 except as follows:

(1) Where §§ 17.65 through 17.72 reference § 17.63.

(2) Because VA does not physically place veterans in medical foster homes, VA also does not assist veterans in moving out of medical foster homes as we do for veterans in other community residential care facilities under § 17.72(d)(2); however, VA will assist such veterans in locating an approved medical foster home when relocation is necessary.

(e) *Duties of Medical foster home caregivers*. The medical foster home caregiver, with assistance from relief caregivers, provides a safe environment, room and board, supervision, and personal assistance, as appropriate for each veteran.

(Authority: 38 U.S.C. 501, 1730)

[77 FR 5188, Feb. 2, 2012]

§ 17.74 Standards applicable to medical foster homes.

(a) *General*. A medical foster home must:

(1) Meet all applicable state and local regulations, including construction, maintenance, and sanitation regulations.

(2) Have safe and functioning systems for heating, hot and cold water, electricity, plumbing, sewage, cooking, laundry, artificial and natural light, and ventilation. Ventilation for cook stoves is not required.

(3) Except as otherwise provided in this section, meet the applicable provisions of chapters 1 through 11 and 24, and section 33.7 of NFPA 101 (incorporated by reference, see § 17.1), and the other codes and chapters identified in this section, as applicable. Existing buildings or installations that do not comply with the installation provisions of the codes or standards referenced in paragraph (b)(1) through (5), (b)(8), and (b)(10) of § 17.1 shall be permitted to be continued in service, provided that the lack of conformity with these codes and standards does not present a serious hazard to the occupants.

(b) *Community residential care facility standards applicable to medical foster homes*. Medical foster homes must comply with § 17.63(c), (d), (f), (h), (j) and (k).

(c) *Activities*. The facility must plan and facilitate appropriate recreational and leisure activities.

(d) *Residents' bedrooms*. Each veteran resident must have a bedroom:

(1) With a door that closes and latches;

(2) That contains a suitable bed and appropriate furniture; and

(3) That is single occupancy, unless the veteran agrees to a multi-occupant bedroom.

(e) *Windows.* VA may grant provisional approval for windows used as a secondary means of escape that do not meet the minimum size and dimensions required by chapter 24 of NFPA 101 (incorporated by reference, see § 17.1) if the windows are a minimum of 5.0 square feet (and at least 20 inches wide and at least 22 inches high). The secondary means of escape must be brought into compliance with chapter 24 no later than 60 days after a veteran resident is placed in the home.

(f) *Special locking devices.* Special locking devices that do not comply with section 7.2.1.5 of NFPA 101 (incorporated by reference, see § 17.1) are permitted where the clinical needs of the veteran resident require specialized security measures and with the written approval of:

(1) The responsible VA clinician; and

(2) The VA fire/safety specialist or the Director of the VA Medical Center of jurisdiction.

(g) *Smoke and carbon monoxide (CO) detectors and smoke and CO alarms.* Medical foster homes must comply with this paragraph (g) no later than 60 days after the first veteran is placed in the home. Prior to compliance, VA inspectors will provisionally approve a medical foster home for the duration of this 60-day period if the medical foster home mitigates risk through the use of battery-operated single station alarms, provided that the alarms are installed before any veteran is placed in the home.

(1) Smoke detectors or smoke alarms must be provided in accordance with sections 24.3.4.1.1 or 24.3.4.1.2 of NFPA 101 (incorporated by reference, see § 17.1); section 24.3.4.1.3 of NFPA 101 will not be used. In addition, smoke alarms must be interconnected so that the operation of any smoke alarm causes an alarm in all smoke alarms within the medical foster home. Smoke detectors or smoke alarms must not be installed in the kitchen or any other location subject to causing false alarms.

(2) CO detectors or CO alarms must be installed in any medical foster home with a fuel-burning appliance, fireplace, or an attached garage, in accordance with NFPA 720 (incorporated by reference, see § 17.1).

(3) Combination CO/smoke detectors and combination CO/smoke alarms are permitted.

(4) Smoke detectors and smoke alarms must initiate a signal to a remote supervising station to notify emergency forces in the event of an alarm.

(5) Smoke and/or CO alarms and smoke and/or CO detectors, and all other elements of a fire alarm system, must be inspected, tested, and maintained in accordance with NFPA 72 (incorporated by reference, see § 17.1) and NFPA 720 (incorporated by reference, see § 17.1).

(h) *Sprinkler systems.* (1) If a sprinkler system is installed, it must be inspected, tested, and maintained in accordance with NFPA 25 (incorporated by reference, see § 17.1), unless the sprinkler system is installed in accordance with NFPA 13D (incorporated by reference, see § 17.1). If a sprinkler system is installed in accordance with NFPA 13D, it must be inspected annually by a competent person.

(2) If sprinkler flow or pressure switches are installed, they must activate notification appliances in the medical foster home, and must initiate a signal to the remote supervising station.

(i) *Fire extinguishers.* At least one 2–A:10–B:C rated fire extinguisher must be visible and readily accessible on each floor, including basements, and must be maintained in accordance with the manufacturer's instructions. Portable fire extinguishers must be inspected, tested, and maintained in accordance with NFPA 10 (incorporated by reference, see § 17.1).

(j) *Emergency lighting.* Each occupied floor must have at least one plug-in rechargeable flashlight, operable and readily accessible, or other approved emergency lighting. Such emergency lighting must be tested monthly and replaced if not functioning.

(k) *Fireplaces.* A non-combustible hearth, in addition to protective glass doors or metal mesh screens, is required for fireplaces. Hearths and protective devices must meet all applicable state and local fire codes.

(l) *Portable heaters.* Portable heaters may be used if they are maintained in good working condition and:

(1) The heating elements of such heaters do not exceed 212 degrees Fahrenheit (100 degrees Celsius);

(2) The heaters are labeled; and

(3) The heaters have tip-over protection.

(m) *Oxygen safety*. Any area where oxygen is used or stored must not be near an open flame and must have a posted ''No Smoking'' sign. Oxygen cylinders must be adequately secured or protected to prevent damage to cylinders. Whenever possible, transfilling of liquid oxygen must take place outside of the living areas of the home.

(n) *Smoking*. Smoking must be prohibited in all sleeping rooms, including sleeping rooms of non-veteran residents. Ashtrays must be made of noncombustible materials.

(o) *Special/other hazards*. (1) Extension cords must be three-pronged, grounded, sized properly, and not present a hazard due to inappropriate routing, pinching, damage to the cord, or risk of overloading an electrical panel circuit.

(2) Flammable or combustible liquids and other hazardous material must be safely and properly stored in either the original, labeled container or a safety can as defined by NFPA 30 (incorporated by reference, see §17.1).

(p) *Emergency egress and relocation drills*. Operating features of the medical foster home must comply with section 33.7 of NFPA 101 (incorporated by reference, see §17.1), except that section 33.7.3.6 of NFPA 101 does not apply. Instead, VA will enforce the following requirements:

(1) Before placement in a medical foster home, the veteran will be clinically evaluated by VA to determine whether the veteran is able to participate in emergency egress and relocation drills. Within 24 hours after arrival, each veteran resident must be shown how to respond to a fire alarm and evacuate the medical foster home, unless the veteran resident is unable to participate.

(2) The medical foster home caregiver must demonstrate the ability to evacuate all occupants within three minutes to a point of safety outside of the medical foster home that has access to a public way, as defined in NFPA 101 (incorporated by reference, see §17.1).

(3) If all occupants are not evacuated within three minutes or if a veteran resident is either permanently or temporarily unable to participate in drills, then the medical foster home will be given a 60-day provisional approval, after which time the home must have established one of the following remedial options or VA will terminate the approval in accordance with §17.65.

(i) The home is protected throughout with an automatic sprinkler system in accordance with section 9.7 of NFPA 101 (incorporated by reference, see §17.1) and whichever of the following apply: NFPA 13 (incorporated by reference, see §17.1); NFPA 13R (incorporated by reference, see §17.1); or NFPA 13D (incorporated by reference, see §17.1).

(ii) Each veteran resident who is permanently or temporarily unable to participate in a drill or who fails to evacuate within three minutes must have a bedroom located at the ground level with direct access to the exterior of the home that does not require travel through any other portion of the residence, and access to the ground level must meet the requirements of the Americans with Disabilities Act. The medical foster home caregiver's bedroom must also be on ground level.

(4) The 60-day provisional approval under paragraph (p)(3) of this section may be contingent upon increased fire prevention measures, including but not limited to prohibiting smoking or use of a fireplace. However, each veteran resident who is temporarily unable to participate in a drill will be permitted to be excused from up to two drills within one 12-month period, provided that the two excused drills are not consecutive, and this will not be a cause for VA to not approve the home.

(5) For purposes of paragraph (p), the term *all occupants* means every person in the home at the time of the emergency egress and relocation drill, including non-residents.

(q) *Records of compliance with this section*. The medical foster home must comply with §17.63(i) regarding facility records, and must document all inspection, testing, drills and maintenance activities required by this section. Such documentation must be maintained for 3 years or for the period specified by the applicable NFPA

standard, whichever is longer. Documentation of emergency egress and relocation drills must include the date, time of day, length of time to evacuate the home, the name of each medical foster home caregiver who participated, the name of each resident, whether the resident participated, and whether the resident required assistance.

(r) *Local permits and emergency response.* Where applicable, a permit or license must be obtained for occupancy or business by the medical foster home caregiver from the local building or business authority. When there is a home occupant who is incapable of self-preservation, the local fire department or response agency must be notified by the medical foster home within 7 days of the beginning of the occupant's residency.

(s) *Equivalencies.* Any equivalencies to VA requirements must be in accordance with section 1.4.3 of NFPA 101 (incorporated by reference, see § 17.1), and must be approved in writing by the appropriate Veterans Health Administration, Veterans Integrated Service Network (VISN) Director. A veteran living in a medical foster home when the equivalency is granted or who is placed there after it is granted must be notified in writing of the equivalencies and that he or she must be willing to accept such equivalencies. The notice must describe the exact nature of the equivalency, the requirements of this section with which the medical foster home is unable to comply, and explain why the VISN Director deemed the equivalency necessary. Only equivalencies that the VISN Director determines do not pose a risk to the health or safety of the veteran may be granted. Also, equivalencies may only be granted when technical requirements of this section cannot be complied with absent undue expense, there is no other nearby home which can serve as an adequate alternative, and the equivalency is in the best interest of the veteran.

(t) *Cost of medical foster homes.* (1) Payment for the charges to veterans for the cost of medical foster home care is not the responsibility of the United States Government.

(2) The resident or an authorized personal representative and a representative of the medical foster home facility must agree upon the charge and payment procedures for medical foster home care.

(3) The charges for medical foster home care must be comparable to prices charged by other assisted living and nursing home facilities in the area based on the veteran's changing care needs and local availability of medical foster homes. (The Office of Management and Budget has approved the information collection requirements in this section under control number 2900–0777.)

(Authority: 38 U.S.C. 501, 1730)

[77 FR 5189, Feb. 2, 2012, as amended at 80 FR 44862, July 28, 2015]

USE OF SERVICES OF OTHER FEDERAL AGENCIES

§ 17.80 Alcohol and drug dependence or abuse treatment and rehabilitation in residential and nonresidential facilities by contract.

(a) Alcohol and drug dependence or abuse treatment and rehabilitation may be authorized by contract in nonresidential facilities and in residential facilities provided by halfway houses, therapeutic communities, psychiatric residential treatment centers and other community-based treatment facilities, when considered to be medically advantageous and cost effective for the following:

(1) Veterans who have been or are being furnished care by professional staff over which the Secretary has jurisdiction and such transitional care is reasonably necessary to continue treatment;

(2) Persons in the Armed Forces who, upon discharge therefrom will become eligible veterans, when duly referred with authorization for Department of Veterans Affairs medical center hospital care in preparation for treatment and rehabilitation in this program under the following limitations:

(i) Such persons may be accepted by transfer only during the last 30 days of such person's enlistment or tour of duty,

(ii) The person requests transfer in writing for treatment for a specified

period of time during the last 30 days of such person's enlistment period or tour of duty,

(iii) Treatment does not extend beyond the period of time specified in the request unless such person requests in writing an extension for a further specified period of time and such request is approved by the Department of Veterans Affairs Medical Center Director authorizing treatment and rehabilitation,

(iv) Such care and treatment will be provided as if the person were a veteran, subject to reimbursement by the respective military service for the costs of hospital care and control treatment provided while the person is an active duty member.

(b) The maximum period for one treatment episode is limited to 60 days. The Department of Veterans Affairs Medical Center Director may authorize one 30-day extension.

(c) Any person who has been discharged or released from active military, naval or air service, and who, upon application for treatment and rehabilitative services under the authority of this section is determined to be legally ineligible for such treatment or rehabilitation services shall be:

(1) Provided referral services to assist the person, to the maximum extent possible, in obtaining treatment and rehabilitation services from sources outside the Department of Veterans Affairs, not at Department of Veterans Affairs expense and,

(2) If pertinent, advised of the right to apply to the appropriate military, naval or air service and the Department of Veterans Affairs for review of such person's discharge or release from such service.

(Authority: 38 U.S.C. 1720A)

[47 FR 57706, Dec. 28, 1982. Redesignated at 61 FR 21965, May 13, 1996, as amended at 61 FR 56897, Nov. 5, 1996]

§ 17.81 Contracts for residential treatment services for veterans with alcohol or drug dependence or abuse disabilities.

(a) Contracts for treatment services authorized under §17.80(a) may be awarded in accordance with applicable Department of Veterans Affairs and Federal procurement procedures. Such contracts will be awarded only after the quality and effectiveness, including adequate protection for the safety of the residents of the contractor's program, has been determined and then only to contractors, determined by the Under Secretary for Health or designee to meet the following requirements.

(1) Meet fire safety requirements as follows:

(i) The building must meet the requirements in the applicable provisions of NFPA 101 (incorporated by reference, *see* §17.1) and the other publications referenced in those provisions. Any equivalencies or variances to VA requirements must be approved by the appropriate Veterans Health Administration Veterans Integrated Service Network (VISN) Director.

(ii) Where applicable, the home must have a current occupancy permit issued by the local and state governments in the jurisdiction where the home is located.

(iii) All Department of Veterans Affairs sponsored residents will be mentally and physically capable of leaving the building, unaided, in the event of an emergency. Halfway house, therapeutic community and other residential program management must agree that all the other residents in any building housing veterans will also have such capability.

(iv) There must be at least one staff member on duty 24 hours a day.

(v) The facility must meet the following additional requirements, if the provisions for One and Two-Family Dwellings, as defined in NFPA 101, are applicable to the facility:

(A) Portable fire extinguishers shall be installed, inspected, and maintained in accordance with NFPA 10 (incorporated by reference, *see* §17.1).

(B) The facility shall meet the requirements in section 33.7 of NFPA 101.

(vi) An annual fire and safety inspection shall be conducted at the halfway house or residential facility by qualified Department of Veterans Affairs personnel. If a review of past Department of Veterans Affairs inspections or inspections made by the local authorities indicates that a fire and safety inspection would not be necessary, then the visit to the facility may be waived.

(2) Be in compliance with existing standards of State safety codes and local, and/or State health and sanitation codes.

(3) Be licensed under State or local authority.

(4) Where applicable, be accredited by the State.

(5) Comply with the requirements of the ''Confidentiality of Alcohol and Drug Abuse Patient Records'' (42 CFR part II) and the ''Confidentiality of Certain Medical Records'' (38 U.S.C. 7332), which shall be part of the contract.

(6) Demonstrate an existing capability to furnish the following:

(i) A supervised alcohol and drug free environment, including active affiliation with Alcoholics Anonymous (AA) programs.

(ii) Staff sufficient in numbers and position qualifications to carry out the policies, responsibilities, and programs of the facility.

(iii) Board and room.

(iv) Laundry facilities for residents to do their own laundry.

(v) Structured activities.

(vi) Appropriate group activities, including physical activities.

(vii) Health and personal hygiene maintenance.

(viii) Monitoring administration of medications.

(ix) Supportive social service.

(x) Individual counseling as appropriate.

(xi) Opportunities for learning/development of skills and habits which will enable Department of Veterans Affairs sponsored residents to adjust to and maintain freedom from dependence on or involvement with alcohol or drug abuse or dependence during or subsequent to leaving the facility.

(xii) Support for the individual desire for sobriety (alcohol/drug abuse-free life style).

(xiii) Opportunities for learning, testing, and internalizing knowledge of illness/recovery process, and for upgrading skills and improving personal relationships.

(7) Data normally maintained and included in a medical record as a function of compliance with State or community licensing standards will be accessible.

(b) Representatives of the Department of Veterans Affairs will inspect the facility prior to award of a contract to assure that prescribed requirements can be met. Inspections may also be carried out at such other times as deemed necessary by the Department of Veterans Affairs.

(c) All requirements in this rule, and Department of Veterans Affairs reports of inspection of residential facilities furnishing treatment and rehabilitation services to eligible veterans shall to the extent possible, be made available to all government agencies charged with the responsibility of licensing or otherwise regulating or inspecting such institutions.

(d) An individual case record will be created for each client which shall be maintained in security and confidence as required by the ''Confidentiality of Alcohol and Drug Abuse Patient Records'' (42 CFR part 2) and the ''Confidentiality of Certain Medical Records'' (38 U.S.C. 7332), and will be made available on a need to know basis to appropriate Department of Veterans Affairs staff members involved with the treatment program of the veterans concerned.

(e) Contractors under this section shall provide reports of budget and case load experience upon request from a Department of Veterans Affairs official.

(Authority: 38 U.S.C. 1720A)

[47 FR 57707, Dec. 28, 1982. Redesignated and amended at 61 FR 21965, 21967, May 13, 1996; 61 FR 63720, Dec. 2, 1996; 69 FR 18803, Apr. 9, 2004; 76 FR 10249, Feb. 24, 2011]

§ 17.82 Contracts for outpatient services for veterans with alcohol or drug dependence or abuse disabilities.

(a) Contracts for treatment services authorized under § 17.80 may be awarded in accordance with applicable Department of Veterans Affairs and Federal procurement procedures. Such contracts will be awarded only after the quality and effectiveness, including adequate protection for the safety of the participants of the contractor's program, has been determined and then only to contractors determined by the Under Secretary for Health or designee

to be fully capable of meeting the following standards:

(1) The following minimum fire safety requirements must be met:

(i) The building must meet the requirements in the applicable provisions of the NFPA 101 (incorporated by reference, *see* § 17.1) and the other publications referenced in those provisions. Any equivalencies or variances to VA requirements must be approved by the appropriate Veterans Health Administration Veterans Integrated Service Network (VISN) Director.

(ii) Where applicable, the facility must have a current occupancy permit issued by the local and state governments in the jurisdiction where the home is located.

(iii) All Department of Veterans Affairs sponsored patients will be mentally and physically capable of leaving the building, unaided, in the event of an emergency.

(iv) As a minimum, fire exit drills must be held at least quarterly, and a written plan for evacuation in the event of fire shall be developed and reviewed annually. The plan shall outline the duties, responsibilities and actions to be taken by the staff in the event of a fire emergency. This plan shall be implemented during fire exit drills.

(v) An annual fire and safety inspection shall be conducted at the facility by qualified Department of Veterans Affairs personnel. If a review of past Department of Veterans Affairs inspections or inspections made by the local authorities indicates that a fire and safety inspection would not be necessary, then the visit to the facility may be waived.

(2) Conform to existing standards of State safety codes and local and/or State health and sanitation codes.

(3) Be licensed under State or local authority.

(4) Where applicable, be accredited by the State.

(5) Comply with the requirements of the ''Confidentiality of Alcohol and Drug Abuse Patient Records'' (42 CFR part 2) and the ''Confidentiality of Certain Medical Records'' (38 U.S.C. 7332), which shall be part of the contract.

(6) Demonstrate an existing capability to furnish the following:

(i) A supervised, alcohol and drug free environment, including active affiliation with Alcoholics Anonymous (AA) programs.

(ii) Staff sufficient in numbers and position qualifications to carry out the policies, responsibilities, and programs of the facility.

(iii) Structured activities.

(iv) Appropriate group activities.

(v) Monitoring medications.

(vi) Supportive social service.

(vii) Individual counseling as appropriate.

(viii) Opportunities for learning/development of skills and habits which will enable Department of Veterans Affairs sponsored residents to adjust to and maintain freedom from dependence on or involvement with alcohol or drug abuse or dependence during or subsequent to leaving the facility.

(ix) Support for the individual desire for sobriety (alcohol/drug abuse-free life style).

(x) Opportunities for learning, testing, and internalizing knowledge of illness/recovery process, and to upgrade skills and improve personal relationships.

(7) Data normally maintained and included in a medical record as a function of compliance with State or community licensing standards will be accessible.

(b) Representatives of the Department of Veterans Affairs will inspect the facility prior to award of a contract to assure that prescribed requirements can be met. Inspections may also be carried out at such other times as deemed necessary by the Department of Veterans Affairs.

(c) All requirements in this rule and Department of Veterans Affairs reports of inspection of residential facilities furnishing treatment and rehabilitation services to eligible veterans shall, to the extent possible, be made available to all government agencies charged with the responsibility of licensing or otherwise regulating or inspecting such institutions.

(d) An individual case record will be created for each client which shall be maintained in security and confidence as required by the ''Confidentiality of Alcohol and Drug Abuse Patient Records'' (42 CFR part 2) and the

''Confidentiality of Certain Medical Records'' (38 U.S.C. 7332), and will be made available on a need to know basis to appropriate Department of Veterans Affairs staff members involved with the treatment program of the veterans concerned.

(Authority: 38 U.S.C. 1720A)

[47 FR 57708, Dec. 28, 1982. Redesignated and amended at 61 FR 21965, 21967, May 13, 1996; 61 FR 63720, Dec. 2, 1996; 62 FR 17072, Apr. 9, 1997; 69 FR 18803, Apr. 9, 2004; 76 FR 10249, Feb. 24, 2011]

§ 17.83 Limitations on payment for alcohol and drug dependence or abuse treatment and rehabilitation.

The authority to enter into contracts shall be effective for any fiscal year only to such extent or in such amounts as are provided in appropriation acts, and payments shall not exceed these amounts.

(Authority: Pub. L. 96–22, 38 U.S.C. 1720A)

[47 FR 57708, Dec. 28, 1982. Redesignated at 61 FR 21965, May 13, 1996]

RESEARCH-RELATED INJURIES

§ 17.85 Treatment of research-related injuries to human subjects.

(a) VA medical facilities shall provide necessary medical treatment to a research subject injured as a result of participation in a research project approved by a VA Research and Development Committee and conducted under the supervision of one or more VA employees. This section does not apply to:

(1) Treatment for injuries due to noncompliance by a subject with study procedures, or

(2) Research conducted for VA under a contract with an individual or a non-VA institution.

NOTE TO §17.85(a)(1) AND (a)(2): Veterans who are injured as a result of participation in such research may be eligible for care from VA under other provisions of this part.

(b) Except in the following situations, care for VA research subjects under this section shall be provided in VA medical facilities.

(1) If VA medical facilities are not capable of furnishing economical care or are not capable of furnishing the care or services required, VA medical facility directors shall contract for the needed care.

(2) If inpatient care must be provided to a non-veteran under this section, VA medical facility directors may contract for such care.

(3) If a research subject needs treatment in a medical emergency for a condition covered by this section, VA medical facility directors shall provide reasonable reimbursement for the emergency treatment in a non-VA facility.

(c) For purposes of this section, ''VA employee'' means any person appointed by VA as an officer or employee and acting within the scope of his or her appointment (VA appoints officers and employees under title 5 and title 38 of the United States Code).

(Authority: 38 U.S.C. 501, 7303)

[63 FR 11124, Mar. 6, 1998]

CARE DURING CERTAIN DISASTERS AND EMERGENCIES

§ 17.86 Provision of hospital care and medical services during certain disasters and emergencies under 38 U.S.C. 1785.

(a) This section sets forth regulations regarding the provision of hospital care and medical services under 38 U.S.C. 1785.

(b) During and immediately following a disaster or emergency referred to in paragraph (c) of this section, VA under 38 U.S.C. 1785 may furnish hospital care and medical services to individuals (including those who otherwise do not have VA eligibility for such care and services) responding to, involved in, or otherwise affected by that disaster or emergency.

(c) For purposes of this section, a *disaster* or *emergency* means:

(1) A major disaster or emergency declared by the President under the Robert T. Stafford Disaster Relief and Emergency Assistance Act (42 U.S.C. 5121 *et seq.*) (Stafford Act); or

(2) A disaster or emergency in which the National Disaster Medical System established pursuant to section 2811(b) of the Public Health Service Act (42 U.S.C. 300hh–11(b)) is activated either by the Secretary of Health and Human Services under paragraph (3)(A) of that section or as otherwise authorized by law.

(d) For purposes of paragraph (b) of this section, the terms *hospital care* and *medical services* have the meanings given such terms by 38 U.S.C. 1701(5) and 1701(6).

(e) Unless the cost of care is charged at rates agreed upon in a sharing agreement as described in § 17.102(e), the cost of hospital care and medical services provided under this section to an officer or employee of a department or agency of the United States (other than VA) or to a member of the Armed Forces shall be calculated in accordance with the provisions of § 17.102(c) and (h). Other individuals who receive hospital care or medical services under this section are responsible for the cost of the hospital care or medical services when charges are mandated by Federal law (including applicable appropriation acts) or when the cost of care or services is not reimbursed by other-than-VA Federal departments or agencies. When individuals are responsible under this section for the cost of hospital care or medical services, VA will bill in the amounts calculated in accordance with the provisions of § 17.102(h), without applying the exception provided in the first paragraph of § 17.102.

(f) VA may furnish care and services under this section to a veteran without regard to whether that individual is enrolled in the VA healthcare system under 38 U.S.C. 1705 and § 17.36 of this part.

(Authority: 38 U.S.C. 501, 1785)

[73 FR 26946, May 12, 2008]

VOCATIONAL TRAINING AND HEALTH-CARE 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, Sept. 12, 2014]

§ 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 one-time 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: 38 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 veteans 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; 64 FR 54218, Oct. 6, 1999; 79 FR 54615, Sept. 12, 2014]

§ 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, Sept. 12, 2014]

§ 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 under contract with VA, including 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 § 3.1(u) (Section 306 Pension) or § 3.1(w) (Improved Pension), of this chapter, as a veteran of a period of war as defined by 38 U.S.C. 101(11) (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))

[68 FR 43929, July 25, 2003, as amended at 74 FR 44291, Aug. 28, 2009; 78 FR 42456, July 16, 2013; 79 FR 54615, Sept. 12, 2014; 81 FR 46602, July 18, 2016]

§ 17.97 [Reserved]

§ 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, 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, Sept. 12, 2014]

CHARGES, WAIVERS, AND COLLECTIONS

§ 17.101 Collection or recovery by VA for medical care or services provided or furnished to a veteran for a nonservice-connected disability.

(a)(1) *General.* This section covers collection or recovery by VA, under 38

U.S.C. 1729, for medical care or services provided or furnished to a veteran:

(i) For a nonservice-connected disability for which the veteran is entitled to care (or the payment of expenses of care) under a health plan contract;

(ii) For a nonservice-connected disability incurred incident to the veteran's employment and covered under a worker's compensation law or plan that provides reimbursement or indemnification for such care and services; or

(iii) For a nonservice-connected disability incurred as a result of a motor vehicle accident in a State that requires automobile accident reparations insurance.

(2) *Methodologies*. Based on the methodologies set forth in this section, the charges billed will include the following types of charges, as appropriate: Acute inpatient facility charges; skilled nursing facility/sub-acute inpatient facility charges; partial hospitalization facility charges; outpatient facility charges; physician and other professional charges, including professional charges for anesthesia services and dental services; pathology and laboratory charges; observation care facility charges; ambulance and other emergency transportation charges; and charges for durable medical equipment, drugs, injectables, and other medical services, items, and supplies identified by HCPCS Level II codes. In addition, the charges billed for prescription drugs not administered during treatment will be the amount determined under paragraph (m) of this section. Data for calculating actual charge amounts based on the methodologies set forth in this section will either be published in a notice in the FEDERAL REGISTER or will be posted on the Internet site of the Veterans Health Administration Chief Business Office, currently at *http://www.va.gov/cbo*, under ''Charge Data.'' For care for which VA has established a charge, VA will bill using its most recent published or posted charge. For care for which VA has not established a charge, VA will bill according to the methodology set forth in paragraph (a)(8) of this section.

(3) *Data sources*. In this section, data sources are identified by name. The specific editions of these data sources used to calculate actual charge amounts, and information on where these data sources may be obtained, will be presented along with the data for calculating actual charge amounts, either in notices in the FEDERAL REGISTER or on the Internet site of the Veterans Health Administration Chief Business Office, currently at *http://www.va.gov/cbo*, under ''Charge Data.''

(4) *Amount of recovery or collection—third party liability*. A third-party payer liable under a health plan contract has the option of paying either the billed charges described in this section or the amount the health plan demonstrates is the amount it would pay for care or services furnished by providers other than entities of the United States for the same care or services in the same geographic area. If the amount submitted by the health plan for payment is less than the amount billed, VA will accept the submission as payment, subject to verification at VA's discretion in accordance with this section. A VA employee having responsibility for collection of such charges may request that the third party health plan submit evidence or information to substantiate the appropriateness of the payment amount (e.g., health plan or insurance policies, provider agreements, medical evidence, proof of payment to other providers in the same geographic area for the same care and services VA provided).

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

APC means Medicare Ambulatory Payment Classification.

CMS means the Centers for Medicare and Medicaid Services.

CPI-U means Consumer Price Index—All Urban Consumers.

CPT code and *CPT procedure code* mean Current Procedural Terminology code, a five-digit identifier defined by the American Medical Association for a specified physician service or procedure.

DME means Durable Medical Equipment.

DRG means Diagnosis Related Group.

Geographic area means a three-digit ZIP Code area, where three-digit ZIP Codes are the first three digits of

standard U.S. Postal Service ZIP Codes.

HCPCS code means a Healthcare Common Procedure Coding System Level II identifier, consisting of a letter followed by four digits, defined by CMS for a specified physician service, procedure, test, supply, or other medical service.

ICU means Intensive Care Unit, including coronary care units.

MDR means Medical Data Research, a medical charge database published by Ingenix, Inc.

MedPAR means the Medicare Provider Analysis and Review file.

Non-provider-based means a VA health care entity (such as a small VA community-based outpatient clinic) that functions as the equivalent of a doctor's office or for other reasons does not meet CMS provider-based criteria, and, therefore, is not entitled to bill outpatient facility charges.

Provider-based means the outpatient department of a VA hospital or any other VA health care entity that meets CMS provider-based criteria. Provider-based entities are entitled to bill outpatient facility charges.

RBRVS means Resource-Based Relative Value Scale.

RVU means Relative Value Unit.

Unlisted procedures mean procedures, services, items, and supplies that have not been defined or specified by the American Medical Association or CMS, and the CPT and HCPCS codes used to report such procedures, services, items, and supplies.

(6) *Provider-based and non-provider-based entities and charges.* Each VA health care entity (medical center, hospital, community-based outpatient clinic, independent outpatient clinic, etc.) is designated as either provider-based or non-provider-based. Provider-based entities are entitled to bill outpatient facility charges; non-provider-based entities are not. The charges for physician and other professional services provided at non-provider-based entities will be billed as professional charges only. Professional charges for both provider-based entities and non-provider-based entities are produced by the methodologies set forth in this section, with professional charges for provider-based entities based on facility practice expense RVUs, and professional charges for non-provider-based entities based on non-facility practice expense RVUs.

(7) *Charges for medical care or services provided by non-VA providers at VA expense.* When medical care or services are furnished at the expense of the VA by non-VA providers, the charges billed for such care or services will be the higher of the charges determined according to this section, or the amount VA paid to the non-VA provider.

(8) *Charges when a new DRG or CPT/HCPCS code identifier does not have an established charge.* When VA does not have an established charge for a new DRG or CPT/HCPCS code to be used in determining a billing charge under the applicable methodology in this section, then VA will establish an interim billing charge or establish an interim charge to be used for determining a billing charge under the applicable methodology in paragraphs (a)(8)(i) through (a)(8)(viii) of this section.

(i) If a new DRG or CPT/HCPCS code identifier replaces a DRG or CPT/HCPCS code identifier, the most recently established charge for the identifier being replaced will continue to be used for determining a billing charge under paragraphs (b), (e), (f), (g), (h), (i), (k), or (l) of this section until such time as VA establishes a charge for the new identifier.

(ii) If medical care or service is provided or furnished at VA expense by a non-VA provider and a charge cannot be established under paragraph (a)(8)(i) of this section, then VA's billing charge for such care or service will be the amount VA paid to the non-VA provider without additional calculations under this section.

(iii) If a new CPT/HCPCS code has been established for a prosthetic device or durable medical equipment subject to paragraph (l) of this section and a charge cannot be established under paragraphs (a)(8)(i) or (ii) of this section, VA's billing charge for such prosthetic device or durable medical equipment will be 1 and ½ times VA's average actual cost without additional calculations under this section.

(iv) If a new medical identifier DRG code has been assigned to a particular type of medical care or service and a

charge cannot be established under paragraphs (a)(8)(i) through (iii) of this section, then until such time as VA establishes a charge for the new medical identifier DRG code, the interim charge for use in paragraph (b) of this section will be the average charge of all medical DRG codes that are within plus or minus 10 of the numerical relative weight assigned to the new medical identifier DRG code.

(v) If a new surgical identifier DRG code has been assigned to a particular type of medical care or service and a charge cannot be established under paragraphs (a)(8)(i) through (iv) of this section, then until such time as VA establishes a charge for the new surgical identifier DRG code, the interim charge for use in paragraph (b) of this section will be the average charge of all surgical DRG codes that are within plus or minus 10 of the numerical relative weight assigned to the new surgical identifier DRG code.

(vi) If a new identifier CPT/HCPCS code is assigned to a particular type or item of medical care or service and a charge cannot be established under paragraphs (a)(8)(i) through (v) of this section, then until such time as VA establishes a charge for the new identifier for use in paragraphs (e), (f), (g), (h), (i), (k), or (l) of this section, VA's billing charge will be the Medicare allowable charge multiplied by 1 and ½, without additional calculations under this section.

(vii) If a new identifier CPT/HCPCS code is assigned to a particular type or item of medical care or service and a charge cannot be established under paragraphs (a)(8)(i) through (vi) of this section, then until such time as VA establishes a charge for the new identifier, the interim charge for use in paragraphs (e), (f), (g), (h), (i), (k), or (l) of this section will be the charge for the CPT/HCPCS code that is closest in characteristics to the new CPT/HCPCS code.

(viii) If a charge cannot be established under paragraphs (a)(8)(i) through (a)(8)(vii) of this section, then VA will not charge under this section for the care or service.

(9) *Care provided under special treatment authorities.* (i) Notwithstanding any other provisions in this section, VA will not seek recovery or collection of reasonable charges from a third party payer for:

(A) Hospital care, medical services, and nursing home care provided by VA or at VA expense under 38 U.S.C. 1710(a)(2)(F) and (e).

(B) Counseling and appropriate care and services furnished to veterans for psychological trauma authorized under 38 U.S.C. 1720D.

(C) Medical examination, and hospital care, medical services, and nursing home care furnished to veteran for cancer of the head or neck as authorized under 38 U.S.C. 1720E.

(ii) VA may continue to exercise its right to recover or collect reasonable charges from third parties, pursuant to this section, for the cost of care that VA provides to these same veterans for conditions and disabilities that VA determines are not covered by any of the special treatment authorities.

(b) *Acute inpatient facility charges.* When VA provides or furnishes acute inpatient services within the scope of care referred to in paragraph (a)(1) of this section, acute inpatient facility charges billed for such services will be determined in accordance with the provisions of this paragraph. Acute inpatient facility charges consist of per diem charges for room and board and for ancillary services that vary by geographic area and by DRG. These charges are calculated as follows:

(1) *Formula.* For each acute inpatient stay, or portion thereof, for which a particular DRG assignment applies, the total acute inpatient facility charge is the sum of the applicable charges determined pursuant to paragraphs (b)(1)(i), (ii), and (iii) of this section. For purposes of this section, standard room and board days and ICU room and board days are mutually exclusive: VA will bill either a standard room and board per diem charge or an ICU room and board per diem charge, as applicable, for each day of a given acute inpatient stay.

(i) *Standard room and board charges.* Multiply the nationwide standard room and board per diem charge determined pursuant to paragraph (b)(2) of this section by the appropriate geographic

area adjustment factor determined pursuant to paragraph (b)(3) of this section. The result constitutes the area-specific standard room and board per diem charge. Multiply this amount by the number of days for which standard room and board charges apply to obtain the total acute inpatient facility standard room and board charge.

(ii) *ICU room and board charges.* Multiply the nationwide ICU room and board per diem charge determined pursuant to paragraph (b)(2) of this section by the appropriate geographic area adjustment factor determined pursuant to paragraph (b)(3) of this section. The result constitutes the area-specific ICU room and board per diem charge. Multiply this amount by the number of days for which ICU room and board per diem charges apply to obtain the total acute inpatient facility ICU room and board charge.

(iii) *Ancillary charges.* Multiply the nationwide ancillary per diem charge determined pursuant to paragraph (b)(2) of this section by the appropriate geographic area adjustment factor determined pursuant to paragraph (b)(3) of this section. The result constitutes the area-specific ancillary per diem charge. Multiply this amount by the number of days of acute inpatient care to obtain the total acute inpatient facility ancillary charge.

NOTE TO PARAGRAPH (b)(1): If there is a change in a patient's condition and/or treatment during a single acute inpatient stay such that the DRG assignment changes (for example, a psychiatric patient who develops a medical or surgical problem), then calculations of acute inpatient facility charges will be made separately for each DRG, according to the number of days of care applicable for each DRG, and the total acute inpatient facility charge will be the sum of the total acute inpatient facility charges for the different DRGs.

(2) *Per diem charges.* To establish a baseline, two nationwide average per diem amounts for each DRG are calculated, one from the MedPAR file and one from the MedStat claims database, a database of nationwide commercial insurance claims. Average per diem charges are calculated based on all available charges, except for care reported for emergency room, ambulance, professional, and observation care. These two data sources may report charges for two differing periods of time; when this occurs, the data source charges with the earlier center date are trended forward to the center date of the other data source, based on changes to the inpatient hospital services component of the CPI-U. Results obtained from these two data sources are then combined into a single weighted average per diem charge for each DRG. The resulting charge for each DRG is then separated into its two components, a room and board component and an ancillary component, with the per diem charge for each component calculated by multiplying the weighted average per diem charge by the corresponding percentage determined pursuant to paragraph (b)(2)(i) of this section. The room and board per diem charge is further differentiated into a standard room and board per diem charge and an ICU room and board per diem charge by multiplying the average room and board charge by the corresponding DRG-specific ratios determined pursuant to paragraph (b)(2)(ii) of this section. The resulting per diem charges for standard room and board, ICU room and board, and ancillary services for each DRG are then each multiplied by the final ratio determined pursuant to paragraph (b)(2)(iii) of this section to reflect the nationwide 80th percentile charges. Finally, the resulting amounts are each trended forward from the center date of the trended data sources to the effective time period for the charges, as set forth in paragraph (b)(2)(iv) of this section. The results constitute the nationwide 80th percentile standard room and board, ICU room and board, and ancillary per diem charges.

(i) *Room and board charge and ancillary charge component percentages.* Using only those cases from the MedPAR file for which a distinction between room and board charges and ancillary charges can be determined, the percentage of the total charges for room and board compared to the combined total charges for room and board and ancillary services, and the percentage of the total charges for ancillary services compared to the combined total charges for room and board and ancillary services, are calculated by DRG.

(ii) *Standard room and board per diem charge and ICU room and board per diem charge ratios.* Using only those cases from the MedPAR file for which a distinction between room and board and ancillary charges can be determined, overall average per diem room and board charges are calculated by DRG. Then, using the same cases, an average standard room and board per diem charge is calculated by dividing total non-ICU room and board charges by total non-ICU room and board days. Similarly, an average ICU room and board per diem charge is calculated by dividing total ICU room and board charges by total ICU room and board days. Finally, ratios of standard room and board per diem charges *to* average overall room and board per diem charges are calculated by DRG, as are ratios of ICU room and board per diem charges *to* average overall room and board per diem charges.

(iii) *80th percentile.* Using cases from the MedPAR file with separately identifiable semi-private room rates, the ratio of the day-weighted 80th percentile semi-private room and board per diem charge *to* the average semi-private room and board per diem charge is obtained for each geographic area. The geographic area-based ratios are averaged to obtain a final 80th percentile ratio.

(iv) *Trending forward.* 80th percentile charges for each DRG, obtained as described in paragraph (b)(2) of this section, are trended forward based on changes to the inpatient hospital services component of the CPI-U. Actual CPI-U changes are used from the center date of the trended data sources through the latest available month as of the time the calculations are performed. The three-month average annual trend rate as of the latest available month is then held constant to the midpoint of the calendar year in which the charges are primarily expected to be used. The projected total CPI-U change so obtained is then applied to the 80th percentile charges.

(3) *Geographic area adjustment factors.* For each geographic area, the average per diem room and board charges and ancillary charges from the MedPAR file are calculated for each DRG. The DRGs are separated into two groups, surgical and non-surgical. For each of these groups of DRGs, for each geographic area, average room and board per diem charges and ancillary per diem charges are calculated, weighted by nationwide VA discharges and by average lengths of stay from the combined MedPAR file and MedStat claims database. This results in four average per diem charges for each geographic area: room and board for surgical DRGs, ancillary for surgical DRGs, room and board for non-surgical DRGs, and ancillary for non-surgical DRGs. Four corresponding national average per diem charges are obtained from the MedPAR file, weighted by nationwide VA discharges and by average lengths of stay from the combined MedPAR file and MedStat claims database. Four geographic area adjustment factors are then calculated for each geographic area by dividing each geographic area average per diem charge by the corresponding national average per diem charge.

(c) *Skilled nursing facility/sub-acute inpatient facility charges.* When VA provides or furnishes skilled nursing/sub-acute inpatient services within the scope of care referred to in paragraph (a)(1) of this section, skilled nursing facility/sub-acute inpatient facility charges billed for such services will be determined in accordance with the provisions of this paragraph. The skilled nursing facility/sub-acute inpatient facility charges are per diem charges that vary by geographic area. The facility charges cover care, including room and board, nursing care, pharmaceuticals, supplies, and skilled rehabilitation services (e.g., physical therapy, inhalation therapy, occupational therapy, and speech-language pathology), that is provided in a nursing home or hospital inpatient setting, is provided under a physician's orders, and is performed by or under the general supervision of professional personnel such as registered nurses, licensed practical nurses, physical therapists, occupational therapists, speech-language pathologists, and audiologists. These charges are calculated as follows:

(1) *Formula.* For each stay, multiply the nationwide per diem charge determined pursuant to paragraph (c)(2) of

this section by the appropriate geographic area adjustment factor determined pursuant to paragraph (c)(3) of this section. The result constitutes the area-specific per diem charge. Finally, multiply the area-specific per diem charge by the number of days of care to obtain the total skilled nursing facility/sub-acute inpatient facility charge.

(2) *Per diem charge*. To establish a baseline, a nationwide average per diem billed charge is calculated based on charges reported in the MedPAR skilled nursing facility file. For this purpose, the following MedPAR charge categories are included: room and board (private, semi-private, and ward), physical therapy, occupational therapy, inhalation therapy, speech-language pathology, pharmacy, medical/surgical supplies, and ''other'' services. The following MedPAR charge categories are excluded from the calculation of the per diem charge and will be billed separately, using the charges determined as set forth in other applicable paragraphs of this section, when these services are provided to skilled nursing patients or sub-acute inpatients: ICU and CCU room and board, laboratory, radiology, cardiology, dialysis, operating room, blood and blood administration, ambulance, MRI, anesthesia, durable medical equipment, emergency room, clinic, outpatient, professional, lithotripsy, and organ acquisition services. The resulting average per diem billed charge is then multiplied by the 80th percentile adjustment factor determined pursuant to paragraph (c)(2)(i) of this section to obtain a nationwide 80th percentile charge level. Finally, the resulting amount is trended forward to the effective time period for the charges, as set forth in paragraph (c)(2)(ii) of this section.

(i) *80th percentile adjustment factor*. Using the MedPAR skilled nursing facility file, the ratio of the day-weighted 80th percentile room and board per diem charge to the day-weighted average room and board per diem charge is obtained for each geographic area. The geographic area-based ratios are averaged to obtain the 80th percentile adjustment factor.

(ii) *Trending forward*. The 80th percentile charge is trended forward based on changes to the inpatient hospital services component of the CPI-U. Actual CPI-U changes are used from the time period of the source data through the latest available month as of the time the calculations are performed. The three-month average annual trend rate as of the latest available month is then held constant to the midpoint of the calendar year in which the charges are primarily expected to be used. The projected total CPI-U change so obtained is then applied to the 80th percentile charge.

(3) *Geographic area adjustment factors*. The average billed per diem charge for each geographic area is calculated from the MedPAR skilled nursing facility file. This amount is divided by the nationwide average billed charge calculated in paragraph (c)(2) of this section. The geographic area adjustment factor for charges for each VA facility is the ratio for the geographic area in which the facility is located.

(d) *Partial hospitalization facility charges*. When VA provides or furnishes partial hospitalization services that are within the scope of care referred to in paragraph (a)(1) of this section, the facility charges billed for such services will be determined in accordance with the provisions of this paragraph. Partial hospitalization facility charges are per diem charges that vary by geographic area. These charges are calculated as follows:

(1) *Formula*. For each partial hospitalization stay, multiply the nationwide per diem charge determined pursuant to paragraph (d)(2) of this section by the appropriate geographic area adjustment factor determined pursuant to paragraph (d)(3) of this section. The result constitutes the area-specific per diem charge. Finally, multiply the area-specific per diem charge by the number of days of care to obtain the total partial hospitalization facility charge.

(2) *Per diem charge*. To establish a baseline, a nationwide median per diem billed charge is calculated based on charges associated with partial hospitalization from the outpatient facility component of the Medicare Standard Analytical File 5 percent Sample. That median per diem billed charge is then multiplied by the 80th percentile

adjustment factor determined pursuant to paragraph (d)(2)(i) of this section to obtain a nationwide 80th percentile charge level. Finally, the resulting amount is trended forward to the effective time period for the charges, as set forth in paragraph (d)(2)(ii) of this section.

(i) *80th percentile adjustment factor.* The 80th percentile adjustment factor for partial hospitalization facility charges is the same as that computed for skilled nursing facility/sub-acute inpatient facility charges under paragraph (c)(2)(i) of this section.

(ii) *Trending forward.* The 80th percentile charge is trended forward based on changes to the outpatient hospital services component of the CPI-U. Actual CPI-U changes are used from the time period of the source data through the latest available month as of the time the calculations are performed. The three-month average annual trend rate as of the latest available month is then held constant to the midpoint of the calendar year in which the charges are primarily expected to be used. The projected total CPI-U change so obtained is then applied to the 80th percentile charges, as described in paragraph (d)(2) of this section.

(3) *Geographic area adjustment factors.* The geographic area adjustment factors for partial hospitalization facility charges are the same as those computed for outpatient facility charges under paragraph (e)(4) of this section.

(e) *Outpatient facility charges.* When VA provides or furnishes outpatient facility services that are within the scope of care referred to in paragraph (a)(1) of this section, the charges billed for such services will be determined in accordance with the provisions of this paragraph. Charges for outpatient facility services vary by geographic area and by CPT/HCPCS code. These charges apply in the situations set forth in paragraph (e)(1) of this section and are calculated as set forth in paragraph (e)(2) of this section.

(1) *Settings and circumstances in which outpatient facility charges apply.* Outpatient facility charges consist of facility charges for procedures, diagnostic tests, evaluation and management services, and other medical services, items, and supplies provided in the following settings and circumstances:

(i) Outpatient departments and clinics at VA medical centers;

(ii) Other VA provider-based entities; and

(iii) VA non-provider-based entities, for procedures and tests for which no corresponding professional charge is established under the provisions of paragraph (f) of this section.

(2) *Formula.* For each outpatient facility charge CPT/HCPCS code, multiply the nationwide 80th percentile charge determined pursuant to paragraph (e)(3) of this section by the appropriate geographic area adjustment factor determined pursuant to paragraph (e)(4) of this section. The result constitutes the area-specific outpatient facility charge. When multiple surgical procedures are performed during the same outpatient encounter by a provider or provider team, the outpatient facility charges for such procedures will be reduced as set forth in paragraph (e)(5) of this section.

(3) *Nationwide 80th percentile charges by CPT/HCPCS code.* For each CPT/HCPCS code for which outpatient facility charges apply, the nationwide 80th percentile charge is calculated as set forth in either paragraph (e)(3)(i) or (e)(3)(ii) of this section. The resulting amount is trended forward to the effective time period for the charges, as set forth in paragraph (e)(3)(iii) of this section. The results constitute the nationwide 80th percentile outpatient facility charges by CPT/HCPCS code.

(i) *Nationwide 80th percentile charges for CPT/HCPCS codes which have APC assignments.* Using the outpatient facility charges reported in the outpatient facility component of the Medicare Standard Analytical File 5 percent Sample, claim records are selected for which all charges can be assigned to an APC. Using this subset of the 5 percent Sample data, nationwide median charge *to* Medicare APC payment amount ratios, by APC, and nationwide 80th percentile *to* median charge ratios, by APC, are computed according to the methodology set forth in paragraphs (e)(3)(i)(A) and (e)(3)(i)(B) of this section, respectively. The product of these two ratios by APC is then computed, resulting in a composite nationwide

80th percentile charge *to* Medicare APC payment amount ratio. This ratio is then compared to the alternate nationwide 80th percentile charge *to* Medicare APC payment amount ratio computed in paragraph (e)(3)(i)(C) of this section, and the lesser amount is selected and multiplied by the current Medicare APC payment amount. The resulting product is the APC-specific nationwide 80th percentile charge amount for each applicable CPT/HCPCS code.

(A) *Nationwide median charge to Medicare APC payment amount ratios.* For each CPT/HCPCS code, the ratio of median billed charge *to* Medicare APC payment amount is determined. The weighted average of these ratios for each APC is then obtained, using the reported 5 percent Sample frequencies as weights. In addition, corresponding ratios are calculated for each of the APC categories set forth in paragraph (e)(3)(i)(D) of this section, again using the reported 5 percent Sample frequencies as weights. For APCs where the 5 percent Sample frequencies provide a statistically credible result, the APC-specific weighted average nationwide median charge *to* Medicare APC payment amount ratio so obtained is accepted without further adjustment. However, if the 5 percent Sample data do not produce statistically credible results for any specific APC, then the APC category-specific ratio is applied for that APC.

(B) *Nationwide 80th percentile to median charge ratios.* For each CPT/HCPCS code, a geographically normalized nationwide 80th percentile billed charge amount is divided by a similarly normalized nationwide median billed charge amount. The weighted average of these ratios for each APC is then obtained, using the reported 5 percent Sample frequencies as weights. In addition, corresponding ratios are calculated for each of the APC categories set forth in paragraph (e)(3)(i)(D) of this section, again using the reported 5 percent Sample frequencies as weights. For APCs where the 5 percent Sample frequencies provide a statistically credible result, the APC-specific weighted average nationwide 80th percentile *to* median charge ratio so obtained is accepted without further adjustment. However, if the 5 percent Sample data do not produce statistically credible results for any specific APC, then the APC category-specific ratio is applied for that APC.

(C) *Alternate nationwide 80th percentile charge to Medicare APC payment amount ratios.* A minimum 80th percentile charge *to* Medicare APC payment amount ratio is set at 2.0 for APCs with Medicare APC payment amounts of $25 or less. A maximum 80th percentile charge *to* Medicare APC payment amount ratio is set at 6.5 for APCs with Medicare APC payment amounts of $10,000 or more. Using linear interpolation with these endpoints, the alternate APC-specific nationwide 80th percentile charge *to* Medicare APC payment amount ratio is then computed, based on the Medicare APC payment amount.

(D) *APC categories for the purpose of establishing 80th percentile to median factors.* For the purpose of the statistical methodology set forth in paragraph (e)(3)(i) of this section, APCs are assigned to the following APC categories:

(*1*) Radiology.

(*2*) Drugs.

(*3*) Office, Home, and Urgent Care Visits.

(*4*) Cardiovascular.

(*5*) Emergency Room Visits.

(*6*) Outpatient Psychiatry, Alcohol and Drug Abuse.

(*7*) Pathology.

(*8*) Surgery.

(*9*) Allergy Immunotherapy, Allergy Testing, Immunizations, and Therapeutic Injections.

(*10*) All APCs not assigned to any of the above groups.

(ii) *Nationwide 80th percentile charges for CPT/HCPCS codes which do not have APC assignments.* Nationwide 80th percentile billed charge levels by CPT/HCPCS code are computed from the outpatient facility component of the MDR database, from the MedStat claims database, and from the outpatient facility component of the Medicare Standard Analytical File 5 percent Sample. If the MDR database contains sufficient data to provide a statistically credible 80th percentile charge, then that result is retained for this purpose. If the MDR database does not provide a statistically credible 80th percentile charge, then the result from

the MedStat database is retained for this purpose, provided it is statistically credible. If neither the MDR nor the MedStat databases provide statistically credible results, then the nationwide 80th percentile billed charge computed from the 5 percent Sample data is retained for this purpose. The nationwide 80th percentile charges retained from each of these data sources are trended forward to the effective time period for the charges, as set forth in paragraph (e)(3)(iii) of this section.

(iii) *Trending forward*. The charges for each CPT/HCPCS code, obtained as described in paragraph (e)(3) of this section, are trended forward based on changes to the outpatient hospital services component of the CPI-U. Actual CPI-U changes are used from the time period of the source data through the latest available month as of the time the calculations are performed. The three-month average annual trend rate as of the latest available month is then held constant to the midpoint of the calendar year in which the charges are primarily expected to be used. The projected total CPI-U change so obtained is then applied to the 80th percentile charges, as described in paragraph (e)(3) of this section.

(4) *Geographic area adjustment factors*. For each geographic area, a single adjustment factor is calculated as the arithmetic average of the outpatient geographic area adjustment factor published in the Milliman USA, Inc., Health Cost Guidelines (this factor constitutes the ratio of the level of charges for each geographic area *to* the nationwide level of charges), and a geographic area adjustment factor developed from the MDR database (*see* paragraph (a)(3) of this section for Data Sources). The MDR-based geographic area adjustment factors are calculated as the ratio of the CPT/HCPCS code weighted average charge level for each geographic area *to* the nationwide CPT/HCPCS code weighted average charge level.

(5) *Multiple surgical procedures*. When multiple surgical procedures are performed during the same outpatient encounter by a provider or provider team as indicated by multiple surgical CPT/HCPCS procedure codes, then each CPT/HCPCS procedure code will be billed at 100 percent of the charges established under this section.

(f) *Physician and other professional charges except for anesthesia services and certain dental services*. When VA provides or furnishes physician and other professional services, other than professional anesthesia services and certain professional dental services, within the scope of care referred to in paragraph (a)(1) of this section, physician and other professional charges billed for such services will be determined in accordance with the provisions of this paragraph. Charges for professional dental services identified by CPT code are determined in accordance with the provisions of this paragraph; charges for professional dental services identified by HCPCS Level II code are determined in accordance with the provisions of paragraph (h) of this section. Physician and other professional charges consist of charges for professional services that vary by geographic area, by CPT/HCPCS code, by site of service, and by modifier, where applicable. These charges are calculated as follows:

(1) *Formula*. For each CPT/HCPCS code or, where applicable, each CPT/HCPCS code and modifier combination, multiply the total geographically-adjusted RVUs determined pursuant to paragraph (f)(2) of this section by the applicable geographically-adjusted conversion factor (a monetary amount) determined pursuant to paragraph (f)(3) of this section to obtain the physician charge for each CPT/HCPCS code in a particular geographic area. Then, multiply this charge by the appropriate factors for any charge-significant modifiers, determined pursuant to paragraph (f)(4) of this section.

(2)(i) *Total geographically-adjusted RVUs for physician services that have Medicare RVUs*. The work expense and practice expense RVUs for CPT/HCPCS codes, other than the codes described in paragraphs (f)(2)(ii) and (f)(2)(iii) of this section, are compiled using Medicare Physician Fee Schedule RVUs. The sum of the geographically-adjusted work expense RVUs determined pursuant to paragraph (f)(2)(i)(A) of this section and the geographically-adjusted

practice expense RVUs determined pursuant to paragraph (f)(2)(i)(B) of this section equals the total geographically-adjusted RVUs.

(A) *Geographically-adjusted work expense RVUs.* For each CPT/HCPCS code for each geographic area, the Medicare Physician Fee Schedule work expense RVUs are multiplied by the work expense Medicare Geographic Practice Cost Index. The result constitutes the geographically-adjusted work expense RVUs.

(B) *Geographically-adjusted practice expense RVUs.* For each CPT/HCPCS code for each geographic area, the Medicare Physician Fee Schedule practice expense RVUs are multiplied by the practice expense Medicare Geographic Practice Cost Index. The result constitutes the geographically-adjusted practice expense RVUs. In these calculations, facility practice expense RVUs are used to obtain geographically-adjusted practice expense RVUs for use by provider-based entities, and non-facility practice expense RVUs are used to obtain geographically-adjusted practice expense RVUs for use by non-provider-based entities.

(ii) *RVUs for CPT/HCPCS codes that do not have Medicare RVUs and are not designated as unlisted procedures.* For CPT/HCPCS codes that are not assigned RVUs in paragraphs (f)(2)(i) or (f)(2)(iii) of this section, total RVUs are developed based on various charge data sources. For these CPT/HCPCS codes, the nationwide 80th percentile billed charges are obtained, where statistically credible, from the MDR database. For any remaining CPT/HCPCS codes, the nationwide 80th percentile billed charges are obtained, where statistically credible, from the Part B component of the Medicare Standard Analytical File 5 percent Sample. For any remaining CPT/HCPCS codes, the nationwide 80th percentile billed charges are obtained, where statistically credible, from the Prevailing Healthcare Charges System nationwide commercial insurance database. For each of these CPT/HCPCS codes, nationwide total RVUs are obtained by taking the nationwide 80th percentile billed charges obtained using the preceding three databases and dividing by the untrended nationwide conversion factor for the corresponding CPT/HCPCS code group determined pursuant to paragraphs (f)(3) and (f)(3)(i) of this section. For any remaining CPT/HCPCS codes that have not been assigned RVUs using the preceding data sources, the nationwide total RVUs are calculated by summing the work expense and non-facility practice expense RVUs found in Ingenix/St. Anthony's RBRVS. The resulting nationwide total RVUs obtained using these four data sources are multiplied by the geographic area adjustment factors determined pursuant to paragraph (f)(2)(iv) of this section to obtain the area-specific total RVUs.

(iii) *RVUs for CPT/HCPCS codes designated as unlisted procedures.* For CPT/HCPCS codes designated as unlisted procedures, total RVUs are developed based on the weighted median of the total RVUs of CPT/HCPCS codes within the series in which the unlisted procedure code occurs. A nationwide VA distribution of procedures and services is used for the purpose of computing the weighted median. The resulting nationwide total RVUs are multiplied by the geographic area adjustment factors determined pursuant to paragraph (f)(2)(iv) of this section to obtain the area-specific total RVUs.

(iv) *RVU geographic area adjustment factors for CPT/HCPCS codes that do not have Medicare RVUs, including codes that are designated as unlisted procedures.* The adjustment factor for each geographic area consists of the weighted average of the work expense and practice expense Medicare Geographic Practice Cost Indices for each geographic area using charge data for representative CPT/HCPCS codes statistically selected and weighted for work expense and practice expense.

(3) *Geographically-adjusted 80th percentile conversion factors.* CPT/HCPCS codes are separated into the following 23 CPT/HCPCS code groups: allergy immunotherapy, allergy testing, cardiovascular, chiropractor, consults, emergency room visits and observation care, hearing/speech exams, immunizations, inpatient visits, maternity/cesarean deliveries, maternity/non-deliveries, maternity/normal deliveries, miscellaneous medical, office/home/urgent care visits, outpatient psychiatry/

alcohol and drug abuse, pathology, physical exams, physical medicine, radiology, surgery, therapeutic injections, vision exams, and well baby exams. For each of the 23 CPT/HCPCS code groups, representative CPT/HCPCS codes are statistically selected and weighted so as to give a weighted average RVU comparable to the weighted average RVU of the entire CPT/HCPCS code group (the selected CPT/HCPCS codes are set forth in the Milliman USA, Inc., Health Cost Guidelines fee survey); see paragraph (a)(3) of this section for Data Sources. The 80th percentile charge for each selected CPT/HCPCS code is obtained from the MDR database. A nationwide conversion factor (a monetary amount) is calculated for each CPT/HCPCS code group as set forth in paragraph (f)(3)(i) of this section. The nationwide conversion factors for each of the 23 CPT/HCPCS code groups are trended forward to the effective time period for the charges, as set forth in paragraph (f)(3)(ii) of this section. The resulting amounts for each of the 23 groups are multiplied by geographic area adjustment factors determined pursuant to paragraph (f)(3)(iii) of this section, resulting in geographically-adjusted 80th percentile conversion factors for each geographic area for the 23 CPT/HCPCS code groups for the effective charge period.

(i) *Nationwide conversion factors.* Using the nationwide 80th percentile charges for the selected CPT/HCPCS codes from paragraph (f)(3) of this section, a nationwide conversion factor is calculated for each of the 23 CPT/HCPCS code groups by dividing the weighted average charge by the weighted average RVU.

(ii) *Trending forward.* The nationwide conversion factors for each of the 23 CPT/HCPCS code groups, obtained as described in paragraph (f)(3)(i) of this section, are trended forward based on changes to the physicians' services component of the CPI-U. Actual CPI-U changes are used from the time period of the source data through the latest available month as of the time the calculations are performed. The three-month average annual trend rate as of the latest available month is then held constant to the midpoint of the calendar year in which the charges are primarily expected to be used. The projected total CPI-U change so obtained is then applied to the 23 conversion factors.

(iii) *Geographic area adjustment factors.* Using the 80th percentile charges for the selected CPT/HCPCS codes from paragraph (f)(3) of this section for each geographic area, a geographic area-specific conversion factor is calculated for each of the 23 CPT/HCPCS code groups by dividing the weighted average charge by the weighted average geographically-adjusted RVU. The resulting conversion factor for each geographic area for each of the 23 CPT/HCPCS code groups is divided by the corresponding nationwide conversion factor determined pursuant to paragraph (f)(3)(i) of this section. The resulting ratios are the geographic area adjustment factors for the conversion factors for each of the 23 CPT/HCPCS code groups for each geographic area.

(4) *Charge adjustment factors for specified CPT/HCPCS code modifiers.* Surcharges are calculated in the following manner: From the Part B component of the Medicare Standard Analytical File 5 percent Sample, the ratio of weighted average billed charges for CPT/HCPCS codes with the specified modifier to the weighted average billed charge for CPT/HCPCS codes with no charge modifier is calculated, using the frequency of procedure codes with the modifier as weights in both weighted average calculations. The resulting ratios constitute the surcharge factors for specified charge-significant CPT/HCPCS code modifiers.

(5) *Certain charges for providers other than physicians.* When services for which charges are established according to the preceding provisions of this paragraph (f) are performed by providers other than physicians, the charges for those services will be as determined by the preceding provisions of this paragraph, except as follows:

(i) *Outpatient facility charges.* When the services of providers other than physicians are furnished in outpatient facility settings or in other facilities

designated as provider-based, and outpatient facility charges for those services have been established under paragraph (e) of this section, then the outpatient facility charges established under paragraph (e) will apply instead of the charges established under this paragraph (f).

(ii) *Charges for professional services.* Charges for the professional services of the following providers will be 100 percent of the amount that would be charged if the care had been provided by a physician:

(A) Nurse practitioner.

(B) Clinical nurse specialist.

(C) Physician Assistant.

(D) Clinical psychologist.

(E) Clinical social worker.

(F) Dietitian.

(G) Clinical pharmacist.

(H) Marriage and family therapist.

(I) Licensed professional mental health counselor.

(g) *Professional charges for anesthesia services.* When VA provides or furnishes professional anesthesia services within the scope of care referred to in paragraph (a)(1) of this section, professional anesthesia charges billed for such services will be determined in accordance with the provisions of this paragraph. Charges for professional anesthesia services personally performed by anesthesiologists will be 100 percent of the charges determined as set forth in this paragraph. Charges for professional anesthesia services provided by non-medically directed certified registered nurse anesthetists will also be 100 percent of the charges determined as set forth in this paragraph. Charges for professional anesthesia services provided by medically directed certified registered nurse anesthetists will be 100 percent of the charges determined as set forth in this paragraph. Professional anesthesia charges consist of charges for professional services that vary by geographic area, by CPT/HCPCS code base units, and by number of time units. These charges are calculated as follows:

(1) *Formula.* For each anesthesia CPT/HCPCS code, multiply the total anesthesia RVUs determined pursuant to paragraph (g)(2) of this section by the applicable geographically-adjusted conversion factor (a monetary amount) determined pursuant to paragraph (g)(3) of this section to obtain the professional anesthesia charge for each CPT/HCPCS code in a particular geographic area.

(2) *Total RVUs for professional anesthesia services.* The total anesthesia RVUs for each anesthesia CPT/HCPCS code are the sum of the base units (as compiled by CMS) for that CPT/HCPCS code and the number of time units reported for the anesthesia service, where one time unit equals 15 minutes. For anesthesia CPT/HCPCS codes designated as unlisted procedures, base units are developed based on the weighted median base units for anesthesia CPT/HCPCS codes within the series in which the unlisted procedure code occurs. A nationwide VA distribution of procedures and services is used for the purpose of computing the weighted median base units.

(3) *Geographically-adjusted 80th percentile conversion factors.* A nationwide 80th percentile conversion factor is calculated according to the methodology set forth in paragraph (g)(3)(i) of this section. The nationwide conversion factor is then trended forward to the effective time period for the charges, as set forth in paragraph (g)(3)(ii) of this section. The resulting amount is multiplied by geographic area adjustment factors determined pursuant to paragraph (g)(3)(iii) of this section, resulting in geographically-adjusted 80th percentile conversion factors for each geographic area for the effective charge period.

(i) *Nationwide conversion factor.* Preliminary 80th percentile conversion factors for each area are compiled from the MDR database. Then, a preliminary nationwide weighted-average 80th percentile conversion factor is calculated, using as weights the population (census) frequencies for each geographic area as presented in the Milliman USA, Inc., Health Cost Guidelines (*see* paragraph (a)(3) of this section for Data Sources). A nationwide 80th percentile fee by CPT/HCPCS code is then computed by multiplying this conversion factor by the MDR base units for each CPT/HCPCS code. An adjusted 80th percentile conversion factor by CPT/HCPCS code is then calculated by dividing the nationwide 80th percentile

fee for each procedure code by the anesthesia base units (as compiled by CMS) for that CPT/HCPCS code. Finally, a nationwide weighted average 80th percentile conversion factor is calculated using combined frequencies for billed base units and time units from the part B component of the Medicare Standard Analytical File 5 percent Sample as weights.

(ii) *Trending forward.* The nationwide conversion factor, obtained as described in paragraph (g)(3)(i) of this section, is trended forward based on changes to the physicians' services component of the CPI-U. Actual CPI-U changes are used from the time period of the source data through the latest available month as of the time the calculations are performed. The three-month average annual trend rate as of the latest available month is then held constant to the midpoint of the calendar year in which the charges are primarily expected to be used. The projected total CPI-U change so obtained is then applied to the conversion factor.

(iii) *Geographic area adjustment factors.* The preliminary 80th percentile conversion factors for each geographic area described in paragraph (g)(3)(i) of this section are divided by the corresponding preliminary nationwide 80th percentile conversion factor also described in paragraph (g)(3)(i). The resulting ratios are the adjustment factors for each geographic area.

(h) *Professional charges for dental services identified by HCPCS Level II codes.* When VA provides or furnishes outpatient dental professional services within the scope of care referred to in paragraph (a)(1) of this section, and such services are identified by HCPCS code rather than CPT code, the charges billed for such services will be determined in accordance with the provisions of this paragraph. The charges for dental services vary by geographic area and by HCPCS code. These charges are calculated as follows:

(1) *Formula.* For each HCPCS dental code, multiply the nationwide 80th percentile charge determined pursuant to paragraph (h)(2) of this section by the appropriate geographic area adjustment factor determined pursuant to paragraph (h)(3) of this section. The result constitutes the area-specific dental charge.

(2) *Nationwide 80th percentile charges by HCPCS code.* For each HCPCS dental code, 80th percentile charges are extracted from three independent data sources: Prevailing Healthcare Charges System database; National Dental Advisory Service nationwide pricing index; and the Dental UCR Module of the Comprehensive Healthcare Payment System, a release from Ingenix from a nationwide database of dental charges (*see* paragraph (a)(3) of this section for Data Sources). Charges for each database are then trended forward to a common date, based on actual changes to the dental services component of the CPI-U. Charges for each HCPCS dental code from each data source are combined into an average 80th percentile charge by means of the methodology set forth in paragraph (h)(2)(i) of this section. HCPCS dental codes designated as unlisted are assigned 80th percentile charges by means of the methodology set forth in paragraph (h)(2)(ii) of this section. Finally, the resulting amounts are each trended forward to the effective time period for the charges, as set forth in paragraph (h)(2)(iii) of this section. The results constitute the nationwide 80th percentile charge for each HCPCS dental code.

(i) *Averaging methodology.* The average charge for any particular HCPCS dental code is calculated by first computing a preliminary mean average of the three charges for each code. Statistical outliers are identified and removed by testing whether any charge differs from the preliminary mean charge by more than 50 percent of the preliminary mean charge. In such cases, the charge most distant from the preliminary mean is removed as an outlier, and the average charge is calculated as a mean of the two remaining charges. In cases where none of the charges differ from the preliminary mean charge by more than 50 percent of the preliminary mean charge, the average charge is calculated as a mean of all three reported charges.

(ii) *Nationwide 80th percentile charges for HCPCS dental codes designated as unlisted procedures.* For HCPCS dental

codes designated as unlisted procedures, 80th percentile charges are developed based on the weighted median 80th percentile charge of HCPCS dental codes within the series in which the unlisted procedure code occurs. The distribution of procedures and services from the Prevailing Healthcare Charges System nationwide commercial insurance database is used for the purpose of computing the weighted median.

(iii) *Trending forward*. 80th percentile charges for each dental procedure code, obtained as described in paragraph (h)(2) of this section, are trended forward based on the dental services component of the CPI-U. Actual CPI-U changes are used from the time period of the source data through the latest available month as of the time the calculations are performed. The three-month average annual trend rate as of the latest available month is then held constant to the midpoint of the calendar year in which the charges are primarily expected to be used. The projected total CPI-U change so obtained is then applied to the 80th percentile charges.

(3) *Geographic area adjustment factors*. A geographic adjustment factor (consisting of the ratio of the level of charges in a given geographic area *to* the nationwide level of charges) for each geographic area and dental class of service is obtained from Milliman USA, Inc., Dental Health Cost Guidelines, a database of nationwide commercial insurance charges and relative costs; and a normalized geographic adjustment factor computed from the Dental UCR Module of the Comprehensive Healthcare Payment System compiled by Ingenix, as follows: Using local and nationwide average charges reported in the Ingenix data, a local weighted average charge for each dental class of procedure codes is calculated using utilization frequencies from the Milliman USA, Inc., Dental Health Cost Guidelines as weights (*see* paragraph (a)(3) of this section for Data Sources). Similarly, using nationwide average charge levels, a nationwide average charge by dental class of procedure codes is calculated. The normalized geographic adjustment factor for each dental class of procedure codes and for each geographic area is the ratio of the local average charge divided by the corresponding nationwide average charge. Finally, the geographic area adjustment factor is the arithmetic average of the corresponding factors from the data sources mentioned in the first sentence of this paragraph (h)(3).

(i) *Pathology and laboratory charges*. When VA provides or furnishes pathology and laboratory services within the scope of care referred to in paragraph (a)(1) of this section, charges billed for such services will be determined in accordance with the provisions of this paragraph. Pathology and laboratory charges consist of charges for services that vary by geographic area and by CPT/HCPCS code. These charges are calculated as follows:

(1) *Formula*. For each CPT/HCPCS code, multiply the total geographically-adjusted RVUs determined pursuant to paragraph (i)(2) of this section by the applicable geographically-adjusted conversion factor (a monetary amount) determined pursuant to paragraph (i)(3) of this section to obtain the pathology/laboratory charge for each CPT/HCPCS code in a particular geographic area.

(2)(i) *Total geographically-adjusted RVUs for pathology and laboratory services that have Medicare-based RVUs*. Total RVUs are developed based on the Medicare Clinical Diagnostic Laboratory Fee Schedule (CLAB). The CLAB payment amounts are upwardly adjusted such that the adjusted payment amounts are, on average, equivalent to Medicare Physician Fee Schedule payment levels, using statistical comparisons to the 80th percentile derived from the MDR database. These adjusted payment amounts are then divided by the corresponding Medicare conversion factor to derive RVUs for each CPT/HCPCS code. The resulting nationwide total RVUs are multiplied by the geographic adjustment factors determined pursuant to paragraph (i)(2)(iv) of this section to obtain the area-specific total RVUs.

(ii) *RVUs for CPT/HCPCS codes that do not have Medicare-based RVUs and are not designated as unlisted procedures*. For CPT/HCPCS codes that are not assigned RVUs in paragraphs (i)(2)(i) or

(i)(2)(iii) of this section, total RVUs are developed based on various charge data sources. For these CPT/HCPCS codes, the nationwide 80th percentile billed charges are obtained, where statistically credible, from the MDR database. For any remaining CPT/HCPCS codes, the nationwide 80th percentile billed charges are obtained, where statistically credible, from the Part B component of the Medicare Standard Analytical File 5 percent Sample. For any remaining CPT/HCPCS codes, the nationwide 80th percentile billed charges are obtained, where statistically credible, from the Prevailing Healthcare Charges System nationwide commercial insurance database. For each of these CPT/HCPCS codes, nationwide total RVUs are obtained by taking the nationwide 80th percentile billed charges obtained using the preceding three databases and dividing by the untrended nationwide conversion factor determined pursuant to paragraphs (i)(3) and (i)(3)(i) of this section. For any remaining CPT/HCPCS codes that have not been assigned RVUs using the preceding data sources, the nationwide total RVUs are calculated by summing the work expense and nonfacility practice expense RVUs found in Ingenix/St. Anthony's RBRVS. The resulting nationwide total RVUs obtained using these four data sources are multiplied by the geographic area adjustment factors determined pursuant to paragraph (i)(2)(iv) of this section to obtain the area-specific total RVUs.

(iii) *RVUs for CPT/HCPCS codes designated as unlisted procedures.* For CPT/HCPCS codes designated as unlisted procedures, total RVUs are developed based on the weighted median of the total RVUs of CPT/HCPCS codes within the series in which the unlisted procedure code occurs. A nationwide VA distribution of procedures and services is used for the purpose of computing the weighted median. The resulting nationwide total RVUs are multiplied by the geographic area adjustment factors determined pursuant to paragraph (i)(2)(iv) of this section to obtain the area-specific total RVUs.

(iv) *RVU geographic area adjustment factors for CPT/HCPCS codes that do not have Medicare RVUs, including codes that are designated as unlisted procedures.* The adjustment factor for each geographic area consists of the weighted average of the work expense and practice expense Medicare Geographic Practice Cost Indices for each geographic area using charge data for representative CPT/HCPCS codes statistically selected and weighted for work expense and practice expense.

(3) *Geographically-adjusted 80th percentile conversion factors.* Representative CPT/HCPCS codes are statistically selected and weighted so as to give a weighted average RVU comparable to the weighted average RVU of the entire pathology/laboratory CPT/HCPCS code group (the selected CPT/HCPCS codes are set forth in the Milliman USA, Inc., Health Cost Guidelines fee survey). The 80th percentile charge for each selected CPT/HCPCS code is obtained from the MDR database. A nationwide conversion factor (a monetary amount) is calculated as set forth in paragraph (i)(3)(i) of this section. The nationwide conversion factor is trended forward to the effective time period for the charges, as set forth in paragraph (i)(3)(ii) of this section. The resulting amount is multiplied by a geographic area adjustment factor determined pursuant to paragraph (i)(3)(iv) of this section, resulting in the geographically-adjusted 80th percentile conversion factor for the effective charge period.

(i) *Nationwide conversion factors.* Using the nationwide 80th percentile charges for the selected CPT/HCPCS codes from paragraph (i)(3) of this section, a nationwide conversion factor is calculated by dividing the weighted average charge by the weighted average RVU.

(ii) *Trending forward.* The nationwide conversion factor, obtained as described in paragraph (i)(3) of this section, is trended forward based on changes to the physicians' services component of the CPI-U. Actual CPI-U changes are used from the time period of the source data through the latest available month as of the time the calculations are performed. The three-month average annual trend rate as of the latest available month is then held constant to the midpoint of the calendar year in which the charges are

primarily expected to be used. The projected total CPI-U change so obtained is then applied to the pathology/laboratory conversion factor.

(iii) *Geographic area adjustment factor.* Using the 80th percentile charges for the selected CPT/HCPCS codes from paragraph (i)(3) of this section for each geographic area, a geographic area-specific conversion factor is calculated by dividing the weighted average charge by the weighted average geographically-adjusted RVU. The resulting geographic area conversion factor is divided by the corresponding nationwide conversion factor determined pursuant to paragraph (i)(3)(i) of this section. The resulting ratios are the geographic area adjustment factors for pathology and laboratory services for each geographic area.

(j) *Observation care facility charges.* When VA provides observation care within the scope of care referred to in paragraph (a)(1) of this section, the facility charges billed for such care will be determined in accordance with the provisions of this paragraph. The charges for this care vary by geographic area and number of hours of care. These charges are calculated as follows:

(1) *Formula.* For each occurrence of observation care, add the nationwide base charge determined pursuant to paragraph (j)(2) of this section to the product of the number of hours in observation care and the hourly charge also determined pursuant to paragraph (j)(2) of this section. Then multiply this amount by the appropriate geographic area adjustment factor determined pursuant to paragraph (j)(3) of this section. The result constitutes the area-specific observation care facility charge.

(2)(i) *Nationwide 80th percentile observation care facility charges.* To calculate nationwide base and hourly facility charges, all claims with observation care line items are selected from the outpatient facility component of the Medicare Standard Analytical File 5 percent Sample. Then, using the 80th percentile observation line item charges for each unique hourly length of stay, a standard linear regression technique is used to calculate the nationwide 80th percentile base charge and 80th percentile hourly charge. Finally, the resulting amounts are each trended forward to the effective time period for the charges, as set forth in paragraph (j)(2)(ii) of this section. The results constitute the nationwide 80th percentile base and hourly facility charges for observation care.

(ii) *Trending forward.* The nationwide 80th percentile base and hourly facility charges for observation care, obtained as described in paragraph (j)(2)(i) of this section, are trended forward based on changes to the outpatient hospital services component of the CPI-U. Actual CPI-U changes are used from the time period of the source data through the latest available month as of the time the calculations are performed. The three-month average annual trend rate as of the latest available month is then held constant to the midpoint of the calendar year in which the charges are primarily expected to be used. The projected total CPI-U change so obtained is then applied to the 80th percentile charges.

(3) *Geographic area adjustment factors.* The geographic area adjustment factors for observation care facility charges are the same as those computed for outpatient facility charges under paragraph (e)(4) of this section.

(k) *Ambulance and other emergency transportation charges.* When VA provides ambulance and other emergency transportation services that are within the scope of care referred to in paragraph (a)(1) of this section, the charges billed for such services will be determined in accordance with the provisions of this paragraph. The charges for these services vary by HCPCS code, length of trip, and geographic area. These charges are calculated as follows:

(1) *Formula.* For each occasion of ambulance or other emergency transportation service, add the nationwide base charge for the appropriate HCPCS code determined pursuant to paragraph (k)(2)(i) of this section to the product of the number of miles traveled and the appropriate HCPCS code mileage charge determined pursuant to paragraph (k)(2)(ii) of this section. Then multiply this amount by the appropriate geographic area adjustment factor determined pursuant to paragraph

(k)(3) of this section. The result constitutes the area-specific ambulance or other emergency transportation service charge.

(2)(i) *Nationwide 80th percentile all-inclusive base charge.* To calculate a nationwide all-inclusive base charge, all ambulance and other emergency transportation claims are selected from the outpatient facility component of the Medicare Standard Analytical File 5 percent Sample. Excluding professional and mileage charges, as well as all-inclusive charges which are reported on such claims, the total charge per claim, including incidental supplies, is computed. Then, the 80th percentile amount for each HCPCS code is computed. Finally, the resulting amounts are each trended forward to the effective time period for the charges, as set forth in paragraph (k)(2)(iii) of this section. The results constitute the nationwide 80th percentile all-inclusive base charge for each HCPCS base charge code.

(ii) *Nationwide 80th percentile mileage charge.* To calculate a nationwide mileage charge, all ambulance and other emergency transportation claims are selected from the outpatient facility component of the Medicare Standard Analytical File 5 percent Sample. Excluding professional, incidental, and base charges, as well as claims with all-inclusive charges, the total mileage charge per claim is computed. This amount is divided by the number of miles reported on the claim. Then, the 80th percentile amount for each HCPCS code, using miles as weights, is computed. Finally, the resulting amounts are each trended forward to the effective time period for the charges, as set forth in paragraph (k)(2)(iii) of this section. The results constitute the nationwide 80th percentile mileage charge for each HCPCS mileage code.

(iii) *Trending forward.* The nationwide 80th percentile charge for each HCPCS code, obtained as described in paragraphs (k)(2)(i) and (k)(2)(ii) of this section, is trended forward based on changes to the outpatient hospital services component of the CPI-U. Actual CPI-U changes are used from the time period of the source data through the latest available month as of the time the calculations are performed. The three-month average annual trend rate as of the latest available month is then held constant to the midpoint of the calendar year in which the charges are primarily expected to be used. The projected total CPI-U change so obtained is then applied to the 80th percentile charges.

(3) *Geographic area adjustment factors.* The geographic area adjustment factors for ambulance and other emergency transportation charges are the same as those computed for outpatient facility charges under paragraph (e)(4) of this section.

(l) *Charges for durable medical equipment, drugs, injectables, and other medical services, items, and supplies identified by HCPCS Level II codes.* When VA provides DME, drugs, injectables, or other medical services, items, or supplies that are identified by HCPCS Level II codes and that are within the scope of care referred to in paragraph (a)(1) of this section, the charges billed for such services, items, and supplies will be determined in accordance with the provisions of this paragraph. The charges for these services, items, and supplies vary by geographic area, by HCPCS code, and by modifier, when applicable. These charges are calculated as follows:

(1) *Formula.* For each HCPCS code, multiply the nationwide charge determined pursuant to paragraphs (l)(2), (l)(3), and (l)(4) of this section by the appropriate geographic area adjustment factor determined pursuant to paragraph (l)(5) of this section. The result constitutes the area-specific charge.

(2) *Nationwide 80th percentile charges for HCPCS codes with RVUs.* For each applicable HCPCS code, RVUs are compiled from the data sources set forth in paragraph (l)(2)(i) of this section. The RVUs are multiplied by the charge amount for each incremental RVU determined pursuant to paragraph (l)(2)(ii) of this section, and this amount is added to the fixed charge amount also determined pursuant to paragraph (l)(2)(ii) of this section. Then, for each HCPCS code, this charge is multiplied by the appropriate 80th percentile to median charge ratio determined pursuant to paragraph (l)(2)(iii) of this section. Finally, the

resulting amount is trended forward to the effective time period for the charges, as set forth in paragraph (l)(2)(iv) of this section to obtain the nationwide 80th percentile charge.

(i) *RVUs for DME, drugs, injectables, and other medical services, items, and supplies.* For the purpose of the statistical methodology set forth in paragraph (l)(2)(ii) of this section, HCPCS codes are assigned to the following HCPCS code groups. For the HCPCS codes in each group, the RVUs or amounts indicated constitute the RVUs:

(A) Chemotherapy Drugs: Ingenix/St. Anthony's RBRVS Practice Expense RVUs.

(B) Other Drugs: Ingenix/St. Anthony's RBRVS Practice Expense RVUs.

(C) DME—Hospital Beds: Medicare DME Fee Schedule amounts.

(D) DME—Medical/Surgical Supplies: Medicare DME Fee Schedule amounts.

(E) DME—Orthotic Devices: Medicare DME Fee Schedule amounts.

(F) DME—Oxygen and Supplies: Medicare DME Fee Schedule amounts.

(G) DME—Wheelchairs: Medicare DME Fee Schedule amounts.

(H) Other DME: Medicare DME Fee Schedule amounts.

(I) Enteral/Parenteral Supplies: Medicare Parenteral and Enteral Nutrition Fee Schedule amounts.

(J) Surgical Dressings and Supplies: Medicare DME Fee Schedule amounts.

(K) Vision Items—Other Than Lenses: Medicare DME Fee Schedule amounts.

(L) Vision Items—Lenses: Medicare DME Fee Schedule amounts.

(M) Hearing Items: Ingenix/St. Anthony's RBRVS Practice Expense RVUs.

(ii) *Charge amounts.* Using combined Part B and DME components of the Medicare Standard Analytical File 5% Sample, the median billed charge is calculated for each HCPCS code. A mathematical approximation methodology based on least squares techniques is applied to the RVUs specified for each of the groups set forth in paragraph (l)(2)(i) of this section, yielding two charge amounts for each HCPCS code group: a charge amount per incremental RVU, and a fixed charge amount.

(iii) *80th Percentile to median charge ratios.* Two ratios are obtained for each HCPCS code group set forth in paragraph (l)(2)(i) of this section by dividing the weighted average 80th percentile charge by the weighted average median charge derived from two data sources: Medicare data, as represented by the combined Part B and DME components of the Medicare Standard Analytical File 5% Sample; and the MDR database. Charge frequencies from the Medicare data are used as weights when calculating all weighted averages. For each HCPCS code group, the smaller of the two ratios is selected as the adjustment from median to 80th percentile charges.

(iv) *Trending forward.* The charges for each HCPCS code, obtained as described in paragraph (l)(2)(iii) of this section, are trended forward based on changes to the medical care commodities component of the CPI-U. Actual CPI-U changes are used from the time period of the source data through the latest available month as of the time the calculations are performed. The three-month average annual trend rate as of the latest available month is then held constant to the midpoint of the calendar year in which the charges are primarily expected to be used. The projected total CPI-U change so obtained is then applied to the 80th percentile charges, as described in paragraph (l)(2)(iii) of this section.

(3) *Nationwide 80th percentile charges for HCPCS codes without RVUs.* For each applicable HCPCS code, 80th percentile charges are extracted from three independent data sources: the MDR database; Medicare, as represented by the combined Part B and DME components of the Medicare Standard Analytical File 5 percent Sample; and Milliman USA, Inc., Optimized HMO (Health Maintenance Organization) Data Sets (*see* paragraph (a)(3) of this section for Data Sources). Charges from each database are then trended forward to the effective time period for the charges, as set forth in paragraph (l)(3)(i) of this section. Charges for each HCPCS code from each data source are combined into an average 80th percentile charge by means of the methodology set forth in paragraph (l)(3)(ii) of this section. The results constitute the nationwide

80th percentile charge for each applicable HCPCS code.

(i) *Trending forward.* The charges from each database for each HCPCS code, obtained as described in paragraph (l)(3) of this section, are trended forward based on changes to the medical care commodities component of the CPI-U. Actual CPI-U changes are used from the time period of each source database through the latest available month as of the time the calculations are performed. The three-month average annual trend rate as of the latest available month is then held constant to the midpoint of the calendar year in which the charges are primarily expected to be used. The projected total CPI-U change so obtained is then applied to the 80th percentile charges, as described in paragraph (l)(3) of this section.

(ii) *Averaging methodology.* The average 80th percentile trended charge for any particular HCPCS code is calculated by first computing a preliminary mean average of the three charges for each HCPCS code. Statistical outliers are identified and removed by testing whether any charge differs from the preliminary mean charge by more than 5 times the preliminary mean charge, or by less than 0.2 times the preliminary mean charge. In such cases, the charge most distant from the preliminary mean is removed as an outlier, and the average charge is calculated as a mean of the two remaining charges. In cases where none of the charges differ from the preliminary mean charge by more than 5 times the preliminary mean charge, or less than 0.2 times the preliminary mean charge, the average charge is calculated as a mean of all three reported charges.

(4) *Nationwide 80th percentile charges for HCPCS codes designated as unlisted or unspecified.* For HCPCS codes designated as unlisted or unspecified procedures, services, items, or supplies, 80th percentile charges are developed based on the weighted median 80th percentile charges of HCPCS codes within the series in which the unlisted or unspecified code occurs. A nationwide VA distribution of procedures, services, items, and supplies is used for the purpose of computing the weighted median.

(5) *Geographic area adjustment factors.* For the purpose of geographic adjustment, HCPCS codes are combined into two groups: drugs and DME/supplies, as set forth in paragraph (l)(5)(i) of this section. The geographic area adjustment factor for each of these groups is calculated as the ratio of the area-specific weighted average charge determined pursuant to paragraph (l)(5)(ii) of this section divided by the nationwide weighted average charge determined pursuant to paragraph (l)(5)(iii) of this section.

(i) *Combined HCPCS code groups for geographic area adjustment factors for DME, drugs, injectables, and other medical services, items, and supplies.* For the purpose of the statistical methodology set forth in paragraph (l)(5) of this section, each of the HCPCS code groups set forth in paragraph (l)(2)(i) of this section is assigned to one of two combined HCPCS code groups, as follows:

(A) Chemotherapy Drugs: Drugs.

(B) Other Drugs: Drugs.

(C) DME—Hospital Beds: DME/supplies.

(D) DME—Medical/Surgical Supplies: DME/supplies.

(E) DME—Orthotic Devices: DME/supplies.

(F) DME—Oxygen and Supplies: DME/supplies.

(G) DME—Wheelchairs: DME/supplies.

(H) Other DME: DME/supplies.

(I) Enteral/Parenteral Supplies: DME/supplies.

(J) Surgical Dressings and Supplies: DME/supplies.

(K) Vision Items—Other Than Lenses: DME/supplies.

(L) Vision Items—Lenses: DME/supplies.

(M) Hearing Items: DME/supplies.

(ii) *Area-specific weighted average charges.* Using the median charges by HCPCS code from the MDR database for each geographic area and utilization frequencies by HCPCS code from the combined Part B and DME components of the Medicare Standard Analytical File 5 percent Sample, an area-specific weighted average charge is calculated for each combined HCPCS code group.

(iii) *Nationwide weighted average charges*. Using the area-specific weighted average charges determined pursuant to paragraph (l)(5)(ii) of this section, a nationwide weighted average charge is calculated for each combined HCPCS code group, using as weights the population (census) frequencies for each geographic area as presented in the Milliman USA, Inc., Health Cost Guidelines (see paragraph (a)(3) of this section for Data Sources).

(m) *Charges for prescription drugs not administered during treatment*. Notwithstanding other provisions of this section regarding VA charges, when VA provides or furnishes prescription drugs not administered during treatment, within the scope of care referred to in paragraph (a)(1) of this section, charges billed separately for such prescription drugs will consist of the amount that equals the total of the actual cost to VA for the drugs and the national average of VA administrative costs associated with dispensing the drugs for each prescription. The actual VA cost of a drug will be the actual amount expended by the VA facility for the purchase of the specific drug. The administrative cost will be determined annually using VA's managerial cost accounting system. Under this accounting system, the average administrative cost is determined by adding the total VA national drug general overhead costs (such as costs of buildings and maintenance, utilities, billing, and collections) to the total VA national drug dispensing costs (such as costs of the labor of the pharmacy department, packaging, and mailing) with the sum divided by the actual number of VA prescriptions filled nationally. Based on this accounting system, VA will determine the amount of the average administrative cost annually for the prior fiscal year (October through September) and then apply the charge at the start of the next calendar year.

NOTE TO §17.101: The charges generated by the methodology set forth in this section are the same charges prescribed by the Office of Management and Budget for use under the Federal Medical Care Recovery Act, 42 U.S.C. 2651–2653.

(Authority: 38 U.S.C. 101, 501, 1701, 1705, 1710, 1720D, 1720E, 1721, 1722, 1729)

(The Office of Management and Budget has approved the information collection requirements in this section under control number 2900–0606)

[68 FR 70715, Dec. 19, 2003, as amended at 69 FR 1061, Jan. 7, 2004; 72 FR 68072, Dec. 4, 2007; 75 FR 61623, Oct. 6, 2010; 83 FR 31454, July 6, 2018]

§ 17.102 Charges for care or services.

Except as provided in §17.101, charges at the indicated rates shall be made for Department of Veterans Affairs hospital care or medical services (including, but not limited to, dental services, supplies, medicines, orthopedic and prosthetic appliances, and domiciliary or nursing home care) as follows:

(a) *Furnished in error or on tentative eligibility*. Charges at rates prescribed by the Under Secretary for Health shall be made for inpatient or outpatient care or services (including domiciliary care) authorized for any person on the basis of eligibility as a veteran or a tentative eligibility determination under §17.34 but he or she was subsequently found to have been ineligible for such care or services as a veteran because the military service or any other eligibility requirement was not met, or

(b) *Furnished in a medical emergency*. Charges at rates prescribed by the Under Secretary for Health shall be made for any inpatient or outpatient care or services rendered any person in a medical emergency who was not eligible for such care or services as a veteran, if:

(1) The care or services were rendered as a humanitarian service, under §17.43(b)(1) or §17.95 to a person neither claiming eligibility as a veteran nor for whom the establishment of eligibility as a veteran was expected, or

(2) The person for whom care or services were rendered was a Department of Veterans Affairs employee or a member of a Department of Veterans Affairs employee's family; or

(c) *Furnished beneficiaries of the Department of Defense or other Federal agencies*. Except as provided for in paragraph (f) of this section and the

second sentence of this paragraph, charges at rates prescribed by the Office of Management and Budget shall be made for any inpatient or outpatient care or services authorized for a member of the Armed Forces on active duty or for any beneficiary or designee of any other Federal agency. Charges for services provided a member or former member of a uniformed service who is entitled to retired or retainer pay, or equivalent pay, will be at rates prescribed by the Secretary (E.O. 11609, dated July 22, 1971, 36 FR 13747), or

(d) *Furnished pensioners of allied nations.* Charges at rates prescribed by the Under Secretary for Health shall be made for any inpatient or outpatient care or services rendered a pensioner of a nation allied with the United States in World War I and World War II; or

(e) *Furnished under sharing agreements.* Charges at rates agreed upon in an agreement for sharing specialized medical resources shall be made for all medical care or services, either on an inpatient or outpatient basis, rendered to a person designated by the other party to the agreement as a patient to be benefited under the agreement; or

(f) *Furnished military retirees with chronic disability.* Charges for subsistence at rates prescribed by the Under Secretary for Health shall be made for the period during which hospital care is rendered when such care is rendered to a member or former member of the Armed Forces required to pay the subsistence rate under § 17.47 (b)(2) and (c)(2).

(g) *Furnished for research purposes.* Charges will not be made for medical services, including transportation, furnished as part of an approved Department of Veterans Affairs research project, except that if the services are furnished to a person who is not eligible for the services as a veteran, the medical care appropriation shall be reimbursed from the research appropriation at the same rates used for billings under paragraph (b) of this section.

(h) *Computation of charges.* The method for computing the charges under § 17.86 and under paragraphs (a), (b), (d), (f), and (g) and the last sentence of paragraph (c) of this section is based on the Monthly Program Cost Report (MPCR), which sets forth the actual basic costs and per diem rates by type of inpatient care, and actual basic costs and rates for outpatient care visits or prescriptions filled. Factors for depreciation of buildings and equipment and Central Office overhead are added, based on accounting manual instructions. Additional factors are added for interest on capital investment and for standard fringe benefit costs covering government employee retirement and disability costs. The current year billing rates are projected on prior year actual rates by applying the budgeted percentage increase. In addition, based on the detail available in the MPCR, VA intends to, on each bill break down the all-inclusive rate into its three principal components; namely, physician cost, ancillary services cost, and nursing, room and board cost. The rates generated by the foregoing methodology will be published by either VA or OMB in the 'Notices' section of the FEDERAL REGISTER.

(Authority: 38 U.S.C. 1729; sec. 19013, Pub. L. 99–272)

[32 FR 11382, Aug. 5, 1967, as amended at 34 FR 7807, May 16, 1969; 35 FR 11470, July 17, 1970; 36 FR 18794, Sept. 22, 1971; 47 FR 50861, Nov. 10, 1982; 47 FR 58249, Dec.30, 1982; 52 FR 3010, Jan. 30, 1987. Redesignated and amended at 61 FR 21965, 21967, May 13, 1996; 62 FR 17072, Apr. 9, 1997. Redesignated and amended at 64 FR 22678, 22683, Apr. 27, 1999; 69 FR 1061, Jan. 7, 2004; 73 FR 26946, May 12, 2008]

§ 17.103 Referrals of compromise settlement offers.

Any offer to compromise or settle any charges or claim for $20,000 or less asserted by the Department of Veterans Affairs in connection with the medical program shall be referred as follows:

(a) *To Chief Financial Officers of the Consolidated Patient Account Centers.* If the debt represents charges made under §§ 17.108, 17.110, or 17.111, the compromise offer shall be referred to the Chief Financial Officer of the Consolidated Patient Account Center (CPAC) for application of the collection standards in § 1.900 *et seq.* of this chapter, provided:

(1) The debt does not exceed $1,000, and

(2) There has been a previous denial of waiver of the debt by the CPAC Committee on Waivers and Compromises.

(b) *To Regional Counsel.* If the debt in any amount represents charges for medical services for which there is or may be a claim against a third party tort-feasor or under workers' compensation laws or Pub. L. 87–693; 76 Stat. 593 (see § 1.903 of this chapter) or involves a claim contemplated by § 1.902 of this chapter over which the Department of Veterans Affairs lacks jurisdiction, the compromise offer (or request for waiver or proposal to terminate or suspend collection action) shall be promptly referred to the field station Regional Counsel having jurisdiction in the area in which the claim arose, or

(c) *To Committee on Waivers and Compromises.* If one of the following situations contemplated in paragraph (c)(1) through (3) of this section applies

(1) If the debt represents charges made under § 17.101(a), but is not of a type contemplated in paragraph (a) of this section, or

(2) If the debt represents charges for medical services made under § 17.101(b), or

(3) A claim arising in connection with any transaction of the Veterans Health Administration for which the instructions in paragraph (a) or (b) of this section or in § 17.105(c) are not applicable, then, the compromise offer should be referred for disposition under § 1.900 *et seq.* of this chapter to the field station Committee on Waivers and Compromises which shall take final action.

[39 FR 26403, July 19, 1974, as amended at 47 FR 58250, Dec. 30, 1982. Redesignated and amended at 61 FR 21966, 21967, May 13, 1996; 62 FR 17072, Apr. 9, 1997; 80 FR 23241, Apr. 27, 2015]

§ 17.104 Terminations and suspensions.

Any proposal to suspend or terminate collection action on any charges or claim for $20,000 or less asserted by the Department of Veterans Affairs in connection with the medical program shall be referred as follows:

(a) *Of charges for medical services.* If the debt represents charges made under §§ 17.108, 17.110, or 17.111 questions concerning suspension or termination of collection action shall be referred to the Chief Financial Officer of the Consolidated Patient Account Center for application of the collection standards in § 1.900 *et seq.* of this chapter, or

(b) *Of other debts.* If the debt is of a type other than those contemplated in paragraph (a) of this section, questions concerning suspension or termination of collection action shall be referred in accordance with the same referral procedures for compromise offers (except the Fiscal activity shall make final determinations in terminations or suspensions involving claims of $150 or less pursuant to the provisions of § 1.900 *et seq.* of this chapter.)

[34 FR 7807, May 16, 1969, as amended at 39 FR 26403, July 19, 1974. Redesignated and amended at 61 FR 21966, 21967, May 13, 1996; 80 FR 23241, Apr. 27, 2015]

§ 17.105 Waivers.

Applications or requests for waiver of debts or claims asserted by the Department of Veterans Affairs in connection with the medical program generally will be denied by the facility Fiscal activity on the basis there is no legal authority to waive debts, unless the question of waiver should be referred as follows:

(a) *Of charges for medical services.* If the debt represents charges made under § 17.102, the application or request for waiver should be referred for disposition under § 1.900 *et seq.* of this chapter to the field facility Committee on Waivers and Compromises which shall take final action, or

(b) *Of claims against third persons and other claims.* If the debt is of a type contemplated in § 17.103(b), the waiver question should be referred in accordance with the same referral procedures for compromise offers in such categories of claims, or

(c) *Of charges for copayments.* If the debt represents charges for outpatient medical care, inpatient hospital care, medication or extended care services copayments made under §§ 17.108, 17.110, 17.111, or 17.4600, the claimant must request a waiver by submitting VA Form 5655 (Financial Status Report) to the Consolidated Patient Account Center (CPAC) Chief Financial Officer. The

claimant must submit this form within the time period provided in §1.963(b) of this chapter and may request a hearing under §1.966(a) of this chapter. The CPAC Chief Financial Officer may extend the time period for submitting a claim if the Chairperson of the Committee on Waivers and Compromises could do so under §1.963(b) of this chapter. The CPAC Chief Financial Officer will apply the standard ''equity and good conscience'' in accordance with §§1.965 and 1.966(a) of this chapter, and may waive all or part of the claimant's debts. A decision by the CPAC Chief Financial Officer under this provision is final (except that the decision may be reversed or modified based on new and material evidence, fraud, a change in law or interpretation of law, or clear and unmistakable error shown by the evidence in the file at the time of the prior decision as provided in §1.969 of this chapter) and may be appealed in accordance with 38 CFR parts 19 and 20.

(d) *Other debts.* If the debt represents any claim or charges other than those contemplated in paragraphs (a) and (b) of this section, and is a debt for which waiver has been specifically provided for by law or under the terms of a contract, initial action shall be taken at the station level for referral of the request for waiver through channels for action by the appropriate designated official. If, however, the question of waiver may also involve a concurrent opportunity to negotiate a compromise settlement, the application shall be referred to the Committee on Waivers and Compromises.

(The Office of Management and Budget has approved the information collection requirements in this section under control number 2900–0165)

[39 FR 26403, July 19, 1974. Redesignated and amended at 61 FR 21966, 21967, May 13, 1996; 69 FR 62204, Oct. 25, 2004; 80 FR 23241, Apr. 27, 2015; 84 FR 26017, June 5, 2019]

§ 17.106 VA collection rules; third-party payers.

(a)(1) *General rule.* VA has the right to recover or collect reasonable charges from a third-party payer for medical care and services provided for a nonservice-connected disability in or through any VA facility to a veteran who is also a beneficiary under the third-party payer's plan. VA's right to recover or collect is limited to the extent that the beneficiary or a nongovernment provider of care or services would be eligible to receive reimbursement or indemnification from the third-party payer if the beneficiary were to incur the costs on the beneficiary's own behalf.

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

Automobile liability insurance means insurance against legal liability for health and medical expenses resulting from personal injuries arising from operation of a motor vehicle. Automobile liability insurance includes:

(A) Circumstances in which liability benefits are paid to an injured party only when the insured party's tortious acts are the cause of the injuries; and

(B) Uninsured and underinsured coverage, in which there is a third-party tortfeasor who caused the injuries (*i.e.*, benefits are not paid on a no-fault basis), but the insured party is not the tortfeasor.

Health-plan contract means any plan, policy, program, contract, or liability arrangement that provides compensation, coverage, or indemnification for expenses incurred by a beneficiary for medical care or services, items, products, and supplies. It includes but is not limited to:

(A) Any plan offered by an insurer, reinsurer, employer, corporation, organization, trust, organized health care group or other entity.

(B) Any plan for which the beneficiary pays a premium to an issuing agent as well as any plan to which the beneficiary is entitled as a result of employment or membership in or association with an organization or group.

(C) Any Employee Retirement Income and Security Act (ERISA) plan.

(D) Any Multiple Employer Trust (MET).

(E) Any Multiple Employer Welfare Arrangement (MEWA).

(F) Any Health Maintenance Organization (HMO) plan, including any such plan with a point-of-service provision or option.

(G) Any individual practice association (IPA) plan.

(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.

(Authority: 31 U.S.C. 3711, 38 U.S.C. 501, 1729, 42 U.S.C. 2651)

[76 FR 37204, June 24, 2011, as amended at 79 FR 54616, Sept. 12, 2014]

DISCIPLINARY CONTROL OF BENEFICIARIES RECEIVING HOSPITAL, DOMICILIARY OR NURSING HOME CARE

§ 17.107 VA response to disruptive behavior of patients.

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

VA medical facility means VA medical centers, outpatient clinics, and domiciliaries.

(b) *Response to disruptive patients*. The time, place, and/or manner of the provision of a patient's medical care may be restricted by written order of the Chief of Staff of the VA Medical Center of jurisdiction or his or her designee if:

(1) The Chief of Staff or designee determines pursuant to paragraph (c) of this section that the patient's behavior at a VA medical facility has jeopardized or could jeopardize the health or safety of other patients, VA staff, or guests at the facility, or otherwise interfere with the delivery of safe medical care to another patient at the facility;

(2) The order is narrowly tailored to address the patient's disruptive behavior and avoid undue interference with the patient's care;

(3) The order is signed by the Chief of Staff or designee, and a copy is entered into the patient's permanent medical record;

(4) The patient receives a copy of the order and written notice of the procedure for appealing the order to the Network Director of jurisdiction as soon as possible after issuance; and

(5) The order contains an effective date and any appropriate limits on the

duration of or conditions for continuing the restrictions. The Chief of Staff or designee may order restrictions for a definite period or until the conditions for removing conditions specified in the order are satisfied. Unless otherwise stated, the restrictions imposed by an order will take effect upon issuance by the Chief of Staff or designee. Any order issued by the Chief of Staff or designee shall include a summary of the pertinent facts and the bases for the Chief of Staff's or designee's determination regarding the need for restrictions.

(c) *Evaluation of disruptive behavior.* In making determinations under paragraph (b) of this section, the Chief of Staff or designee must consider all pertinent facts, including any prior counseling of the patient regarding his or her disruptive behavior or any pattern of such behavior, and whether the disruptive behavior is a result of the patient's individual fears, preferences, or perceived needs. A patient's disruptive behavior must be assessed in connection with VA's duty to provide good quality care, including care designed to reduce or otherwise clinically address the patient's behavior.

(d) *Restrictions.* The restrictions on care imposed under this section may include but are not limited to:

(1) Specifying the hours in which nonemergent outpatient care will be provided;

(2) Arranging for medical and any other services to be provided in a particular patient care area (e.g., private exam room near an exit);

(3) Arranging for medical and any other services to be provided at a specific site of care;

(4) Specifying the health care provider, and related personnel, who will be involved with the patient's care;

(5) Requiring police escort; or

(6) Authorizing VA providers to terminate an encounter immediately if certain behaviors occur.

(e) *Review of restrictions.* The patient may request the Network Director's review of any order issued under this section within 30 days of the effective date of the order by submitting a written request to the Chief of Staff. The Chief of Staff shall forward the order and the patient's request to the Network Director for a final decision. The Network Director shall issue a final decision on this matter within 30 days. VA will enforce the order while it is under review by the Network Director. The Chief of Staff will provide the patient who made the request written notice of the Network Director's final decision.

NOTE TO § 17.107: Although VA may restrict the time, place, and/or manner of care under this section, VA will continue to offer the full range of needed medical care to which a patient is eligible under title 38 of the United States Code or Code of Federal Regulations. Patients have the right to accept or refuse treatments or procedures, and such refusal by a patient is not a basis for restricting the provision of care under this section.

(Authority: 38 U.S.C. 501, 901, 1721)

[75 FR 69883, Nov. 16, 2010. Redesignated at 76 FR 37204, June 24, 2011; 79 FR 54616, Sept. 12, 2014]

COPAYMENTS

§ 17.108 Copayments for inpatient hospital care and outpatient medical care.

(a) *General.* This section sets forth requirements regarding copayments for inpatient hospital care and outpatient medical care provided to veterans by VA.

(b) *Copayments for inpatient hospital care.* (1) Except as provided in paragraphs (d) or (e) of this section, a veteran, as a condition of receiving inpatient hospital care provided by VA (provided either directly by VA or obtained by VA by contract, provider agreement, or sharing agreement), must agree to pay VA (and is obligated to pay VA) the applicable copayment, as set forth in paragraph (b)(2), (b)(3), or (b)(4) of this section.

(2) The copayment for inpatient hospital care shall be, during any 365-day period, a copayment equaling the sum of:

(i) $10 for every day the veteran receives inpatient hospital care, and

(ii) The lesser of:

(A) The sum of the inpatient Medicare deductible for the first 90 days of care and one-half of the inpatient Medicare deductible for each subsequent 90 days of care (or fraction thereof) after the first 90 days of such care during such 365-day period, or

(B) VA's cost of providing the care.

(3) The copayment for inpatient hospital care for veterans enrolled in priority category 7 shall be 20 percent of the amount computed under paragraph (b)(2) of this section.

(4) For inpatient hospital care furnished through the Veterans Choice Program under §§ 17.1500 through 17.1540, or the Veterans Community Care Program under §§ 17.4000 through 17.4040, the copayment amount at the time of furnishing such care or services by a non-VA entity or provider is $0. VA will determine and assess the veteran's copayment amount at the end of the billing process, but at no time will a veteran's copayment be more than the amount identified in paragraph (b)(2) or (3) of this section.

NOTE TO § 17.108(b): The requirement that a veteran agree to pay the copayment would be met by submitting to VA a signed VA Form 10–10EZ. This is the application form for enrollment in the VA healthcare system and also is the document used for providing means-test information annually.

(c) *Copayments for outpatient medical care.* (1) Except as provided in paragraphs (d), (e), or (f) of this section, a veteran, as a condition for receiving outpatient medical care provided by VA (provided either directly by VA or obtained by VA by contract, provider agreement, or sharing agreement), must agree to pay VA (and is obligated to pay VA) a copayment as set forth in paragraph (c)(2) or (c)(4) of this section.

(2) The copayment for outpatient medical care is $15 for a primary care outpatient visit and $50 for a specialty care outpatient visit. If a veteran has more than one primary care encounter on the same day and no specialty care encounter on that day, the copayment amount is the copayment for one primary care outpatient visit. If a veteran has one or more primary care encounters and one or more specialty care encounters on the same day, the copayment amount is the copayment for one specialty care outpatient visit.

(3) For purposes of this section, a primary care visit is an episode of care furnished in a clinic that provides integrated, accessible healthcare services by clinicians who are accountable for addressing a large majority of personal healthcare needs, developing a sustained partnership with patients, and practicing in the context of family and community. Primary care includes, but is not limited to, diagnosis and management of acute and chronic biopsychosocial conditions, health promotion, disease prevention, overall care management, and patient and caregiver education. Each patient's identified primary care clinician delivers services in the context of a larger interdisciplinary primary care team. Patients have access to the primary care clinician and much of the primary care team without need of a referral. In contrast, specialty care is generally provided through referral. A specialty care outpatient visit is an episode of care furnished in a clinic that does not provide primary care, and is only provided through a referral. Some examples of specialty care provided at a specialty care clinic are radiology services requiring the immediate presence of a physician, audiology, optometry, magnetic resonance imagery (MRI), computerized axial tomography (CAT) scan, nuclear medicine studies, surgical consultative services, and ambulatory surgery.

(4) For outpatient medical care furnished through the Veterans Choice Program under §§ 17.1500 through 17.1540, or the Veterans Community Care Program under §§ 17.4000 through 17.4040, the copayment amount at the time of furnishing such care or services by a non-VA entity or provider is $0. VA will determine and assess the veteran's copayment amount at the end of the billing process, but at no time will a veteran's copayment be more than the amount identified in paragraph (c)(2) of this section.

NOTE TO § 17.108(c): The requirement that a veteran agree to pay the copayment would be met by submitting to VA a signed VA Form 10–10EZ. This is the application form for enrollment in the VA healthcare system and also is the document used for providing means-test information annually.

(d) *Veterans not subject to copayment requirements for inpatient hospital care or outpatient medical care.* The following veterans are not subject to the copayment requirements of this section:

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

(2) A veteran who is a former prisoner of war.

(3) A veteran awarded a Purple Heart.

(4) A veteran who was discharged or released from active military service for a disability incurred or aggravated in the line of duty;

(5) A veteran who receives disability compensation under 38 U.S.C. 1151.

(6) A veteran whose entitlement to disability compensation is suspended pursuant to 38 U.S.C. 1151, but only to the extent that the veteran's continuing eligibility for care is provided for in the judgment or settlement described in 38 U.S.C. 1151.

(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.

(13) A veteran who was awarded the Medal of Honor.

(e) *Services not subject to copayment requirements for inpatient hospital care, outpatient medical care, or urgent care.* The following are not subject to the copayment requirements under this section or, except for § 17.108(e)(1), (2), (4), (10), and (14), the copayment requirements under § 17.4600.

(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, pneumonococcal 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;

(16) In-home video telehealth care; and

(17) Mental health peer support services.

(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.

[66 FR 63448, Dec. 6, 2001, as amended at 68 FR 60854, Oct. 24, 2003; 70 FR 22596, May 2, 2005; 73 FR 20532, Apr. 16, 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, Sept. 24, 2014; 79 FR 65584, Nov. 5, 2014; 79 FR 70939, Nov. 28, 2014; 84 FR 7815, Mar. 5, 2019; 84 FR 26017, 26306, June 5, 2019]

§ 17.109 Presumptive eligibility for psychosis and mental illness other than psychosis.

(a) *Psychosis*. Eligibility for benefits under this part is established by this section for treatment of an active psychosis, and such condition is exempted from copayments under §§ 17.108, 17.110, and 17.111 for any veteran of World War II, the Korean conflict, the Vietnam era, or the Persian Gulf War who developed such psychosis:

(1) Within 2 years after discharge or release from the active military, naval, or air service; and

(2) Before the following date associated with the war or conflict in which he or she served:

(i) World War II: July 26, 1949.

(ii) Korean conflict: February 1, 1957.

(iii) Vietnam era: May 8, 1977.

(iv) Persian Gulf War: The end of the 2-year period beginning on the last day of the Persian Gulf War.

(b) *Mental illness (other than psychosis)*. Eligibility under this part is established by this section for treatment of an active mental illness (other than psychosis), and such condition is exempted from copayments under §§ 17.108, 17.110, and 17.111 for any veteran of the Persian Gulf War who developed such mental illness other than psychosis:

(1) Within 2 years after discharge or release from the active military, naval, or air service; and

(2) Before the end of the 2-year period beginning on the last day of the Persian Gulf War.

(c) *No minimum service required*. Eligibility for care and waiver of copayments will be established under this section without regard to the veteran's length of active-duty service.

(Authority: 38 U.S.C. 501, 1702, 5303A)

[78 FR 28143, May 14, 2013]

§ 17.110 Copayments for medication.

(a) *General*. This section sets forth requirements regarding copayments for medications provided to veterans by VA. For purposes of this section, the term ''medication'' means prescription and over-the-counter medications, as determined by the Food and Drug Administration (FDA), but does not mean medical supplies, oral nutritional supplements, or medical devices. Oral nutritional supplements are commercially prepared nutritionally enhanced products used to supplement the intake of individuals who cannot meet nutrient needs by diet alone.

(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 each 30-day or less supply of Tier 1 medications, the copayment amount is $5.

(ii) For each 30-day or less supply of Tier 2 medications, the copayment amount is $8.

(iii) For each 30-day or less supply of Tier 3 medications, the copayment amount is $11.

(iv) For purposes of this section:

(A) *Multi-source medication* is any one of the following:

(*1*) A medication that has been and remains approved by the FDA—

(*i*) Under sections 505(b)(2) or 505(j) of the Food, Drug, and Cosmetic Act (FDCA, 21 U.S.C. 355), and that has been granted an A-rating in the current version of the FDA's Approved Drug Products with Therapeutic Equivalence Evaluations (the Orange Book); or

(*ii*) Under section 351(k) of the Public Health Service Act (PHSA, 42 U.S.C. 262), and that has been granted an I or B rating in the current version of the FDA's Lists of Licensed Biological Products with Reference Product Exclusivity and Biosimilarity or Interchangeability Evaluations (the Purple Book). FDA determines both therapeutic equivalence for drugs and interchangeability for biological products.

(*2*) A medication that—

(*i*) Has been and remains approved by the FDA pursuant to FDCA section 505(b)(1) or PHSA section 351(a);

(*ii*) Which is referenced by at least one FDA-approved product that meets the criteria of paragraph (b)(1)(iv)(A)(*1*) of this section; and

(*iii*) Which is covered by a contracting strategy in place with pricing such that it is lower in cost than other generic sources.

(*3*) A medication that—

(*i*) Has been and remains approved by the FDA pursuant to FDCA section 505(b)(1) or PHSA section 351(a); and

(*ii*) Has the same active ingredient or active ingredients, works in the same way and in a comparable amount of time, and is determined by VA to be substitutable for another medication that has been and remains approved by the FDA pursuant to FDCA section 505(b)(1) or PHSA section 351(a). This may include but is not limited to insulin and levothyroxine.

(*4*) A listed drug, as defined in 21 CFR 314.3, that has been approved under FDCA section 505(c) and is marketed, sold, or distributed directly or indirectly to retail class of trade with either labeling, packaging (other than repackaging as the listed drug in blister packs, unit doses, or similar packaging for use in institutions), product code, labeler code, trade name, or trademark that differs from that of the listed drug.

(B) *Tier 1 medication* means a multi-source medication that has been identified using the process described in paragraph (b)(2) of this section.

(C) *Tier 2 medication* means a multi-source medication that is not identified using the process described in paragraph (b)(2) of this section.

(D) *Tier 3 medication* means a medication approved by the FDA under a New Drug Application (NDA) or a biological product approved by the FDA pursuant to a biologics license agreement (BLA) that retains its patent protection and exclusivity and is not a multi-source medication identified in paragraph (b)(1)(iv)(A)(*3*) or (*4*) of this section.

(2) *Determining Tier 1 medications.* Not less than once per year, VA will identify a subset of multi-source medications as Tier 1 medications using the criteria below. Only medications that meet all of the criteria in paragraphs (b)(2)(i), (ii), and (iii) will be eligible to be considered Tier 1 medications, and only those medications that meet all of the criteria in paragraph (b)(2)(i) of this section will be assessed using the criteria in paragraphs (b)(2)(ii) and (iii).

(i) A medication must meet all of the following criteria:

(A) The VA acquisition cost for the medication is less than or equal to $10 for a 30-day supply of medication;

(B) The medication is not a topical cream, a product used to treat musculoskeletal conditions, an antihistamine, or a steroid-containing medication;

(C) The medication is available on the VA National Formulary;

(D) The medication is not an antibiotic that is primarily used for short periods of time to treat infections; and

(E) The medication primarily is used to either treat or manage a chronic condition, or to reduce the risk of adverse health outcomes secondary to the chronic condition, for example, medications used to treat high blood pressure to reduce the risks of heart attack, stroke, and kidney failure. For purposes of this section, conditions that typically are known to persist for 3 months or more will be considered chronic.

(ii) The medication must be among the top 75 most commonly prescribed multi-source medications that meet the criteria in paragraph (b)(2)(i) of this section, based on the number of prescriptions issued for a 30-day or less supply on an outpatient basis during a fixed period of time.

(iii) VA must determine that the medication identified provides maximum clinical value consistent with budgetary resources.

(3) *Information on Tier 1 medications.* Not less than once per year, VA will publish a list of Tier 1 medications in the FEDERAL REGISTER and on VA's Web site at *www.va.gov/health*.

(4) *Veterans Choice Program.* For medications furnished through the Veterans Choice Program under §§ 17.1500 through 17.1540, or the Veterans Community Care Program under §§ 17.4000 through 17.4040, the copayment amount

at the time the veteran fills the prescription is $0. VA will determine and assess the veteran's copayment amount at the end of the billing process, but at no time will a veteran's copayment be more than the amount identified in paragraphs (b)(1)(i) through (iii) of this section.

(5) *Copayment cap*. The total amount of copayments for medications in a calendar year for an enrolled veteran will not exceed $700.

(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.

(11) Medication for a veteran who was awarded the Medal of Honor.

[66 FR 63451, Dec. 6, 2001, as amended at 74 FR 69285, Dec. 31, 2009; 75 FR 32672, June 9, 2010; 75 FR 54030, Sept. 3, 2010; 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 79317, Dec. 30, 2013; 79 FR 57414, Sept. 24, 2014; 79 FR 63821, Oct. 27, 2014; 79 FR 65585, Nov. 5, 2014; 80 FR 55545, Sept. 16, 2015; 81 FR 88120, Dec. 7, 2016; 81 FR 89390, Dec. 12, 2016; 84 FR 7815, Mar. 5, 2019; 84 FR 26306, June 5, 2019]

§ 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.

(3) For hospital care and medical services considered non-institutional care furnished through the Veterans Choice Program under §§ 17.1500 through 17.1540, as well as extended care services furnished through the Veterans Community Care Program under §§ 17.4000 through 17.4040, the copayment amount at the time of furnishing such care or services by a non-VA entity or provider is $0. VA will determine and assess the veteran's copayment amount at the end of the billing process, but at no time will a veteran's copayment be more than the amount identified in paragraph (b)(1) or (2) of this section.

(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 equal to the Maximum Community Spouse Resource Standard published by the Centers for Medicare and Medicaid Services (CMS) as of January 1 of the current calendar year 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.

(10) A veteran who was awarded the Medal of Honor.

[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; 78 FR 70864, Nov. 27, 2013; 79 FR 57414, Sept. 24, 2014; 79 FR 65585, Nov. 5, 2014; 84 FR 7815, Mar. 5, 2019; 84 FR 26307, June 5, 2019]

CEREMONIES

§ 17.112 Services or ceremonies on Department of Veterans Affairs hospital or center reservations.

(a) Services or ceremonies on Department of Veterans Affairs hospital or center reservations are subject to the following limitations:

(1) All activities must be conducted with proper decorum, and not interfere with the care and treatment of patients. Organizations must provide assurance that their members will obey all rules in effect at the hospital or center involved, and act in a dignified and proper manner;

(2) Partisan activities are inappropriate and all activities must be nonpartisan in nature. An activity will be considered partisan and therefore inappropriate if it includes commentary in support of, or in opposition to, or attempts to influence, any current policy of the Government of the United States or any State of the United States. If the activity is closely related to partisan activities being conducted outside the hospital or center reservations, it will be considered partisan and therefore inappropriate.

(b) Requests for permission to hold services or ceremonies will be addressed to the Secretary, or the Director of the Department of Veterans Affairs hospital or center involved. Such applications will describe the proposed activity in sufficient detail to enable a determination as to whether it meets the standards set forth in paragraph (a) of this section. If permission is granted, the Director of the hospital or center involved will assign an appropriate time, and render assistance where appropriate. No organization will be given exclusive permission to use the hospital or center reservation on any particular occasion. Where several requests are received for separate activities, the Director will schedule each so as to avoid overlapping or interference, or require appropriate modifications in the scope or timing of the activity.

[35 FR 2389, Feb. 3, 1970. Redesignated at 61 FR 21966, May 13, 1996, and further redesignated at 67 FR 35040, May 17, 2002]

REIMBURSEMENT FOR LOSS BY NATURAL DISASTER OF PERSONAL EFFECTS OF HOSPITALIZED OR NURSING HOME PATIENTS

§ 17.113 Conditions of custody.

When the personal effects of a patient who has been or is hospitalized or receiving nursing home care in a Department of Veterans Affairs hospital or center were or are duly delivered to a designated location for custody and

loss of such personal effects has occurred or occurs by fire, earthquake, or other natural disaster, either during such storage or during laundering, reimbursement will be made as provided in §§ 17.113 and 17.114.

[39 FR 1843, Jan. 15, 1974. Redesignated and amended at 61 FR 21966, 21967, May 13, 1996, and further redesignated at 67 FR 35039, May 17, 2002]

§ 17.114 Submittal of claim for reimbursement.

The claim for reimbursement for personal effects damaged or destroyed will be submitted by the patient to the Director. The patient will separately list and evaluate each article with a notation as to its condition at the time of the fire, earthquake, or other natural disaster *i.e.*, whether new, worn, etc. The date of the fire, earthquake, or other natural disaster will be stated. It will be certified by a responsible official that each article listed was stored in a designated location at the time of loss by fire, earthquake, or other natural disaster or was in process of laundering. The patient will further state whether the loss of each article was complete or partial, permitting of some further use of the article. The responsible official will certify that the amount of reimbursement claimed on each article of personal effects is not in excess of the fair value thereof at time of loss. The certification will be prepared in triplicate, signed by the responsible officer who made it, and countersigned by the Director of the medical center. After the above papers have been secured, voucher will be prepared, signed, and certified, and forwarded to the Fiscal Officer for approval, payment to be made in accordance with fiscal procedure. The original list of property and certificate are to be attached to voucher.

[39 FR 1843, Jan. 15, 1974, as amended at 49 FR 5616, Feb. 14, 1984. Redesignated at 61 FR 21966, May 13, 1996, and further redesignated at 67 FR 35039, May 17, 2002]

§ 17.115 Claims in cases of incompetent patients.

Where the patient is insane and incompetent, the patient will not be required to make claim for reimbursement for personal effects lost by fire, earthquake, or other natural disaster as required under the provisions of § 17.113. The responsible official will make claim for the patient, adding the certification in all details as provided for in § 17.113. After countersignature of this certification by the Director, payment will be made as provided in § 17.113, and the amount thereby disbursed will be turned over to the Director for custody.

[39 FR 1843, Jan. 15, 1974, as amended at 49 FR 5616, Feb. 14, 1984. Redesignated and amended at 61 FR 21966, 21967, May 13, 1996, and further redesignated at 67 FR 35039, May 17, 2002]

Reimbursement to Employees for the Cost of Repairing or Replacing Certain Personal Property Damaged or Destroyed by Patients or Members

§ 17.116 Adjudication of claims.

Claims comprehended. Claims for reimbursing Department of Veterans Affairs employees for cost of repairing or replacing their personal property damaged or destroyed by patients or members while such employees are engaged in the performance of their official duties will be adjudicated by the Director of the medical center concerned. Such claims will be considered under the following conditions, both of which must have existed and, if either one is lacking, reimbursement or payment for the cost or repair of the damaged article will not be authorized:

(a) The claim must be for an item of personal property normally used by the employee in his or her day to day employment, e.g., eyeglasses, hearing aids, clothing, etc., and,

(b) Such personal property was damaged or destroyed by a patient or domiciliary member while the employee was engaged in the performance of official duties.

Reimbursement or payment as provided in this paragraph will be made in a fair and reasonable amount, taking into consideration the condition and

reasonable value of the article at the time it was damaged or destroyed.

[28 FR 5083, May 22, 1963, as amended at 39 FR 1843, Jan. 15, 1974; 49 FR 5616, Feb. 14, 1984. Redesignated and amended at 61 FR 21965, May 13, 1996, and further redesignated at 67 FR 35039, May 17, 2002]

PAYMENT AND REIMBURSEMENT OF THE EXPENSES OF MEDICAL SERVICES NOT PREVIOUSLY AUTHORIZED

§ 17.120 Payment or reimbursement for emergency treatment furnished by non-VA providers to certain veterans with service-connected disabilities.

To the extent allowable, payment or reimbursement of the expenses of emergency treatment, not previously authorized, in a private or public (or Federal) hospital not operated by the Department of Veterans Affairs, or of any emergency treatment not previously authorized including transportation (except prosthetic appliances, similar devices, and repairs) will be paid on the basis of a claim timely filed, under the following circumstances:

(a) *For veterans with service connected disabilities.* Emergency treatment not previously authorized was rendered to a veteran in need of such emergency treatment:

(1) For an adjudicated service-connected disability;

(2) For nonservice-connected disabilities associated with and held to be aggravating an adjudicated service-connected disability;

(3) For *any disability* of a veteran who has a total disability permanent in nature resulting from a service-connected disability (does not apply outside of the States, Territories, and possessions of the United States, the District of Columbia, and the Commonwealth of Puerto Rico); or

(4) For any illness, injury or dental condition in the case of a veteran who is participating in a rehabilitation program under 38 U.S.C. ch. 31 and who is medically determined to be in need of hospital care or medical services for any of the reasons enumerated in § 17.47(i)(2); and

(Authority: 38 U.S.C. 1724, 1728)

(b) *In a medical emergency.* Emergency treatment not previously authorized including medical services, professional services, ambulance services, ancillary care and medication (including a short course of medication related to and necessary for the treatment of the emergency condition that is provided directly to or prescribed for the patient for use after the emergency condition is stabilized and the patient is discharged) was rendered in a medical emergency of such 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 is met by 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. And,

(c) *When Federal facilities are unavailable.* VA or other Federal facilities that VA has an agreement with to furnish health care services for veterans were not feasibly available, and an attempt to use them beforehand or obtain prior VA authorization for the services required would not have been reasonable, sound, wise, or practicable, or treatment had been or would have been refused.

(Authority: 38 U.S.C. 1724, 1728, 7304)

[39 FR 1844, Jan. 15, 1974, as amended at 49 FR 5616, Feb. 14, 1984; 51 FR 8672, Mar. 13, 1986; 56 FR 3422, Jan. 30, 1991. Redesignated at 61 FR 21966, May 13, 1996; 76 FR 79070, Dec. 21, 2011; 80 FR 79484, Dec. 22, 2015]

§ 17.121 Limitations on payment or reimbursement of the costs of emergency treatment not previously authorized.

(a) *Emergency Treatment.* Except as provided in paragraph (b) of this section, VA will not approve claims for payment or reimbursement of the costs of emergency treatment not previously authorized for any period beyond the date on which the medical emergency

ended. For this purpose, VA considers that an emergency ends when the designated VA clinician at the VA facility has determined that, based on sound medical judgment, the veteran who received emergency treatment:

(1) Could have been transferred from the non-VA facility to a VA medical center (or other Federal facility that VA has an agreement with to furnish health care services for veterans) for continuation of treatment, or

(2) Could have reported to a VA medical center (or other Federal facility that VA has an agreement with to furnish health care services for veterans) for continuation of treatment.

(b) *Continued non-emergency treatment*. Claims for payment or reimbursement of the costs of emergency treatment not previously authorized may only be approved for continued, non-emergency treatment, if:

(1) The non-VA facility notified VA at the time the veteran could be safely transferred to a VA facility (or other Federal facility that VA has an agreement with to furnish health care services for veterans), and the transfer of the veteran was not accepted; and

(2) The non-VA facility made and documented reasonable attempts to request transfer of the veteran to a VA facility (or to another Federal facility that VA has an agreement with to furnish health care services for veterans), which means the non-VA facility contacted either the VA Transfer Coordinator, Administrative Officer of the Day, or designated staff responsible for accepting transfer of patients, at a local VA (or other Federal facility) and documented such contact in the veteran's progress/physicians' notes, discharge summary, or other applicable medical record.

(c) *Refusal of transfer*. If a stabilized veteran who requires continued non-emergency treatment refuses to be transferred to an available VA facility (or other Federal facility that VA has an agreement with to furnish health care services for veterans), VA will make payment or reimbursement only for the expenses related to the initial evaluation and the emergency treatment furnished to the veteran up to the point of refusal of transfer by the veteran.

(Authority: 38 U.S.C. 1724, 1728, 7304)

[76 FR 79071, Dec. 21, 2011]

§ 17.122 Payment or reimbursement of the expenses of repairs to prosthetic appliances and similar devices furnished without prior authorization.

The expenses of repairs to prosthetic appliances, or similar appliances, therapeutic or rehabilitative aids or devices, furnished without prior authorization, but incurred in the care of an adjudicated service-connected disability (or, in the case of a veteran who is participating in a rehabilitation program under 38 U.S.C. ch. 31 and who is determined to be in need of the repairs for any of the reasons enumerated in § 17.47(g)) may be paid or reimbursed on the basis of a timely filed claim, if

(Authority: 38 U.S.C. 1728)

(a) Obtaining the repairs locally was necessary, expedient, and not a matter of preference to using authorized sources, and

(b) The costs were reasonable, except that where it is determined the costs were excessive or unreasonable, the claim may be allowed to the extent the costs were deemed reasonable and disallowed as to the remainder. In no circumstances will any claim for repairs be allowed to the extent the costs exceed $125.

(Authority: 38 U.S.C. 1728, 7304)

[33 FR 19011, Dec. 20, 1968, as amended at 49 FR 5616, Feb. 14, 1984; 51 FR 8672, Mar. 13, 1986. Redesignated and amended at 61 FR 21966, 21967, May 13, 1996]

§ 17.123 Claimants.

A claim for payment or reimbursement of services not previously authorized may be filed by the veteran who received the services (or his/her guardian) or by the hospital, clinic, or community resource which provided the services, or by a person other than the veteran who paid for the services.

[39 FR 1844, Jan. 15, 1974, as amended at 45 FR 53807, Aug. 13, 1980. Redesignated at 61 FR 21966, May 13, 1996]

§ 17.124 Preparation of claims.

Claims for costs of services not previously authorized shall be on such forms as shall be prescribed and shall include the following:

(a) The claimant shall specify the amount claimed and furnish bills, vouchers, invoices, or receipts or other documentary evidence establishing that such amount was paid or is owed, and

(b) The claimant shall provide an explanation of the circumstances necessitating the use of community medical care, services, or supplies instead of Department of Veterans Affairs care, services, or supplies, and

(c) The claimant shall furnish such other evidence or statements as are deemed necessary and requested for adjudication of the claim.

[33 FR 19011, Dec. 20, 1968, as amended at 39 FR 1844, Jan. 15, 1974. Redesignated at 61 FR 21966, May 13, 1996]

§ 17.125 Where to file claims.

Generally, VA must preauthorize VA payment for health care services provided in the community when such care is provided in a State as that term is defined in 38 U.S.C. 101(20).

(a) Where VA payment for such services has not been authorized in advance, claims for payment for such health care services provided in a State should be submitted to the VA medical facility nearest to where those services were provided.

(b) Claims for payment for hospital care and outpatient services authorized under § 17.35(a) and provided in Canada must be submitted to Veterans Affairs Canada, Foreign Countries Operations Unit, 2323 Riverside Dr., 2nd Floor, Ottawa, Ontario, Canada K1A OP5.

(c) All other claims for payment for hospital care and outpatient services authorized under § 17.35(a) and provided outside a State must be submitted to the Foreign Medical Program, P.O. Box 469061, Denver, CO 80246–9061.

[83 FR 29448, June 25, 2018]

§ 17.126 Timely filing.

Claims for payment or reimbursement of the expenses of medical care or services not previously authorized must be filed within the following time limits:

(a) A claim must be filed within 2 years after the date the care or services were rendered (and in the case of continuous care, payment will not be made for any part of the care rendered more than 2 years prior to filing claim), or

(b) In the case of case or services rendered prior to a VA adjudication allowing service-connection:

(1) The claim must be filed within 2 years of the date the veteran was notified by VA of the allowance of the award of service-connection.

(2) VA payment may be made for care related to the service-connected disability received only within a 2-year period prior to the date the veteran filed the original or reopened claim which resulted in the award of service-connection but never prior to the effective date of the award of service-connection within that 2-year period.

(3) VA payment will never be made for any care received beyond this 2-year period whether service connected or not.

(Authority: 38 U.S.C. 7304)

[33 FR 19012, Dec. 20, 1968, as amended at 39 FR 1844, Jan. 15, 1974; 45 FR 53807, Aug. 13, 1980; 51 FR 8673, Mar. 13, 1986. Redesignated at 61 FR 21966, May 13, 1996]

§ 17.127 Date of filing claims.

The date of filing any claim for payment or reimbursement of the expenses of medical care and services not previously authorized shall be the postmark date of a formal claim, or the date of any preceding telephone call, telegram, or other communication constituting an informal claim.

[39 FR 1844, Jan. 15, 1974. Redesignated at 61 FR 21966, May 13, 1996]

§ 17.128 Allowable rates and fees.

When it has been determined that a veteran has received public or private hospital care or outpatient medical services, the expenses of which may be paid under § 17.120 of this part, the payment of such expenses shall be paid in

accordance with §§ 17.55 and 17.56 of this part.

(Authority: Section 233, Pub. L. 99–576)

[63 FR 39515, July 23, 1998]

§ 17.129 Retroactive payments prohibited.

When a claim for payment or reimbursement of expenses of services not previously authorized has not been timely filed in accordance with the provisions of § 17.126, the expenses of any such care or services rendered prior to the date of filing the claim shall not be paid or reimbursed. In no event will a bill or claim be paid or allowed for any care or services rendered prior to the effective date of any law, or amendment to the law, under which eligibility for the medical services at Department of Veterans Affairs expense has been established.

[39 FR 1844, Jan. 15, 1974. Redesignated and amended at 61 FR 21966, 21968, May 13, 1996]

§ 17.130 Payment for treatment dependent upon preference prohibited.

No reimbursement or payment of services not previously authorized will be made when such treatment was procured through private sources in preference to available Government facilities.

[39 FR 1844, Jan. 15, 1974. Redesignated at 61 FR 21966, May 13, 1996]

§ 17.131 Payment of abandoned claims prohibited.

Any informal claim for the payment or reimbursement of medical expenses which is not followed by a formal claim, or any formal claim which is not followed by necessary supporting evidence, within 1 year from the date of the request for a formal claim or supporting evidence shall be deemed abandoned, and payment or reimbursement shall not be authorized on the basis of such abandoned claim or any future claim for the same expenses. For the purpose of this section, time limitations shall be computed from the date following the date of request for a formal claim or supporting evidence.

[33 FR 19012, Dec. 20, 1968. Redesignated at 61 FR 21966, May 13, 1996]

§ 17.132 Appeals.

When any claim for payment or reimbursement of expenses of medical care or services rendered in non-Department of Veterans Affairs facilities or from non-Department of Veterans Affairs resources has been disallowed, the claimant shall be notified of the reasons for the disallowance and of the right to initiate an appeal to the Board of Veterans Appeals by filing a Notice of Disagreement, and shall be furnished such other notices or statements as are required by part 19 of this chapter, governing appeals.

[33 FR 19012, Dec. 20, 1968. Redesignated at 61 FR 21966, May 13, 1996]

RECONSIDERATION OF DENIED CLAIMS

§ 17.133 Procedures.

(a) *Scope*. This section sets forth reconsideration procedures regarding claims for benefits administered by the Veterans Health Administration (VHA). These procedures apply to claims for VHA benefits regarding decisions that are appealable to the Board of Veterans' Appeals (e.g., reimbursement for non-VA care not authorized in advance, reimbursement for beneficiary travel expenses, reimbursement for home improvements or structural alterations, etc.). These procedures do not apply when other regulations providing reconsideration procedures do apply (this includes CHAMPVA (38 CFR 17.270 through 17.278) and spina bifida (38 CFR 17.904) and any other regulations that contain reconsideration procedures). Also, these procedures do not apply to decisions made outside of VHA, such as decisions made by the Veterans Benefits Administration and adopted by VHA for decisionmaking. These procedures are not mandatory, and a claimant may choose to appeal the denied claim to the Board of Veterans' Appeals pursuant to 38 U.S.C. 7105 without utilizing the provisions of this section. Submitting a request for reconsideration shall constitute a notice of disagreement for purposes of filing a timely notice of disagreement under 38 U.S.C. 7105(b).

(b) *Process*. An individual who disagrees with the initial decision denying the claim in whole or in part may obtain reconsideration under this section

by submitting a reconsideration request in writing to the Director of the healthcare facility of jurisdiction within one year of the date of the initial decision. The reconsideration decision will be made by the immediate supervisor of the initial VA decision-maker. The request must state why it is concluded 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 the dispute will be returned to the sender without further consideration. The request for reconsideration may include a request for a meeting with the immediate supervisor of the initial VA decision-maker, the claimant, and the claimant's representative (if the claimant wishes to have a representative present). Such a meeting shall only be for the purpose of discussing the issues and shall not include formal procedures (e.g., presentation, cross-examination of witnesses, etc.). The meeting will be taped and transcribed by VA if requested by the claimant and a copy of the transcription shall be provided to the claimant. After reviewing the matter, the immediate supervisor of the initial VA decision-maker shall issue a written decision that affirms, reverses, or modifies the initial decision.

NOTE TO § 17.133: The final decision of the immediate supervisor of the initial VA decision-maker will inform the claimant of further appellate rights for an appeal to the Board of Veterans' Appeals.

(The Office of Management and Budget has approved the information collection requirements in this section under control number 2900–0600)

(Authority: 38 U.S.C. 511, 38 U.S.C. 7105)

[64 FR 44660, Aug. 17, 1999]

DELEGATION OF AUTHORITY

§ 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, Sept. 12, 2014]

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.

(d) *Authorized benefits.* Except as noted in paragraph (d)(3) of this section, VA will provide to a veteran enrolled under 38 U.S.C. 1705 only the following benefits for one service dog at any given time in accordance with this section:

(1) A commercially available insurance policy, to the extent commercially practicable, that meets the following minimum requirements:

(i) VA, and not the veteran, will be billed for any premiums, copayments, or deductibles associated with the policy; however, the veteran will be responsible for any cost of care that exceeds the maximum amount authorized by the policy for a particular procedure, course of treatment, or policy year. If a dog requires care that may exceed the policy's limit, the insurer will, whenever reasonably possible under the circumstances, provide advance notice to the veteran.

(ii) The policy will guarantee coverage for all treatment (and associated prescription medications), subject to premiums, copayments, deductibles or annual caps, determined to be medically necessary, including euthanasia, by any veterinarian who meets the requirements of the insurer. The veteran will not be billed for these covered costs, and the insurer will directly reimburse the provider.

(iii) The policy will not exclude dogs with preexisting conditions that do not prevent the dog from being a service dog.

(2) Hardware, or repairs or replacements for hardware, that are clinically determined to be required by the dog to perform the tasks necessary to assist the veteran with his or her impairment. To obtain such devices, the veteran must contact the Prosthetic and Sensory Aids Service at his or her local VA medical facility and request the items needed.

(3) Payments for travel expenses associated with obtaining a dog under paragraph (c)(1) of this section. Travel costs will be provided only to a veteran who has been prescribed a service dog by a VA clinical team under paragraph (b) of this section. Payments will be made as if the veteran is an eligible beneficiary under 38 U.S.C. 111 and 38 CFR part 70, without regard to whether the veteran meets the eligibility criteria as set forth in 38 CFR part 70. Note: VA will provide payment for travel expenses related to obtaining a replacement service dog, even if the veteran is receiving other benefits under this section for the service dog that the veteran needs to replace.

(4) The veteran is responsible for procuring and paying for any items or expenses not authorized by this section. This means that VA will not pay for

items such as license tags, nonprescription food, grooming, insurance for personal injury, non-sedated dental cleanings, nail trimming, boarding, pet-sitting or dog-walking services, over-the-counter medications, or other goods and services not covered by the policy. The dog is not the property of VA; VA will never assume responsibility for, or take possession of, any service dog.

(e) *Dog must maintain ability to function as a service dog.* To continue to receive benefits under this section, the service dog must maintain its ability to function as a service dog. If at any time VA learns from any source that the dog is medically unable to maintain that role, or VA makes a clinical determination that the veteran no longer requires the dog, VA will provide at least 30 days notice to the veteran before benefits will no longer be authorized.

(Authority: 38 U.S.C. 501, 1714)

(The Office of Management and Budget has approved the information collection requirements in this section under control number 2900–0785.)

[77 FR 54381, Sept. 5, 2012]

§ 17.149 Sensori-neural aids.

(a) Notwithstanding any other provision of this part, VA will furnish needed sensori-neural aids (*i.e.*, eyeglasses, contact lenses, hearing aids) only to veterans otherwise receiving VA care or services and only as provided in this section.

(b) VA will furnish needed sensori-neural aids (*i.e.*, eyeglasses, contact lenses, hearing aids) to the following veterans:

(1) Those with a compensable service-connected disability;

(2) Those who are former prisoners of war;

(3) Those awarded a Purple Heart;

(4) Those in receipt of benefits under 38 U.S.C. 1151;

(5) Those in receipt of increased pension based on the need for regular aid and attendance or by reason of being permanently housebound;

(6) Those who have a visual or hearing impairment that resulted from the existence of another medical condition for which the veteran is receiving VA care, or which resulted from treatment of that medical condition;

(7) Those with a significant functional or cognitive impairment evidenced by deficiencies in activities of daily living, but not including normally occurring visual or hearing impairments; and

(8) Those visually or hearing impaired so severely that the provision of sensori-neural aids is necessary to permit active participation in their own medical treatment.

(c) VA will furnish needed hearing aids to those veterans who have service-connected hearing disabilities rated 0 percent if there is organic conductive, mixed, or sensory hearing impairment, and loss of pure tone hearing sensitivity in the low, mid, or high-frequency range or a combination of frequency ranges which contribute to a loss of communication ability; however, hearing aids are to be provided only as needed for the service-connected hearing disability.

(Authority: 38 U.S.C. 501,1707(b)

[62 FR 30242, June 3, 1997, as amended at 69 FR 33575, June 16, 2004]

§ 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 § 17.48(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, Sept. 12, 2014]

§ 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, Sept. 12, 2014]

§ 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)

[77 FR 54382, Sept. 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, Sept. 12, 2014]

§ 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]

EDITORIAL NOTE: For FEDERAL REGISTER citations affecting § 17.161, see the List of CFR Sections Affected, which appears in the Finding Aids section of the printed volume and at *www.fdsys.gov*.

§ 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, Sept. 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]

§ 17.169 VA Dental Insurance Program for veterans and survivors and dependents of veterans (VADIP).

(a) *General.* (1) The VA Dental Insurance Program (VADIP) provides premium-based dental insurance coverage through which individuals eligible under paragraph (b) of this section may choose to obtain dental insurance from a participating insurer. Enrollment in VADIP does not affect the insured's eligibility for outpatient dental services and treatment, and related dental appliances, under 38 U.S.C. 1712.

(2) The following definitions apply to this section:

Insured means an individual, identified in paragraph (b) of this section, who has enrolled in an insurance plan through VADIP.

Participating insurer means an insurance company that has contracted with VA to offer a premium-based dental insurance plan to veterans, survivors, and dependents through VADIP. There may be more than one participating insurer.

(b) *Covered veterans and survivors and dependents.* A participating insurer must offer coverage to the following persons:

(1) Any veteran who is enrolled under 38 U.S.C. 1705 in accordance with 38 CFR 17.36.

(2) Any survivor or dependent of a veteran who is eligible for medical care under 38 U.S.C. 1781 and 38 CFR 17.271.

(c) *Premiums, coverage, and selection of participating insurer.* (1) *Premiums.* Premiums and copayments will be paid by the insured in accordance with the terms of the insurance plan. Premiums and copayments will be determined by VA through the contracting process, and will be adjusted on an annual basis. The participating insurer will notify all insureds in writing of the amount and effective date of such adjustment.

(2) *Benefits.* Participating insurers must offer, at a minimum, coverage for the following dental care and services:

(i) *Diagnostic services.*

(A) Clinical oral examinations.

(B) Radiographs and diagnostic imaging.

(C) Tests and laboratory examinations.

(ii) *Preventive services.*

(A) Dental prophylaxis.

(B) Topical fluoride treatment (office procedure).

(C) Sealants.

(D) Space maintenance.

(iii) *Restorative services.*

(A) Amalgam restorations.

(B) Resin-based composite restorations.

(iv) *Endodontic services.*

(A) Pulp capping.

(B) Pulpotomy and pulpectomy.

(C) Root canal therapy.

(D) Apexification and recalcification procedures.

(E) Apicoectomy and periradicular services.

(v) *Periodontic services.*

(A) Surgical services.

(B) Periodontal services.

(vi) *Oral surgery.*

(A) Extractions.

(B) Surgical extractions.

(C) Alveoloplasty.

(D) Biopsy.

(vii) *Other services.*

(A) Palliative (emergency) treatment of dental pain.

(B) Therapeutic drug injection.

(C) Other drugs and/or medications.

(D) Treatment of postsurgical complications.

(E) Crowns.

(F) Bridges.

(G) Dentures.

(3) *Selection of participating insurer.* VA will use the Federal competitive contracting process to select a participating insurer, and the insurer will be responsible for the administration of VADIP.

(d) *Enrollment.* (1) VA, in connection with the participating insurer, will market VADIP through existing VA communication channels to notify all eligible persons of their right to voluntarily enroll in VADIP. The participating insurer will prescribe all further enrollment procedures, and VA will be responsible for confirming that a person is eligible under paragraph (b) of this section.

(2) The initial period of enrollment will be for a period of 12 calendar months, followed by month-to-month enrollment, subject to paragraph (e)(5) of this section, as long as the insured remains eligible for coverage under paragraph (b) of this section and chooses to continue enrollment, so long as VA continues to authorize VADIP.

(3) The participating insurer will agree to continue to provide coverage to an insured who ceases to be eligible under paragraphs (b)(1) through (2) of this section for at least 30 calendar days after eligibility ceased. The insured must pay any premiums due during this 30-day period. This 30-day coverage does not apply to an insured who is disenrolled under paragraph (e) of this section.

(e) *Disenrollment.* (1) Insureds may be involuntarily disenrolled at any time for failure to make premium payments.

(2) Insureds must be permitted to voluntarily disenroll, and will not be required to continue to pay any copayments or premiums, under any of the following circumstances:

(i) For any reason, during the first 30 days that the beneficiary is covered by the plan, if no claims for dental services or benefits were filed by the insured.

(ii) If the insured relocates to an area outside the jurisdiction of the plan that prevents the use of the benefits under the plan.

(iii) If the insured is prevented by serious medical condition from being able to obtain benefits under the plan.

(iv) If the insured would suffer severe financial hardship by continuing in VADIP.

(v) For any reason during the month-to-month coverage period, after the initial 12-month enrollment period.

(3) All insured requests for voluntary disenrollment must be submitted to the insurer for determination of whether the insured qualifies for disenrollment under the criteria in paragraphs (e)(2)(i) through (v) of this section. Requests for disenrollment due to a serious medical condition or financial hardship must include submission of written documentation that verifies the existence of a serious medical condition or financial hardship. The written documentation submitted to the insurer must show that circumstances leading to a serious medical condition or financial hardship originated after the effective date coverage began, and will prevent the insured from maintaining the insurance benefits.

(4) If the participating insurer denies a request for voluntary disenrollment because the insured does not meet any criterion under paragraphs (e)(2)(i) through (v) of this section, the participating insurer must issue a written decision and notify the insured of the basis for the denial and how to appeal. The participating insurer will establish the form of such appeals whether orally, in writing, or both. The decision and notification of appellate rights must be issued to the insured no later than 30 days after the request for voluntary disenrollment is received by the participating insurer. The appeal will be decided and that decision issued in writing to the insured no later than 30 days after the appeal is received by the participating insurer. An insurer's decision of an appeal is final.

(5) Month-to-month enrollment, as described in paragraph (d)(2) of this section, may be subject to conditions in insurance contracts, whereby upon voluntarily disenrolling, an enrollee may be prevented from re-enrolling for a certain period of time as specified in the insurance contract.

(f) Other appeals procedures. Participating insurers will establish and be responsible for determination and appeal procedures for all issues other than voluntary disenrollment.

(g) *Limited preemption of State and local law.* To achieve important Federal interests, including but not limited to the assurance of the uniform delivery of benefits under VADIP and to ensure the operation of VADIP plans at the lowest possible cost to VADIP enrollees, paragraphs (b), (c)(1), (c)(2), (d), and (e)(2) through (5) of this section preempt conflicting State and local laws, including laws relating to the business of insurance. Any State or local law, or regulation pursuant to such law, is without any force or effect on, and State or local governments have no legal authority to enforce them in relation to, the paragraphs referenced in this paragraph or decisions made by VA or a participating insurer under these paragraphs.

(The Office of Management and Budget has approved the information collection requirement in this section under control number 2900–0789.)

[78 FR 32130, May 29, 2013, as amended at 78 FR 62443, Oct. 22, 2013; 82 FR 16288, Apr. 4, 2017]

AUTOPSIES

§ 17.170 Autopsies.

(a) *General.* (1) Except as otherwise provided in this section, the Director of a VA facility may order an autopsy on a decedent who died while undergoing VA care authorized by § 17.38 or § 17.52, if the Director determines that an autopsy is required for VA purposes for the following reasons:

(i) Completion of official records; or

(ii) Advancement of medical knowledge.

(2) VA may order an autopsy to be performed only if consent is first obtained under one of the following circumstances:

(i) Consent is granted by the surviving spouse or next of kin of the decedent;

(ii) Consent is implied where a known surviving spouse or next of kin does not respond within a specified period of time to VA's request for permission to conduct an autopsy;

(iii) Consent is implied where a known surviving spouse or next of kin does not inquire after the well-being of the deceased veteran for a period of at least 6 months before the date of the veteran's death; or

(iv) Consent is implied where there is no known surviving spouse or next of kin of the deceased veteran.

(b) *Death resulting from crime.* If it is suspected that death resulted from crime and if the United States has jurisdiction over the area where the body is found, the Director of the Department of Veterans Affairs facility will inform the Office of Inspector General of the known facts concerning the death. Thereupon the Office of Inspector General will transmit all such information to the United States Attorney for such action as may be deemed appropriate and will inquire whether the United States Attorney objects to an autopsy if otherwise it be appropriate. If the United States Attorney has no objection, the procedure as to autopsy will be the same as if the death had not been reported to him or her.

(c) *Jurisdiction.* If the United States does not have exclusive jurisdiction over the area where the body is found the local medical examiner/coroner will be informed. If the local medical examiner/coroner declines to assume jurisdiction the procedure will be the same as is provided in paragraph (b) of this section. If a Federal crime is indicated by the evidence, the procedure of paragraph (b) of this section will also be followed.

(d) *Applicable law.* (1) The laws of the state where the autopsy will be performed are to be used to identify the person who is authorized to grant VA permission to perform the autopsy and, if more than one person is identified, the order of precedence among such persons.

(2) When the next of kin, as defined by the laws of the state where the autopsy will be performed, consists of a number of persons such as children, parents, brothers and sisters, etc., permission to perform an autopsy may be accepted when granted by the person in the appropriate class who assumes the right and duty of burial.

(e) *Death outside a VA facility*. The Director of a VA facility may order an autopsy on a veteran who was undergoing VA care authorized by § 17.38 or § 17.52, and whose death did not occur in a VA facility. Such authority also includes transporting the body at VA's expense to the facility where the autopsy will be performed, and the return of the body. Consent for the autopsy will be obtained as stated in paragraph (d) of this section. The Director must determine that such autopsy is reasonably required for VA purposes for the following reasons:

(1) The completion of official records; or

(2) Advancement of medical knowledge.

(Authority: 38 U.S.C. 501, 1703, 1710)

[16 FR 5701, June 15, 1951, as amended at 18 FR 2414, Apr. 24, 1953; 24 FR 8330, Oct. 14, 1959; 35 FR 6586, Apr. 24, 1970; 36 FR 23386, Dec. 9, 1971; 45 FR 6939, Jan. 31, 1980. Redesignated and amended at 61 FR 21966, 21968, May 13, 1996; 61 FR 29294, June 10, 1996; 68 FR 17551, Apr. 10, 2003; 77 FR 38181, June 27, 2012]

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, Sept. 12, 2014]

(Authority: 31 U.S.C. 7501–7507)

[52 FR 23825, June 25, 1987. Redesignated at 61 FR 21966, May 13, 1996; 80 FR 43322, July 22, 2015]

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, Sept. 12, 2014]

§ 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, Sept. 12, 2014]

§ 17.241 Sharing medical information services.

(a) *Agreements for exchange of information.* Subject to such terms and conditions as the Under Secretary for Health shall prescribe, Directors of Department of Veterans Affairs medical centers, may enter into agreements with medical schools, Federal, State or local, public or private hospitals, research centers, and individual members of the medical profession, under which medical information and techniques will be freely exchanged and the medical information services of all parties to the agreement will be available for use by any party to the agreement under conditions specified in the agreement.

(b) *Purpose of sharing agreements.* Agreements for the exchange of information shall be used to the maximum extent practicable to create at each Department of Veterans Affairs medical center which has entered into such an agreement, an environment of academic medicine which will help the hospital attract and retain highly trained and qualified members of the medical profession.

(c) *Use of electronic equipment.* Recent developments in electronic equipment shall be utilized under information sharing programs to provide a close educational, scientific, and professional link between Department of Veterans Affairs medical centers and major medical centers.

(d) *Furnishing information services on a fee basis.* The educational facilities and programs established at Department of Veterans Affairs Medical Centers and the electronic link to medical centers

shall be made available for use by medical entities in the surrounding medical community which have not entered into sharing agreements with the Department of Veterans Affairs, in order to bring about utilization of all medical information in the surrounding medical community, particularly in remote areas, and to foster and encourage the widest possible cooperation and consultation among all members of the medical profession in the surrounding medical community.

(e) *Establishing fees for information services.* Subject to such terms and conditions as the Under Secretary for Health shall prescribe, Directors of Department of Veterans Affairs medical centers shall charge for information and educational facilities and services made available under paragraph (d) of this section. The fee may be on an annual or other periodic basis, at rates determined, after appropriate study, to be fair and equitable. The financial status of any user of such services shall be taken into consideration in establishing the amount of the fee to be paid.

[32 FR 6841, May 4, 1967, as amended at 47 FR 58250, Dec. 30, 1982. Redesignated at 61 FR 21966, May 13, 1996, as amended at 62 FR 17072, Apr. 9, 1997]

§ 17.242 Coordination of programs with Department of Health and Human Services.

Programs for sharing specialized medical resources or medical information services shall be coordinated to a maximum extent practicable, with programs carried out under part F, title XVI of the Public Health Service Act under the jurisdiction of the Department of Health and Human Services.

[32 FR 6842, May 4, 1967, as amended at 45 FR 6940, Jan. 31, 1980; 47 FR 58250, Dec. 30, 1982. Redesignated at 61 FR 21966, May 13, 1996]

GRANTS FOR EXCHANGE OF INFORMATION

§ 17.250 Scope of the grant program.

The provisions of § 17.250 through § 17.266 are applicable to grants under 38 U.S.C. 8155 for programs for the exchange of medical information. The purpose of these grants is to assist medical schools, hospitals, and research centers in planning and carrying out agreements for the exchange of medical information, techniques, and information services. The grant funds may be used for the employment of personnel, the construction of facilities, the purchasing of equipment, research, training or demonstration activities when necessary to implement exchange of information agreements.

[33 FR 6011, Apr. 19, 1968. Redesignated and amended at 61 FR 21966, 21968, May 13, 1996]

§ 17.251 The Subcommittee on Academic Affairs.

There is established within the Special Medical Advisory Group authorized under the provisions of 38 U.S.C. 7312 a Subcommittee on Academic Affairs, and the Subcommittee shall advise the Secretary, through the Under Secretary for Health, in matters pertinent to achieving the objectives of programs for exchange of medical information. The Subcommittee shall review each application for a grant and prepare a written report setting forth recommendations as to the final action to be taken on the application.

[42 FR 54804, Oct. 11, 1977. Redesignated at 61 FR 21966, May 13, 1996, as amended at 62 FR 17072, Apr. 9, 1997]

§ 17.252 Ex officio member of subcommittee.

The Assistant Chief Medical Director for Academic Affairs shall be an ex officio member of the Subcommittee on Academic Affairs.

[42 FR 54804, Oct. 11, 1977. Redesignated at 61 FR 21966, May 13, 1996]

§ 17.253 Applicants for grants.

Applicants for grants generally will be persons authorized to represent a medical school, hospital, or research center which has in effect or has tentatively approved an agreement with the Department of Veterans Affairs to exchange medical information.

[33 FR 6011, Apr. 19, 1968. Redesignated at 61 FR 21966, May 13, 1996]

§ 17.254 Applications.

Each application for a grant shall be submitted to the Under Secretary for Health on such forms as shall be prescribed and shall include the following

evidence, assurances, and supporting documents:

(a) *To specify amount.* Each application shall show the amount of the grant requested, and if the grant is to be for more than one objective, the amounts allocated to each objective (e.g., to training, demonstrations, or construction) shall be specified, and

(b) *To include copy of agreement.* Each application shall be accompanied by a copy of the agreement for the exchange of information or information services which the grant funds applied for will implement, and

(c) *To include descriptions and plans.* Each application shall include a description of the use to which the grant funds will be applied in sufficient detail to show need, purpose, and justifications, and shall be illustrated by financial and budgetary data, and

(d) *To include cost participation information.* Each application shall show the amount of the grant requested to be used for direct expenses by category of direct expenses, the amount requested for indirect expenses related to the direct expenses, any additional amounts which will be applied to the program or planning from other Federal agencies, and from other sources, and amounts or expenses which will be borne by the applicant, and

(e) *To include assurance records will be kept.* Each application shall include sufficient assurances that the applicant shall keep records which fully disclose the amount and disposition of the proceeds of the grant, the total cost of the project or undertaking in connection with which the grant is made or used, the portion of the costs supplied by non-Federal sources, and such other records as will facilitate an effective audit. All such records shall be retained by the applicant (grantee) for a period of 3 years after the submission of the final expenditure report, or if litigation, claim or audit is started before the expiration of the 3-year period, the records shall be retained until all litigation, claims or audit findings involving the records have been resolved, and

(f) *To include assurance records will be made available.* Each application shall include sufficient assurances the applicant will give the Secretary and the Comptroller General of the United States, or any of their authorized representatives, access to its books, documents, papers, and records which are pertinent to the grant for the purposes of audit and examination, and

(g) *To include assurance progress reports will be made.* Each application shall include sufficient assurances the applicant will furnish the Under Secretary for Health periodic progress reports in sufficient detail showing the status of the project, planning, program, or system funded by the grant for which application is made, and the extent to which the stated objectives will have been achieved, and

(h) *To include civil rights assurances.* Each application shall include sufficient assurances that no part of the grant funds will be used either by the grantee or by any contractor or subcontractor to be paid from grant funds for any purpose which is inconsistent with regulations promulgated by the Secretary (part 18 of this chapter) implementing title VI of the Civil Rights Act of 1964, or inconsistent with Executive 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, Sept. 12, 2014]

§ 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]

§ 17.257 Awards procedures.

Applications for grants for planning or implementing agreements for the exchange of medical information or information facilities shall be reviewed by the Under Secretary for Health or designee. If it is determined approval of the grant is warranted, recommendations to that effect shall be made to the Secretary in writing and shall be accompanied by the following:

(a) The recommendation for approval shall be accompanied by the written recommendation of the Subcommittee on Academic Affairs, and

(b) The recommendation for approval shall be accompanied by the written draft of the certificate of award stating all conditions which the grantee is required to agree to under the provisions of § 17.258 and all other conditions to which it has been determined the grant will be subject, and

(c) The recommendation shall include a certification that sufficient appropriated funds are available, and that the application for the grant is sufficient in all details as specified in §§ 17.254 through 17.256.

[33 FR 6012, Apr. 19, 1968, as amended at 42 FR 54805, Oct. 11, 1977. Redesignated and amended at 61 FR 21966, 21969, May 13, 1996]

§ 17.258 Terms and conditions to which awards are subject.

Each certificate of award of a grant for planning or implementing an agreement for the exchange of information or information facilities shall specify that the grant is subject to the following terms and conditions:

(a) *Grants subject to terms of agreement for exchange of information.* Each grant shall be subject to, and the certificate shall incorporate by reference, all terms, conditions, and obligations specified in the agreement or planning protocols which the grant will implement, and

(b) *Grants subject to assurances in application.* Each grant shall be subject to all assurances made by the grantee in its application for the grant as required by §§ 17.254 through 17.256, and

(c) *Grants subject to limitations on use of funds.* Each grant shall be subject to the limitations on the use of grant funds, either for direct or indirect costs, as prescribed in §§ 17.259 through 17.261, and

(d) *Grants subject to special provisions.* Each grant shall be subject to any special terms or conditions which may be warranted by circumstances applicable to individual applications, and specified in the certificate of award.

[33 FR 6012, Apr. 19, 1968. Redesignated and amended at 61 FR 21966, 21969, May 13, 1996]

§ 17.259 Direct costs.

Direct costs to which grant funds may be applied may include in proportion to time and effort spent, but are not limited to, fees and costs directly paid to personnel or for fringe benefits, rent, publications, educational programs, training, research, demonstration activities, or construction carried out in connection with pilot programs for planning or exchange of information.

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

§ 17.260 Patient care costs to be excluded from direct costs.

Grant funds for planning or implementing agreements for the exchange of medical information shall not be available for the payment of any hospital, medical, or other costs involving

the care of patients except to the extent that such costs are determined to be incident to research, training, or demonstration activities carried out in connection with an exchange of information program.

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

§ 17.261 Indirect costs.

The grantee shall allocate expenditures as between direct and indirect costs according to generally accepted accounting procedures. The amount allocated for indirect costs may be computed on a percentage basis or on the basis of a negotiated lump-sum allowance. In the method of computation used, only indirect costs shall be included which bear a reasonable relationship to the planning or program funded by the grant and shall not exceed a percentage greater than the percentage the total institutional indirect cost is of the total direct salaries and wages paid by the institution.

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

§ 17.262 Authority to approve applications discretionary.

Notwithstanding any recommendation by the Subcommittee on Academic Affairs of the Special Medical Advisory Group, or any recommendation by the Under Secretary for Health or designee, the final determination on any application for a grant rests solely with the Secretary.

[42 FR 54805, Oct. 11, 1977. Redesignated and amended at 61 FR 21966, 21969, May 13, 1996]

§ 17.263 Suspension and termination procedures.

Termination of a grant means the cancellation of Department of Veterans Affairs sponsorship, in whole or in part, under an agreement at any time prior to the date of completion. Suspension of a grant is an action by the Department of Veterans Affairs which temporarily suspends Department of Veterans Affairs sponsorship under the grant pending corrective action by the grantee or pending a decision to terminate the grant by the Department of Veterans Affairs.

(a) *Posttermination appeal.* The following procedures are applicable for reviewing postaward disputes which may arise in the administration of or carrying out of the Exchange of Medical Information Grant Program.

(1) *Reviewable decisions.* The Department of Veterans Affairs reserves the right to terminate any grant in whole or in part at any time before the date of completion, whenever it determines that the grantee has failed to comply with conditions of the agreement, or otherwise failed to comply with any law, regulation, assurance, term, or condition applicable to the grant.

(2) *Notice.* The Department of Veterans Affairs shall promptly notify the grantee in writing of the determination. The notice shall set forth the reason for the determination in sufficient detail to enable the grantee to respond, and shall inform the grantee of his or her opportunity for review by the Assistant Chief Medical Director as provided in this section.

(3) *Request for appeal.* A grantee with respect to whom a determination described in paragraph (a)(1) of this section has been made, and who desires review, may file with the Assistant Chief Medical Director for Academic Affairs an application for review of such determination. The grantee's application for review must be post-marked no later than 30 days after the postmarked date of notification provided pursuant to paragraph (a)(2) of this section.

(4) *Contents of request.* The application for review must clearly identify the question or questions in dispute, contain a full statement of the grantee's position in respect to such question or questions, and provide pertinent facts and reasons in support of his or her position. The Assistant Chief Medical Director for Academic Affairs will promptly send a copy of the grantee's application to the Department of Veterans Affairs official responsible for the determination which is to be reviewed.

(5) *Effect of submission.* When an application for review has been filed no action may be taken by the Department of Veterans Affairs pursuant to such determination until such application has been disposed of, except that the filing of the application shall not affect

the authority which the constituent agency may have to suspend the system under a grant during proceedings under this section or otherwise to withhold or defer payments under the grant.

(6) *Consideration of request.* When an application for review has been filed with the Assistant Chief Medical Director for Academic Affairs, and it has been determined that the application meets the requirements stated in this paragraph, all background material of the issues shall be reviewed. If the application does not meet the requirements, the grantee shall be notified of the deficiencies.

(7) *Presentation of case.* If the Assistant Chief Medical Director for Academic Affairs believes there is no dispute as to material fact, the resolution of which would be materially assisted by oral testimony, both parties shall be notified of the issues to be considered, and take steps to afford both parties the opportunity for presenting their cases, at the option of the Assistant Chief Medical Director for Academic Affairs, in whole or in part in writing, or in an informal conference. Where it is concluded that oral testimony is required to resolve a dispute over a material fact, both parties shall be afforded an opportunity to present and cross-examine witnesses at a hearing.

(8) *Decision.* After both parties have presented their cases, the Assistant Chief Medical Director for Academic Affairs shall prepare an initial written decision which shall include findings of fact and conclusions based thereon. Copies of the decision shall be mailed promptly to each of the parties together with a notice informing them of their right to appeal the decision of the Secretary, or to the officer or employee to whom the Secretary has delegated such authority, by submitting written comments thereon within a specified reasonable time.

(9) *Final decision.* Upon filing comments with the Secretary, or designated officer or employee, the review of the initial decision shall be conducted on the basis of the decision, the hearing record, if any, and written comments submitted by both parties. The decision shall be final.

(10) *Participation by a party.* Either party may participate in person, or by counsel pursuant to the procedure set forth in this section.

(b) *Termination for convenience.* The Department of Veterans Affairs or the grantee may terminate a grant in whole or in part when both parties agree that the continuation of the project would not produce beneficial results commensurate with the further expenditure of funds. The two parties shall agree upon the termination conditions, including the effective date and, in the case of partial terminations, the portion to be terminated. The grantee shall not incur new obligations for the terminated portion after the effective date, and shall cancel as many outstanding obligations as possible. The Department of Veterans Affairs shall allow full credit to the grantee for the Department of Veterans Affairs share of the noncancellable obligations, properly incurred by the grantee prior to termination.

(c) *Suspension procedures.* When a grantee has failed to comply with the terms of the grant agreement and conditions or standards, the Department of Veterans Affairs may, on reasonable notice to the grantee, suspend the grant and withhold further payments, prohibit the grantee from incurring additional obligations of funds, pending corrective action by the grantee, or make a decision to terminate as described in paragraph (a) of this section. The Department of Veterans Affairs shall allow all necessary and proper costs that the grantee could not reasonably avoid during the period of suspension provided that they meet the provisions of the applicable Federal cost principles.

[42 FR 54805, Oct. 11, 1977. Redesignated at 61 FR 21966, May 13, 1996]

§ 17.264 Recoupments and releases.

In any case where the Department of Veterans Affairs or a grantee's obligations under an exchange of information agreement implemented by grant funds are terminated, or where grant-financed equipment or facilities cease to be used for the purposes for which grant support was given, or when grant-financed property is transferred,

the grantee shall return the proportionate value of such equipment or facility as was financed by the grant. When it is determined the Department of Veterans Affairs equitable interest is greater that proportionate value, then a claim in such greater amount shall be asserted. If it is determined an amount less than proportionate value or less than the Department of Veterans Affairs equitable interest should be recouped, or that the Department of Veterans Affairs should execute any releases, then a proposal concerning such a settlement or releases complete with explanations and justifications shall be submitted to the Assistant Chief Medical Director for Academic Affairs for a final determination.

[42 FR 54805, Oct. 11, 1977. Redesignated at 61 FR 21966, May 13, 1996]

§ 17.265 Payments.

Payments of grant funds are made to grantees through a letter-of-credit, an advance by Treasury check, or a reimbursement by Treasury check, as appropriate. A letter-of-credit is an instrument certified by an authorized official of the Department of Veterans Affairs which authorizes the grantee to draw funds when needed from the Treasury, through a Federal Reserve bank and the grantee's commercial bank and shall be used by the Department of Veterans Affairs where all the following conditions exist:

(a) When there is or will be a continuing relationship between the grantee and the Department of Veterans Affairs for at least a 12-month period and the total amount of advance payments expected to be received within that period is $250,000, or more;

(b) When the grantee has established or demonstrated the willingness and ability to maintain procedures that will minimize the time elapsing between the transfer of funds and their disbursement by the grantee; and

(c) When the grantee's financial management meets the standards for fund control and accountability. An advance by Treasury check is a payment made to a grantee upon its request before outlays are made by the grantee, or through use of predetermined payment schedules and shall be used by the Department of Veterans Affairs when the grantee meets all of the above requirements of this section except that advances will be less than $250,000, or for a period less than 12 months. Reimbursement by Treasury check is a payment made to a grantee upon request for reimbursement from the grantee and shall be the preferred method when the grantee does not meet the requirements of paragraphs (b) and (c) of this section. This method may be used on any construction agreement, or if the major portion of the program is accomplished through private market financing or Federal loans, and the Federal assistance constitutes a minor portion of the program. When the reimbursement method is used, the Department of Veterans Affairs shall make payment within 30 days after receipt of the billing, unless billing is improper. Unless otherwise required by law, payments shall not be withheld for proper charges at any time during the grant period unless a grantee has failed to comply with the program objectives, award conditions, or Federal reporting requirements; or the grantee is indebted.

[42 FR 54806, Oct. 11, 1977. Redesignated at 61 FR 21966, May 13, 1996]

§ 17.266 Copyrights and patents.

If a grant-supported program results in copyrightable material or patentable inventions or discoveries, the United States Government shall have the right to use such publications or inventions on a royalty-free basis.

[33 FR 6013, Apr. 19, 1968. Redesignated at 61 FR 21966, May 13, 1996]

CIVILIAN HEALTH AND MEDICAL PROGRAM OF THE DEPARTMENT OF VETERANS AFFAIRS (CHAMPVA)—MEDICAL CARE FOR SURVIVORS AND DEPENDENTS OF CERTAIN VETERANS

SOURCE: 63 FR 48102, Sept. 9, 1998, unless otherwise noted.

§ 17.270 General provisions.

(a) CHAMPVA is the Civilian Health and Medical Program of the Department of Veterans Affairs and is administered by the Health Administration Center, Denver, Colorado. Pursuant to

38 U.S.C. 1781, VA is authorized to provide medical care in the same or similar manner and subject to the same or similar limitations as medical care furnished to certain dependents and survivors of active duty and retired members of the Armed Forces. The CHAMPVA program is designed to accomplish this purpose. Under CHAMPVA, VA shares the cost of medically necessary services and supplies for eligible beneficiaries as set forth in §§ 17.271 through 17.278.

(b) For purposes of §§ 17.270 through 17.278, the definitions of ''child,'' ''service-connected condition/disability,'' ''spouse,'' and ''surviving spouse'' must be those set forth further in 38 U.S.C. 101. The term ''fiscal year'' refers to October 1, through September 30.

(Authority: 38 U.S.C. 501, 1781)

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

§ 17.271 Eligibility.

(a) *General entitlement.* The following persons are eligible for CHAMPVA benefits provided that they are not eligible under Title 10 for the TRICARE Program or Part A of Title XVIII of the Social Security Act (Medicare) except as provided in paragraph (b) of this section.

(1) The spouse or child of a veteran who has been adjudicated by VA as having a permanent and total service-connected disability;

(2) The surviving spouse or child of a veteran who died as a result of an adjudicated service-connected condition(s); or who at the time of death was adjudicated permanently and totally disabled from a service-connected condition(s);

(3) The surviving spouse or child of a person who died on active military service and in the line of duty and not due to such person's own misconduct; and

(4) An eligible child who is pursuing a full-time course of instruction approved under 38 U.S.C. Chapter 36, and who incurs a disabling illness or injury while pursuing such course (between terms, semesters or quarters; or during a vacation or holiday period) that is not the result of his or her own willful misconduct and that results in the inability to continue or resume the chosen program of education must remain eligible for medical care until:

(i) The end of the six-month period beginning on the date the disability is removed; or

(ii) The end of the two-year period beginning on the date of the onset of the disability; or

(iii) The twenty-third birthday of the child, whichever occurs first.

(Authority: 38 U.S.C. 501, 1781)

(b) *CHAMPVA and Medicare entitlement.* (1) Individuals under age 65 who are entitled to Medicare Part A and enrolled in Medicare Part B, retain CHAMPVA eligibility as secondary payer to Medicare Parts A and B, Medicare supplemental insurance plans, and Medicare HMO plans.

(2) Individuals age 65 or older, and not entitled to Medicare Part A, retain CHAMPVA eligibility.

NOTE TO PARAGRAPH (b)(2): If the person is not eligible for Part A of Medicare, a Social Security Administration ''Notice of Disallowance'' certifying that fact must be submitted. Additionally, if the individual is entitled to only Part B of Medicare, but not Part A, or Part A through the Premium HI provisions, a copy of the individual's Medicare card or other official documentation noting this must be provided.

(3) Individuals age 65 on or after June 5, 2001, who are entitled to Medicare Part A and enrolled in Medicare Part B, are eligible for CHAMPVA as secondary payer to Medicare Parts A and B, Medicare supplemental insurance plans, and Medicare HMO plans for services received on or after October 1, 2001.

(4) Individuals age 65 or older prior to June 5, 2001, who are entitled to Medicare Part A and who have not purchased Medicare Part B, are eligible for CHAMPVA as secondary payer to Medicare Part A and any other health insurance for services received on or after October 1, 2001.

(5) Individuals age 65 or older prior to June 5, 2001, who are entitled to Medicare Part A and who have purchased Medicare Part B must continue to

carry Part B to retain CHAMPVA eligibility as secondary payer for services received on or after October 1, 2001.

(Authority: 38 U.S.C. 501, 1781)

NOTE TO § 17.271: Eligibility criteria specific to Dependency and Indemnity Compensation (DIC) benefits are not applicable to CHAMPVA eligibility determinations.

[63 FR 48102, Sept. 9, 1998, as amended at 67 FR 4359, Jan. 30, 2002; 73 FR 65553, Nov. 4, 2008]

§ 17.272 Benefits limitations/exclusions.

(a) Benefits cover allowable expenses for medical services and supplies that are medically necessary and appropriate for the treatment of a condition and that are not specifically excluded from program coverage. Covered benefits may have limitations. The fact that a physician may prescribe, order, recommend, or approve a service or supply does not, of itself, make it medically necessary or make the charge an allowable expense, even though it is not listed specifically as an exclusion. The following are specifically excluded from program coverage:

(1) Services, procedures or supplies for which the beneficiary has no legal obligation to pay, or for which no charge would be made in the absence of coverage under a health benefits plan.

(2) Services and supplies required as a result of an occupational disease or injury for which benefits are payable under workers' compensation or similar protection plan (whether or not such benefits have been applied for or paid) except when such benefits are exhausted and are otherwise not excluded from CHAMPVA coverage.

(3) Services and supplies that are paid directly or indirectly by a local, State or Federal government agency (Medicaid excluded), including court-ordered treatment. In the case of the following exceptions, CHAMPVA assumes primary payer status:

(i) Medicaid.

(ii) State Victims of Crime Compensation Programs.

(4) Services and supplies that are not medically or psychologically necessary for the diagnosis or treatment of a covered condition (including mental disorder) or injury.

(5) Radiology, laboratory, and pathological services and machine diagnostic testing not related to a specific illness or injury or a definitive set of symptoms.

(6) Services and supplies above the appropriate level required to provide necessary medical care.

(7) Services and supplies related to an inpatient admission primarily to perform diagnostic tests, examinations, and procedures that could have been and are performed routinely on an outpatient basis.

(8) Postpartum inpatient stay of a mother for purposes of staying with the newborn infant (primarily for the purpose of breast feeding the infant) when the infant (but not the mother) requires the extended stay; or continued inpatient stay of a newborn infant primarily for purposes of remaining with the mother when the mother (but not the newborn infant) requires extended postpartum inpatient stay.

(9) Therapeutic absences from an inpatient facility or residential treatment center (RTC).

(10) Custodial care.

(11) Inpatient stays primarily for domiciliary care purposes.

(12) Inpatient stays primarily for rest or rest cures.

(13) Services and supplies provided as a part of, or under, a scientific or medical study, grant, or research program.

(14) Services and supplies not provided in accordance with accepted professional medical standards or related to experimental or investigational procedures or treatment regimens.

(15) Services or supplies prescribed or provided by a member of the beneficiary's immediate family, or a person living in the beneficiary's or sponsor's household.

(16) Services and supplies that are (or are eligible to be) payable under another medical insurance or program, either private or governmental, such as coverage through employment or Medicare.

(17) Services or supplies subject to preauthorization (see § 17.273) that were obtained without the required preauthorization; and services and supplies that were not provided according to the terms of the preauthorization.

(18) Inpatient stays primarily to control or detain a runaway child, whether or not admission is to an authorized institution.

(19) Services and supplies (to include prescription medications) in connection with cosmetic surgery which is performed to primarily improve physical appearance or for psychological purposes or to restore form without correcting or materially improving a bodily function.

(20) Electrolysis.

(21) Dental care with the following exceptions:

(i) Dental care that is medically necessary in the treatment of an otherwise covered medical condition, is an integral part of the treatment of such medical condition, and is essential to the control of the primary medical condition.

(ii) Dental care required in preparation for, or as a result of, radiation therapy for oral or facial cancer.

(iii) Gingival Hyperplasia.

(iv) Loss of jaw substance due to direct trauma to the jaw or due to treatment of neoplasm.

(v) Intraoral abscess when it extends beyond the dental alveolus.

(vi) Extraoral abscess.

(vii) Cellulitis and osteitis which is clearly exacerbating and directly affecting a medical condition currently under treatment.

(viii) Repair of fracture, dislocation, and other injuries of the jaw, to include removal of teeth and tooth fragments only when such removal is incidental to the repair of the jaw.

(ix) Treatment for stabilization of myofascial pain dysfunction syndrome, also referred to as temporomandibular joint (TMJ) syndrome. Authorization is limited to initial radiographs, up to four office visits, and the construction of an occlusal splint.

(x) Total or complete ankyloglossia.

(xi) Adjunctive dental and orthodontic support for cleft palate.

(xii) Prosthetic replacement of jaw due to trauma or cancer.

(22) Nonsurgical treatment of obesity or morbid obesity for dietary control or weight reduction (with the exception of gastric bypass, gastric stapling, or gastroplasty procedures in connection with morbid obesity when determined to be medically necessary) including prescription medications.

(23) Services and supplies related to transsexualism or other similar conditions such as gender dysphoria (including, but not limited to, intersex surgery and psychotherapy, except for ambiguous genitalia which was documented to be present at birth).

(24) Sex therapy, sexual advice, sexual counseling, sex behavior modification, psychotherapy for mental disorders involving sexual deviations (e.g., transvestic fetish), or other similar services, and any supplies provided in connection with therapy for sexual dysfunctions or inadequacies.

(25) Removal of corns or calluses or trimming of toenails and other routine foot care services, except those required as a result of a diagnosed systemic medical disease affecting the lower limbs, such as severe diabetes.

(26) Services and supplies, to include psychological testing, provided in connection with a specific developmental disorder. The following exception applies: Diagnostic and evaluative services required to arrive at a differential diagnosis for an otherwise eligible child unless the state is required to provide those services under Public Law 94–142, *Education for All Handicapped Children Act of 1975 as amended, see 20 U.S.C. chapter 33.*

(27) Surgery to reverse voluntary surgical sterilization procedures.

(28) Services and supplies related to artificial insemination (including semen donors and semen banks), in vitro fertilization, gamete intrafallopian transfer and all other noncoital reproductive technologies.

(29) Nonprescription contraceptives.

(30) Diagnostic tests to establish paternity of a child; or tests to determine sex of an unborn child.

(31) Preventive care (such as routine, annual, or employment-requested physical examinations; routine screening procedures; and immunizations). The following exceptions apply:

(i) Well-child care from birth to age six. Periodic health examinations designed for prevention, early detection, and treatment of disease are covered to

include screening procedures, immunizations, and risk counseling. The following services are payable when required as part of a well-child care program and when rendered by the attending pediatrician, family physician, or a pediatric nurse practitioner.

(A) Newborn examination, heredity and metabolic screening, and newborn circumcision.

(B) Periodic health supervision visits intended to promote optimal health for infants and children to include the following services:

(*1*) History and physical examination.

(*2*) Vision, hearing, and dental screening.

(*3*) Developmental appraisal to include body measurement.

(*4*) Immunizations as recommended by the Centers for Disease Control (CDC) and Prevention Advisory Committee on Immunization Practices.

(*5*) Pediatric blood lead level test.

(*6*) Tuberculosis screening.

(*7*) Blood pressure screening.

(*8*) Measurement of hemoglobin and hematocrit for anemia.

(*9*) Urinalysis.

(C) Additional services or visits required because of specific findings or because the particular circumstances of the individual case are covered if medically necessary and otherwise authorized for benefits under CHAMPVA.

(ii) Rabies vaccine following an animal bite.

(iii) Tetanus vaccine following an accidental injury.

(iv) Rh immune globulin.

(v) Pap smears.

(vi) Mammography tests.

(vii) Genetic testing and counseling determined to be medically necessary.

(viii) Chromosome analysis in cases of habitual abortion or infertility.

(ix) Gamma globulin.

(x) School-required physical examinations for beneficiaries through age 17 that are provided on or after October 1, 2001.

(32) Chiropractic and naturopathic services.

(33) Counseling services that are not medically necessary in the treatment of a diagnosed medical condition (such as educational counseling; vocational counseling; and counseling for socioeconomic purposes, stress management, life style modification, etc.).

(34) Acupuncture, whether used as a therapeutic agent or as an anesthetic.

(35) Hair transplants, wigs, or hairpieces, except that benefits may be extended for one wig or hairpiece per beneficiary (lifetime maximum) when the attending physician certifies that alopecia has resulted from treatment of malignant disease and the beneficiary certifies that a wig or hairpiece has not been obtained previously through the U.S. Government (including the Department of Veterans Affairs). The wig or hairpiece benefit does not include coverage for the following:

(i) Maintenance, wig or hairpiece supplies, or replacement of the wig or hairpiece.

(ii) Hair transplant or any other surgical procedure involving the attachment of hair or a wig or hairpiece to the scalp.

(iii) Any diagnostic or therapeutic method or supply intended to encourage hair growth.

(36) Self-help, academic education or vocational training services and supplies.

(37) Exercise equipment, spas, whirlpools, hot tubs, swimming pools, health club membership or other such charges or items.

(38) General exercise programs, even if recommended by a physician.

(39) Services of an audiologist or speech therapist, except when prescribed by a physician and rendered as a part of treatment addressed to the physical defect itself and not to any educational or occupational deficit.

(40) Eye exercises or visual training (orthoptics).

(41) Eye and hearing examinations except when rendered in connection with medical or surgical treatment of a covered illness or injury or in connection with well-child care.

(42) Eyeglasses, spectacles, contact lenses, or other optical devices with the following exceptions:

(i) When necessary to perform the function of the human lens, lost as a result of intraocular surgery, ocular injury or congenital absence.

(ii) Pinhole glasses prescribed for use after surgery for detached retina.

(iii) Lenses prescribed as ''treatment'' instead of surgery for the following conditions:

(A) Contact lenses used for treatment of infantile glaucoma.

(B) Corneal or scleral lenses prescribed in connection with treatment of keratoconus.

(C) Scleral lenses prescribed to retain moisture when normal tearing is not present or is inadequate.

(D) Corneal or scleral lenses prescribed to reduce a corneal irregularity other than astigmatism.

(iv) The specified benefits are limited to one set of lenses related to one qualifying eye condition as set forth in paragraphs (a)(42)(iii)(A) through (D) of this section. If there is a prescription change requiring a new set of lenses, but still related to the qualifying eye condition, benefits may be extended for a second set of lenses, subject to medical review.

(43) Hearing aids or other auditory sensory enhancing devices.

(44) Prostheses with the following exceptions:

(i) Dental prostheses specifically required in connection with otherwise covered orthodontia directly related to the surgical correction of a cleft palate anomaly.

(ii) Any prostheses, other than dental prostheses, determined to be medically necessary because of significant conditions resulting from trauma, congenital anomalies, or disease, including, but not limited to:

(A) Artificial limbs.

(B) Voice prostheses.

(C) Eyes.

(D) Items surgically inserted in the body as an integral part of a surgical procedure.

(E) Ears, noses, and fingers.

(45) Orthopedic shoes, arch supports, shoe inserts, and other supportive devices for the feet, including special ordered, custom-made built-up shoes, or regular shoes later built up with the following exceptions:

(i) Shoes that are an integral part of an orthopedic brace, and which cannot be used separately from the brace.

(ii) Extra-depth shoes with inserts or custom molded shoes with inserts for individuals with diabetes.

(46) Services or advice rendered by telephone are excluded except that a diagnostic or monitoring procedure which incorporates electronic transmission of data or remote detection and measurement of a condition, activity, or function (biotelemetry) is covered when:

(i) The procedure, without electronic data transmission, is a covered benefit; and

(ii) The addition of electronic data transmission or biotelemetry improves the management of a clinical condition in defined circumstances; and

(iii) The electronic data or biotelemetry device has been classified by the U.S. Food and Drug Administration, either separately or as part of a system, for use consistent with the medical condition and clinical management of such condition.

(47) Air conditioners, humidifiers, dehumidifiers, and purifiers.

(48) Elevators.

(49) Alterations to living spaces or permanent features attached thereto, even when necessary to accommodate installation of covered durable medical equipment or to facilitate entrance or exit.

(50) Items of clothing, even if required by virtue of an allergy (such as cotton fabric versus synthetic fabric and vegetable-dyed shoes).

(51) Food, food substitutes, vitamins or other nutritional supplements, including those related to prenatal care for a home patient whose condition permits oral feeding.

(52) Enuretic (bed-wetting) conditioning programs.

(53) Autopsy and post-mortem examinations.

(54) All camping, even when organized for a specific therapeutic purpose (such as diabetic camp or a camp for emotionally disturbed children), or when offered as a part of an otherwise covered treatment plan.

(55) Housekeeping, homemaker, or attendant services, including a sitter or companion.

(56) Personal comfort or convenience items, such as beauty and barber services, radio, television, and telephone.

(57) Smoking cessation services and supplies.

(58) Megavitamin psychiatric therapy; orthomolecular psychiatric therapy.

(59) All transportation except for specialized transportation with life sustaining equipment, when medically required for the treatment of a covered condition.

(60) Inpatient mental health services in excess of 30 days in any fiscal year (or in an admission), in the case of a patient nineteen years of age or older; 45 days in any fiscal year (or in an admission), in the case of a patient under 19 years of age; or 150 days of residential treatment care in any fiscal year (or in an admission) unless a waiver for extended coverage is granted in advance.

(61) Outpatient mental health services in excess of 23 visits in a fiscal year unless a waiver for extended coverage is granted in advance.

(62) Institutional services for partial hospitalization in excess of 60 treatment days in any fiscal year (or in an admission) unless a waiver for extended coverage is granted in advance.

(63) Detoxification in a hospital setting or rehabilitation facility in excess of seven days.

(64) Outpatient substance abuse services in excess of 60 visits during a benefit period. A benefit period begins with the first date of covered service and ends 365 days later.

(65) Family therapy for substance abuse in excess of 15 visits during a benefit period. A benefit period begins with the first date of covered service and ends 365 days later.

(66) Services that are provided to a beneficiary who is referred to a provider of such services by a provider who has an economic interest in the facility to which the patient is referred, unless a waiver is granted.

(67) Abortion except when a physician certifies that the life of the mother would be endangered if the fetus were carried to term.

(68) Abortion counseling.

(69) Aversion therapy.

(70) Rental or purchase of biofeedback equipment.

(71) Biofeedback therapy for treatment of ordinary muscle tension states (including tension headaches) or for psychosomatic conditions.

(72) Drug maintenance programs where one addictive drug is substituted for another, such as methadone substituted for heroin.

(73) Immunotherapy for malignant diseases except for treatment of Stage O and Stage A carcinoma of the bladder.

(74) Services and supplies provided by other than a hospital, such as nonskilled nursing homes, intermediate care facilities, halfway houses, homes for the aged, or other institutions of similar purpose.

(75) Services performed when the patient is not physically present.

(76) Medical photography.

(77) Special tutoring.

(78) Surgery for psychological reasons.

(79) Treatment of premenstrual syndrome (PMS).

(80) Medications not requiring a prescription, except for insulin and related diabetic testing supplies and syringes.

(81) Thermography.

(82) Removal of tattoos.

(83) Penile implant/testicular prosthesis procedures and related supplies for psychological impotence.

(84) Dermabrasion of the face except in those cases where coverage has been authorized for reconstructive or plastic surgery required to restore body form following an accidental injury or to revise disfiguring and extensive scars resulting from neoplastic surgery.

(85) Chemical peeling for facial wrinkles.

(86) Panniculectomy, body sculpting procedures.

(b) CHAMPVA-determined allowable amount.

(1) The term allowable amount is the maximum CHAMPVA-determined level of payment to a hospital or other authorized institutional provider, a physician or other authorized individual professional provider, or other authorized provider for covered services. The CHAMPVA-allowable amount is determined prior to cost sharing and the application of deductibles and/or other health insurance.

(2) A Medicare-participating hospital must accept the CHAMPVA-determined allowable amount for inpatient services as payment-in-full. (Reference 42 CFR parts 489 and 1003).

(3) An authorized provider of covered medical services or supplies must accept the CHAMPVA-determined allowable amount as payment-in-full.

(4) A provider who has collected and not made appropriate refund, or attempts to collect from the beneficiary, any amount in excess of the CHAMPVA-determined allowable amount may be subject to exclusion from Federal benefit programs.

(Authority: 38 U.S.C. 501, 1781)

[63 FR 48102, Sept. 9, 1998, as amended at 67 FR 4359, Jan. 30, 2002; 73 FR 65553, Nov. 4, 2008]

§ 17.273 Preauthorization.

Preauthorization or advance approval is required for any of the following:

(a) Non-emergent inpatient mental health and substance abuse care including admission of emotionally disturbed children and adolescents to residential treatment centers.

(b) All admissions to a partial hospitalization program (including alcohol rehabilitation).

(c) Outpatient mental health visits in excess of 23 per calendar year and/or more than two (2) sessions per week.

(d) Dental care.

(e) Durable medical equipment with a purchase or total rental price in excess of $2,000.

(f) Organ transplants.

(Authority: 38 U.S.C. 501, 1781)

[63 FR 48102, Sept. 9, 1998, as amended at 74 FR 31374, July 1, 2009]

§ 17.274 Cost sharing.

(a) With the exception of services obtained through VA facilities, CHAMPVA is a cost-sharing program in which the cost of covered services is shared with the beneficiary. CHAMPVA pays the CHAMPVA-determined allowable amount less the deductible, if applicable, and less the beneficiary cost share.

(b) In addition to the beneficiary cost share, an annual (calendar year) outpatient deductible requirement ($50 per beneficiary or $100 per family) must be satisfied prior to the payment of outpatient benefits. There is no deductible requirement for inpatient services or for services provided through VA facilities.

(c) To provide financial protection against the impact of a long-term illness or injury, a calendar year cost limit or ''catastrophic cap'' has been placed on the beneficiary cost-share amount for covered services and supplies. Credits to the annual catastrophic cap are limited to the applied annual deductible(s) and the beneficiary cost-share amount. Costs above the CHAMPVA-allowable amount, as well as costs associated with non-covered services are not credited to the catastrophic cap computation. After a family has paid the maximum cost-share and deductible amounts for a calendar year, CHAMPVA will pay allowable amounts for the remaining covered services through the end of that calendar year.

(i) Through December 31, 2001, the annual cap on cost sharing is $7,500 per CHAMPVA-eligible family.

(ii) Effective January 1, 2002, the cap on cost sharing is $3,000 per CHAMPVA-eligible family.

(d) If the CHAMPVA benefit payment is under $1.00, payment will not be issued. Catastrophic cap and deductible will, however, be credited.

(Authority: 38 U.S.C. 501, 1781)

[67 FR 4359, Jan. 30, 2002, as amended at 67 FR 6875, Feb. 14, 2002]

§ 17.275 Claim filing deadline.

(a) Unless an exception is granted under paragraph (b) of this section, claims for medical services and supplies must be filed with the Center no later than:

(1) One year after the date of service; or

(2) In the case of inpatient care, one year after the date of discharge; or

(3) In the case of retroactive approval for medical services/supplies, 180 days following beneficiary notification of authorization; or

(4) In the case of retroactive approval of CHAMPVA eligibility, 180 days following notification to the beneficiary of authorization for services occurring on or after the date of first eligibility.

(b) Requests for an exception to the claim filing deadline must be submitted, in writing, to the Center and include a complete explanation of the

circumstances resulting in late filing along with all available supporting documentation. Each request for an exception to the claim filing deadline willbe reviewed individually and considered on its own merit. The Director, Health Administration Center, or his or her designee may grant exceptions to the requirements in paragraph (a) of this section if he or she determines that there was good cause for missing the filing deadline. For example, when dual coverage exists CHAMPVA payment, if any, cannot be determined until after the primary insurance carrier has adjudicated the claim. In such circumstances an exception may be granted provided that the delay on the part of the primary insurance carrier is not attributable to the beneficiary. Delays due to provider billing procedures do not constitute a valid basis for an exception.

(Authority: 38 U.S.C. 501, 1781)

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

§ 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]

§ 17.277 Third-party liability/medical care 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 79 FR 54616, Sept. 12, 2014]

§ 17.278 Confidentiality of records.

Confidentiality of records will be maintained in accordance with 38 CFR 1.460 through 1.582.

(Authority: 5 U.S.C. 552, 552a; 38 U.S.C. 501, 1781, 5701, 7332)

IN VITRO FERTILIZATION AND REIMBURSEMENT OF ADOPTION EXPENSES

§ 17.380 In vitro fertilization treatment.

(a)(1) In vitro fertilization may be provided when clinically appropriate to—

(i) A veteran who has a service-connected disability that results in the inability of the veteran to procreate without the use of fertility treatment; and,

(ii) The spouse of such veteran, as provided in § 17.412.

(2) For the purposes of this section, ''a service-connected disability that results in the inability of the veteran to

procreate without the use of fertility treatment'' means, for a male veteran, a service-connected injury or illness that prevents the successful delivery of sperm to an egg; and, for a female veteran with ovarian function and a patent uterine cavity, a service-connected injury or illness that prevents the egg from being successfully fertilized by sperm.

(3) In vitro fertilization treatment will be provided under this section when clinically appropriate and to the same extent such treatment is provided to a member of the Armed Forces who incurs a serious injury or illness on active duty pursuant to 10 U.S.C. 1074(c)(4)(A), as described in the April 3, 2012, memorandum issued by the Assistant Secretary of Defense for Health Affairs on the subject of ''Policy for Assisted Reproductive Services for the Benefit of Seriously or Severely Ill/Injured (Category II or III) Active Duty Service Members,'' and the guidance issued by the Department of Defense to implement such policy, including any limitations on the amount of such benefits available to such a member.

(b) The time periods regarding embryo cryopreservation and storage set forth in part III(G) and in part IV(H) of the memorandum referenced in paragraph (a)(3) of this section do not apply. Embryo cryopreservation and storage may be provided to an individual described in paragraph (a)(1) of this section without limitation on the duration of such cryopreservation and storage.

[82 FR 6275, Jan. 19, 2017, as amended at 82 FR 11153, Feb. 21, 2017; 84 FR 8257, Mar. 7, 2019]

§ 17.390 Reimbursement for qualifying adoption expenses incurred by certain veterans.

(a) *General.* A covered veteran may request reimbursement for qualifying adoption expenses incurred by the veteran in the adoption of a child under 18 years of age.

(1) An adoption for which expenses may be reimbursed under this section includes an adoption by a married or single person, an infant adoption, an intercountry adoption, and an adoption of a child with special needs (as defined in section 473(c) of the Social Security Act (42 U.S.C. 673(c))).

(2) Reimbursement for qualifying adoption expenses may be requested only for an adoption that became final after September 29, 2016, and must be requested:

(i) No later than 2 years after the adoption is final; or,

(ii) In the case of adoption of a foreign child, no later than 2 years from the date the certificate of United States citizenship is issued.

(3) In the case of adoption of a foreign child, reimbursement for qualifying adoption expenses may be requested only after United States citizenship has been granted to the adopted child.

(4) Reimbursement for qualifying adoption expenses may not be made under this section for any expense paid to or for a covered veteran under any other adoption benefits program administered by the Federal Government or under any such program administered by a State or local government.

(b) *Limitations.* (1) Reimbursement per adopted child. No more than $2,000 may be reimbursed under this section to a covered veteran, or to two covered veterans who are spouses of each other, for expenses incurred in the adoption of a child. In the case of two married covered veterans, only one spouse may claim reimbursement for any one adoption.

(2) Maximum reimbursement in any calendar year. No more than $5,000 may be paid under this section to a covered veteran in any calendar year. In the case of two married covered veterans, the couple is limited to a maximum of $5,000 per calendar year.

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

(1) ''Covered veteran'' means a veteran with a service-connected disability that results in the inability of the veteran to procreate without the use of fertility treatment.

(2) ''Qualifying adoption expenses'' means reasonable and necessary expenses that are directly related to the legal adoption of a child under 18 years of age, but only if such adoption is arranged by a qualified adoption agency. Such term does not include any expense incurred:

(i) For items such as clothing, bedding, toys and books;

(ii) For travel; or

(iii) In connection with an adoption arranged in violation of Federal, State, or local law.

(3) ''Reasonable and necessary expenses'' include:

(i) Public and private agency fees, including adoption fees charged by an agency in a foreign country;

(ii) Placement fees, including fees charged to adoptive parents for counseling;

(iii) Legal fees (including court costs) or notary expenses;

(iv) Medical expenses, including hospital expenses of the biological mother and medical care of the child to be adopted; and

(v) Temporary foster care charges when payment of such charges is required before the adoptive child's placement.

(4) ''Qualified adoption agency'' means any of the following:

(i) A State or local government agency which has responsibility under State or local law for child placement through adoption.

(ii) A nonprofit, voluntary adoption agency which is authorized by State or local law to place children for adoption.

(iii) Any other source authorized by a State to provide adoption placement if the adoption is supervised by a court under State or local law.

(iv) A foreign government or an agency authorized by a foreign government to place children for adoption, in any case in which:

(A) The adopted child is entitled to automatic citizenship under section 320 of the Immigration and Nationality Act (8 U.S.C. 1431); or

(B) A certificate of citizenship has been issued for such child under section 322 of that Act (8 U.S.C. 1433).

(d) *Applying for reimbursement of qualifying adoption* expenses. An application for reimbursement must be submitted on a form prescribed for such purpose by VA. Information and documentation must include:

(1) A copy of the final adoption decree, certificate or court order granting the adoption. For U.S. adoptions, the court order must be signed by a judge unless either State law or local court rules authorize that the adoption order may be signed by a commissioner, magistrate or court referee. The covered veteran must submit a full English translation of any foreign language document, to include the translator's certification that he or she is competent to translate the foreign language to English and that his or her translation is complete and correct.

(2) For foreign adoptions, proof of U.S. citizenship of the child, including any of the following:

(i) A copy of Certificate of Citizenship.

(ii) A copy of a U.S. court order that recognizes the foreign adoption, or documents the re-adopting of the child in the United States.

(iii) A letter from the United States Citizenship and Immigration Services, which states the status of the child's adoption.

(iv) A copy of the child's U.S. passport (page with personal information only).

(3) For U.S. adoptions, documentation to show that the adoption was handled by a qualified adoption agency or other source authorized by a State or local law to provide adoption placement. Acceptable forms of proof that the adoption was handled by a qualified adoption agency include:

(i) A copy of placement agreement from the adoption agency showing the agreement entered into between the member and the agency.

(ii) A letter from the adoption agency stating that the agency arranged the adoption and that the agency is a licensed child placing agency in the United States.

(iii) Receipts for payment to the adoption agency, as well as proof, (*e.g.*, a copy of the agency's web page), of the agency's status as a for-profit or nonprofit licensed child placing agency.

(4) For foreign adoptions, documentation to show that the adoption was handled by a qualified adoption agency. In addition to the forms of acceptable proof that the adoption was handled by a qualified adoption agency listed in paragraph (d)(3) of this section, the documentation must also include:

(i) A document that describes the mission of the foreign agency and its

authority from the foreign government to place children for adoption; and

(ii) A placement agreement from the adoption agency or letter from the adoption agency stating the specific services it provided for the adoption.

(5) Documentation to substantiate reasonable and necessary expenses paid by the covered veteran. Acceptable forms of documentation include receipts, cancelled checks, or a letter from the adoption agency showing the amount paid by the member. Receipts from a foreign entity should include the U.S. currency equivalency. Reconstruction of expense records is permissible when the original records are unavailable and the covered veteran submits a notarized affidavit stating the costs.

(6) Checking or savings account information to facilitate VA providing reimbursement to the covered veteran under this section.

(e) *Failure to establish* eligibility. If documents submitted by a covered veteran in support of an application for reimbursement do not establish eligibility for reimbursement or justify claimed expenses, VA will retain the application and advise the covered veteran of additional documentation needed. All requested documentation must be submitted to VA within 90 calendar days of VA request.

(f) *Authority*. Authority to provide reimbursement for qualifying adoption expenses incurred by a covered veteran in the adoption of a child under 18 years of age expires September 30, 2018.

(Approval for information collection under this section has been requested from the Office of Management and Budget)

[83 FR 9212, Mar. 5, 2018]

HOSPITAL CARE AND MEDICAL SERVICES FOR CAMP LEJEUNE VETERANS AND FAMILIES

§ 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 August 1, 1953, 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.

Covered illness or condition means any of 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.

(c) *Limitations*. For a Camp Lejeune veteran, VA will assume that a covered illness or condition is attributable to the veteran's active duty service at Camp Lejeune unless it is clinically determined, under VA clinical practice guidelines, that such an illness or condition resulted from a cause other than such service.

(d) *Copayments*—(1) *Exemption*. (i) Camp Lejeune veterans who served at Camp Lejeune between January 1, 1957, and December 31, 1987, are not subject to copayment requirements for hospital care and medical services provided for a covered illness or condition on or after August 6, 2012.

(ii) Camp Lejeune veterans who served at Camp Lejeune between August 1, 1953, and December 31, 1956, are not subject to copayment requirements for hospital care and medical services provided for a covered illness or condition on or after December 16, 2014.

(2) *Retroactive exemption*. VA will reimburse Camp Lejeune veterans for any copayments paid to VA for hospital care and medical services provided for a covered illness or condition if either of the following is true:

(i) For Camp Lejeune veterans who served at Camp Lejeune between January 1, 1957, and December 31, 1987, VA provided the hospital care or medical services to the Camp Lejeune veteran on or after August 6, 2012, and the veteran requested Camp Lejeune veteran status no later than September 24, 2016; or

(ii) For Camp Lejeune veterans who served at Camp Lejeune between August 1, 1953, and December 31, 1956, VA provided the hospital care or medical services to the Camp Lejeune veteran on or after December 16, 2014, and the veteran requested Camp Lejeune veteran status no later than July 18, 2018.

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

(Authority: 38 U.S.C. 1710)

[81 FR 46605, July 18, 2016]

HOSPITAL CARE AND MEDICAL SERVICES FOR SPOUSES AND FAMILIES

§ 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 August 1, 1953, 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) In the case of a Camp Lejeune family member who resided at Camp Lejeune between January 1, 1957, and December 31, 1987, for hospital care and medical services received prior to the date an application for benefits is filed per paragraph (c) of this section, the hospital care and medical services must have been provided on or after March 26, 2013, but no more than 2 years prior to the date that VA receives the application. The claim for payment or reimbursement must be received by VA no more than 60 days after VA approves the application;

(ii) In the case of a Camp Lejeune family member who resided at Camp Lejeune between August 1, 1953, and December 31, 1956, for hospital care and medical services received prior to the date an application for benefits is filed per paragraph (c) of this section, the hospital care and medical services must have been provided on or after December 16, 2014, but no more than 2 years prior to the date that VA receives the application. The claim for payment or reimbursement must be received by VA no more than 60 days after VA approves the application;

(iii) For hospital care and medical services provided on or after the date an application for benefits is filed per paragraph (c) of this section, 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 a covered illness or condition as defined in § 17.400(b), 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.

(The information collection requirements have been submitted to OMB and are pending OMB approval.)

[82 FR 21122, May 5, 2017]

§ 17.412 Fertility counseling and treatment for certain spouses.

(a)(1) VA may provide fertility counseling and treatment to a spouse of a veteran described in § 17.380 to the extent such services are available to a veteran under § 17.38, and consistent with the benefits relating to reproductive assistance provided to a member of the Armed Forces who incurs a serious injury or illness on active duty pursuant to 10 U.S.C. 1074(c)(4)(A), as described in the April 3, 2012, memorandum issued by the Assistant Secretary of Defense for Health Affairs on the subject of ''Policy for Assisted Reproductive Services for the Benefit of Seriously or Severely Ill/Injured (Category II or III) Active Duty Service Members,'' and the guidance issued by the Department of Defense to implement such policy, including any limitations on the amount of such benefits available to such a member.

(2) VA may provide in vitro fertilization to a spouse of a veteran described in § 17.380 when clinically appropriate and consistent with the benefits relating to reproductive assistance provided to a member of the Armed Forces who incurs a serious injury or illness on active duty pursuant to 10 U.S.C. 1074(c)(4)(A), as described in the April 3, 2012, memorandum issued by the Assistant Secretary of Defense for Health Affairs on the subject of ''Policy for Assisted Reproductive Services for the Benefit of Seriously or Severely Ill/Injured (Category II or III) Active Duty Service Members,'' and the guidance issued by the Department of Defense to implement such policy, including any limitations on the amount of such benefits available to such a member.

(b) The time periods regarding embryo cryopreservation and storage set forth in part III(G) and in part IV(H) of the memorandum referenced in paragraph (a) of this section do not apply. Embryo cryopreservation and storage may be provided to a spouse of a covered veteran without limitation on the

duration of such cryopreservation and storage.

[82 FR 6276, Jan. 19, 2017, as amended at 81 FR 11153, Feb. 21, 2017; 84 FR 8257, Mar. 7, 2019]

AUTHORITY OF HEALTH CARE PROVIDERS TO PRACTICE IN VA

§ 17.415 Full practice authority for advanced practice registered nurses.

(a) *Advanced practice registered nurse (APRN)*. For purposes of this section, an advanced practice registered nurse (APRN) is an individual who:

(1) Has completed a nationally-accredited, graduate-level educational program that prepares them for one of the three APRN roles of Certified Nurse Practitioner (CNP), Clinical Nurse Specialist (CNS), or Certified Nurse-Midwife (CNM);

(2) Has passed a national certification examination that measures knowledge in one of the APRN roles described in paragraph (a)(1) of this section;

(3) Has obtained a license from a State licensing board in one of three recognized APRN roles described in paragraph (a)(1) of this section; and

(4) Maintains certification and licensure as required by paragraphs (a)(2) and (3) of this section.

(b) *Full practice authority*. For purposes of this section, full practice authority means the authority of an APRN to provide services described in paragraph (d) of this section without the clinical oversight of a physician, regardless of State or local law restrictions, when that APRN is working within the scope of their VA employment.

(c) *Granting of full practice authority*. VA may grant full practice authority to an APRN subject to the following:

(1) Verification that the APRN meets the requirements established in paragraph (a) of this section; and

(2) Determination that the APRN has demonstrated the knowledge and skills necessary to provide the services described in paragraph (d) of this section without the clinical oversight of a physician, and is thus qualified to be privileged for such scope of practice.

(d) *Services provided by an APRN with full practice authority*. (1) Subject to the limitations established in paragraph (d)(2) of this section, the full practice authority for each of the three APRN roles includes, but is not limited to, providing the following services:

(i) A CNP has full practice authority to:

(A) Take comprehensive histories, provide physical examinations and other health assessment and screening activities, diagnose, treat, and manage patients with acute and chronic illnesses and diseases;

(B) Order laboratory and imaging studies and integrate the results into clinical decision making;

(C) Prescribe medication and durable medical equipment;

(D) Make appropriate referrals for patients and families, and request consultations;

(E) Aid in health promotion, disease prevention, health education, and counseling as well as the diagnosis and management of acute and chronic diseases.

(ii) A CNS has full practice authority to provide diagnosis and treatment of health or illness states, disease management, health promotion, and prevention of illness and risk behaviors among individuals, families, groups, and communities within their scope of practice.

(iii) A CNM has full practice authority to provide a range of primary health care services to women, including gynecologic care, family planning services, preconception care (care that women veterans receive before becoming pregnant, including reducing the risk of birth defects and other problems such as the treatment of diabetes and high blood pressure), prenatal and postpartum care, childbirth, and care of a newborn, and treating the partner of their female patients for sexually transmitted disease and reproductive health, if the partner is also enrolled in the VA healthcare system or is not required to enroll.

(2) The full practice authority of an APRN is subject to the limitations imposed by the Controlled Substances Act, 21 U.S.C. 801 *et seq.*, and that APRN's State licensure on the authority to prescribe, or administer controlled substances, as well as any other limitations on the provision of VA care

set forth in applicable Federal law and policy.

(e) *Preemption of State and local law.* To achieve important Federal interests, including but not limited to the ability to provide the same comprehensive care to veterans in all States under 38 U.S.C. 7301, this section preempts conflicting State and local laws relating to the practice of APRNs when such APRNs are working within the scope of their VA employment. Any State or local law, or regulation pursuant to such law, is without any force or effect on, and State or local governments have no legal authority to enforce them in relation to, activities performed under this section or decisions made by VA under this section.

[81 FR 90206, Dec. 14, 2016]

§ 17.417 Health care providers practicing via telehealth.

(a) *Definitions.* The following definitions apply to this section.

(1) *Beneficiary.* The term beneficiary means a veteran or any other individual receiving health care under title 38 of the United States Code.

(2) *Health care provider.* The term health care provider means an individual who:

(i) Is licensed, registered, or certified in a State to practice a health care specialty identified under 38 U.S.C. 7402(b);

(ii) Is appointed to an occupation in the Veterans Health Administration that is listed in or authorized under 38 U.S.C. 7401(1) or (3);

(iii) Maintains credentials (*e.g.*, a license, registration, or certification) in accordance with the requirements of his or her health care specialty as identified under 38 U.S.C. 7402(b); and

(iv) Is not a VA-contracted health care provider.

(3) *State.* The term State means a State as defined in 38 U.S.C. 101(20), or a political subdivision of such a State.

(4) *Telehealth.* The term telehealth means the use of electronic information or telecommunications technologies to support clinical health care, patient and professional health-related education, public health, and health administration.

(b) *Health care provider's practice via telehealth.* (1) Health care providers may provide telehealth services, within their scope of practice, functional statement, and/or in accordance with privileges granted to them by VA, irrespective of the State or location within a State where the health care provider or the beneficiary is physically located. Health care providers' practice is subject to the limitations imposed by the Controlled Substances Act, 21 U.S.C. 801, *et seq.*, on the authority to prescribe or administer controlled substances, as well as any other limitations on the provision of VA care set forth in applicable Federal law and policy. This section only grants health care providers the ability to practice telehealth within the scope of their VA employment and does not otherwise grant health care providers additional authorities that go beyond what is required or authorized by Federal law and regulations or as defined in the laws and practice acts of the health care providers' State license, registration, or certification.

(2) Situations where a health care provider's VA practice of telehealth may be inconsistent with a State law or State license, registration, or certification requirements related to telehealth include when:

(i) The beneficiary and the health care provider are physically located in different States during the episode of care;

(ii) The beneficiary is receiving services in a State other than the health care provider's State of licensure, registration, or certification;

(iii) The health care provider is delivering services in a State other than the health care provider's State of licensure, registration, or certification;

(iv) The health care provider is delivering services either on or outside VA property;

(v) The beneficiary is receiving services while she or he is located either on or outside VA property;

(vi) The beneficiary has or has not previously been assessed, in person, by the health care provider; or

(vii) Other State requirements would prevent or impede the practice of health care providers delivering telehealth to VA beneficiaries.

(c) *Preemption of State law.* To achieve important Federal interests, including,

but not limited to, the ability to provide the same complete health care and hospital service to beneficiaries in all States under 38 U.S.C. 7301, this section preempts conflicting State laws relating to the practice of health care providers when such health care providers are practicing telehealth within the scope of their VA employment. Any State law, rule, regulation or requirement pursuant to such law, is without any force or effect on, and State governments have no legal authority to enforce them in relation to, this section or decisions made by VA under this section.

[83 FR 21906, May 11, 2018]

CONFIDENTIALITY OF HEALTHCARE QUALITY ASSURANCE REVIEW RECORDS

AUTHORITY: 38 U.S.C. 5705.

SOURCE: 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)

§ 17.501 Confidential and privileged documents.

(a) Documents and parts of documents are considered confidential and privileged if they were produced by or for the VA in the process of conducting systematic healthcare reviews for the purpose of improving the quality of health care or improving the utilization of healthcare resources in VA healthcare facilities and meet the criteria in paragraphs (b) and (c) of this section. The four classes of healthcare quality assurance reviews with examples are:

(1) Monitoring and evaluation reviews conducted by a facility:

(i) Medical records reviews,

(ii) Drug usage evaluations,

(iii) Blood usage reviews,

(iv) Surgical case/invasive procedure reviews,

(v) Service and program monitoring including monitoring performed by individual services or programs, several services or programs working together, or individuals from several services or programs working together as a team,

(vi) Mortality and morbidity reviews,

(vii) Infection control review and surveillance,

(viii) Occurrence screening,

(ix) Tort claims peer reviews (except reviews performed to satisfy the requirements of a governmental body or a professional health care organization which is licensing practitioners or monitoring their professional performance),

(x) Admission and continued stay reviews,

(xi) Diagnostic studies utilization reviews,

(xii) Reports of special incidents (VA Form 10-2633 or similar forms) and follow-up documents unless developed during or as a result of a Board of Investigation;

(2) Focused reviews which address specific issues or incidents and which are designated by the reviewing office at the outset of the review as protected by 38 U.S.C. 5705 and the regulations in §§ 17.500 through 17.511; focused reviews may be either:

(i) Facility focused reviews;

(ii) VA Central Office or Regional focused reviews;

(3) VA Central Office or Regional general oversight reviews to assess facility compliance with VA program requirements if the reviews are designated by the reviewing office at the outset of the review as protected by 38 U.S.C. 5705 and the regulations in §§ 17.500 through 17.511; and

(4) Contracted external reviews of care, specifically designated in the contract or agreement as reviews protected by 38 U.S.C. 5705 and the regulations in §§ 17.500 through 17.511.

(b) The Under Secretary for Health, Regional Director or facility Director will describe in advance in writing those quality assurance activities included under the classes of healthcare quality assurance reviews listed in paragraph (a) of this section. Only documents and parts of documents resulting from those activities which have been so described are protected by 38 U.S.C. 5705 and the regulations in §§ 17.500 through 17.511. If an activity is not described in a VA Central Office or Regional policy document, this requirement may be satisfied at the facility level by description in advance of the activity and its designation as protected in the facility quality assurance plan or other policy document.

(c) Documents and parts of documents generated by activities which meet the criteria in paragraphs (a) and (b) of this section shall be confidential and privileged only if they:

(1) Identify, either implicitly or explicitly, individual practitioners, patients, or reviewers except as provided in paragraph (g)(6) of this section; or

(2) Contain discussions relating to the quality of VA medical care or utilization of VA medical resources by healthcare evaluators during the course of a review of quality assurance information or data, even if they do not identify practitioners, patients, or reviewers; or

(3) Are individual committee, service, or study team minutes, notes, reports, memoranda, or other documents either produced by healthcare evaluators in deliberating on the findings of healthcare reviews, or prepared for purposes of discussion or consideration by healthcare evaluators during a quality assurance review; or

(4) Are memoranda, letters, or other documents from the medical facility to the Regional Director or VA Central Office which contain information generated by a quality assurance activity meeting the criteria in § 17.501 (a) and (b); or

(5) Are memoranda, letters, or other documents produced by the Regional Director or VA Central Office which either respond to or contain information generated by a quality assurance activity meeting the criteria in § 17.501 (a) and (b).

(d) Documents which meet the criteria in this section are confidential and privileged whether they are produced at the medical facility, Regional or VA Central Office levels, or by external contractors performing healthcare quality assurance reviews.

(e) Documents which are confidential and privileged may be in written, computer, electronic, photographic or any other form.

(f) Documents which contain confidential and privileged material in one part, but not in others, such as Clinical Executive Board minutes, should be filed and maintained as if the entire document was protected by 38 U.S.C. 5705. This is not required if the confidential and privileged material is deleted.

(g) The following records and documents and parts of records and documents are not confidential even if they meet the criteria in paragraphs (a) through (c) of this section:

(1) Statistical information regarding VA healthcare programs or activities that does not implicitly or explicitly

identify individual VA patients or VA employees or individuals involved in the quality assurance process;

(2) Summary documents or records which only identify study topics, the period of time covered by the study, criteria, norms, and/or major overall findings, but which do not identify individual healthcare practitioners, even by implication;

(3) The contents of Credentialing and Privileging folders as described in VACO policy documents (38 U.S.C. 5705-protected records shall not be filed in Credentialing and Privileging folders);

(4) Records and documents developed during or as a result of Boards of Investigations;

(5) Completed patient satisfaction survey questionnaires and findings from patient satisfaction surveys;

(6) Records and documents which only indicate the number of patients treated by a practitioner, either by diagnosis or in aggregate, or number of procedures performed by a practitioner, either by procedure or in aggregate;

(7) Records and documents developed during or as a result of reviews performed to satisfy the requirements of a governmental body or a professional healthcare organization which is licensing practitioners or monitoring their professional performance, e.g., National Practitioner Data Bank, Federation of State Medical Boards, and National Council of State Boards of Nursing;

(8) Documents and reports developed during or as a result of site visits by the Office of the Medical Inspector except to the extent that the documents and reports contain information that meets the criteria described in this section and are produced by or for VA by other than the Office of Medical Inspector;

(9) External reviews conducted by VA Central Office or a Region other than those designated by the reviewing office under paragraph (a)(2) or (a)(3) of this section as protected by 38 U.S.C. 5705 and the regulations in §§17.500 through 17.511;

(10) Documents and reports of Professional Standards Boards, Credentialing Committees, Executive Committees of Medical Staff, and similar bodies, insofar as the documents relate to the credentialing and privileging of practitioners;

(11) Documents and reports developed during or as a result of data validation activities;

(12) Documents and reports developed during or as a result of occupational health monitoring;

(13) Documents and reports developed during or as a result of safety monitoring not directly related to the care of specified individual patients;

(14) Documents and reports developed during or as a result of resource management activities not directly related to the care of specified individual patients; and

(15) Information and records derived from patient medical records or facility administrative records, which are not protected by 38 U.S.C. 5705 and the regulations in §§17.500 through 17.511, may be sent or communicated to a third party payor who has asked for this information in response to a VA request for reimbursement based on Public Law 99–272 and Public Law 101–508. Reviews conducted at the request of the third party payor do not generate records protected by 38 U.S.C. 5705 and the regulations in §§17.500 through 17.511 since the reviews are not undertaken as part of the VA's quality assurance program.

(Authority: 38 U.S.C. 5705)

§17.502 Applicability of other statutes.

(a) Disclosure of quality assurance records and documents which are not confidential and privileged under 38 U.S.C. 5705 and the confidentiality regulations in §§17.500 through 17.511 will be governed by the provisions of the Freedom of Information Act, and, if applicable, the Privacy Act and any other VA or federal confidentiality statutes.

(b) When included in a quality assurance review, confidential records protected by other confidentiality statutes such as 5 U.S.C. 552a (the Privacy Act), 38 U.S.C. 7332 (drug and alcohol abuse, sickle cell anemia, HIV infection), and 38 U.S.C. 5701 (veterans' names and addresses) retain whatever confidentiality protection they have under these laws and applicable regulations and will be handled accordingly.

To the extent that information protected by 38 U.S.C. 5701 or 7332 or the Privacy Act is incorporated into quality assurance records, the information in the quality assurance records is still protected by these statutes.

(Authority: 38 U.S.C. 5705)

§ 17.503 Improper disclosure.

(a) Improper disclosure is the disclosure of confidential and privileged healthcare quality assurance review records or documents (or information contained therein), as defined in § 17.501, to any person who is not authorized access to the records or documents under the statute and the regulations in §§ 17.500 through 17.511.

(b) ''Disclosure'' means the communication, transmission, or conveyance in any way of any confidential and privileged quality assurance records or documents or information contained in them to any individual or organization in any form by any means.

(Authority: 38 U.S.C. 5705)

§ 17.504 Disclosure methods.

(a) Disclosure of confidential and privileged quality assurance records and documents or the information contained therein outside VA, where permitted by the statute and the regulations in §§ 17.500 through 17.511, will always be by copies, abstracts, summaries, or similar records or documents prepared by the Department of Veterans Affairs and released to the requestor. The original confidential and privileged quality assurance records and documents will not be removed from the VA facility by any person, VA employee or otherwise, except in accordance with § 17.508(c) or where otherwise legally required.

(b) Disclosure of confidential and privileged quality assurance records and documents to authorized individuals under either § 17.508 or § 17.509 shall bear the following statement: ''These documents or records (or information contained herein) are confidential and privileged under the provisions of 38 U.S.C. 5705, which provide for fines up to $20,000 for unauthorized disclosures thereof, and the implementing regulations. This material shall not be disclosed to anyone without authorization as provided for by that law or the regulations in §§ 17.500 through 17.511.''

(Authority: 38 U.S.C. 5705)

§ 17.505 Disclosure authorities.

The VA medical facility Director, Regional Director, Under Secretary for Health, or their designees are authorized to disclose any confidential and privileged quality assurance records or documents under their control to other agencies, organizations, or individuals where 38 U.S.C. 5705 or the regulations in §§ 17.500 through 17.511 expressly provide for disclosure.

(Authority: 38 U.S.C. 5705)

§ 17.506 Appeal of decision by Veterans Health Administration to deny disclosure.

When a request for records or documents subject to the regulations in §§ 17.500 through 17.511 is denied in whole or in part by the VA medical facility Director, Regional Director or Under Secretary for Health, the VA official denying the request in whole or in part will notify the requestor in writing of the right to appeal this decision to the General Counsel of the Department of Veterans Affairs within 60 days of the date of the denial letter. The final Department decision will be made by the General Counsel or the Deputy General Counsel.

(Authority: 38 U.S.C. 5705)

§ 17.507 Employee responsibilities.

(a) All VA employees and other individuals who have access to records designated as confidential and privileged under 38 U.S.C. 5705 and the regulations in §§ 17.500 through 17.511 will treat the findings, views, and actions relating to quality assurance in a confidential manner.

(b) All individuals who have had access to records designated as confidential and privileged under 38 U.S.C. 5705 and the regulations in §§ 17.500 through 17.511 will not disclose such records or information therein to any person or organization after voluntary or involuntary termination of their relationship to the VA.

(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 53355, Oct. 24, 1994, as amended at 79 FR 54616, Sept. 12, 2014]

§ 17.510 Redisclosure.

No person or entity to whom a quality assurance record or document has been disclosed under § 17.508 or § 17.509 shall make further disclosure of such record or document except as provided for in 38 U.S.C. 5705 and the regulations in §§ 17.500 through 17.511.

(Authority: 38 U.S.C. 5705)

§ 17.511 Penalties for violations.

Any person who knows that a document or record is a confidential and privileged quality assurance document or record described in §§ 17.500 through 17.511 and willfully discloses such confidential and privileged quality assurance record or document or information contained therein, except as authorized by 38 U.S.C. 5705 or the regulations in §§ 17.500 through 17.511, shall be fined not more than $5,000 in the case of a first offense and not more than $20,000 in the case of each subsequent offense.

(Authority: 38 U.S.C. 5705)

VA Health Professional Scholarship Program

AUTHORITY: 38 U.S.C. 7601–7619, 7633, 7634, and 7636.

§ 17.600 Purpose.

The purpose of §§ 17.600 through 17.612 is to establish the requirements for the award of scholarships under the VA Health Professional Scholarship Program (HPSP) to students pursuing a course of study leading to a degree in certain health care occupations, listed in 38 U.S.C. 7401(1) and (3), to assist in providing an adequate supply of such personnel for VA. The HPSP allows VA

to provide scholarship awards to facilitate recruitment and retention of employees in several hard-to-fill health care occupations.

(Authority: 38 U.S.C. 7601(b))

[78 FR 51069, Aug. 20, 2013]

§ 17.601 Definitions.

The following definitions apply to §§ 17.600 through 17.636:

Acceptable level of academic standing means the level at which a participant may continue to attend school under the standards and practices of the school at which a participant is enrolled in a course of study for which an HPSP or VIOMPSP scholarship was awarded.

Acceptance agreement means a signed legal document between VA and a participant of the HPSP or VIOMPSP that specifies the obligations of VA and the participant upon acceptance to the HPSP or VIOMPSP. An acceptance agreement must incorporate by reference, and cannot be inconsistent with, §§ 17.600 through 17.612 (for HPSP agreements) or §§ 17.626 through 17.636 (for VIOMPSP agreements), and must include:

(1) A mobility agreement.

(2) Agreement to accept payment of the scholarship.

(3) Agreement to perform obligated service.

(4) Agreement to maintain enrollment and attendance in the course of study for which the scholarship was awarded, and to maintain an acceptable level of academic standing.

Affiliation agreement means a legal document that enables the clinical education of trainees at a VA or non-VA medical facility. An affiliation agreement is required for all education or training that involves direct patient contact, or contact with patient information, by trainees from a non-VA institution.

Citizen of the United States means any person born, or lawfully naturalized, in the United States, subject to its jurisdiction and protection, and owing allegiance thereto.

Credential means the licensure, registration, certification, required education, relevant training and experience, and current competence necessary to meet VA's qualification standards for employment in certain health care occupations.

Degree represents the successful completion of the course of study for which a scholarship was awarded.

(1) *HPSP*. For the purposes of the HPSP, VA recognizes the following degrees: a doctor of medicine; doctor of osteopathy; doctor of dentistry; doctor of optometry; doctor of podiatry; or an associate, baccalaureate, master's, or doctorate degree in another health care discipline needed by VA.

(2) *VIOMPSP*. For the purposes of the VIOMPSP, VA recognizes a bachelor's, master's, education specialist or doctorate that meets the core curriculum and supervised practice requirements in visual impairment and blindness.

Full-time student means an individual who meets the requirements for full time attendance as defined by the school in which they are enrolled.

HPSP means the VA Health Professional Scholarship Program authorized by 38 U.S.C. 7601 through 7619.

Mobility agreement means a signed legal document between VA and a participant of the HPSP or VIOMPSP, in which the participant agrees to accept assignment at a VA facility selected by VA where he or she will fulfill the obligated service requirement. A mobility agreement must be included in the participant's acceptance agreement. Relocation to another geographic location may be required.

Obligated service means the period of time during which the HPSP or VIOMPSP participant must be employed by VA in a full-time clinical occupation for which the degree prepared the participant as a requirement of the acceptance agreement.

Part-time student—(1) *HPSP*. For the purposes of the HPSP, part-time student means an individual who is a VA employee, and who has been accepted for enrollment or enrolled for study leading to a degree on a less than full-time basis but no less than half-time basis.

(2) *VIOMPSP*. For the purposes of the VIOMPSP, part-time student means an individual who has been accepted for enrollment or enrolled for study leading to a degree on a less than full-time basis but no less than half-time basis.

Participant or scholarship program participant means an individual whose application to the HPSP or VIOMPSP has been approved, whose acceptance agreement has been consummated by VA, and who has yet to complete the period of obligated service or otherwise satisfy the obligation or financial liabilities of such agreement.

Required fees means those fees which are charged by the school to all students pursuing a similar curriculum in the same school.

Scholarship Program means the VA Health Professional Scholarship Program (HPSP) authorized by 38 U.S.C. 7601 through 7619.

School means an academic institution that is accredited by a body or bodies recognized for accreditation by the U.S. Department of Education or by the Council for Higher Education Accreditation (CHEA), and that meets the following requirements:

(1) For the purposes of the HPSP, offers a course of study leading to a degree in a health care service discipline needed by VA.

(2) For the purposes of the VIOMPSP, offers a course of study leading to a degree in visual impairment or orientation and mobility.

School year means for purposes of the HPSP and its stipend payment, and the VIOMPSP, all or part of the 12-month period that starts on the date the participant begins school as a full-time student.

Secretary means the Secretary of Veterans Affairs or designee.

State means one of the several States, Territories and possessions of the United States, the District of Columbia and the Commonwealth of Puerto Rico.

Under Secretary for Health means the Under Secretary for Health of the Department of Veterans Affairs or designee.

VA means the Department of Veterans Affairs.

VA employee means an individual permanently employed by VA. A VA employee does not include an individual who is employed temporarily or on a contractual basis.

VA health care facility means a VA medical center, independent outpatient clinic, domiciliary, nursing home (community living center), residential treatment program, and any of a variety of community based clinics (including community based outpatient clinics, rural health resource centers, primary care telehealth clinics, and Vet Centers), consolidated mail outpatient pharmacies, and research centers.

VIOMPSP means the Visual Impairment and Orientation and Mobility Professional Scholarship Program authorized by 38 U.S.C. 7501 through 7505.

(Authority: 38 U.S.C. 301, 7501(a)(1), 7504, 7602(a), 7604(1)(B), 7633)

[78 FR 51069, Aug. 20, 2013]

§ 17.602 Eligibility.

(a) To be eligible for a scholarship under this program an applicant must—

(1) Be unconditionally accepted for enrollment or be enrolled as a full-time student in an accredited school located in a State;

(2) Be pursuing a degree annually designated by the Secretary for participation in the Scholarship Program;

(Authority: 38 U.S.C. 7602(a)(1), 7612(b)(1))

(3) Be in a discipline or program annually designated by the Secretary for participation in the Scholarship Program;

(4) Be a citizen of the United States; and

(5) Submit an application to participate in the Scholarship Program together with a signed contract.

(6) *Clinical tours.* An applicant for a scholarship under the HPSP must agree to perform clinical tours while enrolled in the course of education or training for which the scholarship is provided. VA will determine the assignments and locations of the clinical tour.

(Authority: 38 U.S.C. 7618(b))

(b) To be eligible for a scholarship as a part-time student under this program, an applicant must satisfy requirements of paragraph (a) of this section and in addition must—

(1) Be a full-time VA employee permanently assigned to a VA health care facility at the time of application and on the date when the scholarship is awarded;

(2) Remain a VA employee for the duration of the scholarship award.

(Authority: 38 U.S.C. 7612(c)(3)(B))

(c) Any applicant who, at the time of application, owes a service obligation to any other entity to perform service after completion of the course of study is ineligible to receive a scholarship under the Department of Veterans Affairs Scholarship Program.

(Authority: 38 U.S.C. 7602(b))

(Approved by the Office of Management and Budget under control number 2900–0352)

[47 FR 10810, Mar. 12, 1982, as amended at 48 FR 37399, Aug. 18, 1983; 54 FR 28674, July 7, 1989; 78 FR 51070, Aug. 20, 2013]

§ 17.603 Availability of HPSP scholarships.

(a) *General.* A HPSP scholarship will be awarded only when necessary to assist VA in alleviating shortages or anticipated shortages of personnel in the health professions stated in paragraph (b) of this section. VA will determine the existence of shortage of personnel in accordance with specific criteria for each health care profession. VA has the authority to establish the number of scholarships to be awarded in a fiscal year, and the number that will be awarded to full-time and part-time students.

(b) *Qualifying fields of education.* VA will grant HPSP scholarships in a course of study in those disciplines or programs where recruitment is necessary for the improvement of health care of veterans. Those disciplines or programs are listed in 38 U.S.C. 7401(1) and (3).

(Authority: 38 U.S.C. 7401(1), (3), 7612(b)(2), 7612(b)(4), and 7603(b)(1))

[78 FR 51070, Aug. 20, 2013]

§ 17.604 Application for the HPSP.

An applicant for the HPSP must submit an accurate and complete application, including a signed written acceptance agreement.

(Authority: 38 U.S.C. 7612(c)(1)(B))

(The Office of Management and Budget has approved the information collection requirements in this section under control number 2900–0793.)

[78 FR 51070, Aug. 20, 2013]

§ 17.605 Selection of participants.

(a) *General.* In deciding which HPSP application to approve, VA will first consider applications submitted by applicants entering their final year of education or training and applicants who previously received HPSP scholarships and who meet the conditions of paragraph (f) of this section. Except for paragraph (f) of this section, applicants will be evaluated and selected using the criteria specified in paragraph (b) of this section. If there are a larger number of equally qualified applicants than there are awards to be made, then VA will first select veterans, and then use a random method as the basis for further selection. In selecting participants to receive awards as part-time students, VA may, at VA's discretion—

(Authority: 38 U.S.C. 7612(b)(5))

(1) Award scholarships geographically to part-time students so that available scholarships may be distributed on a relatively equal basis to students working throughout the VA health care system, and/or

(2) Award scholarships on the basis of retention needs within the VA health care system.

(Authority: 38 U.S.C. 7603(d))

(b) *Selection.* In evaluating and selecting participants, the Secretary will take into consideration those factors determined necessary to assure effective participation in the Scholarship Program. The factors may include, but not be limited to—

(1) Work/volunteer experience, including prior health care employment and Department of Veterans Affairs employment;

(2) Faculty and employer recommendations;

(3) Academic performance; and

(4) Career goals.

(Authority: 38 U.S.C. 7633)

(c) *Selection of part-time students.* Factors in addition to those specified in paragraph (b) of this section, which may be considered in awarding scholarships to part-time students may include, but are not limited to:

(1) Length of service of a VA employee in a health care facility;

(2) Honors and awards received from VA, and other sources;

(3) VA work performance evaluation;

(4) A recommendation for selection for a part-time scholarship from a VA Medical District.

(Authority: 38 U.S.C. 7452(d)(1))

(d) *Notification of approval.* VA will notify the individual in writing that his or her application has been accepted and approved. An individual becomes a participant in the program upon receipt of such approval by VA.

(e) *Duration of scholarship award.* Subject to the availability of funds for the Scholarship Program, the Secretary will award a participant a full-time scholarship under these regulations for a period of from 1 to 4 school years and a participant of a part-time scholarship for a period of 1 to 6 school years.

(Authority: 38 U.S.C. 7612(c)(1)(A) and 7614(3))

(f) *Continuation awards.* Subject to the availability of funds for the Scholarship Program and selection, the Secretary will award a continuation scholarship for completion of the degree for which the scholarship was awarded if—

(1) The award will not extend the total period of Scholarship Program support beyond 4 years for a full-time scholarship, and beyond 6 years for a part-time scholarship; and

(2) The participant remains eligible for continued participation in the Scholarship Program.

(Authority: 38 U.S.C. 7603(d))

(Approved by the Office of Management and Budget under control number 2900–0352)

[48 FR 37399, Aug. 18, 1983, as amended at 54 FR 28674, July 7, 1989; 78 FR 51070, Aug. 20, 2013]

§ 17.606 Award procedures.

(a) *Amount of scholarship.* (1) A scholarship award will consist of (i) tuition and required fees, (ii) other educational expenses, including books and laboratory equipment, and (iii) except as provided in paragraph (a)(2) of this section, a monthly stipend, for the duration of the scholarship award. All such payments to scholarship participants are exempt from Federal taxation.

(Authority: 38 U.S.C. 7636)

(2) No stipend may be paid to a participant who is a full-time VA employee.

(3) The Secretary may determine the amount of the stipend paid to participants, whether part-time students or full-time students, but that amount may not exceed the maximum amount provided for in 38 U.S.C. 7613(b).

(4) In the case of a part-time student who is a part-time employee, the maximum stipend, if more than a nominal stipend is paid, will be reduced in accordance with the proportion that the number of credit hours carried by such participant bears to the number of credit hours required to be carried by a full-time student in the course of training being pursued by the participant.

(5) A full stipend may be paid only for the months the part-time student is attending classes.

(Authority: 38 U.S.C. 7614(2))

(6) The Secretary may make arrangements with the school in which the participant is enrolled for the direct payment of the amount of tuition and/or reasonable educational expenses on the participant's behalf.

(Authority: 38 U.S.C. 7613(c))

(7) A participant's eligibility for a stipend ends at the close of the month in which degree requirements are met.

(b) *Leave-of-absence, repeated course work.* The Secretary may suspend scholarship payments to or on behalf of a participant if the school (1) approves a leave-of-absence for the participant for health, personal, or other reasons, or (2) requires the participant to repeat course work for which the Secretary previously has made payments under the Scholarship Program. Additional costs relating to the repeated course work will not be paid under this program. Any scholarship payments suspended under this section will be resumed by the Secretary upon notification by the school that the participant has returned from the leave-of-absense or has satisfactorily completed the repeated course work and is proceeding

as a full-time student in the course of study for which the scholarship was awarded.

(Authority: 38 U.S.C. 7633)

[48 FR 37400, Aug. 18, 1983, as amended at 55 FR 40170, Oct. 2, 1990]

§ 17.607 Obligated service.

(a) *General*. Except as provided in paragraph (d) of this section, each participant is obligated to provide service as a Department of Veterans Affairs employee in full-time clinical practice in the participant's discipline in an assignment or location determined by the Secretary.

(Authority: 38 U.S.C. 7616(a))

(b) *Beginning of service*. (1)(i) *Date of employment*. Except as provided in paragraph (b)(2) of this section, a participant's obligated service will begin on the date VA appoints the participant as a full-time VA employee in a clinical occupation for which the degree prepared the participant. VA will appoint the participant to such position as soon as possible, but no later than 90 days after the date that the participant receives his or her degree, or the date the participant becomes licensed in a State or becomes certified, whichever is later. VA will actively assist and monitor participants to ensure State licenses or certificates are obtained in a minimal amount of time following graduation. If a participant fails to obtain his or her degree, or fails to become licensed in a State or become certified no later than 180 days after receiving the degree, the participant is considered to be in breach of the acceptance agreement.

(ii) *Notification*. VA will notify the participant of the work assignment and its location no later than 60 days before the date on which the participant must begin work.

(iii) *VA mentor*. VA will ensure that the participant is assigned a mentor who is employed at the same facility where the participant performs his or her obligated service at the commencement of such service.

(2) Obligated service shall begin on the degree completion date for a participant who, on that date, is a full-time VA employee working in a capacity for which the degree program prepared the participant.

(Authority: 38 U.S.C. 7616(b), 7616(c), 7618(a))

(c) *Duration of service*—(1) *Full-time student*. A participant who attended school as a full-time student will agree to serve as a full-time clinical employee in the Veterans Health Administration for 1 calendar year for each school year or part thereof for which a scholarship was awarded, but for no less than 2 years.

(2) *Part-time student*. Obligated service to VA for a participant who attended school as a part-time student must be satisfied by full-time clinical employment. The period of obligated service will be reduced from that which a full-time student must serve under paragraph (c)(1) of this section in accordance with the proportion that the number of credit hours carried by the part-time student in any school year bears to the number of credit hours required to be carried by a full-time student who is pursuing the same degree; however, the period of obligated service will not be for less than 1 year.

(Authority: 38 U.S.C. 7612(c)(1)(B), 7612(c)(3)(A), 7618(c))

(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]

§ 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, Sept. 12, 2014]

§ 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, Sept. 12, 2014]

§ 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:

$$A = 3\Phi \left(\frac{t-s}{t}\right)$$

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.

The amount which the United States is entitled to recover shall be paid within 1 year of the date on which the applicant failed to begin or complete the period of obligated service, as determined by the Secretary.

(Authority: 38 U.S.C. 7617(c)(1)(2))

(Approved by the Office of Management and Budget under control number 2900–0352)

[47 FR 10810, Mar. 12, 1982; 47 FR 13523, Mar. 31, 1982, as amended at 48 FR 37400, Aug. 18, 1983; 54 FR 28676, July 7, 1989; 54 FR 46611, Nov. 6, 1989; 61 FR 24237, May 14, 1996]

§ 17.611 Bankruptcy.

Any payment obligation incurred may not be discharged in bankruptcy under title 11 U.S.C. until 5 years after

the date on which the payment obligation is due. This section applies to participants in the HPSP and the VIOMPSP.

(Authority: 38 U.S.C. 7505(d), 7634(c))

[78 FR 51071, Aug. 20, 2013]

§ 17.612 Cancellation, waiver, or suspension of obligation.

(a) *General.* (1) This section applies to participants in the HPSP or the VIOMPSP.

(2) Any obligation of a participant for service or payment will be cancelled upon the death of the participant.

(Authority: 38 U.S.C. 7634(a))

(b) *Waivers or suspensions.* (1) A participant may seek a waiver or suspension of the obligated service or payment obligation incurred under this program by submitting a written request to VA setting forth the basis, circumstances, and causes which support the requested action. Requests for waivers or suspensions must be submitted to VA no later than 1 year after the date VA notifies the participant that he or she is in breach of his or her acceptance agreement. A participant seeking a waiver or suspension must comply with requests for additional information from VA no later than 30 days after the date of any such request.

(i) *Waivers.* A waiver is a permanent release by VA of the obligation either to repay any scholarship funds that have already been paid to or on behalf of the participant, or to fulfill any other acceptance agreement requirement. If a waiver is granted, then the waived amount of scholarship funds may be considered taxable income.

(ii) *Suspensions.* VA may approve an initial request for a suspension for a period of up to 1 year. A suspension may be extended for one additional year, after which time the participant will be in breach of his or her acceptance agreement. If a suspension is approved:

(A) VA will temporarily discontinue providing any scholarship funds to or on behalf of the participant while the participant's scholarship is in a suspended status; or

(B) VA will temporarily delay the enforcement of acceptance agreement requirements.

(2) The Secretary may waive or suspend any service or payment obligation incurred by a participant whenever compliance by the participant (i) is impossible, due to circumstances beyond the control of the participant or (ii) whenever the Secretary concludes that a waiver or suspension of compliance would be in the best interest of the Department of Veterans Affairs.

(Authority: 38 U.S.C. 7634(b))

(c) Compliance by a participant with a service or payment obligation will be considered impossible due to circumstances beyond the control of the participant if the Secretary determines, on the basis of such information and documentation as may be required, that the participant suffers from a physical or mental disability resulting in permanent inability to perform the service or other activities which would be necessary to comply with the obligation.

(d) Waivers or suspensions of service or payment obligations, when not related to paragraph (c) of this section, and when considered in the best interest of the Department of Veterans Affairs, will be determined by the Secretary on an individual basis.

(e) *Eligibility to reapply for award.* Any previous participant of any federally sponsored scholarship program who breached his or her acceptance agreement or similar agreement in such scholarship program is not eligible to apply for a HPSP or VIOMPSP. This includes participants who previously applied for, and received, a waiver under this section.

(f) *Finality of decisions.* Decisions to approve or disapprove waiver requests are final and binding determinations. Such determinations are not subject to reconsideration or appeal.

(Authority: 38 U.S.C. 7505(c), 7634(a), 7634(b))

[47 FR 10810, Mar. 12, 1982, as amended at 78 FR 51071, Aug. 20, 2013]

VISUAL IMPAIRMENT AND ORIENTATION AND MOBILITY PROFESSIONAL SCHOLARSHIP PROGRAM

SOURCE: Sections 17.625 through 17.636 appear at 78 FR 51071, Aug. 20, 2013, unless otherwise noted.

§ 17.625 Purpose.

The purpose of §§ 17.625 through 17.636 is to establish the requirements for the award of scholarships under the Visual Impairment and Orientation and Mobility Professional Scholarship Program (VIOMPSP) to students pursuing a program of study leading to a degree in visual impairment or orientation and mobility. The scholarship is designed to increase the supply of qualified Blind Rehabilitation Specialists and Blind Rehabilitation Outpatient Specialists available to VA. The scholarship will be publicized throughout educational institutions in the United States, with an emphasis on disseminating information to such institutions with high numbers of Hispanic students and to historically black colleges and universities.

(Authority: 38 U.S.C. 7501)

§ 17.626 Definitions.

For the definitions that apply to §§ 17.625 through 17.636, see § 17.601.

(Authority: 38 U.S.C. 501)

§ 17.627 Eligibility for the VIOMPSP.

(a) *General.* To be eligible for the VIOMPSP, an applicant must meet the following requirements:

(1) Be unconditionally accepted for enrollment or currently enrolled in a program of study leading to a degree in orientation and mobility, low vision therapy, or vision rehabilitation therapy, or a dual degree (a program in which an individual becomes certified in two of the three professional certifications offered by the Academy for Certification of Visual Rehabilitation and Education Professionals) at an accredited educational institution that is in a State;

(2) Be a citizen of the United States; and

(3) Submit an application to participate in the VIOMPSP, as described in § 17.629.

(b) *Obligated service to another entity.* Any applicant who, at the time of application, owes a service obligation to any other entity to perform service after completion of the course of study is ineligible to receive a VIOMPSP scholarship.

(Authority: 38 U.S.C. 7501(a), 7502(a), 7504(3))

§ 17.628 Availability of VIOMPSP scholarships.

VA will make awards under the VIOMPSP only when VA determines it is necessary to assist in alleviating shortages or anticipated shortages of personnel in visual impairment or orientation and mobility programs. VA's determination of the number of VIOMPSP scholarships to be awarded in a fiscal year, and the number that will be awarded to full-time and/or part-time students, is subject to the availability of appropriations.

(Authority: 38 U.S.C. 7501(a), 7503(c)(2))

§ 17.629 Application for the VIOMPSP.

(a) *Application-general.* Each individual desiring a VIOMPSP scholarship must submit an accurate and complete application, including a signed written acceptance agreement.

(b) *VA's duties.* VA will notify applicants prior to acceptance in the VIOMPSP of the following information:

(1) A fair summary of the rights and liabilities of an individual whose application is approved by VA and whose acceptance agreement is consummated by VA; and

(2) Full description of the terms and conditions that apply to participation in the VIOMPSP and service in VA.

(Authority: 38 U.S.C. 501(a), 7502(a)(2))

(The Office of Management and Budget has approved the information collection requirements in this section under control number 2900–0793.)

§ 17.630 Selection of VIOMPSP participants.

(a) *General.* In deciding which VIOMPSP applications to approve, VA will first consider applications submitted by applicants entering their final year of education or training. Applicants will be evaluated and selected

using the criteria specified in paragraph (b) of this section. If there are a larger number of equally qualified applicants than there are awards to be made, then VA will first select veterans, and then use a random method as the basis for further selection.

(b) *Selection criteria*. In evaluating and selecting participants, VA will take into consideration those factors determined necessary to assure effective participation in the VIOMPSP. These factors will include, but are not limited to, the following:

(1) Academic performance;

(2) Work/volunteer experience, including prior rehabilitation or health care employment and VA employment;

(3) Faculty and employer recommendations; or

(4) Career goals.

(c) *Notification of approval*. VA will notify the individual in writing that his or her application has been accepted and approved. An individual becomes a participant in the program upon receipt of such approval by VA.

(d) *Duration of VIOMPSP award*. VA will award a VIOMPSP scholarship for a period of time equal to the number of years required to complete a program of study leading to a degree in orientation and mobility, low vision therapy, or vision rehabilitation therapy, or a dual degree. The number of years covered by an individual scholarship award will be based on the number of school years that the participant has yet to complete his or her degree at the time the VIOMPSP scholarship is awarded. Subject to the availability of funds, VA will award the VIOMPSP as follows:

(1) *Full-time scholarship*. A full-time scholarship is awarded for a minimum of 1 school year to a maximum of 4 school years;

(2) *Part-time scholarships*. A part-time scholarship is awarded for a minimum of 1 school year to a maximum of 6 school years.

(Authority: 38 U.S.C. 7504(3))

§ 17.631 Award procedures.

(a) *Amount of scholarship*. (1) A VIOMPSP scholarship award will not exceed the total tuition and required fees for the program of study in which the applicant is enrolled. All such payments to scholarship participants are exempt from Federal taxation.

(2) The total amount of assistance provided under the VIOMPSP for an academic year to an individual who is a full-time student may not exceed $15,000.00.

(3) The total amount of assistance provided under the VIOMPSP for an academic year to a participant who is a part-time student shall bear the same ratio to the amount that would be paid under paragraph (a)(2) of this section if the participant were a full-time student as the coursework carried by the participant to full-time coursework.

(4) The total amount of assistance provided to an individual may not exceed $45,000.00.

(5) In the case of an individual enrolled in a program of study leading to a dual degree described in § 17.627(a)(1), such tuition and fees will not exceed the amounts necessary for the minimum number of credit hours to achieve such dual degree.

(6) Financial assistance may be provided to an individual under the VIOMPSP to supplement other educational assistance to the extent that the total amount of educational assistance received by the individual during an academic year does not exceed the total tuition and fees for such academic year.

(7) VA will make arrangements with the school in which the participant is enrolled to issue direct payment for the amount of tuition or fees on behalf of the participant.

(b) *Repeated course work*. Additional costs relating to the repeated course work will not be paid under this program. VA will resume any scholarship payments suspended under this section upon notification by the school that the participant has returned from the leave-of-absence or has satisfactorily completed the repeated course work and is pursuing the course of study for which the VIOMPSP was awarded.

(Authority: 38 U.S.C. 7503, 7504(3))

§ 17.632 Obligated service.

(a) *General provision*. Except as provided in paragraph (d) of this section, each participant is obligated to provide service as a full-time clinical VA employee in the rehabilitation practice of

the participant's discipline in an assignment or location determined by VA.

(b) *Beginning of service.* A participant's obligated service will begin on the date on which the participant obtains any required applicable credentials and when appointed as a full-time clinical VA employee in a position for which the degree prepared the participant. VA will appoint the participant to such position as soon as possible, but no later than 90 days after the date that the participant receives his or her degree, or the date the participant obtains any required applicable credentials, whichever is later. If a participant fails to obtain his or her degree, or fails to obtain any required applicable credentials within 180 days after receiving the degree, the participant is considered to be in breach of the acceptance agreement.

(c) *Duration of service.* The participant will agree to serve as a full-time clinical VA employee for 3 calendar years which must be completed no later than 6 years after the participant has completed the program for which the scholarship was awarded and received a degree referenced in § 17.627(a)(1).

(d) *Location and assignment of obligated service.* VA reserves the right to make final decisions on the location and assignment of the obligated service. A participant who receives a scholarship must agree as part of the participant's mobility agreement that he or she is willing to accept the location and assignment where VA assigns the obligated service. Geographic relocation may be required.

(e) *Creditability of advanced clinical training.* No period of advanced clinical training will be credited towards satisfying the period of obligated service incurred under the VIOMPSP.

(Authority: 38 U.S.C. 7504(2)(D), 7504(3))

§ 17.633 Deferment of obligated service.

Deferment of obligated service under the VIOMPSP is treated in the same manner as deferment of obligated service under the HPSP under § 17.608.

(Authority: 38 U.S.C. 7504(3))

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

(a) *Participant refuses to accept payment of the VIOMPSP.* If a participant, other than one described in paragraph (b) of this section, refuses to accept payment or instructs the school not to accept payment of the VIOMPSP scholarship provided by VA, the participant must, in addition to any obligation incurred under the agreement, pay to the United States the amount of $1,500 in liquidated damages. Payment of this amount must be made no later than 90 days from the date that the participant fails to accept payment of the VIOMPSP or instructs the school not to accept payment.

(b) *Participant fails to complete course of study or does not obtain certification.* A participant described in paragraphs (b)(1) through (4) of this section must, instead of otherwise fulfilling the terms of his or her acceptance agreement, pay to the United States an amount equal to all VIOMPSP funds awarded under the acceptance agreement. Payment of this amount must be made no later than 1 year after the date that the participant meets any of the criteria described in paragraphs (b)(1) through (4) of this section, unless VA determines that a longer period is necessary to avoid hardship. No interest will be charged on any part of this indebtedness. A participant will pay such amount if one of the following criteria is met:

(1) The participant fails to maintain an acceptable level of academic standing;

(2) The participant is dismissed from the school for disciplinary reasons;

(3) The participant, for any reason, voluntarily terminates the course of study or program for which the scholarship was awarded including a reduction of course load from full-time to part-time before completing the course of study or program; or

(4) The participant fails to become certified in the discipline for which the degree prepared the participant, if applicable, no later than 180 days after the date such person becomes eligible to apply for certification.

(c) *Participant fails to perform all or any part of their service obligation.* (1)

Participants who breach their agreements by failing to begin or complete their service obligation, for any reason, including the loss, revocation, suspension, restriction, or limitation of required certification, and other than provided for under paragraph (b) of this section, must repay the portion of all VIOMPSP funds paid to or on behalf of the participant, adjusted for the service that they provided. To calculate the unearned portion of VIOMPSP funds, subtract the number of months of obligated service rendered from the total months of obligated service owed, divide the remaining months by the total obligated service, then multiply by the total amount of VIOMPSP funds paid to or on behalf of the participant. The following formula may be used in determining the unearned portion:

A = P((t-s)/t) in which

"A" is the amount the United States is entitled to recover;

"P" is the amounts paid under the VIOMPSP, to or on behalf of the participant;

"t" is the total number of months in the participant's period of obligated service; and

"s" is the number of months of obligated service rendered.

(2) The amount that the United States is entitled to recover will be paid no later than 1 year after the date the applicant failed to begin or complete the period of obligated service, as determined by VA.

(Authority: 38 U.S.C. 7505(a), 7505(b))

§ 17.635 Bankruptcy.

Bankruptcy under the VIOMPSP is treated in the same manner as bankruptcy for the HPSP under § 17.611.

(Authority: 38 U.S.C. 7505(c), 7505(d))

§ 17.636 Cancellation, waiver, or suspension of obligation.

Cancellation, waiver, or suspension procedures under the VIOMPSP are the same as those procedures for the HPSP under § 17.612.

(Authority: 38 U.S.C. 7505(c))

PROGRAM FOR REPAYMENT OF EDUCATIONAL LOANS FOR CERTAIN VA PSYCHIATRISTS

SOURCE: 81 FR 66820, Sept. 29, 2016, unless otherwise noted.

§ 17.640 Purpose.

The purpose of §§ 17.640 through 17.647 is to establish the requirements for the program for the repayment of educational loans (PREL) obtained by physician residents pursuing a certification in psychiatry.

§ 17.641 Definitions.

The following definitions apply to §§ 17.640 through 17.647.

Acceptance of conditions means a signed document between VA and a participant of the PREL, in which the participant must agree to a period of obligated service, to maintain an acceptable level of performance determined by supervisory review in the position to which VA appoints the participant, to terms and amount of payment, and to relocate, if required, to a location determined by VA at the participant's expense in exchange for educational loan repayments under the PREL. VA will provide a list of available locations for the period of obligated service in the acceptance of conditions. The applicant will choose the preferred location, in ranking order, for the completion of his or her obligated service from the locations on this list. However, VA will ultimately make the final determination as to where the applicant will perform his or her period of obligated service. A participant of the PREL must agree that he or she is willing to accept the location and position to which VA appoints the participant.

Educational loan means a loan, government or commercial, made for educational purposes by institutions that are subject to examination and supervision in their capacity as lending institutions by an agency of the United States or of the state in which the lender has its principal place of business. Loans must be for the actual costs paid for tuition, and other reasonable educational expenses such as living expenses, fees, books, supplies, educational equipment and materials,

and laboratory expenses. Loans must be obtained from a government entity, a private financial institution, a school, or any other authorized entity stated in this definition. The following loans do not qualify for the PREL:

(1) Loans obtained from family members, relatives, or friends;

(2) Loans made prior to, or after, the individual's qualifying education;

(3) Any portion of a consolidated loan that is not specifically identified with the education and purposes for which the PREL may be authorized, such as home or auto loans merged with educational loans;

(4) Loans for which an individual incurred a service obligation for repayment or agreed to service for future cancellation;

(5) Credit card debt;

(6) Parent Plus Loans;

(7) Loans that have been paid in full;

(8) Loans that are in default, delinquent, not in a current payment status, or have been assumed by a collection agency;

(9) Loans not obtained from a bank, credit union, savings and loan association, not-for-profit organization, insurance company, school, and other financial or credit institution which is subject to examination and supervision in its capacity as a lending institution by an agency of the United States or of the state in which the lender has its principal place of business;

(10) Loans for which supporting documentation is not available;

(11) Loans that have been consolidated with loans of other individuals, such as spouses, children, friends, or other family member; or

(12) Home equity loans or other non-educational loans.

PREL means the program for the repayment of educational loans for certain VA psychiatrists established in §§ 17.640 through 17.647.

§ 17.642 Eligibility.

(a) *General.* To be eligible for the PREL, an applicant must meet all of the following requirements:

(1) Be a U.S. citizen or permanent resident.

(2) Be enrolled in the final year of a post-graduate physician residency program leading to either a specialty qualification in psychiatric medicine or a subspecialty qualification of psychiatry (the program must be accredited by the Accreditation Council for Graduate Medical Education or the American Osteopathic Association, and, by the time of VA employment, must:

(i) Have completed all psychiatry residency training;

(ii) Have received a completion certificate from the Program Director confirming successful completion of the residency program; and

(iii) Certify intention to apply for board certification in the specialty of psychiatry (through the American Board of Medical Specialties or the American Osteopathic Association) within two years after completion of residency.

(3) Be licensed or eligible for licensure to practice medicine by meeting the following requirements by the time of VA employment:

(i) Have at least one full, active, current, and unrestricted license that authorizes the licensee to practice in any State, Territory, or possession of the United States, the District of Columbia, or the Commonwealth of Puerto Rico;

(ii) Document graduation from a school of medicine accredited by the Liaison Committee on Medical Education or the American Osteopathic Association; or, if an international medical graduate, verify that requirements for certification by the Educational Commission for Foreign Medical Graduates have been met.

(b) Simultaneous participation in another repayment program. Any applicant who, at the time of application, is participating in any other program of the Federal Government that repays the educational loans of the applicant is not eligible to participate in the PREL.

§ 17.643 Application for the PREL.

(a) *General.* A complete application for the PREL consists of a completed application form, letters of reference, and personal statement.

(b) *References*. The applicant must provide the following letters of reference and sign a release of information form for VA to contact such references. The letters of reference should include the following:

(1) One letter of reference from the Program Director of the core psychiatry program in which the applicant trained or is training, or the Program Director of any psychiatry subspecialty program in which the applicant is training, which indicates that the applicant is in good to excellent standing;

(2) One or more letters of reference from faculty members under which the applicant trained;

(3) One letter of reference from a peer colleague who is familiar with the psychiatry practice and character of the applicant.

(c) *Personal statement*. The personal statement must include the following documentation:

(1) A cover letter that provides the following information:

(i) Why the applicant is interested in VA employment;

(ii) The applicant's interest in working at a particular VA medical facility;

(iii) Likely career goals, including career goals in VA; and

(iv) A brief summary of past employment or training and accomplishments, including any particular clinical areas of interest (*e.g.*, substance abuse).

(2) The following information must be provided on a VA form or online collection system and is subject to VA verification:

(i) Attestation that the applicant is not participating in any other loan repayment program.

(ii) A summary of the applicant's educational debt, which includes the total debt amount and when the debt was acquired. The health professional debt covered the loan must be specific to education that was required, used, and qualified the applicant for appointment as a psychiatrist.

(iii) The name of the lending agency that provided the educational loan.

(3) A full curriculum vitae.

[81 FR 66820, Sept. 29, 2016, as amended at 82 FR 4795, Jan. 17, 2017]

EFFECTIVE DATE NOTE: At 81 FR 66820, Sept. 29, 2016, § 17.643 was added. This section contains information collection and recordkeeping requirements and will not become effective until approval has been given by the Office of Management and Budget.

§ 17.644 Selection of participants.

(a) *Selection criteria*. In evaluating and selecting participants, VA will consider the following factors:

(1) The applicant meets all of the eligibility criteria in § 17.642 and has submitted a complete application under § 17.643;

(2) The strength of the applicant's letters of reference;

(3) The applicant is in good to excellent standing in the residency program, as determined from the Program Director letter of reference;

(4) The applicant demonstrates a strong commitment to VA's mission and core values;

(5) The applicant has personal career goals that match VA needs (*i.e.*, to work with patients suffering from traumatic brain injury, substance abuse, or post-traumatic stress disorder);

(6) The applicant's expresses a desire to work at a location that matches with VA needs; and

(7) The applicant does not have any identifiable circumstances relating to education, training, licensure, certification and review of health status, previous experience, clinical privileges, professional references, malpractice history and adverse actions, or criminal violations that would adversely affect the applicant's credentialing process.

(b) *Selection*. VA will select not less than 10 individuals who meet the requirements of this section to participate in the program for the repayment of educational loans for each year in which VA carries out the program.

(c) *Notification of selection*. VA will notify applicants that they have been selected in writing. An individual becomes a participant in the PREL once the participant submits and VA signs the acceptance of conditions.

[81 FR 66820, Sept. 29, 2016, as amended at 82 FR 4796, Jan. 17, 2017]

§ 17.645 Award procedures.

(a) *Repayment amount.* (1) VA may pay not more than $30,000 in educational loan repayment for each year of obligated service.

(2) An educational loan repayment may not exceed the actual amount of principal and interest on an educational loan or loans.

(b) *Payment.* VA will pay the participant, or the lending institution on behalf of the participant, directly for the principal and interest on the participant's educational loans. Payments will be made monthly or annually for each applicable service period, depending on the terms of the acceptance of conditions. Participants must provide VA documentation that shows the amounts that were credited or posted by the lending institution to a participant's educational loan during an obligated service period. VA will issue payments after the participant commences the period of obligated service. Payments are exempt from Federal taxation.

§ 17.646 Obligated service.

(a) *General provision.* A participant's obligated service will begin on the date on which the participant begins full-time, permanent employment with VA in the field of psychiatric medicine in a location determined by VA. Obligated service must be full-time, permanent employment and does not include any period of temporary or contractual employment.

(b) *Duration of service.* The participant will agree in the acceptance of conditions to serve for an obligated service period of 2 or more calendar years.

(c) *Location and position of obligated service.* VA reserves the right to make final decisions on the location and position of the obligated service.

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

(a) *Participant fails to satisfy obligated service.* A participant of the PREL who fails to satisfy the period of obligated service will be liable to the United States, in lieu of such obligated service, for the full amount of benefit they expected to receive in the agreement, pro-rated for completed service days.

(b) *Repayment period.* The participant will pay the amount of damages that the United States is entitled to recover under this section in full to the United States no later than 1 year after the date of the breach of the agreement.

CHAPLAIN SERVICES

§ 17.655 Ecclesiastical endorsing organizations.

(a) *Purpose.* This section establishes the eligibility requirements that an ecclesiastical endorsing organization must meet in order to provide ecclesiastical endorsements of individuals who are seeking employment as VA chaplains or seeking to be engaged by VA under contract or appointed as on-facility fee basis VA chaplains under 38 U.S.C. 7405. Acceptance of an ecclesiastical endorsement by VA does not imply any approval by VA of the theology or practices of an ecclesiastical endorsing organization, nor does it obligate VA to employ the endorsed individual or any other member of the organization.

(b) *Definitions.* The following definitions apply to this section:

(1) *Ecclesiastical endorsement* means a written statement addressed to VA and signed by the designated endorsing official of an ecclesiastical endorsing organization certifying that an individual is in good standing with the faith group or denomination and, in the opinion of the endorsing official, is qualified to perform the full range of ministry, including all sacraments, rites, ordinances, rituals, and liturgies required by members of the faith group. Ecclesiastical endorsement is a condition of employment as a VA chaplain. An individual must obtain and maintain a full and active ecclesiastical endorsement to be employed as a VA chaplain.

(2) *Ecclesiastical endorsing official* means an individual who is authorized to provide or withdraw ecclesiastical endorsements on behalf of an ecclesiastical endorsing organization.

(3) *Ecclesiastical endorsing organization* means an organization that meets the eligibility requirements of paragraph

(c) of this section and has been properly designated as an endorsing organization in accordance with paragraph (e) of this section.

(c) *Eligibility to serve as an ecclesiastical endorsing organization*. An ecclesiastical endorsing organization must meet the following requirements before such organization can endorse an applicant for VA chaplaincy:

(1) Be organized and function exclusively or substantially to provide religious ministries to a lay constituency and possess authority to both grant and withdraw initial and subsequent ecclesiastical endorsements;

(2) Have tax-exempt status as a religious organization or church under the Internal Revenue Code, section 501(c)(3);

(3) Agree to abide by all Federal and VA laws, regulations, policies, and issuances on the qualification and endorsement of persons for service as VA chaplains;

(4) Agree to notify VA in writing of any withdrawal of an existing ecclesiastical endorsement within ten days after the date of such withdrawal;

(5) Provide VA the documents stated in paragraph (d) of this section;

(6) Notify VA in writing within 30 days of any change of the name, address or contact information of the individual that it designates as its ecclesiastical endorsing official; and

(7) An ecclesiastical endorsing organization that is part of an endorsing organization by which its members can be endorsed cannot become a separate endorsing organization without the written permission of the larger endorsing organization.

(d) *Request to designate ecclesiastical endorser*. In order for an ecclesiastical endorsing organization to be recognized by VA such organization must submit the following:

(1) A complete VA form that requests the designation of an ecclesiastical endorsing official;

(2) A copy of an Internal Revenue Service document verifying that the organization currently holds a section 501(c)(3) exempt status as a church for Federal tax purposes from the Internal Revenue Service (IRS) (note ''church'' is used by the IRS not to denote a belief system, but to distinguish ''churches'' from other types of religious organizations; see IRS Instructions for Form 1023 Schedule A). Such rules stipulate that the particular religious beliefs of the organization are truly and sincerely held and that the practices and rituals associated with the organization's religious belief or creed are not illegal or contrary to clearly defined public policy. In order to determine whether a particular religious organization has properly acquired, and currently maintains, an IRS tax exempt status and does not engage in practices that are illegal or contrary to defined public policy, VA shall take appropriate steps to verify compliance with these requirements;

(3) A document verifying that the organization shall provide chaplains who shall function in a pluralistic environment, and who shall support directly and indirectly the free exercise of religion by all veterans, their family members, and other persons authorized to be served by VA;

(4) That it agrees to abide by all VA Directives, Instructions, and other guidance, regulations and policies on the qualification and endorsement of ministers for service as VA chaplains;

(5) Documentation that states the structure of the organization, including copies of the articles of incorporation, by-laws and constitution, membership requirements of the organization, if any, the religious beliefs and practices of the organization, and the organization's requirements to become clergy; and

(6) The name and address of the individual who is applying to become a VA chaplain.

(e) *Approval of request to designate an ecclesiastical endorsing official*. If an ecclesiastical endorsing organization meets the requirements of paragraph (c) of this section and has submitted the documents stated in paragraph (d) of this section, VA will notify the organization in writing that such organization has been designated as an ecclesiastical endorsing organization. The designation will be for a period of 3 years from the date of notification. Once an organization is designated as an ecclesiastical endorsing organization, VA will accept ecclesiastical endorsements from that organization

without requiring any further documentation from the organization during the 3 year period, unless VA receives evidence that an organization no longer meets the requirements of this section. VA will only take action on an initial request to designate an ecclesiastical endorsing official when VA receives an application from an individual who is seeking employment as a VA chaplain or is seeking to be engaged under VA contract or appointed as on-facility fee basis VA chaplains under 38 U.S.C. 7405.

(f) *Reporting requirement.* (1) To certify that VA chaplains continue to be endorsed by an ecclesiastical endorsing organization, such organization must provide VA an alphabetical listing of individuals who are endorsed by that endorsing organization and are employed as VA chaplains or are engaged by VA under contract or appointed as on-facility fee basis VA chaplains under 38 U.S.C. 7405 by January 1 of every calendar year.

(2) In order for VA to continue to recognize an ecclesiastical endorsing organization, such organization must provide written documentation that it continues to meet the requirements of this section every 3 years.

(g) *Rescission of ecclesiastical endorsing organization.* VA may rescind an organization's status as an ecclesiastical endorsing organization and refuse to accept ecclesiastical endorsements from such organization if it no longer meets the requirements of paragraph (c) of this section. VA will take the following steps before it rescinds the organization's status:

(1) VA will give the ecclesiastical endorsing organization written notice stating the reasons for the rescission and give the organization 60 days to provide a written reply addressing VA's concerns.

(2) VA will notify the ecclesiastical endorsing organization and all VA chaplains endorsed by the organization in writing of its decision after VA reviews the evidence provided by the organization or after the 60 day time period has expired, whichever comes first.

(3) Ecclesiastical endorsing organizations that are notified that they may no longer endorse individuals for VA chaplaincy because they do not meet the requirements of paragraph (c) of this section must resubmit all of the evidence stated in paragraph (d) of this section in order to be reconsidered as an endorsing organization.

(4) If an ecclesiastical endorsing organization is no longer able to endorse individuals for VA chaplaincy in accordance with this section, all ecclesiastical endorsements issued by that organization are considered to be withdrawn.

(The Office of Management and Budget has approved the information collection requirements in this section under control number 2900–0852.)

[82 FR 51772, Nov. 8, 2017]

GRANTS FOR TRANSPORTATION OF VETERANS IN HIGHLY RURAL AREAS

AUTHORITY: Sec. 307, Pub. L. 111–163; 38 U.S.C. 501 and as noted in specific sections.

SOURCE: 78 FR 19593, Apr. 2, 2013, unless otherwise noted.

§ 17.700 Purpose and scope.

This section establishes the Grants for Transportation of Veterans in Highly Rural Areas program. Under this program, the Department of Veterans Affairs (VA) provides grants to eligible entities to assist veterans in highly rural areas through innovative transportation services to travel to VA medical centers, and to otherwise assist in providing transportation services in connection with the provision of VA medical care to these veterans.

(Authority: Sec. 307, Pub. L. 111–163; 38 U.S.C. 501)

§ 17.701 Definitions.

For the purposes of §§ 17.700–17.730 and any Notice of Fund Availability issued pursuant to such sections:

Applicant means an eligible entity that submits an application for a grant announced in a Notice of Fund Availability.

Eligible entity means:

(1) A Veterans Service Organization, or

(2) A State veterans service agency.

Grantee means an applicant that is awarded a grant under this section.

Highly rural area means an area consisting of a county or counties having

a population of less than seven persons per square mile.

Notice of Fund Availability means a Notice of Fund Availability published in the FEDERAL REGISTER in accordance with § 17.710.

Participant means a veteran in a highly rural area who is receiving transportation services from a grantee.

Provision of VA medical care means the provision of hospital or medical services authorized under sections 1710, 1703, and 8153 of title 38, United States Code.

State veterans service agency means the element of a State government that has responsibility for programs and activities of that government relating to veterans benefits.

Subrecipient means an entity that receives grant funds from a grantee to perform work for the grantee in the administration of all or part of the grantee's program.

Transportation services means the direct provision of transportation, or assistance with providing transportation, to travel to VA medical centers and other VA or non-VA facilities in connection with the provision of VA medical care.

Veteran means a person who served in the active military, naval, or air service, and who was discharged or released therefrom under conditions other than dishonorable.

Veterans Service Organization means an organization recognized by the Secretary of Veterans Affairs for the representation of veterans under section 5902 of title 38, United States Code.

(Authority: Sec. 307, Pub. L. 111–163; 38 U.S.C. 501)

§ 17.702 Grants—general.

(a) *One grant per highly rural area.* VA may award one grant per fiscal year to a grantee for each highly rural area in which the grantee provides transportation services. Transportation services may not be simultaneously provided by more than one grantee in any single highly rural area.

(b) *Maximum amount.* Grant amounts will be specified in the Notice of Funding Availability, but no grant will exceed $50,000.

(c) *No matching requirement.* A grantee will not be required to provide matching funds as a condition of receiving such grant.

(d) *Veterans will not be charged.* Transportation services provided to veterans through utilization of a grant will be free of charge.

(Authority: Sec. 307, Pub. L. 111–163; 38 U.S.C. 501)

§ 17.703 Eligibility and application.

(a) *Eligible entity.* The following may be awarded a grant:

(1) A Veterans Service Organization.

(2) A State veterans service agency.

(b) *Initial application.* To apply for an initial grant, an applicant must submit to VA a complete grant application package, as described in the Notice of Fund Availability.

(c) *Renewal application.* Grantees may apply for one renewal grant per fiscal year, after receiving an initial grant, if the grantee's program will remain substantially the same. The grantee must submit to VA a complete renewal application as described in the Notice of Fund Availability.

(d) *Subrecipients.* Grantees may provide grant funds to other entities, if such entities are identified as subrecipients in grant applications to perform work for grantees in the administration of all or part of grantees' programs.

(Authority: Sec. 307, Pub. L. 111–163; 38 U.S.C. 501)

(The Office of Management and Budget has approved the information collection requirement in this section under control number 2900–0790)

§ 17.705 Scoring criteria and selection.

(a) *Initial grant scoring.* Applications will be scored using the following selection criteria:

(1) VA will award up to 40 points based on the program's plan for successful implementation, as demonstrated by the following:

(i) Program scope is defined, and applicant has specifically indicated the mode(s) or method(s) of transportation services to be provided by the applicant or identified subrecipient.

(ii) Program budget is defined, and applicant has indicated that grant funds will be sufficient to completely implement the program.

(iii) Program staffing plan is defined, and applicant has indicated that there will be adequate staffing for delivery of transportation services according to the program's scope.

(iv) Program timeframe for implementation is defined, and applicant has indicated that the delivery of transportation services will be timely.

(2) VA will award up to 30 points based on the program's evaluation plan, as demonstrated by the following:

(i) Measurable goals for determining the success of delivery of transportation services.

(ii) Ongoing assessment of paragraph (a)(2)(i), with a means of adjusting the program as required.

(3) VA will award up to 20 points based on the applicant's community relationships in the areas to receive transportation services, as demonstrated by the following:

(i) Applicant has existing relationships with state or local agencies or private entities, or will develop such relationships, and has shown these relationships will enhance the program's effectiveness.

(ii) Applicant has established past working relationships with state or local agencies or private entities which have provided transportation services similar to those offered by the program.

(4) VA will award up to 10 points based on the innovative aspects of the program, as demonstrated by the following:

(i) How program will identify and serve veterans who otherwise would be unable to obtain VA medical care through conventional transportation resources.

(ii) How program will use new or alternative transportation resources.

(b) *Initial grant selection.* VA will use the following process to award initial grants:

(1) VA will rank those applications that receive at least the minimum amount of total points and points per category set forth in the Notice of Fund Availability. The applications will be ranked in order from highest to lowest scores.

(2) VA will use the applications' ranking as the basis for awarding grants. VA will award grants for the highest ranked applications for which funding is available.

(c) *Renewal grant scoring.* Renewal applications will be scored using the following selection criteria:

(1) VA will award up to 55 points based on the success of the grantee's program, as demonstrated by the following:

(i) Application shows that the grantee or identified subrecipient provided transportation services which allowed participants to be provided medical care timely and as scheduled.

(ii) Application shows that participants were satisfied with the transportation services provided by the grantee or identified subrecipient, as described in the Notice of Fund Availability.

(2) VA will award up to 35 points based on the cost effectiveness of the program, as demonstrated by the following:

(i) The grantee or identified subrecipient administered the program on budget.

(ii) Grant funds were utilized in a sensible manner, as interpreted by information provided by the grantee to VA under § 17.725(a)(1) through (a)(7).

(3) VA will award up to 15 points based on the extent to which the program complied with:

(i) The grant agreement.

(ii) Applicable laws and regulations.

(d) *Renewal grant selection.* VA will use the following process to award renewal grants:

(1) VA will rank those applications that receive at least the minimum amount of total points and points per category set forth in the Notice of Fund Availability. The applications will be ranked in order from highest to lowest scores.

(2) VA will use the applications' ranking as the basis for awarding grants. VA will award grants for the highest ranked applications for which funding is available.

(Authority: Sec. 307, Pub. L. 111–163; 38 U.S.C. 501)

§ 17.710 Notice of Fund Availability.

When funds are available for grants, VA will publish a Notice of Fund Availability in the FEDERAL REGISTER. The notice will identify:

(a) The location for obtaining grant applications;

(b) The date, time, and place for submitting completed grant applications;

(c) The estimated amount and type of grant funding available;

(d) The length of term for the grant award;

(e) The minimum number of total points and points per category that an applicant or grantee must receive in order for a supportive grant to be funded;

(f) The timeframes and manner for payments under the grant; and

(g) Those areas identified by VA to be the ''highly rural areas'' in which grantees may provide transportation services funded under this rule.

(Authority: Sec. 307, Pub. L. 111–163; 38 U.S.C. 501)

§ 17.715 Grant agreements.

(a) *General.* After a grantee is awarded a grant in accordance with § 17.705(b) or § 17.705(d), VA will draft a grant agreement to be executed by VA and the grantee. Upon execution of the grant agreement, VA will obligate the approved amount to the grantee. The grant agreement will provide that:

(1) The grantee must operate the program in accordance with the provisions of this section and the grant application.

(2) If a grantee's application identified a subrecipient, such subrecipient must operate the program in accordance with the provisions of this section and the grant application.

(3) If a grantee's application identified that funds will be used to procure or operate vehicles to directly provide transportation services, the following requirements must be met:

(i) Title to the vehicles must vest solely in the grantee or identified subrecipient, or with leased vehicles in an identified lender.

(ii) The grantee or identified subrecipient must, at a minimum, provide motor vehicle liability insurance for the vehicles to the same extent they would insure vehicles procured with their own funds.

(iii) All vehicle operators must be licensed in a U.S. State or Territory to operate such vehicles.

(iv) Vehicles must be safe and maintained in accordance with the manufacturer's recommendations.

(v) Vehicles must be operated in accordance with applicable Department of Transportation regulations concerning transit requirements under the Americans with Disabilities Act.

(b) *Additional requirements.* Grantees and identified subrecipients are subject to the Uniform Administrative Requirements, Cost Principles, and Audit Requirements for Federal Awards under 2 CFR part 200, and subject to 2 CFR parts 25 and 170, if applicable.

(Authority: Sec. 307, Pub. L. 111–163; 38 U.S.C. 501)

[78 FR 19593, Apr. 2, 2013, as amended at 80 FR 43322, July 22, 2015]

§ 17.720 Payments under the grant.

Grantees are to be paid in accordance with the timeframes and manner set forth in the Notice of Fund Availability.

(Authority: Sec. 307, Pub. L. 111–163; 38 U.S.C. 501)

§ 17.725 Grantee reporting requirements.

(a) *Program efficacy.* All grantees who receive either an initial or renewed grant must submit to VA quarterly and annual reports which indicate the following information:

(1) Record of time expended assisting with the provision of transportation services.

(2) Record of grant funds expended assisting with the provision of transportation services.

(3) Trips completed.

(4) Total distance covered.

(5) Veterans served.

(6) Locations which received transportation services.

(7) Results of veteran satisfaction survey.

(b) *Quarterly fiscal report.* All grantees who receive either an initial or renewal grant must submit to VA a quarterly report which identifies the expenditures of the funds which VA authorized and obligated.

(c) *Program variations.* Any changes in a grantee's program activities which result in deviations from the grant agreement must be reported to VA.

(d) *Additional reporting*. Additional reporting requirements may be requested by VA to allow VA to fully assess program effectiveness.

(Authority: Sec. 307, Pub. L. 111–163; 38 U.S.C. 501)

(The Office of Management and Budget has approved the information collection requirements in this section under control numbers 2900–0709 and 2900–0770)

§ 17.730 Recovery of funds by VA.

(a) *Recovery of funds*. VA may recover from the grantee any funds that are not used in accordance with a grant agreement. If VA decides to recover funds, VA will issue to the grantee a notice of intent to recover grant funds, and grantee will then have 30 days to submit documentation demonstrating why the grant funds should not be recovered. After review of all submitted documentation, VA will determine whether action will be taken to recover the grant funds.

(b) *Prohibition of further grants*. When VA determines action will be taken to recover grant funds from the grantee, the grantee is then prohibited from receipt of any further grant funds.

(Authority: Sec. 307, Pub. L. 111–163; 38 U.S.C. 501)

TRANSITIONAL HOUSING LOAN PROGRAM

SOURCE: 59 FR 49579, Sept. 29, 1994, unless otherwise noted.

§ 17.800 Purpose.

The purpose of the Transitional Housing Loan Program regulations is to establish application provisions and selection criteria for loans to non-profit organizations for use in initial start-up costs for transitional housing for veterans who are in (or have recently been in) a program for the treatment of substance abuse. This program is intended to increase the amount of transitional housing available for such veterans who need a period of supportive housing to encourage sobriety maintenance and reestablishment of social and community relationships.

§ 17.801 Definitions.

(a) *Applicant:* A non-profit organization making application for a loan under this program.

(b) *Non-profit organization:* A secular or religious organization, no part of the net earnings of which may inure to the benefit of any member, founder, contributor, or individual. The organization must include a voluntary board and must either maintain or designate an entity to maintain an accounting system which is operated in accordance with generally accepted accounting principles. If not named in, or approved under Title 38 U.S.C. (United States Code), Section 5902, a non-profit organization must provide VA with documentation which demonstrates approval as a non-profit organization under Internal Revenue Code, Section 501.c(3).

(c) *Recipient:* A non-profit organization which has received a loan from VA under this program.

(d) *Veteran:* A person who served in the active military, naval, or air service, and who was discharged or released therefrom under conditions other than dishonorable.

(Authority: Sec. 8 of Pub. L. 102–54, 105 Stat 271, 38 U.S.C. 501)

§ 17.802 Application provisions.

(a) To obtain a loan under these Transitional Housing Loan Program regulations, an application must be submitted by the applicant in the form prescribed by VA in the application package. The completed application package must be submitted to the Deputy Associate Director for Psychiatric Rehabilitation Services, (302/111C), VA Medical Center, 100 Emancipation Drive, Hampton, VA 23667. An application package may be obtained by writing to the proceeding address or telephoning (804) 722–9961 x3628. (This is not a toll-free number)

(b) The application package includes exhibits to be prepared and submitted, including:

(1) Information concerning the applicant's income, assets, liabilities and credit history,

(2) Information for VA to verify the applicant's financial information,

(3) Identification of the official(s) authorized to make financial transactions on behalf of the applicant,

(4) Information concerning:

(i) The history, purpose and composition of the applicant,

(ii) The applicant's involvement with recovering substance abusers, including:

(A) Type of services provided,

(B) Number of persons served,

(C) Dates during which each type of service was provided,

(D) Names of at least two references of government or community groups whom the organization has worked with in assisting substance abusers,

(iii) The applicant's plan for the provision of transitional housing to veterans including:

(A) Means of identifying and screening potential residents,

(B) Number of occupants intended to live in the residence for which the loan assistance is requested,

(C) Residence operating policies addressing structure for democratic self-government, expulsion policies for non-payment, alcohol or illegal drug use or disruptive behavior,

(D) Type of technical assistance available to residents in the event of house management problems,

(E) Anticipated cost of maintaining the residence, including rent and utilities,

(F) Anticipated charge, per veteran, for residing in the residence,

(G) Anticipated means of collecting rent and utilities payments from residents,

(H) A description of the housing unit for which the loan is sought to support, including location, type of neighborhood, brief floor plan description, etc., and why this residence was selected for this endeavor.

(iv) The applicant's plans for use of the loan proceeds.

(Authority: Sec. 8 of Pub. L. 102–54, 105 Stat. 271, 38 U.S.C. 501)

§ 17.803 Order of consideration.

Loan applications will be considered on a first-come-first-serve basis, subject to availability of funds for loans and awards will be made on a first-come-first-serve basis to applicants who meet the criteria for receiving a loan. If no funds are available for loans, applications will be retained in the order of receipt for consideration as funds become available.

(Authority: Sec. 8 of Pub. L. 102–54, 105 Stat. 271, 38 U.S.C. 501)

§ 17.804 Loan approval criteria.

Upon consideration of the application package, loan approval will be based on the following:

(a) Favorable financial history and status,

(1) A minimum of a two-year credit history,

(2) No open liens, judgments, and no unpaid collection accounts,

(3) No more than two instances where payments were ever delinquent beyond 60 days,

(4) Net ratio: (monthly expenses divided by monthly cash flow) that does not exceed 40%,

(5) Gross ratio: (total indebtedness divided by gross annual cash flow) that does not exceed 35%,

(6) At least two favorable credit references,

(b) Demonstrated ability to successfully address the needs of substance abusers as determined by a minimum of one year of successful experience in providing services, such as, provision of housing, vocational training, structured job seeking assistance, organized relapse prevention services, or similar activity. Such experience would involve at least twenty-five substance abusers, and would be experience which could be verified by VA inquiries of government or community groups with whom the applicant has worked in providing these services.

(c) An acceptable plan for operating a residence designed to meet the conditions of a loan under this program, which will include:

(1) Measures to ensure that residents are eligible for residency, *i.e.*, are veterans, are in (or have recently been in) a program for the treatment of substance abuse, are financially able to pay their share of costs of maintaining the residence, and agree to abide by house rules and rent/utilities payment provisions,

(2) Adequate rent/utilities collections to cover cost of maintaining the residence,

(3) Policies that ensure democratic self-run government, including expulsion policies, and

(4) Available technical assistance to residents in the event of house management problems.

(d) Selection of a suitable housing unit for use as a transitional residence in a neighborhood with no known illegal drug activity, and with adequate living space for number of veterans planned for residence (at least one large bedroom for every three veterans, at least one bathroom for every four veterans, adequate common space for entire household)

(e) Agreements, signed by an official authorized to bind the recipient, which include:

(1) The loan payment schedule in accordance with the requirements of Pub. L. 102–54, with the interest rate being the same as the rate the VA is charged to borrow these funds from the U.S. Department of Treasury and with a penalty of 4% of the amount due for each failure to pay an installment by the date specified in the loan agreement involved, and

(2) The applicant's intent to use proceeds of loan only to cover initial startup costs associated with the residence, such as security deposit, furnishings, household supplies, and any other initial startup costs.

(Authority: Sec. 8 of Pub. L. 102–54, 105 Stat. 271, 38 U.S.C. 501)

§ 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)

HEALTH CARE BENEFITS FOR CERTAIN CHILDREN OF VIETNAM VETERANS AND VETERANS WITH COVERED SERVICE IN KOREA—SPINA BIFIDA AND COVERED BIRTH DEFECTS

SOURCE: 68 FR 1010, Jan. 8, 2003, unless otherwise noted.

§ 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), The Joint Commission, 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.

Day health care means a therapeutic program prescribed by an approved health care provider that provides necessary medical services, rehabilitation, therapeutic activities, socialization, nutrition, and transportation services in a congregate setting. Day health care may be provided as a component of outpatient care or respite care.

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, long-term 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.

Health-related services means homemaker or home health aide services furnished in the individual's home or other place of residence to the extent that those services provide assistance with Activities of Daily Living and Instrumental Activities of Daily Living that have therapeutic value.

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.

Home health aide services is a component of health-related services providing personal care and related support services to an individual in the home or other place of residence. Home health aide services may include assistance with Activities of Daily Living such as: Bathing; toileting; eating; dressing; aid in ambulating or transfers; active and passive exercises; assistance with medical equipment; and routine health monitoring. Home health aide services must be provided according to the individual's written plan of care and must be prescribed by an approved health care provider.

Homemaker services is a component of health-related services encompassing certain activities that help to maintain a safe, healthy environment for an individual in the home or other place of residence. Such services contribute to the prevention, delay, or reduction of risk of harm or hospital, nursing home, or other institutional care. Homemaker services include assistance with personal care; home management; completion of simple household tasks; nutrition, including menu planning and meal preparation; consumer education; and hygiene education. Homemaker services may include assistance with Instrumental Activities of Daily Living, such as: Light housekeeping; laundering; meal preparation; necessary services to maintain a safe and sanitary environment in the areas of the home used by the individual; and services essential to the comfort and cleanliness of the individual and ensuring individual safety. Homemaker services must be provided according to the individual's written plan of care and must be prescribed by an approved health care provider.

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

Long-term care means home care, nursing home care, and respite care.

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

Other place of residence includes an assisted living facility or residential group home.

Outpatient care means care and treatment, including day health care and 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, including day health 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)

[68 FR 1010, Jan. 8, 2003, as amended at 76 FR 4249, Jan. 25, 2011; 79 FR 54616, Sept. 12, 2014; 81 FR 19890, Apr. 6, 2016]

§ 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.

[68 FR 1010, Jan. 8, 2003, as amended at 76 FR 4249, Jan. 25, 2011]

§ 17.902 Preauthorization.

(a) Preauthorization from VA is required for the following services or benefits under §§ 17.900 through 17.905: Rental or purchase of durable medical equipment with a total rental or purchase price in excess of $300, respectively; day health care provided as outpatient care; dental services; homemaker services; outpatient mental health services in excess of 23 visits in a calendar year; substance abuse treatment; training; transplantation services; and travel (other than mileage at the General Services Administration rate for privately owned automobiles). Authorization will only be given in spina bifida cases where it is demonstrated that the care is medically

necessary. In cases of other covered birth defects, authorization will only be given where it is demonstrated that the care is medically necessary and related to the covered birth defects. Requests for provision of health care requiring preauthorization shall be made to the Health Administration Center and may be made by telephone, facsimile, mail, or hand delivery. The application must contain the following:

(1) Name of child,

(2) Child's Social Security number,

(3) Name of veteran,

(4) Veteran's Social Security number,

(5) Type of service requested,

(6) Medical justification,

(7) Estimated cost, and

(8) Name, address, and telephone number of provider.

(b) Notwithstanding the provisions of paragraph (a) of this section, preauthorization is not required for a condition for which failure to receive immediate treatment poses a serious threat to life or health. Such emergency care should be reported by telephone to the Health Administration Center within 72 hours of the emergency.

(Authority: 38 U.S.C. 101(2), 1802–1803, 1811–1813, 1831)

(The Office of Management and Budget has approved the information collection requirements in this section under control number 2900–0219)

[68 FR 1010, Jan. 8, 2003, as amended at 76 FR 4249, Jan. 25, 2011; 81 FR 19890, Apr. 6, 2016]

§ 17.903 Payment.

(a)(1) Payment for services or benefits under §§ 17.900 through 17.905 will be determined utilizing the same payment methodologies as provided for under the Civilian Health and Medical Program of the Department of Veterans Affairs (CHAMPVA) (see § 17.270). For those services or benefits covered by §§ 17.900 through 17.905 but not covered by CHAMPVA we will use payment methodologies the same or similar to those used for equivalent services or benefits provided to veterans.

(2) As a condition of payment, the services must have occurred:

(i) For spina bifida, on or after October 1, 1997, and must have occurred on or after the date the child was determined eligible for benefits under § 3.814 of this title.

(ii) For covered birth defects, on or after December 1, 2001, and must have occurred on or after the date the child was determined eligible for benefits under § 3.815 of this title.

(3) Claims from approved health care providers must be filed with the Health Administration Center in writing (facsimile, mail, hand delivery, or electronically) no later than:

(i) One year after the date of service; or

(ii) In the case of inpatient care, one year after the date of discharge; or

(iii) In the case of retroactive approval for health care, 180 days following beneficiary notification of eligibility.

(4) Claims for health care provided under the provisions of §§ 17.900 through 17.905 must contain, as appropriate, the information set forth in paragraphs (a)(4)(i) through (a)(4)(v) of this section.

(i) Patient identification information:

(A) Full name,

(B) Address,

(C) Date of birth, and

(D) Social Security number.

(ii) Provider identification information (inpatient and outpatient services):

(A) Full name and address (such as hospital or physician),

(B) Remittance address,

(C) Address where services were rendered,

(D) Individual provider's professional status (M.D., Ph.D., R.N., etc.), and

(E) Provider tax identification number (TIN) or Social Security number.

(iii) Patient treatment information (long-term care or institutional services):

(A) Dates of service (specific and inclusive),

(B) Summary level itemization (by revenue code),

(C) Dates of service for all absences from a hospital or other approved institution during a period for which inpatient benefits are being claimed,

(D) Principal diagnosis established, after study, to be chiefly responsible for causing the patient's hospitalization,

(E) All secondary diagnoses,

(F) All procedures performed,

(G) Discharge status of the patient, and

(H) Institution's Medicare provider number.

(iv) Patient treatment information for all other health care providers and ancillary outpatient services such as durable medical equipment, medical requisites, and independent laboratories:

(A) Diagnosis,

(B) Procedure code for each procedure, service, or supply for each date of service, and

(C) Individual billed charge for each procedure, service, or supply for each date of service.

(v) Prescription drugs and medicines and pharmacy supplies:

(A) Name and address of pharmacy where drug was dispensed,

(B) Name of drug,

(C) National Drug Code (NDC) for drug provided,

(D) Strength,

(E) Quantity,

(F) Date dispensed,

(G) Pharmacy receipt for each drug dispensed (including billed charge), and

(H) Diagnosis for which each drug is prescribed.

(b) Health care payment will be provided in accordance with the provisions of §§ 17.900 through 17.905. However, the following are specifically excluded from payment:

(1) Care as part of a grant study or research program,

(2) Care considered experimental or investigational,

(3) Drugs not approved by the U.S. Food and Drug Administration for commercial marketing,

(4) Services, procedures, or supplies for which the beneficiary has no legal obligation to pay, such as services obtained at a health fair,

(5) Services provided outside the scope of the provider's license or certification, and

(6) Services rendered by providers suspended or sanctioned by a Federal agency.

(c) Payments made in accordance with the provisions of §§ 17.900 through 17.905 shall constitute payment in full. Accordingly, the health care provider or agent for the health care provider may not impose any additional charge for any services for which payment is made by VA.

(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, 1831)

(The Office of Management and Budget has approved the information collection requirements in this section under control number 2900–0219)

[68 FR 1010, Jan. 8, 2003, as amended at 76 FR 4249, Jan. 25, 2011; 81 FR 19890, Apr. 6, 2016]

§ 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 facsimile, 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, 1831)

(The Office of Management and Budget has approved the information collection requirements in this section under control number 2900–0219)

[68 FR 1010, Jan. 8, 2003, as amended at 76 FR 4250, Jan. 25, 2011; 81 FR 19891, Apr. 6, 2016]

§ 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, 1831)

[68 FR 1010, Jan. 8, 2003, as amended at 76 FR 4250, Jan. 25, 2011]

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)

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

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

(1) A Federal entity;

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

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

(4) An automobile accident reparations insurance carrier; or

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

(c) The term *duplicate payment* means payment made, in whole or in part, for the same emergency services for which VA reimbursed or made payment.

(d) The term *stabilized* means that no material deterioration of the emergency medical condition is likely, within reasonable medical probability, to occur if the veteran is discharged or transferred to a VA or other Federal facility that VA has an agreement with to furnish health care services for veterans.

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

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

[66 FR 36470, July 12, 2001, as amended at 76 FR 79071, Dec. 21, 2011; 77 FR 23617, Apr. 20, 2012]

§ 17.1002 Substantive conditions for payment or reimbursement.

Payment or reimbursement under 38 U.S.C. 1725 for emergency treatment (including medical services, professional services, ambulance services, ancillary care and medication (including a short course of medication related to and necessary for the treatment of the emergency condition that is provided directly to or prescribed for the patient for use after the emergency condition is stabilized and the patient is discharged)) will be made only if all of the following conditions are met:

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

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

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

(d) At the time the emergency treatment was furnished, the veteran was enrolled in the VA health care system and had received medical services under authority of 38 U.S.C. chapter 17 within the 24-month period preceding the furnishing of such emergency treatment;

(e) The veteran is financially liable to the provider of emergency treatment for that treatment;

(f) The veteran does not have coverage under a health-plan contract that would fully extinguish the medical liability for the emergency treatment (this condition cannot be met if the veteran has coverage under a health-plan contract but payment is barred because of a failure by the veteran or the provider to comply with the provisions of that health-plan contract, *e.g.*, failure to submit a bill or medical records within specified time limits, or failure to exhaust appeals of the denial of payment);

(g) If the condition for which the emergency treatment was furnished was caused by an accident or work-related injury, the claimant has exhausted without success all claims and remedies reasonably available to the veteran or provider against a third party for payment of such treatment; and the veteran has no contractual or legal recourse against a third party

that could reasonably be pursued for the purpose of extinguishing, in whole, the veteran's liability to the provider; and

(h) The veteran is not eligible for reimbursement under 38 U.S.C. 1728 for the emergency treatment provided (38 U.S.C. 1728 authorizes VA payment or reimbursement for emergency treatment to a limited group of veterans, primarily those who receive emergency treatment for a service-connected disability).

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

[66 FR 36470, July 12, 2001, as amended at 68 FR 3404, Jan. 24, 2003; 76 FR 79071, Dec. 21, 2011; 77 FR 23617, Apr. 20, 2012; 80 FR 79484, Dec. 22, 2015; 83 FR 979, Jan. 9, 2018]

§ 17.1003 Emergency transportation.

Notwithstanding the provisions of § 17.1002, payment or reimbursement under 38 U.S.C. 1725 for ambulance services, including air ambulance services, may be made for transporting a veteran to a facility only if the following conditions are met:

(a) Payment or reimbursement is authorized under 38 U.S.C. 1725 for emergency treatment provided at a non-VA facility, or payment or reimbursement would have been authorized under 38 U.S.C. 1725 for emergency treatment had:

(1) The veteran's personal liability for the emergency treatment not been fully extinguished by payment by a third party, including under a health-plan contract; or

(2) Death had not occurred before emergency treatment could be provided;

(b) The veteran is financially liable to the provider of the emergency transportation;

(c) The veteran does not have coverage under a health-plan contract that would fully extinguish the medical liability for the emergency transportation (this condition is not met if the veteran has coverage under a health-plan contract but payment is barred because of a failure by the veteran or the provider to comply with the provisions of that health-plan contract);

(d) If the condition for which the emergency transportation was furnished was caused by an accident or work-related injury, the claimant has exhausted without success all claims and remedies reasonably available to the veteran or provider against a third party for payment of such transportation; and the veteran has no contractual or legal recourse against a third party that could reasonably be pursued for the purpose of fully extinguishing the veteran's liability to the provider; and

(e) If the veteran is not eligible for reimbursement for any emergency treatment expenses under 38 U.S.C. 1728.

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

[66 FR 36470, July 12, 2001, as amended at 83 FR 979, Jan. 9, 2018]

§ 17.1004 Filing claims.

(a) A claimant for payment or reimbursement under 38 U.S.C. 1725 must be the entity that furnished the treatment, the veteran who paid for the treatment, or the person or organization that paid for such treatment on behalf of the veteran.

(b) To obtain payment or reimbursement for emergency treatment under 38 U.S.C. 1725, a claimant must submit to the VA medical facility of jurisdiction a completed standard billing form (such as a UB92 or a CMS 1500). Where the form used does not contain a false claims notice, the completed form must also be accompanied by a signed, written statement declaring that ''I hereby certify that this claim meets all of the conditions for payment by VA for emergency medical services under 38 CFR 17.1002 (except for paragraph (e)) and 17.1003. I am aware that 38 U.S.C. 6102(b) provides that one who obtains payment without being entitled to it and with intent to defraud the United States shall be fined in accordance with title 18, United States Code, or imprisoned not more than one year, or both.''

NOTE TO § 17.1004(b): These regulations regarding payment or reimbursement for emergency services for nonservice-connected conditions in non-VA facilities also can be found on the internet at *http://www.va.gov/health/elig*.

(c) Notwithstanding the provisions of paragraph (b) of this section, no specific form is required for a claimant (or

duly authorized representative) to claim payment or reimbursement for emergency transportation charges under 38 U.S.C. 1725. The claimant need only submit a signed and dated request for such payment or reimbursement to the VA medical facility of jurisdiction, together with a bill showing the services provided and charges for which the veteran is personally liable and a signed statement explaining who requested such transportation services and why they were necessary.

(d) To receive payment or reimbursement for emergency services, a claimant must file a claim within 90 days after the latest of the following:

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

(2) The date of death, but only if the death occurred during transportation to a facility for emergency treatment or if the death occurred during the stay in the facility that included the provision of the emergency treatment; or

(3) The date the veteran finally exhausted, without success, action to obtain payment or reimbursement for the treatment from a third party.

(e) If after reviewing a claim the decisionmaker determines that additional information is needed to make a determination regarding the claim, such official will contact the claimant in writing and request additional information. The additional information must be submitted to the decisionmaker within 30 days of receipt of the request or the claim will be treated as abandoned, except that if the claimant within the 30-day period requests in writing additional time, the time period for submission of the information may be extended as reasonably necessary for the requested information to be obtained.

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

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

[66 FR 36470, July 12, 2001, as amended at 68 FR 3404, Jan. 24, 2003; 77 FR 23617, Apr. 20, 2012; 84 FR 26307, June 5, 2019]

§ 17.1005 Payment limitations.

(a) Payment or reimbursement for emergency treatment (including emergency transportation) under 38 U.S.C. 1725 will be calculated as follows:

(1) If an eligible veteran has personal liability to a provider of emergency treatment and no contractual or legal recourse against a third party, including under a health-plan contract, VA will pay the lesser of the amount for which the veteran is personally liable or 70 percent of the applicable Medicare fee schedule amount for such treatment.

(2) If an eligible veteran has personal liability to a provider of emergency treatment after payment by a third party, including under a health-plan contract, VA will pay:

(i) The difference between the amount VA would have paid under paragraph (a)(1) of this section for the cost of the emergency treatment and the amount paid (or payable) by the third party, if that amount would be greater than zero, or;

(ii) If applying paragraph (a)(2)(i) of this section would result in no payment by VA, the lesser of the veteran's remaining personal liability after such third-party payment or 70 percent of the applicable Medicare fee schedule amount for such treatment.

(3) In the absence of a Medicare fee schedule rate for the emergency treatment, VA payment will be the lesser of the amount for which the veteran is personally liable or the amount calculated by the VA Fee Schedule in § 17.56 (a)(2)(i)(B).

(4) Unless rejected and refunded by the provider within 30 days from the date of receipt, the provider will consider VA's payment made under paragraphs (a)(1), (a)(2), or (a)(3) of this section as payment in full and extinguish the veteran's liability to the provider. (Neither the absence of a contract or

agreement between the Secretary and the provider nor any provision of a contract, agreement, or assignment to the contrary shall operate to modify, limit, or negate the requirement in the preceding sentence.)

(5) VA will not reimburse a veteran under this section for any copayment, deductible, coinsurance, or similar payment that the veteran owes the third party or is obligated to pay under a health-plan contract.

(b) Except as provided in paragraph (c) of this section, VA will not approve claims for payment or reimbursement of the costs of emergency treatment not previously authorized for any period beyond the date on which the medical emergency ended. For this purpose, VA considers that an emergency ends when the designated VA clinician at the VA facility has determined that, based on sound medical judgment, a veteran who received emergency treatment:

(1) Could have been transferred from the non-VA facility to a VA medical center (or other Federal facility that VA has an agreement with to furnish health care services for veterans) for continuation of treatment, or

(2) Could have reported to a VA medical center (or other Federal facility that VA has an agreement with to furnish health care services for veterans) for continuation of treatment.

(c) Claims for payment or reimbursement of the costs of emergency treatment not previously authorized may be approved for continued, non-emergency treatment, only if:

(1) The non-VA facility notified VA at the time the veteran could be safely transferred to a VA facility (or other Federal facility that VA has an agreement with to furnish health care services for veterans) and the transfer of the veteran was not accepted, and

(2) The non-VA facility made and documented reasonable attempts to request transfer of the veteran to VA (or to another Federal facility that VA has an agreement with to furnish health care services for veterans), which means the non-VA facility contacted either the VA Transfer Coordinator, Administrative Officer of the Day, or designated staff responsible for accepting transfer of patients at a local VA (or other Federal facility) and documented such contact in the veteran's progress/physicians' notes, discharge summary, or other applicable medical record.

(d) If a stabilized veteran who requires continued non-emergency treatment refuses to be transferred to an available VA facility (or other Federal facility that VA has an agreement with to furnish health care services for veterans), VA will make payment or reimbursement only for the expenses related to the initial evaluation and the emergency treatment furnished to the veteran up to the point of refusal of transfer by the veteran.

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

[66 FR 36470, July 12, 2001, as amended at 68 FR 3404, Jan. 24, 2003; 76 FR 79071, Dec. 21, 2011; 77 FR 23618, Apr. 20, 2012; 78 FR 36093, June 17, 2013; 83 FR 979, Jan. 9, 2018]

§ 17.1006 Decisionmakers.

The Chief of the Health Administration Service or an equivalent official at the VA medical facility of jurisdiction will make all determinations regarding payment or reimbursement under 38 U.S.C. 1725, except that the designated VA clinician at the VA medical facility of jurisdiction will make determinations regarding § 17.1002(b), (c), and (d). Any decision denying a benefit must be in writing and inform the claimant of VA reconsideration and appeal rights.

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

[66 FR 36470, July 12, 2001, as amended at 76 FR 79072, Dec. 21, 2011]

§ 17.1007 Independent right of recovery.

(a) VA has the right to recover its payment under this section when, and to the extent that, a third party makes payment for all or part of the same emergency treatment for which VA reimbursed or made payment under this section.

(1) Under 38 U.S.C. 1725(d)(4), the veteran (or the veteran's personal representative, successor, dependents, or survivors) or claimant shall ensure that the Secretary is promptly notified of any payment received from any third party for emergency treatment furnished to the veteran. The veteran

(or the veteran's personal representative, successor, dependents, or survivors) or claimant shall immediately forward all documents relating to such payment, cooperate with the Secretary in the investigation of such payment and assist the Secretary in enforcing the United States' right to recover any payment made and accepted under this section. The required notification and submission of documentation must be provided by the veteran or claimant to the VA medical facility of jurisdiction within three working days of receipt of notice of the duplicate payment.

(2) If the Chief Financial Officer or equivalent official at the VA medical facility of jurisdiction concludes that payment from a third party was made for all or part of the same emergency treatment for which VA reimbursed or made payment under this section, such VA official shall, except as provided in paragraph (c) of this section, initiate action to collect or recover the amount of the duplicate payment in the same manner as for any other debt owed the United States.

(b)(1) Any amount paid by the United States to the veteran (or the veteran's personal representative, successor, dependents, or survivors) or to any other person or organization paying for such treatment shall constitute a lien in favor of the United States against any recovery the payee subsequently receives from a third party for the same treatment.

(2) Any amount paid by the United States, and accepted by the provider that furnished the veteran's emergency treatment, shall constitute a lien against any subsequent amount the provider receives from a third party for the same emergency treatment for which the United States made payment.

(c) If it is determined that a duplicate payment was made, the Chief Financial Officer or equivalent official at the VA medical facility of jurisdiction may waive recovery of a VA payment made under this section to a veteran upon determining that the veteran has substantially complied with the provisions of paragraph (a)(1) of this section and that actions to recover the payment would not be cost-effective or would conflict with other litigative interests of the United States.

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

§ 17.1008 Balance billing prohibited.

Payment by VA under 38 U.S.C. 1725 on behalf of a veteran to a provider of emergency treatment and any non-emergency treatment that is authorized under § 17.1005(c) of this part shall, unless rejected and refunded by the provider within 30 days of receipt, extinguish all liability on the part of the veteran for that emergency treatment and any non-emergency treatment that is authorized under § 17.1005(c) of this part. Neither the absence of a contract or agreement between VA and the provider nor any provision of a contract, agreement, or assignment to the contrary shall operate to modify, limit, or negate this requirement.

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

[66 FR 36470, July 12, 2001, as amended at 76 FR 79072, Dec. 21, 2011]

EXPANDED ACCESS TO NON-VA CARE THROUGH THE VETERANS CHOICE PROGRAM

SOURCE: Sections 17.1500 through 17.1540 appear at 79 FR 65585, Nov. 5, 2014, unless otherwise noted.

§ 17.1500 Purpose and scope.

(a) *Purpose.* Sections 17.1500 through 17.1540 implement the Veterans Choice Program, authorized by section 101 of the Veterans Access, Choice, and Accountability Act of 2014.

(b) *Scope.* The Veterans Choice Program authorizes VA to furnish hospital care and medical services to eligible veterans, as defined in § 17.1510, through agreements with eligible entities or providers, as defined in § 17.1530.

(Authority: Sec. 101, Pub. L. 113–146, 128 Stat. 1754)

§ 17.1505 Definitions.

For purposes of the Veterans Choice Program under §§ 17.1500 through 17.1540:

Appointment means an authorized and scheduled encounter with a health care provider for the delivery of hospital care or medical services. A visit to an

emergency room or an unscheduled visit to a clinic is not an appointment.

Attempt to schedule means contact with a VA scheduler or VA health care provider in which a stated request by the veteran for an appointment is made.

Episode of care means a necessary course of treatment, including follow-up appointments and ancillary and specialty services, which lasts no longer than 1 calendar year from the date of the first appointment with a non-VA health care provider.

Full-time primary care physician means a single VA physician whose workload, or multiple VA physicians whose combined workload, equates to 0.9 full time equivalent employee working at least 36 clinical hours a week at the VA medical facility and who provides primary care as defined by their privileges or scope of practice and licensure.

Health-care plan means an insurance policy or contract, medical or hospital service agreement, membership or subscription contract, or similar arrangement not administered by the Secretary of Veterans Affairs, under which health services for individuals are provided or the expenses of such services are paid; and does not include any such policy, contract, agreement, or similar arrangement pursuant to title XVIII or XIX of the Social Security Act (42 U.S.C. 1395 et seq.) or chapter 55 of title 10, United States Code.

Residence means a legal residence or personal domicile, even if such residence is seasonal. A person may maintain more than one residence but may only have one residence at a time. If a veteran lives in more than one location during a year, the veteran's residence is the residence or domicile where the person is staying at the time the veteran wants to receive hospital care or medical services through the Program. A post office box or other non-residential point of delivery does not constitute a residence.

Schedule means identifying and confirming a date, time, location, and entity or health care provider for an appointment.

VA medical facility means a VA hospital, a VA community-based outpatient clinic, or a VA health care center, any of which must have at least one full-time primary care physician. A Vet Center, or Readjustment Counseling Service Center, is not a VA medical facility.

Wait-time goals of the Veterans Health Administration means, unless changed by further notice in the FEDERAL REGISTER, a date not more than 30 days from either:

(1) The date that an appointment is deemed clinically appropriate by a VA health care provider. In the event a VA health care provider identifies a time range when care must be provided (e.g., within the next 2 months), VA will use the last clinically appropriate date for determining whether or not such care is timely.

(2) Or, if no such clinical determination has been made, the date that a veteran prefers to be seen for hospital care or medical services.

(Authority: Sec. 101, Pub. L. 113–146, 128 Stat. 1754; Sec. 4005, Pub. L. 114–41, 129 Stat. 443)

[79 FR 65585, Nov. 5, 2014, as amended at 80 FR 74995, Dec. 1, 2015]

§ 17.1510 Eligible veterans.

A veteran must meet the eligibility criteria under both paragraphs (a) and (b) of this section to be eligible for care through the Veterans Choice Program. A veteran must also provide the information required by paragraphs (c) and (d) of this section.

(a) A veteran must be enrolled in the VA health care system under § 17.36.

(b) A veteran must also meet at least one of the following criteria:

(1) The veteran attempts, or has attempted, to schedule an appointment with a VA health care provider, but VA is unable to schedule an appointment for the veteran within:

(i) The wait-time goals of the Veterans Health Administration; or

(ii) With respect to such care or services that are clinically necessary, the period VA determines necessary for such care or services if such period is shorter than the wait-time goals of the Veterans Health Administration.

(2) The veteran's residence is more than 40 miles from the VA medical facility that is closest to the veteran's residence.

(3) The veteran's residence is both:

(i) In a state without a VA medical facility that provides hospital care,

emergency medical services, and surgical care having a surgical complexity of standard (VA maintains a Web site with a list of the facilities that have been designated with at least a surgical complexity of standard. That Web site can be accessed here: *www.va.gov/health/surgery*); and

(ii) More than 20 miles from a medical facility described in paragraph (b)(3)(i) of this section.

(4) The veteran's residence is in a location, other than one in Guam, American Samoa, or the Republic of the Philippines, which is 40 miles or less from a VA medical facility and the veteran:

(i) Must travel by air, boat, or ferry to reach such a VA medical facility; or

(ii) Faces an unusual or excessive burden in traveling to such a VA medical facility based on geographical challenges, such as the presence of a body of water (including moving water and still water) or a geologic formation that cannot be crossed by road; environmental factors, such as roads that are not accessible to the general public, traffic, or hazardous weather; a medical condition that affects the ability to travel; or other factors, as determined by VA, including but not limited to:

(A) The nature or simplicity of the hospital care or medical services the veteran requires;

(B) The frequency that such hospital care or medical services need to be furnished to the veteran; and

(C) The need for an attendant, which is defined as a person who provides required aid and/or physical assistance to the veteran, for a veteran to travel to a VA medical facility for hospital care or medical services.

(c) If the veteran changes his or her residence, the veteran must update VA about the change within 60 days.

(d) A veteran must provide to VA information on any health-care plan under which the veteran is covered prior to obtaining authorization for care under the Veterans Choice Program. If the veteran changes health-care plans, the veteran must update VA about the change within 60 days.

(e) For purposes of calculating the distance between a veteran's residence and the nearest VA medical facility under this section, VA will use the driving distance between the nearest VA medical facility and a veteran's residence. VA will calculate a veteran's driving distance using geographic information system software.

(Authority: Sec. 101, Pub. L. 113–146, 128 Stat. 1754; Section 3(a)(2) of Pub. L. 114–19, 129 Stat. 215)

(The information collection requirements have been submitted to the Office of Management and Budget and are pending OMB approval.)

[79 FR 65585, Nov. 5, 2014, as amended at 80 FR 22909, Apr. 24, 2015; 80 FR 74996, Dec. 1, 2015]

§ 17.1515 Authorizing non-VA care.

(a) *Electing non-VA care.* A veteran eligible for the Veterans Choice Program under § 17.1510 may choose to schedule an appointment with a VA health care provider, be placed on an electronic waiting list for VA care, or have VA authorize the veteran to receive an episode of care for hospital care or medical services under 38 CFR 17.38 from an eligible entity or provider.

(b) *Selecting a non-VA provider.* An eligible veteran may specify a particular non-VA entity or health care provider, if that entity or health care provider meets the requirements of § 17.1530. If an eligible veteran does not specify a particular eligible entity or provider, VA will refer the veteran to a specific eligible entity or provider.

(Authority: Sec. 101, Pub. L. 113–146, 128 Stat. 1754)

(The information collection requirements have been submitted to the Office of Management and Budget and are pending OMB approval.)

§ 17.1520 Effect on other provisions.

(a) *General.* In general, eligibility under the Veterans Choice Program does not affect a veteran's eligibility for hospital care or medical services under the medical benefits package, as defined in § 17.38, or other benefits addressed in this part. Notwithstanding any other provision of this part, VA will pay for and fill prescriptions written by eligible providers under § 17.1530 for eligible veterans under § 17.1510, including prescriptions for drugs, including over-the-counter drugs and medical

and surgical supplies available under the VA national formulary system.

(b) *Copayments*. VA will be liable for any deductibles, cost-shares, or copayments required by an eligible veteran's health-care plan for hospital care and medical services furnished under this Program, to the extent that such reimbursement does not result in expenditures by VA for the furnished care or services in excess of the rate established under § 17.1535. Veterans are also liable for a VA copayment for care furnished under this Program, as required by §§ 17.108(b)(4), 17.108(c)(4), 17.110(b)(4), and 17.111(b)(3).

(c) *Beneficiary travel*. For veterans who are eligible for beneficiary travel benefits under part 70 of this chapter, VA will provide beneficiary travel benefits for travel to and from the location of the eligible entity or provider who furnishes hospital care or medical services for an authorized appointment under the Veterans Choice Program without regard to the limitations in § 70.30(b)(2) of this chapter.

(Authority: 38 U.S.C. 111; Sec. 101, Pub. L. 113–146, 128 Stat. 1754)

§ 17.1525 [Reserved]

§ 17.1530 Eligible entities and providers.

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

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

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

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

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

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

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

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

(d) *Requirements for health care providers*. (1) To be eligible to furnish care or services under the Veterans Choice Program, a health care provider must:

(i) Maintain at least the same or similar credentials and licenses as those required of VA's health care providers, as determined by the Secretary. The agreement reached under paragraph (b) of this section will clarify these requirements. Eligible health care providers must submit verification of such licenses and credentials maintained by the provider to VA at least once per 12-month period.

(ii) Not be excluded from participation in a Federal health care program (as defined in section 1128B(f) of the Social Security Act (42 U.S.C. 1320a–7b(f)) under section 1128 or 1128A of such Act (42 U.S.C. 1320a–7 and 1320a–7a)), not be identified as an excluded source on the list maintained in the System for Award Management or any successor system, and not be identified on the List of Excluded Individuals and Entities that is maintained by the Office of the Inspector General of the U.S. Department of Health and Human Services.

(2) Any entities that are eligible to provide care through the Program must ensure that any of their providers furnishing care and services through the Program meet the standards identified in paragraph (d)(1) of this section. An eligible entity may submit this information on behalf of its providers.

(e) *Other eligible entities and providers.* In accordance with sections 101(a)(1)(B)(v) and 101(d)(5) of the Veterans Access, Choice, and Accountability Act of 2014 (as amended), the following entities or providers are eligible to deliver care under the Veterans Choice Program, subject to the additional criteria established in this section.

(1) A health care provider that is participating in a State Medicaid plan under title XIX of the Social Security Act (42 U.S.C. 1396 *et seq.*), including any physician furnishing services under such program, if the health care provider has an agreement under a State plan under title XIX of such Act (42 U.S.C. 1396 *et seq.*) or a waiver of such a plan;

(2) An Aging and Disability Resource Center, an area agency on aging, or a State agency (as defined in section 102 of the Older Americans Act of 1965 (42 U.S.C. 3002)), or a center for independent living (as defined in section 702 of the Rehabilitation Act of 1973 (29 U.S.C. 796a)).

(3) A health care provider that is not identified in paragraph (e)(1) or (2) of this section, if that provider meets all requirements under paragraph (d) of this section.

(Authority: Sec. 101, Pub. L. 113–146, 128 Stat. 1754; Sec. 4005, Pub. L. 114–41, 129 Stat. 443)

(The information collection requirements have been submitted to the Office of Management and Budget and are pending OMB approval.)

[79 FR 65585, Nov. 5, 2014, as amended at 80 FR 74996, Dec. 1, 2015; 81 FR 24027, Apr. 25, 2016]

§ 17.1535 Payment rates and methodologies.

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

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

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

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

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

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

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

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

(2) For hospital care or medical services furnished for a service-connected disability, as that term is defined at § 3.1(k) of this chapter, or pursuant to

38 U.S.C. 1710(e), 1720D, or 1720E, VA is solely responsible for paying the eligible entity or provider for such hospital care or medical services as are authorized under §§ 17.1500 through 17.1540 and furnished to an eligible veteran.

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

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

[79 FR 65585, Nov. 5, 2014, as amended at 80 FR 66428, Oct. 29, 2015]

§ 17.1540 Claims processing system.

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

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

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

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

VET CENTERS

§ 17.2000 Vet Center services.

(a) *Eligibility for readjustment counseling.* Upon request, VA will provide readjustment counseling to any individual who:

(1) Is a veteran or member of the Armed Forces, including a member of a reserve component of the Armed Forces, who:

(i) Served on active duty in a theater of combat operations or an area of hostilities (*i.e.*, an area at a time during which hostilities occurred in that area); or

(ii) Provided direct emergency medical or mental health care, or mortuary services, to the causalities of combat operations or hostilities, but who at the time was located outside the theater of combat operations or area of hostilities; or

(iii) Engaged in combat with an enemy of the United States or against an opposing military force in a theater of combat operations or an area at a time during which hostilities occurred in that area by remotely controlling an unmanned aerial vehicle operations, notwithstanding whether the physical location of such veteran or member during such combat was within such theater of combat operations or area. Individuals who remotely control unmanned aerial vehicles includes, but is not limited to, individuals who pilot the unmanned aerial vehicle as well as individuals who are crew members of the unmanned aerial vehicle and participate in combat related missions. The crew members include, but are not limited to, intelligence analysts or weapons specialists who control the cameras, engage the weapon systems, as well as those individuals who are directly responsible for the mission of the unmanned aerial vehicle.

(2) Received counseling under this section before January 2, 2013.

(3) Is a family member of a veteran or member of the Armed Forces, including a member of a reserve component of the Armed Forces, who is eligible for readjustment counseling under paragraphs (a)(1) or (a)(2) of this section. For purposes of this section, family member includes, but is not limited to, the spouse, parent, child, step-family

member, extended family member, and any individual who lives with the veteran or member of the Armed Forces, including a member of a reserve component of the Armed Forces, but is not a member of the veteran's or member's family.

(b) *Proof of eligibility*. With the veteran's or member's of the Armed Forces, including a member of a reserve component of the Armed Forces, consent, VA will assist in obtaining proof of eligibility. For the purposes of this section, proof of service in a theater of combat operations or in an area during a period of hostilities in that area will be established by:

(1) A DD Form 214 (Certificate of Release or Discharge from Active Duty) containing notations of service in a designated theater of combat operations; or

(2) Receipt of one of the following medals: The Armed Forces Expeditionary Medal, Service Specific Expeditionary Medal (e.g., Navy Expeditionary Medal), Combat Era Specific Expeditionary Medal (e.g., the Global War on Terrorism Expeditionary Medal), Campaign Specific Medal (e.g., Vietnam Service Medal or Iraq Campaign Medal), or other combat theater awards established by public law or executive order; or

(3) Proof of receipt of Hostile Fire or Imminent Danger Pay (commonly referred to as ''combat pay'') or combat tax exemption after November 11, 1998.

(c) *Referral and advice*. Upon request, VA will provide an individual who does not meet the eligibility requirements of paragraph (a) of this section, solely because the individual was discharged under dishonorable conditions from active military, naval, or air service, the following:

(1) Referral services to assist such individual, to the maximum extent practicable, in obtaining mental health care and services from sources outside VA; and

(2) If pertinent, advice to such individual concerning such individual's rights to apply to:

(i) The appropriate military, naval or air service for review of such individual's discharge or release from such service; and

(ii) VA for a VA benefits eligibility determination under 38 CFR 3.12.

(d) *Readjustment counseling defined*. For the purposes of this section, readjustment counseling includes, but is not limited to: Psychosocial assessment, individual counseling, group counseling, marital and family counseling for military-related readjustment issues, substance abuse assessments, medical referrals, referral for additional VA benefits, employment assessment and referral, military sexual trauma counseling and referral, bereavement counseling, and outreach. A ''psychosocial assessment'' under this paragraph means the holistic assessing of an individual's psychological, social, and functional capacities as it relates to their readjustment from combat theaters. Readjustment counseling is provided to:

(1) Veterans and members of the Armed Forces, including a member of a reserve component of the Armed Forces, for the purpose of readjusting to civilian life or readjustment to continued military service following participation in or in support of operations in a combat theater or area of hostility.

(2) A family member of a member of the Armed Forces, including a member of a reserve component of the Armed Forces, for the purpose of coping with such member's deployment.

(3) A family member of a veteran or member of the Armed Forces, including a member of a reserve component of the Armed Forces, to aid in a veteran's or member's readjustment to civilian or continued military service following participation in or in support of operations in a combat theater or area of hostility, only as it relates to the veteran's or member's military experience.

(e) *Confidentiality*. Benefits under this section are furnished solely by VA Vet Centers, which maintain confidential records independent from any other VA or Department of Defense medical records and which will not disclose such records without either the veteran's or member's of the Armed Forces, including a member of a reserve component of the Armed Forces, voluntary, signed authorization, or a

specific exception permitting their release. For more information, see 5 U.S.C. 552a, 38 U.S.C. 5701 and 7332, 45 CFR parts 160 and 164, and VA's System of Records 64VA15, ''Readjustment Counseling Service Vet Center Program.'' The term Vet Center means a facility that is operated by VA for the provision of services under this section and that is situated apart from a VA general health care facility.

(Authority: 38 U.S.C. 501, 1712A, 1782, and 1783)

[78 FR 57073, Sept. 17, 2013, as amended at 80 FR 46200, Aug. 4, 2015]

HOME IMPROVEMENTS AND STRUCTURAL ALTERATIONS (HISA) PROGRAM

SOURCE: Sections 17.3100 through 17.3130 appear at 79 FR 71660, Dec. 3, 2014, unless otherwise noted.

§ 17.3100 Purpose and scope.

(a) *Purpose*. The purpose of §§ 17.3100 through 17.3130 is to implement the Home Improvements and Structural Alterations (HISA) program. The purpose of the HISA benefits program is to provide eligible beneficiaries monetary benefits for improvements and structural alterations to their homes when such improvements and structural alterations:

(1) Are necessary for the continuation of the provision of home health treatment of the beneficiary's disability; or

(2) Provide the beneficiary with access to the home or to essential lavatory and sanitary facilities.

(b) *Scope*. 38 CFR 17.3100 through 17.3130 apply only to the administration of the HISA benefits program, unless specifically provided otherwise.

(Authority: 38 U.S.C. 501, 1717(a)(2))

§ 17.3101 Definitions.

For the purposes of the HISA benefits program (§§ 17.3100 through 17.3130):

Access to essential lavatory and sanitary facilities means having normal use of the standard structural components of those facilities.

Access to the home means the ability of the beneficiary to enter and exit the home and to maneuver within the home to at least one bedroom and essential lavatory and sanitary facilities.

Beneficiary means a veteran or servicemember who is awarded or who is eligible to receive HISA benefits.

Essential lavatory and sanitary facilities means one bathroom equipped with a toilet and a shower or bath, one kitchen, and one laundry facility.

HISA benefits means a monetary payment by VA to be used for improvements and structural alterations to the home of a beneficiary in accordance with §§ 17.3100 through 17.3130.

Home means the primary place where the beneficiary resides or, in the case of a servicemember, where the beneficiary intends to reside after discharge from service.

Improvement or structural alteration means a modification to a home or to an existing feature or fixture of a home, including repairs to or replacement of previously improved or altered features or fixtures.

Undergoing medical discharge means that a servicemember has been found unfit for duty due to a medical condition by their Service's Physical Evaluation Board, and a date of medical discharge has been issued.

(Authority: 38 U.S.C. 501, 1717)

§ 17.3102 Eligibility.

The following individuals are eligible for HISA benefits:

(a) A veteran who is eligible for medical services under 38 U.S.C. 1710(a).

(b) A servicemember who is undergoing medical discharge from the Armed Forces for a permanent disability that was incurred or aggravated in the line of duty in the active military, naval, or air service. A servicemember would be eligible for HISA benefits while hospitalized or receiving outpatient medical care, services, or treatment for such permanent disability.

(Authority: 38 U.S.C. 501, 1717)

§§ 17.3103–17.3104 [Reserved]

§ 17.3105 HISA benefit lifetime limits.

(a) *General*. Except as provided in paragraph (e) of this section, a beneficiary's HISA benefit is limited to the

lifetime amount established in paragraph (b), (c), or (d) of this section, as applicable. A beneficiary may use HISA benefits to pay for more than one home alteration, until the beneficiary exhausts his or her lifetime benefit. HISA benefits approved by VA for use in a particular home alteration but unused by the beneficiary will remain available for future use.

(b) *HISA benefits for a service-connected disability, a disability treated ''as if'' it were service connected, or for veterans with a service-connected disability rated 50 percent or more.* (1) If a veteran:

(i) Applies for HISA benefits to address a service-connected disability;

(ii) Applies for HISA benefits to address a compensable disability treated ''as if'' it is a service-connected disability and for which the veteran is entitled to medical services under 38 U.S.C. 1710(a)(2)(C) (*e.g.*, a disability acquired through treatment or vocational rehabilitation provided by VA); or

(iii) Applies for HISA benefits to address a nonservice-connected disability, if the beneficiary has a service-connected disability rated at least 50 percent disabling; and

(2) The veteran first applies for HISA benefits:

(i) Before May 5, 2010, then the veteran's lifetime HISA benefit limit is $4,100.

(ii) On or after May 5, 2010, then the veteran's lifetime HISA benefit limit is $6,800.

(c) *HISA benefits for any other disabilities.* If a veteran who is eligible for medical services under 38 U.S.C. 1710(a) applies for HISA benefits to address a disability that is not covered under paragraph (b) of this section, and the veteran first applies for HISA benefits:

(1) Before May 5, 2010, then the veteran's lifetime HISA benefit limit is $1,200; or

(2) On or after May 5, 2010, then the veteran's lifetime HISA benefit limit is $2,000.

(d) *Servicemembers.* If a servicemember is eligible for HISA benefits under § 17.3102(b), and the servicemember first applies:

(1) Before May 5, 2010, then the servicemember's HISA benefit lifetime limit is $4,100; or

(2) On or after May 5, 2010, then the servicemember's HISA benefit lifetime limit is $6,800.

(e) *Increases to HISA benefit lifetime limit.* (1) A veteran who received HISA benefits under paragraph (c) of this section, and who subsequently qualifies for HISA benefits under paragraph (b)(1) of this section on or after May 5, 2010, due to a new award of disability compensation based on service connection or an increased disability rating, may apply for the increased lifetime benefit amount under paragraph (b)(2)(ii) of this section. The increased amount that will be available is $6,800 minus the amount of HISA benefits previously used by the beneficiary.

(2) A veteran who previously received HISA benefits as a servicemember is not eligible for a new lifetime HISA benefit amount based on his or her attaining veteran status, but the veteran may file a HISA claim for any HISA benefit amounts not used prior to discharge. The veteran's subsequent HISA award cannot exceed the applicable award amount under paragraphs (b), (c), or (e)(1) of this section, as applicable, minus the amount of HISA benefits awarded to the veteran while the veteran was a servicemember.

(Authority: 38 U.S.C. 501, 1717)

§§ 17.3106–17.3119 [Reserved]

§ 17.3120 Application for HISA benefits.

(a) *Application package.* To apply for HISA benefits, the beneficiary must submit to VA a complete HISA benefits application package. A complete HISA benefits application package includes all of the following:

(1) A prescription, which VA may obtain on the beneficiary's behalf, written or approved by a VA physician that includes all of the following:

(i) The beneficiary's name, address, and telephone number.

(ii) Identification of the prescribed improvement or structural alteration.

(iii) The diagnosis and medical justification for the prescribed improvement or structural alteration.

(2) A completed and signed VA Form 10–0103, Veterans Application for Assistance in Acquiring Home Improvement and Structural Alterations, including, if desired, a request for advance payment of HISA benefits.

(3) A signed statement from the owner of the property authorizing the improvement or structural alteration to the property. The statement must be notarized if the beneficiary submitting the HISA benefits application is not the owner of the property.

(4) A written itemized estimate of costs for labor, materials, permits, and inspections for the home improvement or structural alteration.

(5) A color photograph of the unimproved area.

(b) *Pre-award inspection of site.* The beneficiary must allow VA to inspect the site of the proposed improvement or structural alteration. VA will not approve a HISA application unless VA has either conducted a pre-award inspection or has determined that no such inspection is needed. No later than 30 days after receiving a complete HISA benefits application, VA will conduct the inspection or determine that no inspection is required.

(c) *Incomplete applications.* If VA receives an incomplete HISA benefits application, VA will notify the applicant of the missing documentation. If the missing documentation is not received by VA within 30 days after such notification, VA will close the application and notify the applicant that the application has been closed. The closure notice will indicate that the application may be re-opened by submitting the requested documentation and updating any outdated information from the original application.

(Authority: 38 U.S.C. 501, 1717)

(The Office of Management and Budget has approved the information collection requirements in this section under control number 2900–0188.)

§§ 17.3121–17.3124 [Reserved]

§ 17.3125 Approving HISA benefits applications.

(a) *Approval of application.* VA will approve the HISA benefits application if:

(1) The application is consistent with §§ 17.3100 through 17.3130, and

(2) VA determines that the proposed improvement or structural alteration is reasonably designed to address the needs of the beneficiary and is appropriate for the beneficiary's home, based on documentation provided and/or through a pre-award inspection of the home.

(b) *Notification of approval.* No later than 30 days after a beneficiary submits a complete application, VA will notify the beneficiary whether an application is approved. The notification will:

(1) State the total benefit amount authorized for the improvement or structural alteration.

(2) State the amount of any advance payment, if requested by the beneficiary, and state that the advance payment must be used for the improvements or structural alterations detailed in the application. The notification will also remind beneficiaries receiving advance payment of the obligation to submit the request for final payment upon completion of the construction.

(3) Provide the beneficiary with the notice of the right to appeal if they do not agree with VA's decision regarding the award.

(Authority: 38 U.S.C. 501, 1717, 7104)

§ 17.3126 Disapproving HISA benefits applications.

VA will disapprove a HISA benefits application if the complete HISA benefits application does not meet all of the criteria outlined in § 17.3125(a). Notification of the decision provided to the beneficiary will include the basis for the disapproval and notice to the beneficiary of his or her right to appeal.

(Authority: 38 U.S.C. 501, 7104)

§§ 17.3127–17.3129 [Reserved]

§ 17.3130 HISA benefits payment procedures.

(a) *Advance payment.* If the beneficiary has requested advance payment of HISA benefits in VA Form 10–0103, as provided in § 17.3120(a)(2), VA will make an advance payment to the beneficiary equal to 50 percent of the total benefit authorized for the improvement or

structural alteration. VA will make the advance payment no later than 30 days after the HISA benefits application is approved. The beneficiary may receive only one advance payment for each approved HISA benefits application. A beneficiary must use the advance payment only for the improvement or structural alteration described in the application and must submit a final payment request, as defined in paragraph (b) of this section, to document such use after the construction is finished.

(b) *Final payment request.* No later than 60 days after the application is approved or, if VA approved an advance payment, no later than 60 days after the advance payment was made, the beneficiary must submit a complete final payment request to VA for payment. The complete final payment request must include:

(1) A statement by the beneficiary that the improvement or structural alteration, as indicated in the application, was completed;

(2) A color photograph of the completed work; and

(3) Documentation of the itemized actual costs for material, labor, permits, and inspections.

(c) *VA action on final payment request.* (1) Prior to approving and remitting the final payment, VA may inspect (within 30 days after receiving the final payment request) the beneficiary's home to determine that the improvement or structural alteration was completed as indicated in the application. No payment will be made if the improvement or structural alteration has not been completed.

(2) No later than 30 days after receipt of a complete final payment request, or, if VA conducts an inspection of the home under paragraph (c)(1) of this section, no later than 30 days after the inspection, VA will make a determination on the final payment request. If approved, VA will remit a final payment to the beneficiary equal to the lesser of:

(i) The approved HISA benefit amount, less the amount of any advance payment, or

(ii) The total actual cost of the improvement or structural alteration, less the amount of any advance payment.

(3) If the total actual cost of the improvement or structural alteration is less than the amount paid to the beneficiary as an advance payment, the beneficiary will reimburse VA for the difference between the advance payment and the total actual costs.

(4) After final payment is made on a HISA benefits application, the application file will be closed and no future HISA benefits will be furnished to the beneficiary for that application. If the total actual cost of the improvement or structural alteration is less than the approved HISA benefit, the balance of the approved amount will be credited to the beneficiary's remaining HISA benefits lifetime balance.

(d) *Failure to submit a final payment request.* (1) If an advance payment was made to the beneficiary, but the beneficiary fails to submit a final payment request in accordance with paragraph (b) of this section within 60 days of the date of the advance payment, VA will send a notice to remind the beneficiary of the obligation to submit the final payment request. If the beneficiary fails to submit the final payment request or to provide a suitable update and explanation of delay within 30 days of this notice, VA may take appropriate action to collect the amount of the advance payment from the beneficiary.

(2) If an advance payment was not made to the beneficiary and the beneficiary does not submit a final payment request in accordance with paragraph (b) of this section within 60 days of the date the application was approved, the application will be closed and no future HISA benefits will be furnished to the beneficiary for that application. Before closing the application, VA will send a notice to the beneficiary of the intent to close the file. If the beneficiary does not respond with a suitable update and explanation for the delay within 30 days, VA will close the file and provide a final notice of closure. The notice will include information about the right to appeal the decision.

(e) *Failure to make approved improvements or structural alterations.* If an inspection conducted pursuant to paragraph (c)(1) of this section reveals that

the improvement or structural alteration has not been completed as indicated in the final payment request, VA may take appropriate action to collect the amount of the advance payment from the beneficiary. VA will not seek to collect the amount of the advance payment from the beneficiary if the beneficiary provides documentation indicating that the project was not completed due to the fault of the contractor, including bankruptcy or misconduct of the contractor.

(Authority: 38 U.S.C. 501, 1717)

(The Office of Management and Budget has approved the information collection requirement in this section under control number 2900–0188.)

VETERANS COMMUNITY CARE PROGRAM

SOURCE: Sections 17.4000 through 17.4040, appear as 84 FR 26307, June 5, 2019, unless otherwise noted.

§ 17.4000 Purpose and scope.

(a) *Purpose*. Sections 17.4000 through 17.4040 implement the Veterans Community Care Program, authorized by 38 U.S.C. 1703.

(b) *Scope*. The Veterans Community Care Program establishes when a covered veteran may elect to have VA authorize an episode of care for hospital care, medical services, or extended care services from an eligible entity or provider. Sections 17.4000 through 17.4040 do not affect eligibility for non-VA care under sections 1724, 1725, 1725A, or 1728 of title 38, United States Code.

§ 17.4005 Definitions.

For purposes of the Veterans Community Care Program under §§ 17.4000 through 17.4040:

Appointment means an authorized and scheduled encounter, including telehealth and same-day encounters, with a health care provider for the delivery of hospital care, medical services, or extended care services.

Covered veteran means a veteran enrolled under the system of patient enrollment in § 17.36, or a veteran who otherwise meets the criteria to receive care and services notwithstanding his or her failure to enroll in § 17.37(a) through (c).

Eligible entity or provider means a health care entity or provider that meets the requirements of § 17.4030.

Episode of care means a necessary course of treatment, including follow-up appointments and ancillary and specialty services, which lasts no longer than 1 calendar year.

Extended care services include the same services as described in 38 U.S.C. 1710B(a).

Full-service VA medical facility means a VA medical facility that provides hospital care, emergency medical services, and surgical care and having a surgical complexity designation of at least ''standard.''

Note 1 to the definition of ''full-service VA medical facility'': VA maintains a website with a list of the facilities that have been designated with at least a surgical complexity of ''standard,'' which can be accessed on VA's website.

Hospital care has the same meaning as defined in 38 U.S.C. 1701(5).

Medical services have the same meaning as defined in 38 U.S.C. 1701(6).

Other health-care plan contract means an insurance policy or contract, medical or hospital service agreement, membership or subscription contract, or similar arrangement not administered by the Secretary of Veterans Affairs, under which health services for individuals are provided or the expenses of such services are paid; and does not include any such policy, contract, agreement, or similar arrangement pursuant to title XVIII or XIX of the Social Security Act (42 U.S.C. 1395 *et seq.*) or chapter 55 of title 10, United States Code.

Residence means a legal residence or personal domicile, even if such residence is seasonal. A covered veteran may maintain more than one residence but may only have one residence at a time. If a covered veteran lives in more than one location during a year, the covered veteran's residence is the residence or domicile where they are staying at the time they want to receive hospital care, medical services, or extended care services through the Veterans Community Care Program. A post office box or other non-residential point of delivery does not constitute a residence.

Schedule means identifying and confirming a date, time, location, and entity or health care provider for an appointment in advance of such appointment.

Note 1 to the definition of ''schedule'': A VA telehealth encounter and a same-day care encounter are considered to be scheduled even if such an encounter is conducted on an ad hoc basis.

VA facility means a VA facility that offers hospital care, medical services, or extended care services.

VA medical service line means a specific medical service or set of services delivered in a VA facility.

§ 17.4010 Veteran eligibility.

Section 1703(d) of title 38, U.S.C., establishes the conditions under which, at the election of the veteran and subject to the availability of appropriations, VA must furnish care in the community through eligible entities and providers. VA has regulated these conditions under paragraphs (a)(1) through (5) of this section. If VA determines that a covered veteran meets at least one or more of the conditions in paragraph (a) of this section and has provided information required by paragraphs (b) and (c) of this section, the covered veteran may elect to receive authorized non-VA care under § 17.4020.

(a) The covered veteran requires hospital care, medical services, or extended care services and:

(1) No VA facility offers the hospital care, medical services, or extended care services the veteran requires.

(2) VA does not operate a full-service VA medical facility in the State in which the veteran resides.

(3) The veteran was eligible to receive care and services from an eligible entity or provider under section 101(b)(2)(B) of the Veterans Access, Choice, and Accountability Act of 2014 (Pub. L. 113–146, sec. 101, as amended; 38 U.S.C. 1701 note) as of June 5, 2018, and continues to reside in a location that would qualify the veteran under that provision, and:

(i) Resides in Alaska, Montana, North Dakota, South Dakota, or Wyoming; or

(ii) Does not reside in one of the States described in paragraph (a)(3)(i) of this section, but received care or services under title 38 U.S.C. between June 6, 2017, and June 6, 2018, and is seeking care before June 6, 2020.

(4) Has contacted an authorized VA official to request the care or services the veteran requires, but VA has determined it is not able to furnish such care or services in a manner that complies with designated access standards established in § 17.4040.

(5) The veteran and the veteran's referring clinician determine it is in the best medical interest of the veteran, for the purpose of achieving improved clinical outcomes, to access the care or services the veteran requires from an eligible entity or provider, based on one or more of the following factors, as applicable:

(i) The distance between the veteran and the facility or facilities that could provide the required care or services;

(ii) The nature of the care or services required by the veteran;

(iii) The frequency the veteran requires the care or services;

(iv) The timeliness of available appointments for the required care or services;

(v) The potential for improved continuity of care;

(vi) The quality of the care provided; or

(vii) Whether the veteran faces an unusual or excessive burden in accessing a VA facility based on consideration of the following:

(A) Excessive driving distance; geographical challenges, such as the presence of a body of water (including moving water and still water) or a geologic formation that cannot be crossed by road; or environmental factors, such as roads that are not accessible to the general public, traffic, or hazardous weather.

(B) Whether care and services are available from a VA facility that is reasonably accessible.

(C) Whether a medical condition of the veteran affects the ability to travel.

(D) Whether there is a compelling reason the veteran needs to receive care and services from a non-VA facility.

(E) The need for an attendant, which is defined as a person who provides required aid and/or physical assistance to the veteran, for a veteran to travel to a VA medical facility for hospital care or medical services.

(6) In accordance with § 17.4015, VA has determined that a VA medical service line that would furnish the care or services the veteran requires is not providing such care or services in a manner that complies with VA's standards for quality.

(b) If the covered veteran changes his or her residence, the covered veteran must update VA about the change within 60 days.

(c) A covered veteran must provide to VA information on any other health-care plan contract under which the veteran is covered prior to obtaining authorization for care and services the veteran requires. If the veteran changes such other health-care plan contract, the veteran must update VA about the change within 60 days.

(d) Review of veteran eligibility determinations. The review of any decisions under paragraph (a) of this section are subject to VA's clinical appeals process, and such decisions may not be appealed to the Board of Veterans' Appeals.

(The information collection is pending Office of Management and Budget approval.)

§ 17.4015 Designated VA medical service lines.

(a) VA may identify VA medical service lines that are underperforming based on the timeliness of care when compared with the same medical service line at other VA facilities and based on data related to two or more distinct and appropriate quality measures of VA's standards for quality when compared with non-VA medical service lines.

(b) VA will make determinations regarding VA medical service lines under this section using data described in paragraph (a) of this section, VA standards for quality, and based on factors identified in paragraph (e) of this section.

(c) VA will announce annually any VA medical service lines identified under paragraph (a) of this section by publishing a document in the FEDERAL REGISTER. Such document will identify and describe the standards for quality VA used to inform the determination under paragraph (a), as well as how the data described in paragraph (a) and factors identified in paragraph (e) of this section were used to make the determinations. Such document will also identify limitations, if any, concerning when and where covered veterans can receive qualifying care and services at their election in the community based on this section. Such limitations may include a defined timeframe, a defined geographic area, and a defined scope of services. VA will also take reasonable steps to provide direct notice to covered veterans affected under this section.

(d) VA will identify no more than 3 VA medical services lines in a single VA facility under this section, and no more than 36 VA medical service lines nationally under this section.

(e) In determining whether a VA medical service line should be identified under paragraph (a) of this section, and to comply with paragraph (c) of this section, VA will consider:

(1) Whether the differences between performance of individual VA medical service lines, and between performance of VA medical service lines and non-VA medical service lines, is clinically significant.

(2) Likelihood and ease of remediation of the VA medical service line within a short timeframe.

(3) Recent trends concerning the VA medical service line or non-VA medical service line.

(4) The number of covered veterans served by the medical service line or that could be affected by the designation.

(5) The potential impact on patient outcomes.

(6) The effect that designating one VA medical service line would have on other VA medical service lines.

§ 17.4020 Authorized non-VA care.

(a) *Electing non-VA care.* Except as provided for in paragraph (d) of this section, a covered veteran eligible for the Veterans Community Care Program under § 17.4010 may choose to schedule an appointment with a VA

health care provider, or have VA authorize the veteran to receive an episode of care for hospital care, medical services, or extended care services from an eligible entity or provider when VA determines such care or services are clinically necessary.

(b) *Selecting an eligible entity or provider*. A covered veteran may specify a particular eligible entity or provider. If a covered veteran does not specify a particular eligible entity or provider, VA will refer the veteran to a specific eligible entity or provider.

(c) *Authorizing emergency treatment*. This paragraph (c) applies only to emergency treatment furnished to a covered veteran by an eligible entity or provider when such treatment was not the subject of an election by a veteran under paragraph (a) of this section. This paragraph (c) does not affect eligibility for, or create any new rules or conditions affecting, reimbursement for emergency treatment under section 1725 or 1728 of title 38, United States Code.

(1) Under the conditions set forth in this paragraph (c), VA may authorize emergency treatment after it has been furnished to a covered veteran. For purposes of this paragraph (c), ''emergency treatment'' has the meaning defined in section 1725(f)(1) of title 38, United States Code.

(2) VA may only authorize emergency treatment under this paragraph (c) if the covered veteran, someone acting on the covered veteran's behalf, or the eligible entity or provider notifies VA within 72-hours of such care or services being furnished and VA approves the furnishing of such care or services under paragraph (c)(3) of this section.

(3) VA may approve emergency treatment of a covered veteran under this paragraph (c) only if:

(i) The veteran is receiving emergency treatment from an eligible entity or provider.

(ii) The notice to VA complies with the provisions of paragraph (c)(4) of this section and is submitted within 72 hours of the beginning of such treatment.

(iii) The emergency treatment only includes services covered by VA's medical benefits package in § 17.38.

(4) Notice to VA must:

(i) Be made to the appropriate VA official at the nearest VA facility;

(ii) Identify the covered veteran; and

(iii) Identify the eligible entity or provider.

(d) *Organ and bone marrow transplant care*. (1) In the case of a covered veteran described in paragraph (d)(3) of this section, the Secretary will determine whether to authorize an organ or bone marrow transplant for the covered veteran through an eligible entity or provider.

(2) The Secretary will make determinations under paragraph (d)(1) of this section, and the primary care provider of the veteran will make determinations concerning whether there is a medically compelling reason to travel outside the region of the Organ Procurement and Transplantation Network in which the veteran resides to receive a transplant, in consideration of, but not limited to, the following factors:

(i) Specific patient factors.

(ii) Which facilities meet VA's standards for quality, including quality metrics and outcomes, for the required transplant.

(iii) The travel burden on covered veterans based upon their medical conditions and the geographic location of eligible transplant centers.

(iv) The timeliness of transplant center evaluations and management.

(3) This paragraph (d) applies to covered veterans who meet one or more conditions of eligibility under § 17.4010(a) and:

(i) Require an organ or bone marrow transplant as determined by VA based upon generally-accepted medical criteria; and

(ii) Have, in the opinion of the primary care provider of the veteran, a medically compelling reason, as determined in consideration of the factors described in paragraph (d)(2) of this section, to travel outside the region of the Organ Procurement and Transplantation Network in which the veteran resides, to receive such transplant.

§ 17.4025 Effect on other provisions.

(a) *General*. No provision in this section may be construed to alter or modify any other provision of law establishing specific eligibility criteria for

certain hospital care, medical services, or extended care services.

(b) *Prescriptions.* Notwithstanding any other provision of this part, VA will:

(1) Pay for prescriptions no longer than 14 days written by eligible entities or providers for covered veterans, including over-the-counter drugs and medical and surgical supplies, available under the VA national formulary system to cover a course of treatment for an urgent or emergent condition.

(2) Fill prescriptions written by eligible entities or providers for covered veterans, including over-the-counter drugs and medical and surgical supplies, available under the VA national formulary system.

(3) Pay for prescriptions written by eligible entities or providers for covered veterans that have an immediate need for durable medical equipment and medical devices that are required for urgent or emergent conditions (*e.g.*, splints, crutches, manual wheelchairs).

(4) Fill prescriptions written by eligible entities or providers for covered veterans for durable medical equipment and medical devices that are not required for urgent or emergent conditions.

(c) *Copayments.* Covered veterans are liable for a VA copayment for care or services furnished under the Veterans Community Care Program, if required by § 17.108(b)(4) or (c)(4), § 17.110(b)(4), or § 17.111(b)(3).

§ 17.4030 Eligible entities and providers.

To be eligible to furnish care and services under the Veterans Community Care Program, entities or providers:

(a) Must enter into a contract, agreement, or other arrangement to furnish care and services under the Veterans Community Care Program under §§ 17.4000 through 17.4040.

(b) Must either:

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

(2) If the provider is an employee of VA, not be acting within the scope of such employment while providing hospital care, medical services, or extended care services through the Veterans Community Care Program under §§ 17.4000 through 17.4040.

(c) Must be accessible to the covered veteran. VA will determine accessibility by considering the following factors:

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

(2) The qualifications of the entity or provider to furnish the hospital care, medical services, or extended care services from the entity or provider; and

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

§ 17.4035 Payment rates.

The rates paid by VA for hospital care, medical services, or extended care services (hereafter referred to as ''services'') furnished pursuant to a procurement contract or an agreement authorized by §§ 17.4100 through 17.4135 will be the rates set forth in the terms of such contract or agreement. Such payment rates will comply with the following parameters:

(a) Except as otherwise provided in this section, payment rates will not exceed the applicable Medicare fee schedule (including but not limited to allowable rates under 42 U.S.C. 1395m) or prospective payment system amount (hereafter ''Medicare rate''), if any, for the period in which the service was provided (without any changes based on the subsequent development of information under Medicare authorities).

(b) With respect to services furnished in a State with an All-Payer Model Agreement under section 1814(b)(3) of the Social Security Act (42 U.S.C. 1395f(b)(3)) that became effective on or after January 1, 2014, the Medicare payment rates under paragraph (a) of this section will be calculated based on the payment rates under such agreement.

(c) Payment rates for services furnished in a highly rural area may exceed the limitations set forth in paragraphs (a) and (b) of this section. The term ''highly rural area'' means an area located in a county that has fewer than seven individuals residing in that county per square mile.

(d) Payment rates may deviate from the parameters set forth in paragraphs (a) through (c) of this section when VA determines, based on patient needs, market analyses, health care provider qualifications, or other factors, that it is not practicable to limit payment for services to the rates available under paragraphs (a) through (c).

(e) Payment rates for services furnished in Alaska are not subject to paragraphs (a) through (d) of this section and will be set forth in the terms of the procurement contract or agreement authorized by §§17.4100 through 17.4135, pursuant to which such services are furnished. If no payment rate is set forth in the terms of such a contract or agreement pursuant to which such services are furnished, payment rates for services furnished in Alaska will follow the Alaska Fee Schedule of the Department of Veterans Affairs.

§ 17.4040 Designated access standards.

(a) The following access standards have been designated to apply for purposes of eligibility determinations to access care in the community through the Veterans Community Care Program under §17.4010(a)(4).

(1) *Primary care, mental health care, and non-institutional extended care services.* VA cannot schedule an appointment for the covered veteran with a VA health care provider for the required care or service:

(i) Within 30 minutes average driving time of the veteran's residence; and

(ii) Within 20 days of the date of request unless a later date has been agreed to by the veteran in consultation with the VA health care provider.

(2) *Specialty care.* VA cannot schedule an appointment for the covered veteran with a VA health care provider for the required care or service:

(i) Within 60 minutes average driving time of the veteran's residence; and

(ii) Within 28 days of the date of request unless a later date has been agreed to by the veteran in consultation with the VA health care provider.

(b) For purposes of calculating average driving time from the veteran's residence in paragraph (a) of this section, VA will use geographic information system software.

VETERANS CARE AGREEMENTS

SOURCE: Sections 17.4100 through 17.4135 appear at 84 FR 21678, May 14, 2019, unless otherwise noted.

§ 17.4100 Definitions.

For the purposes of §§17.4100 through 17.4135, the following definitions apply:

Contract is any of the following: Federal procurement agreements regulated by the Federal Acquisition Regulation; common law contracts; other transactions; or any other instrument. Veterans Care Agreements are excluded from this definition.

Covered individual is an individual who is eligible to receive hospital care, medical services, or extended care services from a non-VA provider under title 38 U.S.C. and title 38 CFR.

Extended care services are the services described in 38 U.S.C. 1710B(a).

Hospital care is defined in 38 U.S.C. 1701(5).

Medical services is defined in 38 U.S.C. 1701(6).

Sharing agreement is an agreement, under statutory authority other than 38 U.S.C. 1703A, by which VA can obtain hospital care, medical services, or extended care services for a covered individual.

VA facility is a point of VA care where covered individuals can receive hospital care, medical services, or extended care services, to include a VA medical center, a VA community-based outpatient clinic, a VA health care center, a VA community living center, a VA independent outpatient clinic, and other VA outpatient services sites.

Veterans Care Agreement is an agreement authorized under 38 U.S.C. 1703A for the furnishing of hospital care, medical services, or extended care services to covered individuals.

§ 17.4105 Purpose and Scope.

(a) *Purpose.* Sections 17.4100 through 17.4135 implement 38 U.S.C. 1703A, as required under section 1703A(j). Section 1703A authorizes VA to enter into and utilize Veterans Care Agreements to furnish hospital care, medical services, and extended care services to a covered individual when such individual is eligible for and requires such care or services that are not feasibly available to

the covered individual through a VA facility, a contract, or a sharing agreement.

(b) *Scope.* Sections 17.4100 through 17.4135 contain procedures, requirements, obligations, and limitations for: The process of certifying entities or providers under 38 U.S.C. 1703A; entering into, administering, furnishing care or services pursuant to, and discontinuing Veterans Care Agreements; and all disputes arising under or related to Veterans Care Agreements. Sections 17.4100 through 17.4135 apply to all entities and providers, where applicable, that are parties to a Veterans Care Agreement, participate in the certification process, or furnish hospital care, medical services, or extended care services pursuant to a Veterans Care Agreement.

§ 17.4110 Entity or provider certification.

(a) *General.* To be eligible to enter into a Veterans Care Agreement, an entity or provider must be certified by VA in accordance with the process and criteria established in paragraph (b) of this section. Additionally, an entity or provider must be actively certified while furnishing hospital care, medical services, or extended care services pursuant to a Veterans Care Agreement that the entity or provider has entered into with VA.

(b) *Process and criteria*—(1) *Application for certification.* An entity or provider must apply for certification by submitting the following information and documentation to VA:

(i) Documentation of applicable medical licenses; and

(ii) All other information and documentation required by VA. This information and documentation may include, but is not limited to, provider first and last names, legal business names, National Provider Identifier (NPI), NPI type, provider identifier type (*e.g.*, individual or group practice), tax identification number, specialty (taxonomy code), business address, billing address, phone number, and care site address.

(2) *Approval or denial of certification.* (i) VA will review all information obtained by VA, including through applicable federal and state records systems and as submitted by the applicant, and will determine eligibility for certification.

(ii) An applicant must submit all information required under paragraph (b)(1) of this section.

(iii) VA will deny an application for certification if VA determines that the entity or provider is excluded from participation in a Federal health care program (as defined in section 1128B(f) of the Social Security Act (42 U.S.C. 1320a–7b(f)) under section 1128 or 1128A of such Act (42 U.S.C. 1320a–7 and 1320a–7a) or is identified as an excluded source on the System for Award Management Exclusions list described in part 9 of title 48, Code of Federal Regulations, and part 180 of title 2 of such Code, or successor regulations.

(iv) VA will deny an application for certification if VA determines that the applicant is already barred from furnishing hospital care, medical services, and extended care services under chapter 17 of title 38, U.S.C., because VA has previously determined the applicant submitted to VA a fraudulent claim, as that term is defined in 38 U.S.C. 1703D(i)(4), for payment for hospital care, medical services, or extended care services.

(v) VA may deny an application for certification if VA determines that based on programmatic considerations, VA is unlikely to seek to enter into a Veterans Care Agreement with the applicant.

(vi) VA will issue a decision approving or denying an application for certification within 120 calendar days of receipt of such application, if practicable. Notices of approval will set forth the effective date and duration of the certification. Notices of denial will set forth the specific grounds for denial and supporting evidence. A denial constitutes VA's final decision on the application.

(3) *Duration of certification and application for recertification.* (i) An entity or provider's certification under this section lasts for a three-year period, unless VA revokes certification during that three-year period pursuant to paragraph (b)(4) of this section.

(ii) A certified entity or provider must maintain its eligibility throughout the period in which it is certified

and must inform VA of any changes or events that would affect its eligibility within 30 calendar days of the change or event.

(iii) A certified entity or provider seeking certification after the end of its current three-year certification must apply for recertification at least 60 calendar days prior to the expiration of its current certification; otherwise, the procedures set forth in paragraph (b)(3)(iv) of this section will apply. Upon application for recertification by the entity or provider, including submitting any new or updated information within the scope of paragraph (b)(1) of this section that VA requests in conjunction with such application for recertification, VA will reassess the entity or provider under the criteria in paragraph (b)(2) of this section. VA will issue a decision approving or denying the application for recertification within 60 calendar days of receiving the application, if practicable. Notice of the decision will be furnished to the applicant in writing. Notices of recertification will set forth the effective date and duration of the certification. Notices of denial will set forth the specific grounds for denial and supporting evidence. A denial constitutes VA's final decision on the application for recertification.

(iv) If a certified entity or provider applies for recertification after the deadline in paragraph (b)(3)(iii) of this section, such application will constitute a new application for certification and will be processed in accordance with paragraphs (b)(1) and (2) of this section.

(4) *Revocation of certification*—(i) *Standard for revocation*. VA may revoke an entity's or provider's certification in accordance with paragraphs (b)(2)(ii) through (v) of this section.

(ii) *Notice of proposed revocation*. When VA determines revocation is appropriate, VA will notify the entity or provider in writing of the proposed revocation. The notice of proposed revocation will set forth the specific grounds for the action and will notify the entity or provider that it has 30 calendar days from the date of issuance to submit a written response addressing either of the following:

(A) Documenting compliance and proving any grounds false, or

(B) Providing information and documentation that demonstrates the entity or provider has, subsequent to the notice of proposed revocation, achieved compliance with all criteria for certification set forth in paragraph (b)(2) of this section.

(iii) *Decision to revoke*. Following the 30-day response period, VA will consider any information and documentation submitted by the entity or provider and will, within 30 calendar days, determine whether revocation is warranted. If VA determines that revocation is not warranted, VA will notify the entity or provider of that determination in writing. If VA determines that revocation is warranted, the entity or provider will immediately lose certified status, and VA will issue a notice of revocation to the entity or provider. Notices of revocation will set forth the specific facts and grounds for, and the effective date of, such revocation. A notice of revocation constitutes VA's final decision.

(iv) *Effect of revocation*. Revocation of certification results in such status being rendered void, and the provider or entity may not furnish services or care to a covered individual under a Veterans Care Agreement prior to applying for and obtaining certified VCA status.

(The information collection requirements have been submitted to the Office of Management and Budget (OMB) and are pending OMB approval.)

§ 17.4115 VA use of Veterans Care Agreements.

(a) *Criteria for using*. VA may furnish hospital care, medical services, or extended care services through a Veterans Care Agreement only if:

(1) Such care or services are furnished to a covered individual who is eligible for such care or services under 38 U.S.C. chapter 17 and requires such care or services; and

(2) Such care or services are not feasibly available to that covered individual through a VA facility, contract, or sharing agreement. For purposes of this subparagraph, hospital care, medical services, or extended care services are not feasibly available through a VA

facility, contract, or sharing agreement when VA determines that the medical condition of the covered individual, the travel involved, the nature of the care or services, or a combination of these factors make the use of a VA facility, contract, or sharing agreement impracticable or inadvisable.

(b) *Standards of conduct and improper business practices*—(1) *General.* (i) Government business shall be conducted in a manner above reproach and, except as authorized by statute or regulation, with complete impartiality and with preferential treatment for none. Transactions relating to the expenditure of public funds require the highest degree of public trust and an impeccable standard of conduct. The general rule is to avoid strictly any conflict of interest or even the appearance of a conflict of interest in Government-contractor relationships. The conduct of Government personnel must be such that they would have no reluctance to make a full public disclosure of their actions.

(ii) VA officials and employees are reminded that there are other statutes and regulations that deal with prohibited conduct, including:

(A) The offer or acceptance of a bribe or gratuity is prohibited by 18 U.S.C. 201. The acceptance of a gift, under certain circumstances, is prohibited by 5 U.S.C. 7353, and 5 CFR part 2635;

(B)(*1*) Certain financial conflicts of interest are prohibited by 18 U.S.C. 208 and regulations at 5 CFR part 2635.

(*2*) Contacts with an entity or provider that is seeking or receives certification under section 17.4110 of this part or is seeking, enters into, and/or furnishes services or care under a Veterans Care Agreement may constitute ''seeking employment,'' (see Subpart F of 5 CFR part 2635). Government officers and employees (employees) are prohibited by 18 U.S.C. 208 and 5 CFR part 2635 from participating personally and substantially in any particular matter that would affect the financial interests of any person from whom the employee is seeking employment. An employee who engages in negotiations or is otherwise seeking employment with an offeror or who has an arrangement concerning future employment with an offeror must comply with the applicable disqualification requirements of 5 CFR 2635.604 and 2635.606. The statutory prohibition in 18 U.S.C. 208 also may require an employee's disqualification from participation in matters pertaining to the certification of an entity or provider or a entering into and administering a Veterans Care Agreement with an entity or provider even if the employee's duties may not be considered ''participating personally and substantially'';

(C) Post-employment restrictions are covered by 18 U.S.C. 207 and 5 CFR part 2641, that prohibit certain activities by former Government employees, including representation of an entity or provider before the Government in relation to any particular matter involving specific parties on which the former employee participated personally and substantially while employed by the Government. Additional restrictions apply to certain senior Government employees and for particular matters under an employee's official responsibility; and

(D) Using nonpublic information to further an employee's private interest or that of another and engaging in a financial transaction using nonpublic information are prohibited by 5 CFR 2635.703.

(2) *Standards and requirements for entities or providers that enter into Veterans Care Agreements.* An entity or provider that enters into a Veterans Care Agreement must comply with the following standards and requirements throughout the term of the Veterans Care Agreement:

(i) Must have a satisfactory performance record.

(ii) Must have a satisfactory record of integrity and business ethics.

(iii) Must notify VA within 30 calendar days of the existence of an indictment, charge, conviction, or civil judgment, or Federal tax delinquency in an amount that exceeds $3,500.

(iv) Must not engage in any of the following:

(A) Commission of fraud or a criminal offense in connection with—

(*1*) Obtaining;

(*2*) Attempting to obtain; or

(*3*) Performing a public contract or subcontract, or a Veterans Care Agreement;

(B) Violation of Federal or State antitrust statutes relating to the submission of offers;

(C) Commission of embezzlement, theft, forgery, bribery, falsification or destruction of records, making false statements, tax evasion, violating Federal criminal tax laws, or receiving stolen property;

(D) Delinquent Federal taxes in an amount that exceeds $3,500. Federal taxes are considered delinquent for purposes of this provision if both of the following criteria apply:

(*1*) The tax liability is finally determined. The liability is finally determined if it has been assessed and all available administrative remedies and rights to judicial review have been exhausted or have lapsed.

(*2*) The taxpayer is delinquent in making payment. A taxpayer is delinquent if the taxpayer has failed to pay the tax liability when full payment was due and required. A taxpayer is not delinquent in cases where enforced collection action is precluded.

(E) Knowing failure by a principal, until 3 years after final payment on any Government contract awarded to the contractor (or any Veterans Care Agreement entered into with the entity or provider), to timely disclose to the Government, in connection with the award or agreement, performance, or closeout of the contract or agreement or a subcontract thereunder, credible evidence of—

(*1*) Violation of Federal criminal law involving fraud, conflict of interest, bribery, or gratuity violations found in Title 18 of the United States Code;

(*2*) Violation of the civil False Claims Act (31 U.S.C. 3729–3733); or

(*3*) Significant overpayment(s) on the contract or Veterans Care Agreement, other than overpayments resulting from contract financing payments. Contract financing payments means an authorized Government disbursement of monies to a contractor prior to acceptance of supplies or services by the Government; or

(F) Commission of any other offense indicating a lack of business integrity or business honesty that seriously and directly affects the present responsibility of an entity or provider.

(v) Must not submit to VA a fraudulent claim, as that term is defined in 38 U.S.C. 1703D(i)(4), for payment for hospital care, medical services, or extended care services.

§ 17.4120 Payment rates.

The rates paid by VA for hospital care, medical services, and extended care services (hereafter in this section referred to as ''services'') furnished pursuant to a Veterans Care Agreement will be the rates set forth in the price terms of the Veterans Care Agreement. Each Veterans Care Agreement will contain price terms for all services within its scope. Such payment rates will comply with the following parameters:

(a) Except as otherwise provided in this section, payment rates will not exceed the applicable Medicare fee schedule or prospective payment system amount (hereafter in this section referred to as ''Medicare rate''), if any, for the period in which the service was provided (without any changes based on the subsequent development of information under Medicare authorities).

(b) With respect to services furnished in a State with an All-Payer Model Agreement under section 1814(b)(3) of the Social Security Act (42 U.S.C. 1395f(b)(3)) that became effective on or after January 1, 2014, the Medicare rate under paragraph (a) will be calculated based on the payment rates under such agreement.

(c) Payment rates for services furnished in a highly rural area may exceed the limitations set forth in paragraphs (a) and (b) of this section. The term ''highly rural area'' means an area located in a county that has fewer than seven individuals residing in that county per square mile.

(d) Payment rates may deviate from the parameters set forth in paragraphs (a) through (c) of this section when VA determines, based on patient needs, market analyses, health care provider qualifications, or other factors, that it is not practicable to limit payment for services to the rates available under paragraphs (a) through (c).

(e) Payment rates for services furnished in Alaska are not subject to paragraphs (a) through (d) of this section.

§ 17.4125 Review of Veterans Care Agreements.

VA will periodically review each Veterans Care Agreement that exceeds $5,000,000 annually, to determine if it is feasible and advisable to furnish the hospital care, medical services, and extended care services that VA has furnished or anticipates furnishing under such Veterans Care Agreements through a VA facility, contract, or sharing agreement instead. If VA determines it is feasible and advisable to provide any such hospital care, medical services, or extended care services in a VA facility or by contract or sharing agreement, it will take action to do so.

§ 17.4130 Discontinuation of Veterans Care Agreements.

(a) Discontinuation of the agreement by the entity or provider requires a written notice of request to discontinue, in accordance with the terms of the Veterans Care Agreement and the following notice requirements:

(1) Written notice must be received by VA at least 45 calendar days before the discontinuation date and must specify the discontinuation date; and

(2) Such notice must be delivered to the designated VA official to which such notice must be submitted under the terms of the Veterans Care Agreement, and the notice and delivery must comply with all terms of the Veterans Care Agreement.

(b)(1) Discontinuation of the agreement by VA requires a written notice of discontinuation to the entity or provider in accordance with the terms of the Veterans Care Agreement and the following notice standards:

(i) Written notice of discontinuation will be issued at least 45 calendar days before the discontinuation date, except as provided in subparagraph (ii).

(ii) Notice may be issued fewer than 45 calendar days before the discontinuation date, including notice that is effective immediately upon issuance, when VA determines such abbreviated or immediate notice is necessary to protect the health of covered individuals or when such abbreviated or immediate notice is permitted under the terms of the Veterans Care Agreement.

(2) Notice will be delivered to the entity or provider in accordance with the terms of the Veterans Care Agreement.

(3) VA may discontinue a Veterans Care Agreement for the following reasons:

(i) If VA determines the entity or provider failed to comply substantially with the provisions of 38 U.S.C. 1703A or 38 CFR 17.4100–17.4135

(ii) If VA determines the entity or provider failed to comply substantially with the provisions, terms, or conditions of the Veterans Care Agreement;

(iii) If VA determines the entity or provider is excluded from participation in a Federal health care program (as defined in section 1128B(f) of the Social Security Act (42 U.S.C. 1320a–7b(f)) under section 1128 or 1128A of such Act (42 U.S.C. 1320a–7 and 1320a–7a), or is identified as an excluded source on the System for Award Management Exclusions list described in part 9 of title 48, Code of Federal Regulations, and part 180 of title 2 of such Code, or successor regulations;

(iv) If VA ascertains that the entity or provider has been convicted of a felony or other serious offense under federal or state law and determines that discontinuation of the Veterans Care Agreement would be in the best interest of a covered individual or VA; or

(v) If VA determines it is reasonable to discontinue the Veterans Care Agreement based on the health care needs of a covered individual.

(The information collection requirements have been submitted to the Office of Management and Budget (OMB) and are pending OMB approval.)

§ 17.4135 Disputes.

(a) *General.* (1) This section establishes the administrative procedures and requirements for asserting and resolving disputes arising under or related to a Veterans Care Agreement. For purposes of this section, a dispute means a disagreement, between VA and the entity or provider that entered into the subject Veterans Care Agreement with VA, that meets the following criteria:

(i) Pertains to one of the subject matters set forth in paragraph (b) of this section;

(ii) Is not resolved informally by mutual agreement of the parties; and

(iii) Culminates in one of the parties demanding or asserting, as a matter of right, the payment of money in a sum certain under the Veterans Care Agreement, the interpretation of the terms of the Veterans Care Agreement or a specific authorization thereunder, or other relief arising under or relating to the Veterans Care Agreement. However, a dispute does not encompass any demand or assertion, as a matter of right, for penalties or forfeitures prescribed by a statute or regulation that another federal agency is specifically authorized to administer, settle, or determine.

(2) The procedures established in this section should only be used when the parties to a Veterans Care Agreement have failed to resolve an issue in controversy by mutual agreement.

(3) The procedures established in this section constitute an entity's or provider's exclusive administrative remedy for disputes under this section.

(4) Disputes under this section are not considered claims for the purposes of laws that would otherwise require the application of sections 7101 through 7109 of title 41 U.S.C.

(5) An entity or provider must first exhaust the procedures established in this section before seeking judicial review under section 1346 of title 28 U.S.C.

(b) *Subject matter of disputes*. Disputes under this section must pertain to:

(1) The scope of one or more specific authorizations under the applicable Veterans Care Agreement; or

(2) Claims for payment under the applicable Veterans Care Agreement.

(c) *Procedures*—(1) *Initiation of dispute*. Disputes under this section must be initiated in accordance with the following procedures and requirements:

(i) Disputes must be initiated by submitting a notice of dispute, in writing, to the designated VA official to which notice must be submitted under the terms of the Veterans Care Agreement. The notice of dispute must comply with, and be submitted in accordance with, applicable terms of the Veterans Care Agreement.

(ii) The notice of dispute must contain all specific assertions or demands, all facts pertinent to the dispute, any specific resolutions or relief sought, and all information and documentation necessary to review and adjudicate the dispute.

(iii) The notice of dispute must be received by the designated VA official to which such notice must be submitted, in accordance with the terms of the Veterans Care Agreement, within 90 calendar days after the accrual of the dispute. For purposes of this paragraph, the accrual of the dispute is the date when all events, that fix the alleged liability of either VA or the entity or provider and permit the applicable demand(s) and assertion(s), were known or should have been known. The term ''accrual of the dispute,'' as defined, has the following meanings in each of the two specific circumstances that follow:

(A) When a dispute consists of an entity or provider asserting that VA has made payment in an incorrect amount, under circumstances where VA has issued a corresponding payment notice and the entity or provider has received such notice, the accrual of the dispute is the date such notice was received by the entity or provider.

(B) When a dispute consists of an entity or provider asserting that VA has improperly denied payment to which it is entitled, under circumstances where VA has issued a corresponding denial of payment notice and the entity or provider has received such notice, the accrual of the dispute is the date such notice was received by the entity or provider.

(2) *VA authority to decide and resolve disputes arising under or relating to Veterans Care Agreements*. (i) A VA official acting within the scope of authority delegated by the Secretary of Veterans Affairs (hereafter referred to in this section as the ''responsible VA official'') will decide and resolve disputes under this section.

(ii) The authority to decide or resolve disputes under this section does not extend to the settlement, compromise, payment, or adjustment of any claim for payment that involves fraud or misrepresentation of fact. For purposes of this paragraph, ''misrepresentation of fact'' means a false statement of substantive fact, or any conduct which

leads to the belief of a substantive fact material to proper understanding of the matter in hand, made with intent to deceive or mislead. If the responsible VA official encounters evidence of misrepresentation of fact or fraud on the part of the entity or provider, the responsible VA official shall refer the matter to the agency official responsible for investigating fraud and may refer the matter to other federal entities as necessary.

(3) *Review of dispute and written decision.* (i) Upon receipt of a notice of dispute, the responsible VA official will review the dispute and all facts pertinent to the dispute.

(ii) If the responsible VA official determines additional information or documentation is required for review and adjudication of the dispute, the official will, within 90 calendar days of VA's receipt of the notice of dispute, provide written notice to both parties, in accordance with the notice provisions of the Veterans Care Agreement, that additional information or documentation is required for review and adjudication of the dispute. Such notice will identify and request the additional information and documentation deemed necessary to review and adjudicate the dispute.

(iii) Upon VA receipt of a notice of dispute that conforms to the requirements of paragraph (c)(1) of this section (including containing all information and documentation necessary to review and adjudicate the dispute), the responsible VA official will take one of the following actions within 90 calendar days:

(A) Issue a written decision, in accordance with the notice provisions of the Veterans Care Agreement, to both parties. The written decision will include:

(*1*) A description of the dispute;

(*2*) A reference to the pertinent terms of the Veterans Care Agreement and any relevant authorizations;

(*3*) A statement of the factual areas of agreement and disagreement;

(*4*) A statement of the responsible official's decision, with supporting rationale; and

(*5*) A statement that the decision constitutes the final agency decision on the matter in dispute.

(B) Upon a determination that additional time is reasonably required to issue a decision, the responsible VA official will provide written notice to both parties, in accordance with the notice provisions of the Veterans Care Agreement, of such determination and the time within which a decision will be issued. The time within which a decision will be issued must be reasonable, taking into account the complexity of the dispute and any other relevant factors, and must not exceed 150 calendar days after receipt of a notice of dispute that conforms to the requirements of paragraph (c)(1) of this section and all information and documentation necessary to review and adjudicate the dispute. The responsible VA official will subsequently issue a written decision in accordance with paragraph (c)(3)(iii)(A) of this section.

(4) *Issuance of decision.* VA will furnish the decision to the entity or provider by any method that provides evidence of receipt.

(5) *Effect of decision.* A written decision issued by the responsible VA official constitutes the agency's final decision on the dispute.

(The information collection requirements have been submitted to the Office of Management and Budget (OMB) and are pending OMB approval.)

§ 17.4600 Urgent care.

(a) *Purpose.* The purpose of this section is to establish procedures for accessing urgent care. Eligible veterans may obtain urgent care, in accordance with the requirements and processes set forth in this section, from qualifying non-VA entities or providers in VA's network that are identified by VA in accordance with paragraph (c)(2) of this section.

(b) *Definitions.* The following definitions apply to this section.

(1) *Eligible veteran* means a veteran described in 38 U.S.C. 1725A(b).

(2) *Episodic care* means care or services provided in a single visit to an eligible veteran for a particular health condition, or a limited set of particular health conditions, without an ongoing relationship being established between the eligible veteran and qualifying non-VA entities or providers.

(3) *Longitudinal management of conditions* means outpatient care that addresses important disease prevention and treatment goals and is dependent upon bidirectional communications that are ongoing over an extended period of time. For purposes of this section, the term ''longitudinal management of conditions'' and ''longitudinal care'' are synonymous.

(4) *Qualifying non-VA entity or provider* means a non-VA entity or provider, including Federally-qualified health centers as defined in 42 U.S.C. 1396d(l)(2)(B), that has entered into a contract, agreement, or other arrangement with the Secretary to furnish urgent care under this section, or has entered into an agreement with a third-party administrator with whom VA has a contract to furnish such care.

(5) *Urgent care* means services provided by a qualifying non-VA entity or provider, and as further defined in paragraphs (b)(5)(i) through (iv) of this section.

(i) Urgent care includes service available from entities or providers submitting claims for payment as a walk-in retail health clinic (Centers for Medicare and Medicaid Services (CMS) Place of Service code 17) or urgent care facility (CMS Place of Service code 20);

(ii)(A) Except as provided in paragraph (b)(5)(ii)(B) or (b)(5)(iv) of this section, urgent care does not include preventive health services, as defined in section 1701(9) of title 38, United States Code, dental care, or chronic disease management.

(B) Urgent care includes immunization against influenza (flu shots), as well as therapeutic vaccines that are necessary in the course of treatment of an otherwise included service and screenings related to the treatment of symptoms associated with an immediate illness or exposure.

(iii) Urgent care may only be furnished as episodic care for eligible veterans needing immediate non-emergent medical attention, and it does not include longitudinal care. Veterans requiring follow-up care as a result of an urgent care visit under this section must contact VA or their VA-authorized primary care provider to arrange such care.

(iv) If VA determines that the provision of additional services is in the interest of eligible veterans, based upon identified health needs, VA may offer such additional services under this section as VA determines appropriate. Such services may be limited in duration and location. VA will inform the public through a FEDERAL REGISTER document, published as soon as practicable, and other communications, as appropriate.

(c) *Procedures.* (1)(i)(A) Eligible veterans may receive urgent care under this section without prior approval from VA.

(B) Eligible veterans must declare at each episode of care if they are using this benefit prior to receiving urgent care under this section.

(2) VA will publish a website providing information on urgent care, including the names, locations, and contact information for qualifying non-VA entities or providers from which urgent care is available under this section.

(3) In general, eligibility under this section does not affect eligibility for hospital care or medical services under the medical benefits package, as defined in §17.38, or other benefits addressed in this title. Nothing in this section waives the eligibility requirements established in other statutes or regulations.

(4) Urgent care furnished under this section must meet VA's standards for quality established under 38 U.S.C. 1703C, as applicable.

(d) *Copayment.* (1) Except as provided in paragraphs (d)(2) and (3) of this section, an eligible veteran, as a condition for receiving urgent care provided by VA under this section, must agree to pay VA (and is obligated to pay VA) a copayment of $30:

(i) After three visits in a calendar year if such eligible veteran is enrolled under §17.36(b)(1) through (6), except those veterans described in §17.36(d)(3)(iii) for all matters not covered by priority category 6.

(ii) If such eligible veteran is enrolled under §17.36(b)(7) or (8), including veterans described in §17.36(d)(3)(iii).

(2) An eligible veteran who receives urgent care under paragraph (b)(5)(iv) of this section or urgent care consisting solely of an immunization

against influenza (flu shot) is not subject to a copayment under paragraph (d)(1) of this section and such a visit shall not count as a visit for purposes of paragraph (d)(1)(i) of this section.

(3) If an eligible veteran would be required to pay more than one copayment under this section, or a copayment under this section and a copayment under § 17.108 or § 17.111, on the same day, the eligible veteran will only be charged the higher copayment.

(e) *Prescriptions.* Notwithstanding any other provision of this part, VA will:

(1) Pay for prescriptions written by qualifying non-VA entities or providers for eligible veterans, including over-the-counter drugs and medical and surgical supplies, available under the VA national formulary system to cover a course of treatment for urgent care no longer than 14 days.

(2) Fill prescriptions for urgent care written by qualifying non-VA entities or providers for eligible veterans, including over-the-counter drugs and medical and surgical supplies, available under the VA national formulary system.

(3) Pay for prescriptions written by qualifying non-VA entities or providers for eligible veterans that have an immediate need for durable medical equipment and medical devices that are required for urgent conditions (*e.g.*, splints, crutches, manual wheelchairs).

(f) *Payments.* Payments made for urgent care constitute payment in full and shall extinguish the veteran's liability to the qualifying non-VA entity or provider. The qualifying non-VA entity or provider may not impose any additional charge on a veteran or his or her health care insurer for any urgent care service for which payment is made by VA. This section does not abrogate VA's right, under 38 U.S.C. 1729, to recover or collect from a third party the reasonable charges of the care or services provided under this section.

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