(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.

(14) A veteran who meets the definition of Indian or urban Indian, as defined in 25 U.S.C. 1603(13) and (28), for inpatient hospital care or outpatient medical care provided on or after January 5, 2022. To demonstrate that they meet the definition of Indian or urban Indian, the veteran must submit to VA any of the documentation described in paragraphs (d)(14)(i) through (vi) of this section:

(i) Documentation issued by a federally recognized Indian Tribe that shows that the veteran is a member of the Tribe;

(ii) Documentation showing that the veteran, irrespective of whether they live on or near a reservation, is a member of a Tribe, band, or other organized group of Indians, including those tribes, bands, or groups terminated since 1940 and those recognized now or in the future by the State in which they reside, or who is a descendant, in the first or second degree, of any such member;

(iii) Documentation showing that the veteran is an Eskimo or Aleut or other Alaska Native;

(iv) Documentation issued by the Department of Interior (DOI) showing that the veteran considered by DOI to be an Indian for any purpose;

(v) Documentation showing that the veteran is considered by the Department of Health and Human Services (HHS) to be an Indian under that Department's regulations; or

(vi) Documentation showing that the veteran resides in an urban center and meets one or more of the following criteria:

(A) Irrespective of whether they live on or near a reservation, is a member of a Tribe, band, or other organized group of Indians, including those tribes, bands, or groups terminated since 1940 and those recognized now or in the future by the State in which they reside, or who is a descendant, in the first or second degree, of any such member;

(B) Is an Eskimo or Aleut or other Alaska Native;

(C) Is considered by the Department of Interior to be an Indian for any purpose; or

(D) Is considered by HHS to be an Indian under that Department's regulations.

(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;

(17) Mental health peer support services; and

(18) An outpatient care visit solely for education on the use of opioid antagonists to reverse the effects of overdoses of specific medications or substances.

(19) Emergent suicide care as authorized under 38 CFR 17.1200–17.1230.

(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.

(g) *Retroactive copayment reimbursement.* After VA determines that the documentation submitted by the veteran meets the criteria in paragraph (d)(14) of this section and VA updates the veteran's record to reflect the veteran's status as an Indian or urban Indian, VA will reimburse veterans exempt under paragraph (d)(14) for any copayments that were paid to VA for inpatient hospital care and outpatient medical care provided on or after January 5, 2022 if they would have been exempt from making such copayments if paragraph (d)(14) had been in effect.

(The Office of Management and Budget has approved the information collection provisions in this section under control number 2900–0920)

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§ 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.