

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.

§ 16.121 [Reserved]

§ 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 17.30 also issued under 38 U.S.C. 1701.

Section 17.32 also issued under 38 U.S.C. 7331-7334.

Section 17.35 is also issued under 38 U.S.C. 1724.

Section 17.37 is also issued under 38 U.S.C. 101, 1701, 1705, 1710, 1720J, 1721, 1722.

Section 17.38 is also issued under 38 U.S.C. 1701 and 1703.

Section 17.43 also issued under 38 U.S.C. 109, 1784, 8111, and 8153.

Section 17.44 also issued under E.O. 10122, 15 FR 2173, 3 CFR, 1949-1953 Comp., p. 313, E.O. 10400, 17 FR 8648, 3 CFR, 1949-1953 Comp., p. 900, and E.O. 11733, 38 FR 20431, 3 CFR, 1971-1975 Comp., p. 792.

Section 17.46 is also issued under 38 U.S.C. 1710.

Section 17.47 is also issued under 38 U.S.C. 1701, 1710, 1721, 1722, 1729, 3104(a)(9), 7333, Pub. L. 99-272; 42 U.S.C. 1396 *et seq.*

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.

Sections 17.61 through 17.74 are also issued under 38 U.S.C. 1730.

Section 17.86 also issued under 38 U.S.C. 1785.

Section 17.101 is also issued under 38 U.S.C. 101, 1701, 1705, 1710, 1721, 1722, 1729.

Section 17.102 also issued under 38 U.S.C. 109, 1711, 1729, 1784, 1784A, 1785, 8111, 8153.

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, 1720J, and 1730A.

Section 17.110 is also issued under 38 U.S.C. 501, 1703, 1710, 1720D, 1720J, 1722A, and 1730A.

Section 17.111 is also issued under 38 U.S.C. 101(28), 501, 1701(7), 1703, 1710, 1710B, 1720B, 1720D, 1722A, and 1730A.

Section 17.125 is also issued under 38 U.S.C. 7304.

Sections 17.156 and 17.157 are also issued under 38 U.S.C. 3901 and 3902.

Section 17.158 is also issued under 38 U.S.C. 3902 and 3903.

Section 17.169 is also issued under 38 U.S.C. 1712C.

Sections 17.243 through 17.248 are also issued under 38 U.S.C. 7302 note.

Sections 17.270, and 17.272 through 17.277 are also issued under 38 U.S.C. 1781.

Section 17.271 is also issued under 38 U.S.C. 1720G(a)(7)(A) and 1781.

Department of Veterans Affairs

§ 17.1

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.

Section 17.278 is also issued under 38 U.S.C. 1781 and 42 U.S.C. 2651.

Section 17.279 is also issued under 5 U.S.C. 552 and 552a; 38 U.S.C. 1781, 5701, and 7332.

Sections 17.380, 17.390 and 17.412 are also issued under sec. 260, Pub. L. 114-223, 130 Stat. 857, and sec. 236, Public Law 115-141, 132 Stat. 348, and sec. 236, div. J, Pub. L 115-141, 132 Stat. 348.

Section 17.395 is also issued under 38 U.S.C. 1788.

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).

Section 17.419 also issued under 38 U.S.C. 1701 (note), 7301, 7306, 7330A, 7401-7403, 7405, 7406, 7408.

Section 17.450 is also issued under 38 U.S.C. 1703E.

Sections 17.525 through 17.531 are also issued under 38 U.S.C. 7691 through 7697.

Sections 17.545 through 17.553 are also issued under 38 U.S.C. 7698, 7699, 7699A, and 7699B.

Sections 17.600 through 17.612 are also issued under 38 U.S.C. 7601-7619, 7633, 7634, 7636, and sec. 104(a), div. V, Public Law 117-328.

Sections 17.613 through 17.618 are also issued under Pub. L. 115-182, sec. 304.

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 17.1200 through 17.1230 are also issued under 38 U.S.C. 1720J.

Section 17.3200 also issued under 38 U.S.C. 1162, 1701, 1707, 1710, 1714, 1717, 3901.

Section 17.3210 also issued under 38 U.S.C. 1701, 1710.

Section 17.3220 also issued under 38 U.S.C. 1701(F), 1710.

Section 17.3230 also issued under 38 U.S.C. 1701(F), 1710, 1714(a).

Section 17.3250 also issued under 38 U.S.C. 1701, 1710, 1725, 1728.

Section 17.3500 is also issued under Pub. L. 102-139 sec. 101.

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 and 1730A.

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(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 the following:

(1) Medical examination, treatment, and rehabilitative services (as defined in 38 U.S.C. 1701(8)).

(2) Surgical services, dental services and appliances as authorized in §§ 17.160 through 17.166, optometric and podiatric services, chiropractic services, preventive health care services set forth in 38 U.S.C. 1701(9), non-institutional extended care, and items and services as authorized in §§ 17.3200 through 17.3250.

(3) 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.

(4) 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

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(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.govinfo.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

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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

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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 Vultee 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.

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(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 co-operation 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.

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(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;

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- (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 directives.**

(a) *Definitions.* The following definitions are applicable for purposes of this section:

Advance directive. A written statement by a person who has decision-making capacity regarding preferences about future health care decisions if that person becomes unable to make those decisions, in any of the following:

(i) *Durable power of attorney for health care.* A durable power of attorney for health care (DPAHC) is a type of advance directive in which an individual designates another person as an agent to make health care decisions on the individual's behalf.

(ii) *Living will.* A living will is a type of advance directive in which an individual documents personal preferences regarding future treatment options. A living will typically includes preferences about life-sustaining treatment, but it may also include preferences about other types of health care.

(iii) *Mental health (or psychiatric) advance directive.* A mental health or psychiatric advance directive is executed by patients whose future decision-making capacity is at risk due to mental illness. In this type of directive, the individual indicates future mental health treatment preferences.

(iv) *State-authorized advance directive.* A state-authorized advance directive is a non-VA DPAHC, living will, mental

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health directive, or other advance directive document that is legally recognized by a state. The validity of state-authorized advance directives is determined pursuant to applicable state law. For the purposes 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 wishes expressed by the patient in the advance directive.

(v) *Department of Defense (DoD) advance medical directive.* A DoD advance medical directive is executed for members of the armed services or military dependents pursuant to 10 U.S.C. 1044C. It may include a durable power of attorney for health care or a living will. Federal law exempts such advance directives from any requirement of form, substance, formality, or recording that is provided for under the laws of an individual state. Federal law requires that this type of advance directive be given the same legal effect as an advance directive prepared and executed in accordance with the laws of the state concerned.

(vi) *VA Advance Directive.* A VA Advance Directive is completed on a form specified by VA. In VA, this form can be used by patients to designate a health care agent and to document treatment preferences, including medical care, surgical care, and mental health care.

Close friend. Any person eighteen years or older who has shown care and concern for the welfare of the patient, 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, and the ability to formulate a judgment and commu-

nicate a clear decision concerning health care treatments

Health care agent. An individual named by the patient in a durable power of attorney for health care (DPAHC) to make health care decisions on the patient's behalf, including decisions regarding the use of life-sustaining treatments, when the patient can no longer do so.

Legal guardian. A person appointed by a court of appropriate jurisdiction to make decisions, including medical decisions, for an individual who has been judicially determined to be incompetent.

Practitioner. A practitioner is any physician, dentist, or health care professional granted specific clinical privileges to perform the treatment or procedure. The term practitioner also includes:

(i) Medical and dental residents, regardless of whether they have been granted specific clinical privileges; and

(ii) Other health care professionals whose scope of practice agreement or other formal delineation of job responsibility specifically permits them to obtain informed consent, and who are appropriately trained and authorized to perform the procedure or to provide the treatment for which consent is being obtained.

Signature consent. The documentation of informed consent with the signature of the patient or surrogate and practitioner on a form prescribed by VA for that purpose.

State-authorized portable orders. Specialized forms or identifiers (e.g., Do Not Attempt Resuscitation (DNAR) bracelets or necklaces) authorized by state law or a state medical board or association, that translate a patient's preferences with respect to life-sustaining treatment decisions into standing portable medical orders.

Surrogate. An individual authorized under this section to make health care decisions on behalf of a patient who lacks decision-making capacity. The term includes a health care agent, legal guardian, next-of-kin, or close friend.

(b) *Informed consent.* Patients receiving health care from VA have the right to accept or refuse any medical treatment or procedure recommended to

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them. Except as otherwise provided in this section, no medical treatment or procedure may be performed without the prior, voluntary informed consent of the patient.

(1) In order to give informed consent, the patient must have decision-making capacity.

(2) In the event that the patient lacks decision-making capacity, the requirements of this section are applicable to consent for treatments or procedures obtained from a surrogate acting on behalf of the patient.

(c) *General requirements for informed consent.* Informed consent is the process by which the practitioner discloses to and discusses appropriate information with a patient so that the patient may make a voluntary choice about whether to accept the proposed diagnostic or therapeutic procedure or course of treatment. Appropriate information is information that a reasonable person in the patient's situation would expect to receive in order to make an informed choice about whether or not to undergo the treatment or procedure. (Appropriate information includes tests that yield information that is extremely sensitive or that may have a high risk of significant consequence (e.g., physical, social, psychological, legal, or economic) that a reasonable person would want to know and consider as part of his or her consent decision.) The specific information and level of detail required will vary depending on the nature of the treatment or procedure.

(1) The informed consent discussion should be conducted in person with the patient whenever practical. If it is impractical to conduct the discussion in person, or the patient expresses a preference for communication through another modality, the discussion may be conducted by telephone, through video conference, or by other VA-approved electronic communication methods.

(2) The practitioner must explain in language understandable to the patient each of the following, as appropriate to the treatment or procedure in question: The nature of the proposed procedure or treatment; expected benefits; reasonably foreseeable associated risks, complications or side effects; reasonable and available alternatives;

and anticipated results if nothing is done.

(3) The patient must be given the opportunity to ask questions, to indicate comprehension of the information provided, and to grant or withhold consent freely without coercion.

(4) The practitioner must advise the patient if the proposed treatment is novel or unorthodox.

(5) The patient may withhold or revoke consent at any time.

(6) Trained personnel may conduct elements of the informed consent process when delegated by the practitioner. However, the practitioner remains responsible for the informed consent process and must personally verify with the patient that the patient has been fully informed and voluntarily consents to the treatment or procedure.

(7) Practitioners may provide necessary medical care in emergency situations without the express consent of the patient when all of the following apply:

(i) Immediate medical care is necessary to preserve life or prevent serious impairment of the health of the patient.

(ii) The patient is unable to consent.

(iii) The practitioner determines that the patient has no surrogate or that waiting to obtain consent from the surrogate would increase the hazard to the life or health of the patient.

(d) *Documentation of informed consent.*

(1) The informed consent process must be appropriately documented in the health record. For treatments and procedures that are low risk and within broadly accepted standards of medical practice, a progress note describing the clinical encounter and the treatment plan are sufficient to document that informed consent was obtained for such treatments or procedures. For tests that provide information that is extremely sensitive or that may have a high risk of significant consequences (e.g., physical, social, psychological, legal, or economic) that a patient might reasonably want to consider as part of the consent decision, the health record must specifically document that the patient or surrogate consented to the specific test.

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(2) The patient's and practitioner's signature on a form prescribed by VA for that purpose is required for all diagnostic and therapeutic treatments or procedures that meet any of the following criteria:

- (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.

(3) Consent for treatments and procedures that require signature consent must be documented in the health record on a form prescribed by VA for that purpose, or as otherwise specified in this paragraph (d).

(i) If the patient or surrogate is unable to execute a signature on the form due to a physical impairment, the patient or surrogate may, in lieu of a signature, sign the consent form with an "X", thumbprint, or stamp. Two adult witnesses must witness the act of signing and sign the consent form. By signing, the witnesses are attesting only to the fact that they saw the patient or surrogate sign the form. As an alternative to such a patient or surrogate using a duly witnessed "X", thumbprint, or stamp to sign the form, a designated third party may sign the form if acting at the direction of the patient or surrogate and in the presence of the patient or surrogate. The signed form must be filed in the patient's health record.

(ii) 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 about upcoming or continuing treatment, the practitioner must initiate a new informed consent process and, if needed, com-

plete a new signature consent form with the patient.

(iii) When signature consent is required, but it is not practicable to obtain the signature in person following the informed consent discussion, a signed VA consent form transmitted by mail, facsimile, in by secure electronic mail, or other VA-approved modalities and scanned into the record, is adequate to proceed with treatment or procedure.

(iv) When signature consent is required, but it is not practicable to obtain the signed consent form, the informed consent conversation conducted by telephone or video conference must be audiotaped, videotaped, or witnessed by a second VA employee in lieu of the signed consent form. The practitioner must document the details of the conversation in the medical record. If someone other than the patient is giving consent, the name of the person giving consent and the authority of that person to act as surrogate must be adequately identified in the medical record.

(e) *Patients who lack decision-making capacity*—(1) *Identifying a surrogate decision maker.* 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 surrogate. Patients who are incapable of giving consent as a matter of law will be deemed to lack decision-making capacity for the purposes of this section.

(i) The following persons are authorized to act as a surrogate to consent on behalf of a patient who lacks decision-making capacity in the following order of priority:

- (A) Health care agent;
- (B) Legal guardian;
- (C) 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
- (D) Close friend.

(ii) A 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; that is, substituted judgment, or, if the patient's specific values and wishes are unknown, the surrogate's decision must be based on the patient's best interest.

(2) *Consent for a patient without a surrogate.* (i) If none of the surrogates listed in paragraph (e)(1) of this section is available, a practitioner may either request the assistance of District Chief Counsel to obtain a legal guardian for health care or follow the procedures outlined in paragraph (e)(2)(ii) of this section.

(ii) Facilities may use the following process to make treatment decisions for patients who lack decision-making capacity and have no surrogate.

(A) For treatments and procedures that involve minimal risk, the practitioner must verify that no authorized surrogate can be located, or that the surrogate is not available. 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.

(B) For procedures that require signature consent, the practitioner must certify that the patient has no surrogate to the best of their knowledge. The attending physician and the Chief of Service (or 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, unless the patient has valid standing orders regarding life-sustaining treatment, such as state-authorized portable orders. 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. The facility Director must be informed about the case and results of the review and may concur with the decision to withhold or withdraw life-sustaining treatment, delegate final decision-making authority to the facility Chief of Staff, or request further review by District Chief Counsel.

(f) *Special consent situations.* (1) In the case of involuntarily committed patients where the forced administration of psychotropic medication is against the will of a patient (or the surrogate does not consent), the following procedural protections must be provided:

(i) 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 must be reviewed by a multi-disciplinary committee appointed by the facility Director for this purpose.

(ii) The multi-disciplinary 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.

(iii) Continued administration of 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.

(2) The patient must be informed if a proposed course of treatment or procedure involves approved medical research in whole or in part. If so, the patient's separate informed consent must be obtained for the components that constitute research pursuant to the informed consent requirements for human-subjects research set forth in part 16 of this title.

(g) *Advance directives*—(1) *General.* To the extent consistent with applicable Federal law, VA policy, and generally accepted standards of medical practice, VA will follow the wishes of a patient expressed in a valid advance directive when the practitioner determines and documents in the patient's health record that the patient lacks decision-making capacity and is unlikely to regain it within a reasonable period of time. An advance directive that is valid in one or more states under applicable law, including a mental health (or psychiatric) advance directive, a valid Department of Defense advance medical directive, or a valid VA Advance Directive will be recognized

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throughout the VA health care system, except for components therein that are inconsistent with applicable Federal law, VA policy, or generally accepted standards of medical practice.

(2) *Signing and witness requirements.* (i) A VA Advance Directive must be signed by the patient. If the patient is unable to sign a VA Advance Directive due to a physical impairment, the patient may sign the advance directive form with an "X", thumbprint, or stamp. In the alternative, the patient may designate a third party to sign the directive at the direction of the patient and in the presence of the patient.

(ii) In all cases, a VA Advance Directive must be signed by the patient in the presence of both witnesses. Witnesses to the patient's signing of an advance directive are attesting by their signatures only to the fact that they saw the patient or designated third party sign the VA Advance Directive form. Neither witness may, to the witness' knowledge, be named as a beneficiary in the patient's estate, appointed as health care agent in the advance directive, or financially responsible for the patient's care. Nor may a witness be the designated third party who has signed the VA Advance Directive form at the direction of the patient and in the patient's presence.

(3) *Instructions in critical situations.* In certain situations, a patient with decision-making capacity may present for care when critically ill and loss of decision-making capacity is imminent. In such situations, VA will document the patient's unambiguous verbal or non-verbal instructions regarding preferences for future health care decisions. These instructions will be honored and given effect should the patient lose decision-making capacity before being able to complete a new advance directive. The patient's instructions must have been expressed to at least two members of the health care team. To confirm that the verbal or non-verbal instructions of the patient are, in fact, unambiguous, the substance of the patient's instructions and the names of at least two members of the health care team to whom they were expressed must be entered in the patient's electronic health record.

(4) *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.

(5) *VA policy and disputes.* Neither the treatment team nor surrogate may override a patient's clear instructions in an advance directive or in instructions given in a critical situation, except that those portions of an advance directive or instructions given in a critical situation that are not consistent with applicable Federal law, VA policy, or generally accepted standards of medical practice will not be given effect.

(The information collection requirements in this section have been approved by the Office of Management and Budget under control number 2900-0556)

[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; 85 FR 31701, May 27, 2020; 87 FR 6427, Feb. 4, 2022]

§ 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;

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- (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

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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.

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(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]

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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.

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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 World War II; 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

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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 ap-

pointment 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.

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(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

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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 quadripareisis; 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 (fore-quarter) 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;

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(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 (hind-quarter) 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; 89 FR 45601, May 23, 2024]

§ 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

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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 Veteran Readiness and Employment (VR&E) 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.

(l) An individual may receive emergent suicide care pursuant to 38 U.S.C. 1720J and 38 CFR 17.1200–17.1230.

[64 FR 54217, Oct. 6, 1999, as amended at 67 FR 35039, May 17, 2002; 78 FR 28142, May 14, 2013; 87 FR 8742, Feb. 16, 2022; 88 FR 2536, Jan. 17, 2023]

§ 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) Prosthetic and rehabilitative items and services as authorized under §§ 17.3200 through 17.3250, and eyeglasses and hearing aids as authorized under § 17.149.

(ix) Home health services authorized under 38 U.S.C. 1717 and 1720C.

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(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 eye-care 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.

(x) Chiropractic services.

(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 health care 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, except when:

(i) The life or the health of the pregnant veteran would be endangered if the pregnancy were carried to term; or

(ii) The pregnancy is the result of an act of rape or incest. Self-reporting from the pregnant veteran constitutes sufficient evidence that an act of rape or incest occurred.

(2) In vitro fertilization. Note: See § 17.380.

(3) Drugs, biologicals, and medical devices not approved by the Food and

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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, 2011; 76 FR 26172, May 5, 2011; 76 FR 78571, Dec. 19, 2011; 82 FR 6275, Jan. 19, 2017; 84 FR 26306, June 5, 2019; 86 FR 84259, Dec. 28, 2020; 87 FR 55296, Sept. 9, 2022; 88 FR 24483, Apr. 21, 2023]

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:

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(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 care.

Hospital 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

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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.

(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; 88 FR 32975, May 23, 2023; 89 FR 86248, Oct. 30, 2024]

§ 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

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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 United States Armed Forces must agree to pay the rate set by the Secretary of Veterans Affairs as prescribed in § 17.102(c), except that no charge will be made for those persons who are members of the Public Health Service, Coast Guard, Coast and Geodetic Survey now NOAA, and enlisted personnel of the Army, Navy, Marine Corps, Air Force, and Space 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; 88 FR 32975, May 23, 2023]

§ 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:

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- (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) 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; 89 FR 86248, Oct. 30, 2024]

§ 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.

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(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.

(2) For purposes of determining eligibility for domiciliary care under §17.46(b)(2) of this part, the phrase no adequate means of support refers to an applicant for or recipient of domiciliary care whose annual income exceeds the maximum annual rate of pension for a veteran in receipt of regular aid and attendance, as defined in 38 U.S.C. 1503, whose deficits in health and/or functional status may render the veteran incapable of achieving or sustaining independence in the community as determined by the Chief of Staff of the VA medical center, or designee. In assessing a veteran's ability to achieve or sustain independence in the community, the Chief of Staff or designee will make a determination of eligibility for domiciliary care based on objective evidence, considering factors including, but not limited to:

(i) The impact of the severity of the veteran's medical condition, disabilities, and symptoms on the veteran's safety in the community;

(ii) The impact of the severity of the veteran's medical condition, disabilities, and symptoms on the veteran's ability to provide self-care;

(iii) The availability of community or family support systems;

(iv) The impact of the severity of the veteran's medical condition, disabilities, and symptoms on the veteran's ability to access and utilize community support systems;

(v) The risk of loss of housing in the community;

(vi) The risk of loss of the veteran's income;

(vii) Access to outpatient mental health and substance use disorder care; and

(viii) The current effectiveness of any outpatient mental health and substance use disorder care provided to the veteran.

(Authority: 38 U.S.C. 1710(a); sec. 701, Pub. L. 98-160, Pub. L. 99-272)

(c) [Reserved]

(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;

(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.

(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.

(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.

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(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.

(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.

(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.

(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.

(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.

(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.

(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;

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(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.

(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.

(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.

(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.

[32 FR 13813, Oct. 4, 1967]

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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.govinfo.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]

Department of Veterans Affairs**§ 17.52****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

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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 than 181 days.

(8) Hospital care or medical services for the treatment of medical emer-

gencies 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]

Department of Veterans Affairs**§ 17.55****§ 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

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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]

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§ 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

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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

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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 unforeseen, 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 activities of daily living and instrumental activities of daily living; and

(c) The facility has been approved in accordance with § 17.63 of this part.

[54 FR 20842, May 15, 1989. Redesignated and amended at 61 FR 21965, 21966, May 13, 1996; 84 FR 33696, July 15, 2019]

§ 17.62 Definitions.

For the purpose of §§ 17.61 through 17.72:

Activities of daily living means basic daily tasks an individual performs as part of self-care which may be used as a measurement of the functional status of a person including: walking; bathing, shaving, brushing teeth, combing hair; dressing; eating; getting in or getting out of bed; and toileting.

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.

Community residential care means the monitoring, supervision, and assistance, in accordance with a statement of needed care, of the activities of daily living activities and instrumental activities of daily living, of referred veterans in an approved home in the community by the facility's provider.

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.

Instrumental activities of daily living are tasks that are not necessary for fundamental functioning, but allow an

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individual to live independently in a community. Instrumental activities of daily living include: housekeeping and cleaning room; meal preparation; taking medications; laundry; assistance with transportation; shopping—for groceries, clothing or other items; ability to use the telephone; ability to manage finances; writing letters; and obtaining appointments.

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.

Paper hearing means a review of the written evidence of record by the hearing official.

[84 FR 33697, July 15, 2019]

§ 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) *Level of care.* The community residential care facility must provide the resident, at a minimum, a base level of care to include room and board; nutrition consisting of three meals per day and two snacks, or as required to meet special dietary needs; laundry services; transportation (either provided or arranged) to VA and healthcare appointments; and accompanying the resident to appointments if needed; 24-hour supervision, if indicated; and care, supervision, and assistance with activities of daily living and instrumental activities of daily living. In those cases where the resident requires more than a base level of care, the medically appropriate level of care must be provided.

(c) *Interior plan.* The facility must:

(1) Have comfortable dining areas, adequate in size for the number of residents;

(2) Have comfortable 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.

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(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 non-disclosure 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

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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

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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.

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(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 cost of community residential care should reflect the cost of providing the base level of care as defined in paragraph (b) of this section.

(3) 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. Any agreement between the resident or an authorized personal representative and the community residential care facility must be approved by the approving official. The charge for care in a community residential care facility must be reviewed annually by the facility and VA, or as required due to changes in care needs.

(4) The charges for community residential care must be reasonable and comparable to the current average rate for residential care in the State or Region for the same level of care provided to the resident. Notwithstanding, any year to year increase in the charge for care in a community residential care facility for the same level of care may not exceed the annual percentage increase in the National Consumer Price

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Index (CPI) for that year. In establishing an individual residential rate, consideration should be given to the level of care required and the individual needs of the resident. The approving official may approve a rate:

(i) Lower than the current average rate for residential care in the State or Region for the same level of care if the community residential care facility and the resident or authorized personal representative agreed to such rate, provided such lower rate does not result in a lower level of care than the resident requires;

(ii) Higher than the current average rate for residential care in the State or Region for the same level of care if the community residential care facility and the resident or authorized personal representative agreed to such rate, and the higher rate is related to the individual needs of the resident which exceed the base level of care as defined in paragraph (b) of this section. Examples of services which exceed the base level of care include, but are not limited to, handling disbursement of funds solely at the request of the resident; fulfilling special dietary requests by the resident or family member; accompanying the resident to an activity center; assisting in or providing scheduled socialization activities; supervision of an unsafe smoker; bowel and bladder care; intervention related to behavioral issues; and transportation other than for VA and healthcare appointments.

(5) The approving official may approve a deviation from the requirements of paragraph (k)(4) of this section if the resident chooses to pay more for care at a facility which exceeds the base level of care as defined in paragraph (b) of this section notwithstanding the resident's needs.

(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; 84 FR 33697, July 15, 2019]

§ 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.

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(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.

[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.

[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.

[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.

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(c) In all hearings, the community residential care facility operator and VA may be represented by counsel.

[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.

[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.

[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

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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.

[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.

[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.

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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

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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.

[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

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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 non-combustible 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

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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

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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.)

[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.

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(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

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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 in-

spection 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.

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(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

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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 non-compliance 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

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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) The cost of care for medical care and services provided under this section will be determined in accordance with the following:

(1) If the care is provided to an officer or employee of a non-VA Federal agency VA will charge the rate agreed upon by the Secretary and the head of such department or agency or the Secretary concerned. If no such rate has been agreed to, VA will charge the Inter-Agency Rate as prescribed in § 17.102(c).

(2) If the care is provided to a member of the Armed Forces VA will charge the rate agreed upon by the Secretary and the head of such branch or the Secretary concerned. If no such rate has been agreed to, VA will charge the Inter-Agency Rate as prescribed in § 17.102(c).

(3) If the care is authorized under a sharing agreement as described in 38 U.S.C. 8111 or 8153 or § 17.240, VA will charge the rate determined in accordance with the sharing agreement.

(4) If the care is provided to an individual who is responsible for the cost of the care, VA will charge the Cost-Based Rate as prescribed in § 17.102(c). Individuals will be responsible for the cost of care or services if mandated by Federal law (including applicable Appropriations Acts) or when the cost of care or services is not reimbursed by other-than-VA Federal departments or agencies.

(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.

[73 FR 26946, May 12, 2008, as amended at 88 FR 32975, May 23, 2023]

Department of Veterans Affairs**§ 17.93****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,

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medical services on an ambulatory or outpatient basis shall be provided to veterans for an adjunct nonservice-connected condition associated with and held to be aggravating a disability from a disease or injury adjudicated as being service-connected.

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

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

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

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

(2) [Reserved]

(Authority: 38 U.S.C. 1710, 1712)

[55 FR 20150, May 15, 1990, as amended at 58 FR 25565, Apr. 27, 1993. Redesignated and amended at 61 FR 21965, 21967, May 13, 1996; 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

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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 tim-

ing 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**§ 17.100 Requirements for provider-based status.**

(a) *Scope.* This section establishes the criteria that VA uses to determine whether a VA medical facility is designated as provider-based for purposes of billing for non-service-connected and non-special treatment authority conditions.

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

Community Based Outpatient Clinic (CBOC). A CBOC is a VA-operated, VA-funded, or VA-reimbursed site of care that is not located within a VA Medical Center. A CBOC can provide primary, specialty, subspecialty, mental health, or any combination of health care delivery services that can be appropriately provided in an outpatient setting.

Community Living Center (CLC). A CLC is a component of the spectrum of long-term care that provides a skilled nursing environment and houses a variety of specialty programs for persons needing short and long stay services. VA CLCs are typically located on, or near a VA medical facility and are VA-owned and operated, but may be free-standing in the community.

Facility. A facility is a point of care where individuals can seek VA health care services, to include a VA Medical Center, CBOC, Health Care Center, CLC, and Other Outpatient Services site.

Health Care Center (HCC). An HCC is a VA-owned, VA-leased, VA-contracted or shared clinic that is operational at least five days per week and provides primary care, mental health care, on site specialty services, and performs ambulatory surgery and/or invasive

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procedures that may require moderate sedation or general anesthesia.

Main provider. A main provider (or parent facility/hospital or provider-based hospital (PBH)) is a provider that either creates, or acquires ownership of, another facility to deliver additional health care services under its name, ownership, and financial and administrative control. For example, VA Medical Centers and HCCs can be main providers.

Other Outpatient Services (OOS). A site that provides outpatient services to veterans, but does not meet the definition of a CBOC or HCC per this section.

Prospective Payment System (PPS). A Prospective Payment System (PPS) is a method of reimbursement in which Medicare payment is made based on a predetermined, fixed amount. The payment amount for a particular service is derived based on the classification system of that service (for example, Medicare Severity Diagnosis-Related Groups for inpatient hospital services furnished by most acute care hospitals).

Provider-based outpatient facility (PBO). A provider-based outpatient facility is a provider of health care services that is either created by, or acquired by, a main provider for the purpose of furnishing additional health care services under the ownership, administrative, and financial control of the main provider, and meets the criteria outlined in this section.

Remote location of a hospital. A remote location of a hospital is a CBOC, OOS Site, or HCC that is located offsite from the main facility.

VA Medical Center (VAMC). A VAMC is a VA facility that provides at least two categories of care (inpatient, outpatient, residential, or institutional extended care).

(c) *Criteria for provider-based status.* In order to be designated as a provider-based facility, the following criteria must be met:

(1) *Licensure.* The facility seeking provider-based status and the main provider must operate under the same license. VA facilities are not licensed by States but all VA facilities are considered licensed for the purpose of collection and recovery by VA as part of

VA's national organization structure and in accordance with VA standards, including standards established or recognized by VA's Offices of the Medical Inspector and Inspector General and major healthcare accreditation organizations.

(2) *Clinical services.* The clinical services of the facility seeking provider-based status and the main provider must be integrated. Integration is demonstrated by the following:

(i) The professional staff of the facility has clinical privileges at the main provider.

(ii) The main provider maintains the same monitoring and oversight (*i.e.* credentialing and privileging) of the facility seeking provider-based status as it does for any other department of the provider.

(iii) The medical director of the facility seeking provider-based status maintains a reporting relationship with the chief medical officer or other similar official of the main provider that has the same frequency, intensity, and level of accountability that exists in the relationship between the medical director of a department of the main provider and the chief medical officer or other similar official of the main provider, and is under the same type of supervision and accountability as any other director, medical or otherwise, of the main provider.

(iv) The medical staff committees or other professional committees at the main provider are responsible for medical activities in the facility seeking provider-based status, including quality assurance, utilization review, and the coordination and integration of services, to the extent practicable, between the facility seeking provider-based status and the main provider.

(v) Medical records for patients treated in the facility seeking provider-based status are integrated into a unified retrieval system (or cross reference) of the main provider.

(vi) Inpatient and outpatient services of the facility seeking provider-based status and the main provider are integrated, and patients treated at the facility who require further care have full access to all services of the main provider and are referred where appropriate to the corresponding inpatient

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or outpatient department or service of the main provider.

(vii) Inpatient and outpatient services of the facility seeking provider-based status and the main provider are recognized under the main provider's accreditation.

(3) *Financial integration.* The financial operations of the facility seeking provider-based status are fully integrated within the financial system of the main provider, as evidenced by shared income and expenses between the main provider and the facility. The costs of a facility that is a hospital department are reported in a cost center of the provider, costs of a facility other than a hospital department are reported in the appropriate cost center or cost centers of the main provider. The main provider's integrated health care system manpower and labor budget and the financial status of any facility seeking provider-based status is incorporated and readily identified in the main provider's integrated system reports.

(4) *Public awareness.* The facility seeking provider-based status must be held out to the public (and other payers) as part of the main provider. Patients of the facility must be made aware that the facility is part of a main provider and that they will be billed accordingly. All literature, brochures, and public relations newsletters from the facility seeking provider-based status must provide the relationship between the main provider and the facility.

(5) *Obligations of hospital outpatient departments and hospital-based facilities.* If the facility seeking provider-based status is a hospital outpatient department or hospital-based facility, the facility must fulfill the obligations described in this paragraph:

(i) The hospital outpatient department must comply with the anti-dumping rules of 42 CFR 489.20(l), (m), (q), and (r) and § 489.24.

(ii) Physician services furnished in hospital outpatient departments or hospital-based facilities must be billed with the correct site-of-service so that appropriate physician and practitioner payment amounts can be determined based on their geographical location.

(iii) Physicians who work in hospital outpatient departments or hospital-based facilities are obligated to comply with the non-discrimination provisions in 42 CFR 489.10(b).

(iv) Hospital outpatient departments must treat all Medicare patients seen on an urgent/emergent basis as hospital outpatients.

(v) In the case of a patient admitted to the hospital as an inpatient after receiving treatment in the hospital outpatient department or hospital-based facility, payments for services in the hospital outpatient department or hospital-based facility are subject to the payment window provisions applicable to PPS hospitals and to hospitals and units excluded from PPS set forth at 42 CFR 412.2(c)(5) and at 42 CFR 413.40(c)(2), respectively.

(vi) The hospital outpatient department must meet applicable VA policies pertaining to hospital health and safety programs.

(vii) VA must treat any facility that is located on the main hospital campus as a department of the hospital.

(6) *Operation under the control of the main provider.* The facility seeking provider-based status is operated under the control of the main provider. Control of the main provider requires:

(i) The main provider and the facility seeking provider-based status have the same governing body.

(ii) The facility seeking provider-based status is operated under the same organizational documents as the main provider. For example, the facility seeking provider-based status must be subject to common bylaws and operating decisions of the governing body of the main provider.

(iii) The main provider has final responsibility for administrative decisions, final approval for contracts with outside parties, final approval for personnel actions, final responsibility for personnel policies (such as code of conduct), and final approval for medical staff appointments in the facility seeking provider-based status.

(7) *Administration and Supervision.* The reporting relationship between the facility seeking provider-based status and the main provider must have the same frequency, intensity, and level of

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accountability that exists in the relationship between the main provider and one of its existing departments, as evidenced by compliance with all of the following requirements:

(i) The facility seeking provider-based status is under the direct supervision of the main provider.

(ii) The facility seeking provider-based status is operated under the same monitoring and oversight by the main provider as any other department of the provider, and is operated just as any other department of the provider with regard to supervision and accountability. The facility director or individual responsible for daily operations at the facility:

(A) Maintains a reporting relationship with a manager at the main provider that has the same frequency, intensity, and level of accountability that exists in the relationship between the main provider and its existing departments; and

(B) Is accountable to the governing body of the main provider, in the same manner as any department head of the provider.

(iii) The following administrative functions of the facility seeking provider-based status are integrated with those of the main provider where the facility is based: Billing services, records, human resources, payroll, employee benefit package, salary structure, and purchasing services. Either the same employees or group of employees handle these administrative functions for the facility and the main provider, or the administrative functions for both the facility and the main provider are contracted out under the same contract agreement; or are handled under different contract agreements, with the contract of the facility or organization being managed by the main provider.

(d) *Illustrations of how the criteria are applied.* (1) A VA facility that is seeking provider-based status that exists under contract arrangements, where only VA patients are seen, may be designated as provider-based if the provider-based requirements in this section are met.

(2) A VA facility seeking provider-based status that exists under contract arrangements, where VA patients and

non-VA patients are seen at the same non-VA owned facility, will have the same provider-based status as the non-VA owned facility that is hosting the VA facility.

(3) A VA owned and operated facility seeking provider-based status, where some or all of the staff are contracted employees, may be designated as provider-based if the provider-based requirements in this section are met.

[85 FR 53174, Aug. 28, 2020]

§ 17.101 Collection or recovery by VA for medical care or services provided or furnished to a veteran for a non-service 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 Office of Community Care, currently at <https://www.va.gov/COMMUNITYCARE>, under "Payer Rates and Charges. 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 Office of Community Care, currently at <https://www.va.gov/COMMUNITYCARE>, under "Payer Rates and Charges.

(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.

FAIR Health means any of the Fair Health Charge Benchmarks products developed by Fair Health.

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.

MarketScan means the MarketScan Commercial Claims & Encounters Database developed by Truven Health Analytics LLC.

MedPAR means the Medicare Provider Analysis and Review file.

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 status and charges.* Facilities that have provider-based status by meeting the criteria in § 17.100 are entitled to bill outpatient facility charges and professional charges. The professional charges for these facilities are produced by the methodologies set forth in this section based on facility expense RVUs. Facilities that do not

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have provider-based status because they do not meet the criteria in § 17.100 are not permitted to bill outpatient facility charges and can only bill a professional charge. The professional charges for these facilities are produced by the methodologies set forth in this section 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 charges determined according to this section.

(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 $\frac{1}{2}$ times VA's aver-

age 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 $\frac{1}{2}$, 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

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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 MarketScan claims database, a database of nationwide commercial insurance claims. Average per diem charges are calculated based on all available charges, except for care

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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 MarketScan 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 MarketScan 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

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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 hos-

pitalization 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/HCPGS 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

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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 6.5 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 2.0 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 Fair Health database, from the MarketScan claims database, and from the outpatient facility component of the Medicare Standard Analytical File 5 Percent Sample. If the Fair Health

database contains sufficient data to provide a statistically credible 80th percentile charge, then that result is retained for this purpose. If the Fair Health database does not provide a statistically credible 80th percentile charge, then the result from the MarketScan database is retained for this purpose, provided it is statistically credible. If neither the Fair Health nor the MarketScan 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, 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 Fair Health database (see paragraph (a)(3) of this section for Data Sources). The Fair Health-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 paragraph (f)(2)(i) or (iii) of this section, total RVUs are developed based on various charge data sources. For these CPT/HCPCS codes, that nationwide 80th percentile billed charges are obtained, where statistically credible, from the FAIR Health 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 each of these CPT/HCPCS codes, nationwide total RVUs are obtained by taking the nationwide 80th percentile billed charges obtained using the preceding

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databases and dividing by the nationwide conversion factor for the corresponding CPT/HCPCS code group determined pursuant to paragraphs (f)(3) introductory text 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 Medicare ASP Pricing RBRVS. The resulting nationwide total RVUs obtained using these 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, 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 FAIR Health 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 serv-

ices 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)

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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 Fair Health 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, 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 Fair Health 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 various independent data sources, including the National Dental Advisory Service nationwide pricing index and the Dental FAIR Health module (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 of the available charges for each code. Statistical outliers are identified and removed. In cases where none of the charges are removed, the average charge is calculated as a mean of all 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. A nationwide VA distribution of procedures and services 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 com-

ponent 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 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 FAIR Health module, as follows: Using local and nationwide average charges reported in the FAIR Health database, a local weighted average charge for each dental class of procedure codes is calculated using utilization frequencies from the Milliman 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

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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 Fair Health 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 (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 FAIR Health 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 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 Medicare ASP Pricing

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RBRVS. The resulting nationwide total RVUs obtained using these 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, Inc., Health Cost Guidelines fee survey). The 80th percentile charge for each selected CPT/HCPCS code is obtained from the FAIR Health 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

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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.

(1) *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 (1)(2), (1)(3), and (1)(4) of this section by the appropriate geographic area adjustment factor determined pursuant to paragraph (1)(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 (1)(2)(i) of this section. The RVUs are multiplied by the charge amount for each incremental RVU determined pursuant to paragraph (1)(2)(ii) of this section, and this amount is added to the fixed charge amount also determined pursuant to paragraph (1)(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 (1)(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 (1)(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 (1)(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: Medicare ASP Pricing RBRVS Practice Expense RVUs.

(B) Other Drugs: Medicare ASP Pricing 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: Medicare ASP Pricing 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 (1)(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 (1)(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 Fair Health 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 (1)(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

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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 (1)(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 two independent data sources: The FAIR Health database and the combined Part B and DME components of the Medicare Standard Analytical File 5 Percent Sample; and Milliman, 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 (1)(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 (1)(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 (1)(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 (1)(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 of the available charges for each HCPCS code. Statistical outliers are identified and removed. In cases where none of the charges are removed,

the average charge is calculated as a mean of all 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 (1)(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 (1)(5)(ii) of this section divided by the nationwide weighted average charge determined pursuant to paragraph (1)(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 (1)(5) of this section, each of the HCPCS code groups set forth in paragraph (1)(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.

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(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 FairHealth 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 (1)(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, 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 sys-

tem, 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; 85 FR 53176, Aug. 28, 2020; 86 FR 16053, Mar. 26, 2021]

§ 17.102 Charges for care or services.

Subject to the methodology set forth in paragraph (c) of this section, and notwithstanding the provisions of § 17.101, VA shall charge for VA care and services provided in the circumstances described as follows:

(a) For hospital care or medical services provided:

(1) As a humanitarian service in a medical emergency in accordance with 38 U.S.C. 1784 or 38 U.S.C. 1784A;

(2) During and immediately following a disaster or emergency in accordance with 38 U.S.C. 1785 and § 17.86;

(3) While attending a national convention of an organization recognized under 38 U.S.C. 5902, for emergency medical treatment, in accordance with 38 U.S.C. 1711;

(4) In error, on the basis of eligibility as a non-veteran recipient of VA hospital care and medical services under title 38 U.S.C., and such an individual subsequently is determined not to have been eligible for such care or services;

(5) To a beneficiary of the Department of Defense or other Federal agency, to include for inpatient or outpatient care or services authorized for a member of the Armed Forces on active duty, a beneficiary or designee of any other Federal agency, and members or former members of a uniformed

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service who are entitled to retired or retainer pay, or equivalent pay; or

(6) To a retiree of the uniformed services with a chronic disability for hospital care identified in Executive Orders 10122, 10400, and 11733 as well as § 17.44.

(b) For hospital care, medical services, domiciliary care, or nursing home care provided:

(1) In error, on the basis of eligibility for such care and services as a veteran under §§ 17.34, 17.36, or 17.37, and such an individual was subsequently determined not to have been eligible for such care or services.

(2) To a discharged member of the armed forces of a nation allied with the United States in World War I or World War II in accordance with 38 U.S.C. 109.

(3) Under a sharing agreement in accordance with 38 U.S.C. 8111 or 8153 and 17.240.

(4) Under any other provision of law that authorizes VA to provide care.

(c) Unless rates or charges are otherwise established in contract, in a sharing agreement, or under Federal law, VA will charge under this section at rates based on the VHA Office of Finance Managerial Cost Accounting (MCA) Cost Reports, 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. 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 VHA Office of Finance MCA Cost Reports are used to determine two separate rates: one rate is the general Cost-Based Rate and the other rate is the Inter-Agency Rate. These rates are published annually by VA on the internet site of the Veterans Health Administration Office of Community Care's website at https://www.va.gov/communitycare/revenue_ops/payer_rates.asp.

(d) The rates for prescription drugs that VA furnishes not administered during treatment are based on the actual cost of the drug plus a national

average of VA administrative costs as described in § 17.101(m).

[88 FR 32975, May 23, 2023]

§ 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

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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

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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 non-government 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, prod-

ucts, 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 within 18 months from the original payment date and adjudicated separately from any other claims submitted to the third-party payer under 38 U.S.C. 1729 or this part. If third-party payers do not submit requests for a refund within this 18-month time frame, VA will not provide a refund to third-party payers for a paid claim for any reason.

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(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 in-

consistent 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).

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(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.

(viii) A third party may not reduce or refuse payment if the facility where the medical treatment was furnished is designated by VA as provider-based, but the facility does not meet the provider-based status requirements under 42 CFR 413.65.

(ix) A provision in a third-party payer's plan that directs payment for care or services be refused or lessened because the billing is not presented in accordance with a specified methodology (such as a line item methodology) is not by itself a permissible ground for refusing or reducing third-party payment.

(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; 85 FR 53176, Aug. 28, 2020; 86 FR 16055, Mar. 26, 2021]

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

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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

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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.

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(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 World War II.

(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;

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(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)

[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; 86 FR 52076, Sept. 20, 2021; 88 FR 2536, Jan. 17, 2023; 88 FR 19871, Apr. 4, 2023; 88 FR 21478, Apr. 11, 2023; 89 FR 45601, May 23, 2024]

§ 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

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§§ 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

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(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)(I) 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.

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(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.

(12) Opioid antagonists furnished to a veteran who is at high risk for overdose of a specific medication or substance in order to reverse the effect of such an overdose.

(i) For purposes of this paragraph (c)(12), a veteran who is at high risk for overdose of a specific medication or substance in order to reverse the effect of such an overdose is a veteran:

(A) Who is prescribed or using opioids, or has an opioid use history, and who is at increased risk for opioid overdose as determined by VA; or

(B) Whose provider deems, based on their clinical judgment, that the veteran may benefit from ready availability of an opioid antagonist.

(ii) Examples of a veteran who is at high risk for overdose of a specific medication or substance in order to reverse the effect of such an overdose include, but are not limited to, the following:

(A) A veteran with an opioid or substance use disorder diagnosis;

(B) A veteran receiving treatment for an opioid or substance use disorder diagnosis, such as receiving opioid agonist therapy or inpatient, residential, or outpatient treatment for such diagnosis, or attending a support group for such diagnosis;

(C) A veteran with a history of prescription opioid misuse or injection opioid use;

(D) A veteran with a history of previous opioid overdose;

(E) A veteran who is taking an extended-release or long-acting prescription opioid;

(F) A veteran with household or community access to opioids who is at increased risk for overdose (e.g., psychiatric disorder or high risk for suicide) as determined by VA; or

(G) A veteran predicted to be at high risk for overdose based on standardized assessments or predictive models (e.g., Risk Index for Overdose or Serious Opioid-induced Respiratory Depression [RIOSORD]; Stratification Tool for Opioid Risk Mitigation [STORM]).

NOTE 1 TO PARAGRAPH (C)(12). The examples in paragraphs (c)(12)(ii)(A) through (G) of this section apply even if the veteran has had a period of abstinence from opioids (e.g., due to treatment, detoxification, incarceration) because loss of tolerance can increase the risk for an overdose.

(13) Medication for an individual as part of emergent suicide care as authorized under 38 CFR 17.1200-17.1230.

(14) A veteran who meets the definition of Indian or urban Indian, as defined in 25 U.S.C. 1603(13) and (28), for medications 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 (c)(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 is 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

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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 DOI to be an Indian for any purpose; or

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

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

[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; 86 FR 52076, Sept. 20, 2021; 88 FR 2536, Jan. 17, 2023; 88 FR 19872, Apr. 4, 2023; 88 FR 21478, Apr. 11, 2023]

§ 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

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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, non-institutional 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

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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.

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(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.

(11) A veteran who meets the definition of Indian or urban Indian, as defined in 25 U.S.C. 1603(13) and (28), is exempt from copayments for noninstitutional extended care including adult day health care, noninstitutional respite care, and noninstitutional geriatric evaluation 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 (f)(11)(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 is 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 DOI to be an Indian for any purpose; or

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

(g) *Retroactive copayment reimbursement.* After VA determines the submitted documentation meets paragraph (f)(11) of this section and updates the veteran's record to reflect the veteran's status as an Indian or urban Indian, VA will reimburse veterans exempt under paragraph (f)(11) for any copayments that were paid to VA for adult day health care, non-institutional respite care, and non-institutional geriatric evaluation provided on or after January 5, 2022, if they would have been exempt from making such copayments if paragraph (f)(11) had been in effect.

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

[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; 88 FR 19872, Apr. 4, 2023; 88 FR 21478, Apr. 11, 2023]

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

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center involved, and act in a dignified and proper manner;

(2) Partisan activities are inappropriate and all activities must be non-partisan 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, re-

imbursement 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

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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]

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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 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

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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; 85 FR 84259, Dec. 28, 2020]

§ 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 [Reserved]**§ 17.123 Claimants.**

A claim for payment or reimbursement of services not previously authorized may be filed by the veteran who

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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 care 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

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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.

(a) This section applies only to legacy claims.

(b) 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, as amended at 87 FR 43748, July 22, 2022]

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). This section applies only to legacy claims.

(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

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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, as amended at 87 FR 43748, July 22, 2022]

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 ap-

roval 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]

SENSORY AND OTHER 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

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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 re-

quirements 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

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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 sensi-

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tivity 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 [Reserved]**§ 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]

Department of Veterans Affairs**§ 17.156****§ 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 [Reserved]**§ 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 subject to the definitions and limitations in §§ 17.157 and 17.158.

(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.

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(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) VA will reimburse or pay for adaptive equipment for automobiles and other conveyances subject to the requirements of 38 CFR 17.158(b).

[53 FR 46607, Nov. 18, 1988. Redesignated at 61 FR 21966, May 13, 1996, as amended at 62 FR 17072, Apr. 9, 1997; 89 FR 51232, June 17, 2024]

§ 17.157 Definitions.

For the purposes of this part:

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 eligible person and enable that person and the conveyance to meet the applicable standards of licensure. Adaptive equipment includes any item 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 38 CFR 17.156, or as deemed necessary in an individual case for an eligible person for the continued safety and functionality of a modified automobile and adaptive equipment. 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.

Altered vehicle means the same as in 49 CFR 567.3.

Alterer means the same as in 49 CFR 567.3.

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Manufacturer means the same as in 49 U.S.C. 30102(a)(6).

Modifier means a motor vehicle repair business that modifies a motor vehicle to enable a person with a disability to operate, or ride as a passenger in, the motor vehicle. VA does not approve, endorse, or assess the abilities of any modifiers to perform any requested or represented modification services.

Registered provider means a manufacturer, modifier, or alterer registered with the Department of Transportation's National Highway Traffic Safety Administration (NHTSA) Modifiers Identification Database currently available at <https://www.nhtsa.gov/apps/modifier/index.htm>. Any manufacturer, modifier, or alterer who is not registered is considered an *unregistered provider*.

Roadside service means emergency roadside services provided to an eligible person performed in connection with the repair, reinstallation, or replacement of adaptive equipment already installed in the automobile or other conveyance. The term is limited solely to services provided to make the adaptive equipment operational and does not include mechanical repair of the engine or other vehicle systems, towing, providing essential fuels and fluids such as gasoline necessary to operate the vehicle, or providing locksmith services.

VA Adaptive Equipment Schedule for Automobiles and Other Conveyances ("Schedule") means the VA schedule that contains the maximum allowable reimbursement amounts for the listed adaptive equipment. The Schedule also includes the maximum hourly labor rates for installation, repair, reinstallation, and replacement of this equipment and allowable fees that VA will pay.

[89 FR 51232, June 17, 2024]

§ 17.158 Limitations on assistance.

(a) *General*. An eligible person will not be provided 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 the control of such person, one of the automobiles or other 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 automobile or other conveyance was lost due to fire, theft, accident, or court action; when repairs are so costly as to be prohibitive; or a different automobile or other conveyance 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 eligible person has sold, given or transferred the automobile or other conveyance to a spouse, family member or other person residing in the same household as the eligible person; or to a business owned by the eligible person, spouse, family member or other person residing in the same household as the eligible person.

(b) *Basis for payment or reimbursement.* VA will reimburse or pay for adaptive equipment that VA determines is needed in accordance with this section based on the information submitted and the VA Adaptive Equipment Schedule for Automobiles and Other Conveyances (Schedule). In addition to paying or reimbursing for specific types of adaptive equipment listed in the Schedule, VA will pay, or reimburse for roadside service, and waste disposal fees consistent with the Schedule. Determination of payment or reimbursement rates are based on the Schedule in effect on the date installation, reinstallation, replacement, or repair is complete. Schedule labor rates are classified as "In Shop (low technology)" or "High Technology." High Technology means labor performed on or modification of adaptive equipment devices or systems that are capable of controlling vehicle functions or driving controls, and operate with a designed logic system, or interface or integrate with an electronic system of the vehicle. In Shop (low technology) means labor performed on or modification of adaptive equipment devices that do not meet the definition of High Technology.

(1) Payments made for adaptive equipment that is authorized under this section shall constitute payment in full and shall extinguish the eligible person's liability to the registered provider. The registered provider may not impose any additional charge on the eligible person for any adaptive equipment that is authorized under this section and for which payment is made by VA.

(2) This paragraph sets forth what must be submitted to VA in order for VA to reimburse or pay for adaptive equipment.

(i) Reimbursement when services performed by registered providers. VA will reimburse eligible persons identified in 38 CFR 17.156(a) who have purchased adaptive equipment (e.g., installations, repairs, reinstallations, replacements) from registered providers. The eligible person must submit to VA a completed VA Form 10-1394, an itemized estimate, and provide VA with either a final itemized: (1) invoice, (2) paid receipt, or (3) bill of sale for the purchase.

(ii) Reimbursement when services performed by unregistered providers. VA will reimburse eligible persons identified in 38 CFR 17.156(a) who have purchased adaptive equipment (e.g., installations, repairs, reinstallations, replacements) from unregistered providers. The eligible person must submit to VA a completed VA Form 10-1394 and a final itemized (1) invoice, (2) paid receipt, or (3) bill of sale for the purchase.

(iii) Payments to registered providers for adaptive equipment. VA will pay registered providers for adaptive equipment (e.g., installations, repairs, reinstallations, replacements) furnished to eligible persons identified in 38 CFR 17.156(a). The following must be submitted before VA will pay. The eligible person or the registered provider must sign and submit to VA a completed VA Form 10-1394 and an itemized estimate prior to the completion of work. The eligible person or registered provider must provide VA with a final itemized invoice after the work is completed.

(iv) In the case of any installation, repair or replacement of adaptive equipment performed outside of the United States where an invoice, estimate, or bill of sale is calculated in a

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foreign currency, an application submitted under this paragraph must include the conversion rate from the foreign currency to U.S. dollars, and calculation of the invoice, estimate, or bill of sale amount in U.S. dollars.

(3) VA will reimburse or pay labor costs as follows:

(i) For any labor costs associated with the installation of adaptive equipment by a registered provider, VA will reimburse or pay the lesser of:

(A) The relevant Schedule hourly labor rate, per paragraph (b) of this section, multiplied by the number of hours listed by the registered provider;

(B) The labor costs included in the itemized estimate; or

(C) The hourly labor rate provided by the registered provider in the final itemized invoice multiplied by the number of hours listed by the registered provider.

(ii) VA does not reimburse or pay labor costs for pre-installed (*i.e.*, original equipment manufacturer) equipment.

(iii) VA does not reimburse or pay labor costs of unregistered providers.

(4) New adaptive equipment. VA will reimburse an eligible person who meets the requirements of (b)(2)(i) or (ii) of this section, or pay a registered provider who meets the requirements of (b)(2)(iii) of this section for new adaptive equipment (including equipment that has been installed or used for one year or less from the date of manufacture listed in the Schedule) as follows:

(i) VA will pay the lesser of the amount for the new adaptive equipment listed in either a final itemized: (1) invoice, (2) paid receipt, or (3) bill of sale for the purchase; or (4) the amount listed in the Schedule.

(ii) VA will reimburse or pay any labor costs consistent with paragraph (b)(3) of this section.

(5) Used adaptive equipment. For used adaptive equipment listed in the Schedule that is more than one (1) year old from the date of manufacture:

(i) VA will depreciate it by twenty (20%) percent per year from the time the equipment was pre-installed or installed as new on an automobile or other conveyance to the time of its re-installation for which reimbursement or payment is being sought for a period

up to five (5) years. VA will reimburse an eligible person, who meets the requirements of (b)(2)(i) or (ii) of this section, or pay a registered provider who meets the requirements of (b)(2)(iii) of this section the lesser of the amount of the adaptive equipment listed in the final itemized invoice, paid receipt, or bill of sale for the purchase or the amount listed in the Schedule reduced by twenty (20%) percent for each year from the time the equipment was pre-installed or installed on the automobile or other conveyance for a period up to five (5) years.

(ii) VA will reimburse or pay any labor costs consistent with paragraph (b)(3) of this section, but will not reimburse or pay labor costs for used equipment that is more than five (5) years old from the date of manufacture.

(6) Unlisted adaptive equipment. For adaptive equipment not listed in the Schedule but meeting the definition of adaptive equipment in 38 CFR 17.157, VA will reimburse an eligible person who meets the requirements of (b)(2)(i) or (ii) of this section, or pay a registered provider who meets the requirements of (b)(2)(iii) of this section:

(i) the lesser of the cost of the adaptive equipment when equal to or less than what VA has paid for a similar item in the past or, when available, the commercially available price for a similar item. If the price of a similar commercially available item is not available, or VA has not previously paid for a similar item, VA will pay or reimburse the billed charges.

(ii) VA will reimburse or pay any labor costs consistent with paragraph (b)(3) of this section.

(7) VA will establish the Schedule on July 17, 2024 based on the most recent available data and each fiscal year thereafter, and publish that Schedule on a publicly accessible page on the www.prosthetics.va.gov website. VA will increase the reimbursement amounts in the Schedule using the indices for two expenditure categories of the Consumer Price Index (CPI) for All Urban Consumers. The index for the expenditure category for "motor vehicle parts and equipment" will be used to calculate the increase in the reimbursement amounts for adaptive equipment on the Schedule, and the index for

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“motor vehicle maintenance and repair” will be used to calculate the increase in the reimbursement amounts for labor. Such increases to the Schedule for adaptive equipment and labor will be equal to the percentage by which the respective index increased during the 12-month period ending with the last month for which CPI data is available. In the event that such index does not increase during such period, there will be no change to the Schedule for the reimbursement amounts for which the index is used to calculate increases. The amounts for the new fiscal year will be rounded up to the whole dollar amount.

(c) *Repair of used adaptive equipment.* Reimbursement or payment for a repair to an item of used adaptive equipment may be provided for adaptive equipment installed on an automobile or other conveyance that meets the limitations of paragraph (a) of this section. VA will pay or reimburse labor costs associated with the repairs in accordance with paragraph (b)(3) of this section.

(1) For repairs to used adaptive equipment, VA will reimburse the eligible person meeting the requirements of (b)(2)(i) or (ii) of this section as follows: the lesser of the amount of the adaptive equipment listed in either a final itemized: (1) invoice, (2) paid receipt, or (3) bill of sale for the purchase.

(2) For repairs to used adaptive equipment, VA will reimburse a registered provider meeting the requirements of (b)(2)(iii) of this section as follows: the lesser of the amount of the adaptive equipment listed in the final itemized (1) invoice, (2) paid receipt, or (3) bill of sale for the purchase.

(The Office of Management and Budget has approved the information collection requirements in this section under control number 2900-0188.)

[89 FR 51233, June 17, 2024]

§ 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)

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(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-

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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.govinfo.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

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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) Alveoplasty.

(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.

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(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.

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(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

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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

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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

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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]

§ 17.243

VA PILOT PROGRAM ON GRADUATE MEDICAL EDUCATION AND RESIDENCY

SOURCE: Sections 17.243 through 17.248 appear at 88 FR 77520, Nov. 13, 2023, unless otherwise noted.

§ 17.243 Purpose and scope.

(a) *Purpose.* This section and §§ 17.244 through 17.248 implement the VA Pilot Program on Graduate Medical Education and Residency (PPGMER), which permits placement of residents in existing or new residency programs in covered facilities and permits VA to reimburse certain costs associated with establishing new residency programs in covered facilities, as authorized by section 403 of Public Law 115-182.

(b) *Scope.* This section and §§ 17.244 through 17.248 apply only to the PPGMER as authorized under section 403 of Public Law 115-182, and not to VA's more general administration of graduate medical residency programs in VA facilities as authorized under 38 U.S.C. 7302(e).

(The Office of Management and Budget has approved the information collection provisions in this section under control number 2900-0936).

[88 FR 77520, Nov. 13, 2023, as amended at 89 FR 1034, Jan. 9, 2024]

§ 17.244 Definitions.

For purposes of §§ 17.243 through 17.248:

Benefit means a benefit provided by VA to a resident that has monetary value in addition to a resident's stipend, which may include but not be limited to health insurance, life insurance, worker's compensation, disability insurance, Federal Insurance Contributions Act taxes, and retirement contributions.

Covered facility means any facility identified in § 17.245.

Educational activities mean all activities in which residents participate to meet educational goals or curriculum requirements of a residency program, to include but not be limited to: clinical duties; research; attendance in didactic sessions; attendance at facility committee meetings; scholarly activities that are part of an accredited training program; and approved educational details.

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Resident means physician trainees engaged in post-graduate specialty or subspecialty training programs that are either accredited by the Accreditation Council for Graduate Medical Education or in the application process for such accreditation. A resident may include an individual in their first post-graduate year (PGY-1) of training (often referred to as an intern), and an individual who has completed training in their primary specialty and continues training in a subspecialty graduate medical education program (generally referred to as a fellow).

Stipend means the annual salary paid by VA for a resident.

VA health care facility means any VA-owned or VA-operated location where VA physicians provide care to veterans, to include but not be limited to a VA medical center, independent outpatient clinic, domiciliary, nursing home (community living center), residential treatment program, and community-based clinic.

§ 17.245 Covered facilities.

A covered facility is any of the following:

- (a) A VA health care facility;
- (b) A health care facility operated by an Indian tribe or tribal organization, as those terms are defined in 25 U.S.C. 5304 and at 25 CFR 273.106;
- (c) A health care facility operated by the Indian Health Service;
- (d) A federally-qualified health center as defined in 42 U.S.C. 1396d(1)(2)(B);
- (e) A health care facility operated by the Department of Defense; or
- (f) Other health care facilities deemed appropriate by VA.

§ 17.246 Consideration factors for placement of residents.

(a) *General.* When determining in which covered facilities residents will be placed, VA shall consider the clinical need for health care providers in an area, as determined by VA's evaluation of the following factors:

- (1) The ratio of veterans to VA providers for a standardized geographic area surrounding a covered facility, including a separate ratio for general practitioners and specialists.

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(i) For purposes of paragraphs (a)(1) and (2) of this section, standardized geographic area means the county in which the covered facility is located.

(ii) VA may consider either or both of the ratio(s) for general practitioners and specialists, where a higher ratio of veterans to VA providers indicates a higher need for health care providers in an area.

(2) The range of clinical specialties of VA and non-VA providers for a standardized geographic area surrounding a covered facility, where the presence of fewer clinical specialties indicates a higher need for health care providers in an area.

(3) Whether the specialty of a provider is included in the most recent staffing shortage determination by VA under 38 U.S.C. 7412.

(4) Whether the covered facility is in the local community of a VA facility that has been designated by VA as an underserved facility pursuant to criteria developed under section 401 of Public Law 115–182.

(5) Whether the covered facility is located in a community that is designated by the Secretary of Health and Human Services as a health professional shortage area under 42 U.S.C. 254e.

(6) Whether the covered facility is in a rural or remote area, where:

(i) A rural area means an area identified by the U.S. Census Bureau as rural; and

(ii) A remote area means an area within a zip-code designated as a frontier and remote area (FAR) code by the Economic Research Service within the United States Department of Agriculture, based on the most recent decennial census and to include all identified FAR code levels.

(7) Such other criteria as VA considers important in determining those covered facilities that are not adequately serving area veterans. These factors may include but are not limited to:

(i) Proximity of a non-VA covered facility to a VA health care facility, such that residents placed in non-VA covered facilities may also receive training in VA health care facilities.

(ii) Programmatic considerations related to establishing or maintaining a

sustainable residency program, such as: whether the stated objectives of a residency program align with VA's workforce needs; the likely or known available educational infrastructure of a new residency program or existing residency program (including the ability to attract and retain qualified teaching faculty); and the ability of the residency program to remain financially sustainable after the cessation of funding that VA may furnish under § 17.248.

(b) *Priority in placements.* For the duration in which the PPGMER is administered, no fewer than 100 residents will be placed in covered facilities operated by either the Indian Health Service, an Indian tribe, a tribal organization, or covered facilities located in the same areas as VA facilities designated by VA as underserved pursuant to criteria developed under section 401 of Public Law 115–182.

§ 17.247 Determination process for placement of residents.

Section 403 of Public Law 115–182 does not authorize a grant program or cooperative agreement program through which covered facilities or any other entity may apply for residents to be placed in covered facilities or to apply for VA to pay or reimburse costs under § 17.248. VA therefore will not conduct a public solicitation to determine those covered facilities in which residents may be placed or to determine costs that may be paid or reimbursed under § 17.248. VA will instead determine those covered facilities in which residents may be placed and determine any costs to be paid or reimbursed under § 17.248 in accordance with the following parameters:

(a) VA Central Office will issue a request for proposal (RFP) to announce opportunities for residents to be placed in covered facilities and to have costs paid or reimbursed under § 17.248. This RFP will describe, at a minimum:

(1) Consideration factors to include the criteria in § 17.246, that will be used to evaluate any responses to the RFP, as well as the relative importance of such consideration factors;

(2) Information required to be in any responses to the RFP; and

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(3) The process to submit a response to the RFP.

(b) Covered facilities will submit responses to the RFP to VA Central Office.

(c) Consistent with paragraph (a) of this section, VA Central Office will evaluate responses to the RFP and will determine those covered facilities where residents may be placed and costs under §17.248 are paid or reimbursed.

§ 17.248 Costs of placing residents and new residency programs.

Once VA determines in which covered facilities residents will be placed in accordance with §§17.246 through 17.247, payment or reimbursement is authorized for the following costs:

(a) *Resident stipends and benefits.* For residents placed in covered facilities, VA may pay only the proportionate cost of resident stipends and benefits that are associated with residents participating in educational activities directly related to the PPGMER, in accordance with any contract, agreement, or other arrangement VA has legal authority to form.

(b) *Costs associated with new residency programs.* (1) If a covered facility establishes a new residency program in which a resident is placed, VA will reimburse the following costs in accordance with any contract, agreement, or other arrangement VA has legal authority to form.

(i) Curriculum development costs, to include but not be limited to costs associated with needs analysis, didactic activities, materials, equipment, consultant fees, and instructional design.

(ii) Recruitment and retention of faculty costs, to include but not be limited to costs associated with advertising available faculty positions, and monetary incentives to fill such positions such as relocation costs and educational loan repayment.

(iii) Accreditation costs, to include but not be limited to the administrative fees incurred by a covered facility in association with applying for only initial accreditation of the program by the Accreditation Council for Graduate Medical Education (ACGME).

(iv) Faculty salary costs, to include only the proportionate cost of faculty

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performing duties directly related to the PPGMER.

(v) Resident education expense costs, to include but not be limited to costs associated with the required purchase of medical equipment and required training, national resident match program participation fees, and residency program management software fees.

(2) VA considers new residency programs as only those residency programs that have initial ACGME accreditation or have continued ACGME accreditation without outcomes, and have not graduated an inaugural class, at the time VA has determined those covered facilities where residents will be placed under §17.247(c).

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

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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

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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 in-

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formation 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

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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

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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 re-

quired 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

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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 than 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]

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§ 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 and definitions.

(a) *Overview of CHAMPVA.* CHAMPVA is the Civilian Health and Medical Program of the Department of Veterans Affairs (VA). Generally, CHAMPVA furnishes 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 under chapter 55 of title 10, United States Code (CHAMPUS), commonly referred to as the TRICARE Select plan. Under CHAMPVA, VA shares the cost of medically necessary services and supplies with eligible beneficiaries within the 50 United States, the District of Columbia, the U.S. territories, and abroad. Under CHAMPVA, medical services and supplies may be provided as follows:

(1) By an authorized non-VA provider.

(2) By a VA provider at a VA facility, on a resource-available basis through the CHAMPVA In-house Treatment Initiative (CITI) to CHAMPVA beneficiaries who are not also eligible for Medicare.

(3) Through VA Medications by Mail (MbM).

(i) Only CHAMPVA beneficiaries who do not have any other type of health insurance that pays for prescriptions, including Medicare Part D, may use MbM.

(ii) Smoking cessation pharmaceutical supplies will only be provided

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through MbM and only to CHAMPVA beneficiaries that are not also eligible for Medicare.

(b) *Definitions.* The following definitions apply to CHAMPVA (§§ 17.270 through 17.278):

Accepted assignment refers to the action of an authorized non-VA provider who accepts responsibility for the care of a CHAMPVA beneficiary and thereby agrees to accept the CHAMPVA determined allowable amount as full payment for services and supplies rendered to the beneficiary. (The provider's acceptance of the CHAMPVA determined allowable amount extinguishes the beneficiary's payment liability to the provider with the exception of applicable cost-shares and deductibles.)

Authorized non-VA provider means an individual or institutional non-VA provider of CHAMPVA-covered medical services and supplies that meets any of the following criteria:

(i) Is licensed or certified by a state to provide the medical services and supplies; or

(ii) Where a state does not offer licensure or certification, is otherwise certified by an appropriate national or professional association that sets standards for the specific medical provider.

Calendar year means January 1 through December 31.

CHAMPVA beneficiary means a person enrolled under § 17.271.

CHAMPVA-covered services and supplies mean those medical services and supplies that are medically necessary and appropriate for the treatment of a condition and that are not specifically excluded under § 17.272(a)(1) through (84).

CHAMPVA determined allowable amount has the meaning set forth in § 17.272(b)(1).

CHAMPVA In-house Treatment Initiative (CITI) means the initiative under 38 U.S.C. 1781(b) under which participating VA medical facilities provide medical services and supplies to CHAMPVA beneficiaries who are not also eligible for Medicare, subject to availability of space and resources.

Child has the definition established in 38 U.S.C. 101.

Claim means a request by an authorized non-VA provider or by a

CHAMPVA beneficiary for payment or reimbursement for medical services and supplies provided to a CHAMPVA beneficiary.

Fiscal year means October 1 through September 30.

Medications by Mail (MbM) means the initiative under which VA provides outpatient prescription medications through the mail to CHAMPVA beneficiaries.

Other health insurance (OHI) means health insurance plans or programs (including Medicare) or third-party coverage that provide coverage to a CHAMPVA beneficiary for expenses incurred for medical services and supplies.

Payer refers to OHI, as defined in this section, that is obligated to pay for CHAMPVA-covered medical services and supplies. In a situation in which, in addition to CHAMPVA, one or more payers is/are responsible to pay for such services and supplies (*i.e.*, a “double coverage” situation), there would be a primary payer (*i.e.*, the payer obligated to pay first), secondary payer (*i.e.*, the payer obligated to pay after the primary payer), etc. In double coverage situations, CHAMPVA would be the last payer.

Service-connected has the definition established in 38 U.S.C. 101.

Spouse refers to a person who is married to a veteran and whose marriage is valid as determined under 38 U.S.C. 103(c).

Surviving spouse refers to a person who was married to and is the widow(er) of a veteran as determined under 38 U.S.C. 103(c).

(c) **Discretionary authority.** When it is determined to be in the best interest of VA, VA may waive any requirement in §§ 17.270 through 17.278, except any requirement specifically set forth in 38 U.S.C. 1781, or otherwise imposed by statute. Such discretionary authority would be used only under very unusual and limited circumstances and not to deny any individual any right, benefit, or privilege provided to him or her by statute or these regulations. Any such waiver will apply only to the individual circumstance or case involved and will in no way be construed to be precedent-setting.

[87 FR 41599, July 13, 2022]

§ 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;

(4) An individual designated as a Primary Family Caregiver, under 38 CFR 71.25(f), who is not entitled to care or services under a health-plan contract (as defined in 38 U.S.C. 1725(f)(2)); and

(5) 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.

(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.

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(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.

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; 87 FR 41600, July 13, 2022]

§ 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 the services and supplies 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, 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.

(iii) Indian Health Service.

(iv) CHAMPVA supplemental policies.

(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

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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 disorder (TMD). Authorization is limited to initial imaging such as radiographs, Computed Tomography, or Magnetic Resonance Imaging; 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

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foot care services, except those required as a result of a diagnosed systemic medical disease affecting the lower limbs, such as severe diabetes.

(26) Surgery to reverse voluntary surgical sterilization procedures.

(27) 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.

(28) Nonprescription contraceptives, except those non-prescription contraceptives used as emergency contraceptives.

(29) Diagnostic tests to establish paternity of a child; or tests to determine sex of an unborn child.

(30) Preventive care (such as employment-requested physical examinations and routine screening procedures). The following exceptions apply, including but not limited to:

(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) Cervical cancer screening.

(vi) Breast cancer screening.

(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.

(xi) Colorectal cancer screening.

(xii) Prostate cancer screening.

(xiii) Annual physical examination.

(xiv) Vaccinations/immunizations.

(31) Chiropractic and naturopathic services.

(32) Counseling services that are not medically necessary in the treatment of a diagnosed medical condition (such as educational counseling; vocational counseling; and counseling for socio-economic purposes, stress management, life style modification, etc.).

(33) Acupuncture, whether used as a therapeutic agent or as an anesthetic.

(34) 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.

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(35) Self-help, academic education or vocational training services and supplies.

(36) Exercise equipment, spas, whirlpools, hot tubs, swimming pools, health club membership or other such charges or items.

(37) General exercise programs, even if recommended by a physician.

(38) Eye exercises or visual training (orthoptics).

(39) 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.

(40) 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)(40)(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.

(41) Hearing aids or other auditory sensory enhancing devices.

(42) 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.

(43) 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.

(44) Telephone Services, with the following exceptions:

(i) Services or advice rendered by telephone (audio only) on or after May 12, 2020, are not excluded when the services are otherwise covered CHAMPVA services provided through this modality and are medically necessary and appropriate.

(ii) 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:

(A) The procedure, without electronic data transmission, is a covered benefit;

(B) The addition of electronic data transmission or biotelemetry improves the management of a clinical condition in defined circumstances; and

(C) 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.

(45) Air conditioners, humidifiers, dehumidifiers, and purifiers.

(46) Elevators.

(47) Alterations to living spaces or permanent features attached thereto, even when necessary to accommodate

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installation of covered durable medical equipment or to facilitate entrance or exit.

(48) Items of clothing, even if required by virtue of an allergy (such as cotton fabric versus synthetic fabric and vegetable-dyed shoes).

(49) Food, food substitutes, vitamins or other nutritional supplements, including those related to care for a home patient whose condition permits oral feeding, except for prenatal vitamins which are medically necessary as a component of prenatal care and prescribed by a VA provider or an authorized non-VA provider as defined in § 17.270 of this part.

(50) Enuretic (bed-wetting) conditioning programs.

(51) Autopsy and post-mortem examinations.

(52) 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.

(53) Housekeeping, homemaker, or attendant services, including a sitter or companion.

(54) Personal comfort or convenience items, such as beauty and barber services, radio, television, and telephone.

(55) Megavitamin psychiatric therapy; orthomolecular psychiatric therapy.

(56) All transportation except for specialized transportation with life sustaining equipment, when medically required for the treatment of a covered condition.

(57) 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.

(58) Abortions, except when:

(i) The life or the health of the pregnant beneficiary would be endangered if the pregnancy were carried to term; or

(ii) The pregnancy is the result of an act of rape or incest. Self-reporting from the pregnant beneficiary constitutes sufficient evidence that an act of rape or incest occurred.

(59) Aversion therapy.

(60) Rental or purchase of biofeedback equipment.

(61) Biofeedback therapy for treatment of ordinary muscle tension states (including tension headaches) or for psychosomatic conditions.

(62) Immunotherapy for malignant diseases except for treatment of Stage O and Stage A carcinoma of the bladder.

(63) Services and supplies provided by other than a hospital, such as non-skilled nursing homes, intermediate care facilities, halfway houses, homes for the aged, or other institutions of similar purpose.

(64) Services performed when the patient is not physically present.

(65) Medical photography.

(66) Special tutoring.

(67) Surgery for psychological reasons.

(68) Treatment of premenstrual syndrome (PMS).

(69) Over-the-counter products except for pharmaceutical smoking cessation supplies that are approved by the U.S. Food and Drug Administration, prescribed, and provided through MbM, and insulin and related diabetic testing supplies and syringes.

(70) Thermography.

(71) Removal of tattoos.

(72) Penile implant/testicular prosthesis procedures and related supplies for psychological impotence.

(73) 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.

(74) Chemical peeling for facial wrinkles.

(75) Panniculectomy, body sculpting procedures.

(76) Medications not approved by the U.S. Food and Drug Administration (FDA), excluding FDA exceptions to the approval requirement.

(77) Services and supplies related to the treatment of dyslexia.

(b) Costs of services and supplies to the extent such amounts are billed over the CHAMPVA determined allowable amount are specifically excluded from coverage.

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(1) The CHAMPVA determined allowable amount is the maximum level of payment by CHAMPVA to an authorized non-VA provider for the provision of CHAMPVA-covered services and supplies to a CHAMPVA beneficiary. The CHAMPVA determined allowable amount is determined before consideration of cost sharing and the application of deductibles or OHI.

(2) A Medicare-participating hospital must accept the CHAMPVA determined allowable amount for inpatient services provided to a CHAMPVA beneficiary as payment in full. See 42 CFR 489.25.

(3) An authorized non-VA provider who accepts responsibility for the care of a CHAMPVA beneficiary thereby agrees to accept the CHAMPVA determined allowable amount as full payment for services and supplies rendered to the beneficiary (*i.e.*, accepted assignment). The provider's acceptance of the CHAMPVA determined allowable amount extinguishes the beneficiary's payment liability to the provider. Any attempts to collect any additional amount from the CHAMPVA beneficiary may result in the provider being excluded from Federal benefits programs. See 42 CFR 1003.105.

[63 FR 48102, Sept. 9, 1998, as amended at 67 FR 4359, Jan. 30, 2002; 73 FR 65553, Nov. 4, 2008; 87 FR 41600, July 13, 2022; 87 FR 55296, Sept. 9, 2022; 89 FR 34136, Apr. 30, 2024]

§ 17.273 Preauthorization.

Preauthorization or advance approval is required for any of the following, except when the benefit is covered by the CHAMPVA beneficiary's other health insurance (OHI):

(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) Dental care. For limitations on dental care, see § 17.272(a)(21)(i) through (xii).

(e) Organ transplants.

(d) Organ transplants.

(e) CHAMPVA will perform a retrospective medical necessity review dur-

ing the coordination of benefits process if:

(1) It is determined that CHAMPVA is the responsible payer for services and supplies but CHAMPVA preauthorization was not obtained prior to delivery of the services or supplies; and,

(2) The claim for payment is filed within the appropriate one-year period.

[63 FR 48102, Sept. 9, 1998, as amended at 74 FR 31374, July 1, 2009; 87 FR 41601, July 13, 2022; 89 FR 34137, Apr. 30, 2024]

§ 17.274 Cost sharing.

(a) *Cost sharing generally.* CHAMPVA is a cost sharing program in which the cost of covered services is shared with the CHAMPVA beneficiary. CHAMPVA pays the CHAMPVA determined allowable amount less the CHAMPVA deductible, if applicable, and less the CHAMPVA beneficiary cost-share.

(1) CHAMPVA beneficiary cost-share requirements do not apply to the following:

(i) Supplies provided through VA MbM.

(ii) Any medical services and supplies provided to a CHAMPVA beneficiary through CITI.

(iii) The following services, even if not provided through CITI:

(A) Colorectal cancer screening.

(B) Breast cancer screening.

(C) Cervical cancer screening.

(D) Prostate cancer screening.

(E) Annual physical exams.

(F) Vaccinations/immunizations.

(G) Well child care from birth to age six, as described in § 17.272(a)(30)(i).

(iv) Hospice services.

(v) Or other preventive services as determined by the Secretary of Veterans Affairs.

(2) [Reserved]

(b) *Deductibles.* In addition to the CHAMPVA beneficiary cost-share, an annual (calendar year) outpatient deductible requirement (\$50 per beneficiary or \$100 per family) must be satisfied prior to VA payment of outpatient benefits. The deductible requirement is waived for:

(1) CHAMPVA-covered services and supplies provided through VA MbM or through CITI.

(2) Inpatient services.

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(3) Preventive services listed in paragraph (a)(1)(iii) of this section.

(4) Hospice services.

(5) Or other services as determined by the Secretary of Veterans Affairs.

(c) *Cost sharing limitations.* To provide financial protection against the impact of a long-term illness or injury, there is a \$3,000 calendar year limit or "catastrophic cap" per CHAMPVA eligible family on the CHAMPVA beneficiary's out-of-pocket costs for allowable services and supplies. After a family has paid \$3,000 in out-of-pocket costs, to include both cost-share and deductible amounts, in a calendar year, CHAMPVA will pay the full allowable amounts for the remaining CHAMPVA-covered services and supplies through the end of that calendar year. Credits to the annual catastrophic cap are limited to the applied annual deductible(s) and the CHAMPVA beneficiary cost-share amount. Costs above the CHAMPVA determined allowable amount, as well as costs associated with non-covered medical services and supplies, are not credited toward the catastrophic cap calculation.

(d) *Non-payment.* If the CHAMPVA benefit payment is under \$1.00, payment will not be issued. Catastrophic cap and deductible will, however, be credited.

(e) *Cost-share calculation.* The CHAMPVA beneficiary's cost-share amount, if not waived under paragraph (a)(1) of this section, is 25 percent of the CHAMPVA determined allowable amount in excess of the annual calendar year deductible (see § 17.275 for procedures related to the calculation of the allowable amount for CHAMPVA-covered services and supplies), except for the following:

(1) For inpatient services subject to the CHAMPVA Diagnosis Related Group (DRG) payment system, the cost-share is the lesser of:

(i) The per diem rate multiplied by the number of inpatient days;

(ii) 25 percent of the hospital's billed amount; or

(iii) The base CHAMPVA DRG rate.

(2) For inpatient mental health low volume hospitals and units (less than 25 mental health discharges per federal fiscal year), the cost-share is the lesser of:

(i) The fixed per diem rate multiplied by the number of inpatient days; or

(ii) 25 percent of the hospital's billed charges.

(f) Cost sharing and annual deductible requirements under paragraphs (a) and (b) of this section do not apply to:

(1) Insertion, removal, and replacement of intrauterine systems, contraceptive implants, or similar FDA approved, granted, or cleared contraceptives that require insertion, removal, and replacement by a health care provider;

(2) Measurement for, and purchase of, contraceptive diaphragms or similar FDA approved, cleared, or granted medical devices, including remeasurement and replacement;

(3) Administration of injectable contraceptives or similar FDA approved, granted, or cleared contraceptives that require administration by a health care provider;

(4) Prescription contraceptives, and prescription or nonprescription contraceptives used as emergency contraceptives, approved, granted, or cleared by the FDA;

(5) Surgical sterilization; and

(6) Outpatient care or evaluation associated with provision of family planning services listed in paragraphs (f)(1) through (5) of this section.

[67 FR 4359, Jan. 30, 2002, as amended at 67 FR 6875, Feb. 14, 2002; 87 FR 41601, July 13, 2022; 89 FR 34137, Apr. 30, 2024]

§ 17.275 CHAMPVA determined allowable amount calculation.

CHAMPVA calculates the allowable amount in the following ways, for the following covered services and supplies:

(a) *Inpatient hospital services (non-mental health).* Unless exempt or subject to a methodology under paragraph (b) or (c) of this section, inpatient hospital services provided in the 50 states, the District of Columbia, and Puerto Rico are subject to the CHAMPVA Diagnosis Related Group (DRG)-based reimbursement methodology. Under the CHAMPVA DRG-based payment system, hospitals are paid a predetermined amount per discharge for inpatient hospital services, which will not exceed the billed amount. Certain inpatient services will be reimbursed under

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the CHAMPVA Cost-to-Charge (CTC) reimbursement methodology.

(b) *Inpatient hospital services (mental health).* The CHAMPVA inpatient mental health per diem reimbursement methodology is used to calculate reimbursement for inpatient mental health hospital care in specialty psychiatric hospitals and psychiatric units of general acute hospitals that are exempt from the CHAMPVA DRG-based payment system. The per diem rate is calculated by multiplying the daily rate by the number of days (length of stay). The daily rate is updated each fiscal year for both high volume hospitals (25 or more discharges per fiscal year) and low volume hospitals (fewer than 25 discharges per fiscal year).

(c) *Other inpatient hospital services.* (1) The CHAMPVA CTC reimbursement methodology is used to calculate reimbursement for inpatient care furnished by hospitals or facilities that are exempt from either of the methodologies in paragraph (a) or (b) of this section. Such hospitals or facilities will be paid at the CHAMPVA CTC ratio times the billed charges that are customary and not in excess of rates or fees the hospital or facility charges the general public for similar services in a community.

(2) The following hospitals and services are subject to the CHAMPVA CTC payment methodology:

(i) Any hospital that qualifies as a cancer hospital under Medicare standards and has elected to be exempt from the Centers for Medicare & Medicaid Services (CMS) prospective payment system.

(ii) Christian Science sanatoriums.

(iii) Critical Access Hospitals.

(iv) Any hospital outside the 50 states, the District of Columbia, or Puerto Rico.

(v) Hospitals within hospitals.

(vi) Long-term care hospitals.

(vii) Non-Medicare participating hospitals.

(viii) Non-VA Federal Health Care Facilities (e.g., military treatment facilities, Indian Health Service).

(ix) Rehabilitation hospitals.

(x) Hospital or hospital-based services subject to state waiver in any state that has implemented a separate DRG-based payment system or similar

payment system in order to control costs.

(xi) Hospitals and services as determined by the Secretary of Veterans Affairs.

(d) *Outpatient hospital services.* The CHAMPVA outpatient prospective payment system (OPPS) is used to calculate the allowable amount for outpatient services provided in hospitals subject to Medicare OPPS. This will include the utilization of TRICARE's reimbursement methodology to include specific coding requirements, ambulatory payment classifications (APCs), nationally established APC amounts, and associated adjustments.

(e) *Outpatient and inpatient non-hospital services.* Payments to individual authorized non-VA providers (not hospitals) for CHAMPVA-covered medical services and supplies provided on an outpatient or inpatient basis, including but not limited to, anesthesia services, laboratory services, and other professional fees associated with individual authorized non-VA providers, are reimbursed based on the lesser of:

(1) The CHAMPVA Maximum Allowable Charge;

(2) The prevailing amount, which is the amount equal to the maximum reasonable amount allowed providers for a specific procedure in a specific locality; or

(3) The billed amount.

(f) *Pharmacy services and supplies.* The CHAMPVA pharmacy services and supplies payment methodology is based on specific CHAMPVA pharmacy points of service, which dictate the amounts paid by VA. VA pays:

(1) For services and supplies obtained from a retail in-network pharmacy, the lesser of the billed amount or the contracted rate; or

(2) For supplies obtained from a retail out-of-network pharmacy, the lesser of the billed amount plus a dispensing fee or the average wholesale price plus a dispensing fee.

(g) *Skilled Nursing Facility (SNF) care.* The CHAMPVA SNF reimbursement methodology is based on the CMS prospective payment system for SNFs under 42 CFR part 413, subpart J.

(h) *Durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS).* The CHAMPVA DMEPOS

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reimbursement methodology is based on the same amounts established under the CMS DMEPOS fee schedule under 42 CFR part 414, subpart D. The CHAMPVA determined allowable amount for DMEPOS is the amount in effect in the specific geographic location at the time CHAMPVA-covered medical services and supplies are provided to a CHAMPVA beneficiary.

(i) *Ambulance services.* CHAMPVA adopts Medicare's Ambulance Fee Schedule (AFS) for ambulance services, with the exception of services furnished by a Critical Access Hospital (CAH). Ambulance services are paid based on the lesser of the Medicare AFS or the billed amount. Ambulance services provided by a CAH are paid on the same bases as the CTC method under paragraph (c) of this section.

(j) *Hospice care.* CHAMPVA hospice reimbursement methodology uses Medicare per diem hospice rates.

(k) *Home health care (intermittent or part-time).* CHAMPVA home health care reimbursement methodology, based on Medicare's home health prospective payment system, uses a fixed case-mix and wage-adjusted episode payment amount to act as payment in full for costs associated with furnishing home health services with exceptions allowing for additional payment to be established.

(l) *Ambulatory surgery.* The CHAMPVA reimbursement methodology for facility charges associated with procedures performed in a free-standing ambulatory surgery center is based on a prospectively determined amount, similar to that used by TRICARE. These facility charges do not include physician fees, anesthesiologist fees, or fees of other authorized non-VA providers; such independent professional fees must be submitted separately from facility fees and are calculated under the methodology in paragraph (e) of this section.

(m) *CHAMPVA-covered medical services and supplies provided outside the United States.* VA shall determine the appropriate reimbursement method(s) for CHAMPVA-covered medical services and supplies provided by authorized non-VA providers outside the United States.

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(n) *Sole Community Hospitals.* The CHAMPVA reimbursement methodology for inpatient services provided in a Sole Community Hospital (SCH) will be the greater of: the allowable amount determined by multiplying the billed charges by the SCH's most recently available cost-to-charge ratio from the CMS Inpatient Provider Specific File or the DRG reimbursement rate.

[87 FR 41602, July 13, 2022]

§ 17.276 Claim filing deadline.

(a) Unless an exception is granted under paragraph (b) of this section, claims for medical services and supplies must be filed 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 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 will be reviewed individually and considered on its own merit. VA may grant exceptions to the requirements in paragraph (a) of this section if it 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.

(c) Claims for CHAMPVA-covered services and supplies provided before the date of the event that qualifies an

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individual under § 17.271 are not reimbursable.

(d) CHAMPVA is the last payer to OHI, as that term is defined in § 17.270(b). CHAMPVA benefits will generally not be paid until the claim has been filed with the OHI and the OHI has issued a final payment determination or explanation of benefits. CHAMPVA is secondary payer to Medicare per the terms of § 17.271(b).

[63 FR 48102, Sept. 9, 1998, as amended at 73 FR 65553, Nov. 4, 2008. Redesignated and amended at 87 FR 41602, 41603, July 13, 2022]

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(a) This section applies only to legacy claims.

(b) Notice of the initial determination regarding payment of CHAMPVA benefits will be provided to the CHAMPVA beneficiary on a CHAMPVA Explanation of Benefits (EOB) form. The EOB form is generated by the CHAMPVA automated payment processing system. If a CHAMPVA beneficiary or provider disagrees with the determination concerning CHAMPVA-covered services and supplies or calculation of benefits, he or she may request reconsideration. Such requests must be submitted to VA in writing within one year of the date of the initial determination. The request must state why the CHAMPVA claimant 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, VA will issue a written determination to the claimant that affirms, reverses, or modifies the previous decision. If the claimant is still dissatisfied, within 90 days of the date of the decision he or she may make a written request for review by VA. After reviewing the claim and any relevant supporting documentation, VA will issue a written determination to the claimant that affirms, reverses, or modifies the previous decision. The decision of VA with respect to benefit coverage and computation of benefits is final. When a CHAMPVA beneficiary has other health insurance (OHI), an

appeal must first be filed with the OHI, and a determination made, before submitting the appeal to CHAMPVA with limited exceptions such as if the OHI deems the issue non-appealable. 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.

[87 FR 41603, July 13, 2022]

§ 17.278 Medical care cost recovery.

VA will actively pursue medical care cost recovery in accordance with applicable law.

[87 FR 41603, July 13, 2022]

§ 17.279 Confidentiality of records.

Confidentiality of records will be maintained in accordance with 38 CFR 1.460 through 1.582.

[63 FR 48102, Sept. 9, 1998. Redesignated and amended at 87 FR 41602, 41603, July 13, 2022]

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

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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 quali-

fying 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;

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(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 non-profit 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

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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.

(The Office of Management and Budget has approved the information collection requirement in this section under control number 2900-0860)

[83 FR 9212, Mar. 5, 2018, as amended at 84 FR 68048, Dec. 13, 2019; 85 FR 31983, May 28, 2020]

HOSPITAL CARE, MEDICAL SERVICES, AND OTHER SERVICES FOR LIVE DONORS**§ 17.395 Transplant procedures with live donors, and related services.**

(a) *Scope.* This section provides for medical and non-medical care and services of persons who volunteer to donate a solid organ, part of a solid organ, or bone marrow for transplantation into an eligible veteran transplant candidate, irrespective of a donor's eligibility to receive VA health care for any reason other than to donate a solid organ, part of a solid organ, or bone marrow. It prescribes the type, timing, and duration of hospital care and medical services VA provides, including medical care or services purchased by agreement from a non-VA facility. It also provides for non-medical care and services essential to the prospective live donor's or live donor's participation and for VA reimbursement for that care and services. The section does not provide for eligible veteran transplant candidates' VA medical benefits.

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

Initial prospective live donor means an intended recipient's prospective live donor who volunteers to donate a kidney to a recipient other than the intended recipient through kidney paired donation.

Intended recipient means the transplant candidate who VA identifies to receive a live donor's solid organ, part of a solid organ, or bone marrow.

Kidney paired donation means one prospective live donor's voluntary donation of a kidney for transplantation into a recipient other than an intended recipient, paired with the transplantation into the intended recipient of a compatible kidney from a different live donor. Note: For purposes of this section, kidney paired donation includes live donor chains.

Live donor means an individual who is:

- (i) Medically suitable for donation;
- (ii) Is a compatible match to an identified veteran transplant candidate; and
- (iii) Has provided informed consent to undergo elective removal of one solid organ, part of a solid organ, or of bone marrow.

Live donor chain means a set of kidney paired donation matches that begins with a donation of a kidney from a live donor without an intended recipient. Such live donor donates a kidney for transplantation into the intended recipient of a prospective live donor. The prospective live donor then donates a kidney for transplantation into a recipient other than the intended recipient. A chain continues to allow donation and receipt of compatible kidneys.

Live Donor Follow-Up Means

- (i) For live donors of a solid organ or part of a solid organ, the collection of clinically relevant post-donation live donor data and the provision of recommended clinical laboratory tests and evaluations consistent with Organ Procurement and Transplantation Network policy, and the provision of direct medical care required to address reasonably foreseeable donor health complications resulting directly from the donation procedure.

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(ii) For live donors of bone marrow, the provision of direct medical care required to address reasonably foreseeable donor health complications resulting directly from the donation procedure.

Prospective live donor means a person who has volunteered to donate a solid organ, part of a solid organ, or bone marrow to an intended recipient, and who has agreed to participate in any activity VA deems necessary to carry out the intended recipient's transplant procedure.

Transplant candidate means an enrolled veteran or a veteran otherwise eligible for VA's medical benefits package who VA determines has a medical need for a solid organ, part of a solid organ, or bone marrow transplant.

Transplant recipient means a transplant candidate who has undergone transplantation and received a solid organ, part of a solid organ, or bone marrow from a live donor.

(c) *Hospital care and medical services.* To obtain a solid organ, part of a solid organ, or bone marrow for a VA transplant candidate, VA may provide the following hospital care and medical services to a prospective live donor or live donor:

(1) Before removal of a solid organ, part of a solid organ, or bone marrow, VA will provide examinations, tests, and studies necessary to qualify a prospective live donor to donate a solid organ, part of a solid organ, or bone marrow.

(2) During removal of a solid organ, part of a solid organ, or bone marrow, VA will provide the surgical procedure to remove a solid organ, part of a solid organ, or bone marrow from the living donor whose solid organ, part of a solid organ, or bone marrow will be transplanted into an intended recipient.

(3) After removal of a solid organ or part of a solid organ, VA will provide all hospital care, medical services, and other services which are necessary and appropriate to live donor follow-up as defined in paragraph (b) of this section for a period not less than that which the Organ Procurement and Transplantation Network prescribes or recommends or for a period of 2 years, whichever is greater.

(4) After bone marrow removal, VA will provide direct medical care required to address reasonably foreseeable live donor health complications resulting directly from the bone marrow donation procedure for a period not greater than 2 years.

(5) A prospective live donor who is also a veteran enrolled in VA's health care system may receive care and services authorized in paragraphs (c)(1) and (2) only under this section. A live donor who is also a veteran enrolled in VA's health care system may opt to receive the care and services authorized under paragraph (c)(3) or (4) under either the medical benefits package codified at §17.38 or under this section, but not both at the same time.

(d) *Non-hospital care and non-medical services.* If VA determines the prospective live donor's or the live donor's presence or proximity is necessary, VA will reimburse the travel costs of the prospective live donor or live donor, including one needed attendant or support person, at the rates provided in §70.30 of this chapter, without the deductibles required by §70.31 of this chapter, for:

(1) Travel between the prospective live donor's or live donor's residence and the site of hospital care or medical services authorized in paragraph (c) of this section; and

(2) Temporary lodging:

(i) While the live donor is hospitalized for the organ removal procedure; or

(ii) While the prospective live donor's or live donor's participation in the live donor program requires the prospective live donor's or live donor's presence away from home at least overnight and the prospective live donor's or live donor's presence or proximity is determined necessary by VA.

(e) *Use of non-VA facilities and non-VA service providers.* (1) If and only if VA and a non-VA facility or non-VA service provider have an agreement governed by 38 U.S.C. 8153 or any other applicable authority in title 38, United States Code, a non-VA facility may provide—

(i) A surgical procedure and care and services described in paragraph (c) of this section; or

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(ii) Non-hospital care or non-medical services described and otherwise reimbursable under paragraph (d) of this section.

(2) The prospective live donor or live donor is eligible for hospital care and medical services, or travel services, at a non-VA facility solely for the procedure, care, and services described in paragraphs (c) and (d) of this section as governed by an agreement described in paragraph (e)(1) of this section.

(f) *Participation terminated without completion of the intended recipient's transplantation procedure.* (1) VA will provide the prospective live donor or live donor the care and services described in this section for any VA-authorized participation in the intended recipient's organ or bone marrow transplantation process even if the transplantation procedure for which the prospective live donor or live donor volunteered to donate a solid organ, part of a solid organ, or bone marrow is not completed.

(2) A prospective live donor or a live donor may withdraw his or her informed consent at any time and for any reason. In the case of revocation of consent, VA will pay all the costs authorized under this section for the prospective live donor or live donor up until when the donor revokes consent and ends his or her participation.

(g) *Limitation on VA obligation in kidney paired donations.* In kidney paired donations, VA's obligation to provide any procedure, hospital care, or medical services under this section extends:

(1) To the initial prospective live donor who elects to participate in a kidney paired donation matching program, but only for the examinations, tests, and studies described in paragraph (c)(1) of this section for a prospective live donor before kidney removal.

(2) To the live donor whose kidney the intended recipient will receive or has received but only for the services described in paragraphs (c)(2) and (3) of this section.

[87 FR 33024, July 1, 2022]

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,

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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

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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 reim-

burse 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.

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(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

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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;

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(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]

§ 17.419 Health care professionals' practice in VA.

(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 professional.* The term health care professional is an individual who:

(i) Is appointed to an occupation in the Veterans Health Administration that is listed in or authorized under 38 U.S.C. 7306, 7401, 7405, 7406, or 7408 or title 5 of the U.S. Code;

(ii) Is not a VA-contracted health care professional; and

(iii) Is qualified to provide health care as follows:

(A) Has an active, current, full, and unrestricted license, registration, certification, or satisfies another State requirement in a State;

(B) Has other qualifications as prescribed by the Secretary for one of the health care professions listed under 38 U.S.C. 7402(b);

(C) Is an employee otherwise authorized by the Secretary to provide health care services; or

(D) Is under the clinical supervision of a health care professional that meets the requirements of subsection (a)(2)(iii)(A)–(C) of this section and is either:

(i) A health professions trainee appointed under 38 U.S.C. 7405 or 7406 participating in clinical or research training under supervision to satisfy program or degree requirements; or

(ii) A health care employee, appointed under title 5 of the U.S. Code, 38 U.S.C. 7401(1) or (3), or 38 U.S.C. 7405 for any category of personnel described in 38 U.S.C. 7401(1) or (3) who must obtain an active, current, full and unrestricted licensure, registration, certification, or meet the qualification standards as defined by the Secretary within the specified time frame.

(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.

(b) *Health care professional's practice.*

(1) When a State law or license, registration, certification, or other requirement prevents or unduly interferes with a health care professional's practice within the scope of their VA employment, the health care professional is required to abide by their Federal duties, which includes, but is not limited to, the following situations:

(i) A health care professional may practice their VA health care profession in any State irrespective of the State where they hold a valid license, registration, certification, or other State qualification; or

(ii) A health care professional may practice their VA health care profession within the scope of the VA national standard of practice as determined by VA.

(2) VA health care professional's practice is subject to the limitations imposed by the Controlled Substances Act, 21 U.S.C. 801 *et seq.* and implementing regulations at 21 CFR 1300 *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.

(c) *Preemption of State law.* Pursuant to the Supremacy Clause, U.S. Const. art. IV, cl. 2, and in order to achieve important Federal interests, including,

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but not limited to, the ability to provide the same complete health care and hospital service to beneficiaries in all States as required by 38 U.S.C. 7301, conflicting State laws, rules, regulations or requirements pursuant to such laws are without any force or effect, and State governments have no legal authority to enforce them in relation to actions by health care professionals within the scope of their VA employment.

[85 FR 71845, Nov. 12, 2020]

CENTER FOR INNOVATION FOR CARE AND PAYMENT

§ 17.450 Center for Innovation for Care and Payment.

(a) *Purpose and organization.* The purpose of this section is to establish procedures for the Center for Innovation for Care and Payment.

(1) The Center for Innovation for Care and Payment will be responsible for working across VA to carry out pilot programs to develop innovative approaches to testing payment and service delivery models to reduce expenditures while preserving or enhancing the quality of care furnished by VA.

(2) The Center for Innovation for Care and Payment will operate within the Veterans Health Administration, which will ensure that the limited number of concurrent pilots under this section are not redundant of or conflicting with ongoing innovation efforts within any specific administration.

(b) *Definitions.* The following definitions apply to this section.

Access refers to entry into or use of VA services.

Patient satisfaction of care and services refers to patients' rating of their experiences of care and services and as further defined in a pilot program proposal.

Payment models refer to the types of payment, reimbursement, or incentives that VA deems appropriate for advancing the health and well-being of beneficiaries.

Pilot program refers to a pilot program conducted under this section.

Quality enhancement refers to improvement or improvements in such

factors as clinical quality, beneficiary-level outcomes, and functional status as documented through improvements in measurement data from a reliable and valid source, and as further defined in a pilot program proposal.

Quality preservation refers to the maintenance of such factors as clinical quality, beneficiary-level outcomes, and functional status as documented through maintenance of measurement data from an evidence-based source, and as further defined in a pilot program proposal.

Reduction in expenditure refers to, but is not limited to, cost stabilization, cost avoidance, or decreases in long- or short-term spending, and as further defined in a pilot program proposal. NOTE: VA will also consider the proposal's potential impact on expenditures for other related Federal programs; however, this potential impact will not count against the limitation in paragraph (d)(2) of this section.

Service delivery models refer to all methods or programs for furnishing care or services.

(c) *Geographic locations.* VA will make decisions regarding the location of each pilot program based upon the appropriateness of testing a specific model in a specific area while taking efforts to ensure that pilot programs are operated in geographically diverse areas of the country. VA will include in its proposal to Congress and publish a document in the *FEDERAL REGISTER* identifying the geographic locations proposed for each pilot program, the rationale for those selections, and how VA believes the selected locations will address deficits in care for a defined population.

(d) *Limitations.* In carrying out pilot programs under this section, VA will not:

(1) Actively operate more than 10 pilot programs at the same time; and

(2) Consistent with 38 U.S.C. 1703E(d), obligate more than \$50 million in any fiscal year in the conduct of the pilot programs (including all administrative and overhead costs, such as measurement, evaluation, and expenses to implement the pilot programs themselves) operated under this section, unless VA determines it to be necessary and submits a report to the appropriate

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Committees of Congress that sets forth the amount of, and justification for, the additional expenditure.

(e) *Waiver of authorities.* In carrying out pilot programs under this section, VA may waive statutory provisions by adding to or removing from statutory text in subchapters I, II, and III of chapter 17, title 38, U.S.C., upon Congressional approval, including waiving any provisions of law in any provision codified in or included as a note to any section in subchapter I, II, or III of chapter 17, title 38.

(1) Upon Congressional approval of the waiver of a provision of law under this section, VA will also deem waived any applicable provision of regulation implementing such law as identified in VA's pilot program proposal.

(2) VA will publish a document in the **FEDERAL REGISTER** providing information about, and seeking comment on, each proposed pilot program upon its submission of a proposal to Congress for approval. VA will publish a document in the **FEDERAL REGISTER** to inform the public of any pilot programs that have been approved by Congress.

(f) *Notice of eligibility.* VA will take reasonable actions to provide direct notice to veterans eligible to participate in a pilot program operated under this section and will provide general notice to other individuals eligible to participate in a pilot program. VA will announce its methods of providing notice to veterans, the public, and other individuals eligible to participate through the document it publishes in the **FEDERAL REGISTER** for each proposed and approved pilot program.

(g) *Evaluation and reporting.* VA will evaluate each pilot program operated under this section and report its findings. Evaluations may be based on quantitative data, qualitative data, or both. Whenever appropriate, evaluations will include a survey of participants or beneficiaries to determine their satisfaction with the pilot program. VA will make the evaluation results available to the public on a VA website on the schedule identified in VA's proposal for the pilot program.

(h) *Expansion of pilot programs.* VA may expand a pilot program consistent with this paragraph (h).

(1) VA may expand the scope or duration of a pilot program if, based on an analysis of the data developed pursuant to paragraph (g) of this section for the pilot program, VA expects the pilot program to reduce spending without reducing the quality of care or improve the quality of patient care without increasing spending. Expansion may only occur if VA determines that expansion would not deny or limit the coverage or provision of benefits for individuals under 38 U.S.C. chapter 17. Expansion of a pilot program may not occur until 60 days after VA has published a document in the **FEDERAL REGISTER** and submitted an interim report to Congress stating its intent to expand a pilot program.

(2) VA may expand the scope of a pilot program by modifying, among other elements of a pilot program, the range of services provided, the qualifying conditions covered, the geographic location of the pilot program, or the population of eligible participants in a manner that increases participation in or benefits under a pilot program.

(3) In general, pilot programs are limited to 5 years of operation. VA may extend the duration of a pilot program by up to an additional 5 years of operation. Any pilot program extended beyond its initial 5-year period must continue to comply with the provisions of this section regarding evaluation and reporting under paragraph (g) of this section.

(i) *Modification of pilot programs.* The Secretary may modify elements of a pilot program in a manner that is consistent with the parameters of the Congressional approval of the waiver described in paragraph (e) of this section. Such modification does not require a submission to Congress for approval under paragraph (e) of this section.

(j) *Termination of pilot programs.* If VA determines that a pilot program is not producing quality enhancement or quality preservation, or is not resulting in the reduction of expenditures, and that it is not possible or advisable to modify the pilot program either through submission of a new waiver request under paragraph (e) of this section or through modification under paragraph (i) of this section, VA will

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terminate the pilot program within 30 days of submitting an interim report to Congress that states such determination. VA will also publish a document in the FEDERAL REGISTER regarding the pilot program's termination.

[84 FR 57329, Oct. 25, 2019, as amended at 89 FR 60827, July 29, 2024]

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

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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;

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(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

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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

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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

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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.

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(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

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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]

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§ 17.510 Rediscovery.

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)

SPECIALTY EDUCATION LOAN REPAYMENT PROGRAM

SOURCE: Sections 17.525 through 17.531 appear at 85 FR 45535, July 29, 2020, unless otherwise noted.

§ 17.525 Purpose.

The purpose of §§ 17.525 through 17.531 is to establish the Specialty Education Loan Repayment Program (SELRP). The SELRP is an incentive program for certain individuals to meet VA's need for physicians in medical specialties for which VA determines that recruitment and retention of qualified personnel is difficult. Assistance under the SELRP may be in addition to other assistance available to individuals under the Educational Assistance Program under 38 U.S.C. 7601.

§ 17.526 Definitions.

The following definitions apply to §§ 17.525 through 17.530:

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

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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 SELRP:

- (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 SELRP 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.

SELRP means the Specialty Education Loan Repayment Program established in §§ 17.525 through 17.530.

State means a State as defined in 38 U.S.C. 101(20), or a political subdivision of such a State.

VA means the Department of Veterans Affairs.

§ 17.527 Eligibility.

(a) *General.* An individual must meet the following requirements to be eligible to participate in the SELRP:

(1) Will be eligible for appointment under 38 U.S.C. 7401 to work as a physician in a medical specialty for which VA determines that recruitment or retention of qualified personnel is difficult. In determining staffing needs, VA will consider the anticipated needs of VA for a period of two to six years in the future. VA will publish these vacancies in a notice in the *FEDERAL REGISTER* on a yearly basis until vacancies are filled.

(2) Owes any amount of principal or interest for an educational loan where the proceeds were used by or on behalf of the individual to pay costs relating to a course of medical education or training that leads to employment as a physician and;

(3) Is:

(i) Recently graduated from an accredited medical or osteopathic school and matched to an accredited residency program in a medical specialty designated by VA; or

(ii) A physician in training with more than 2 years remaining in such training.

(b) *Applicants without a residency match.* An applicant may apply for the SELRP before receiving a residency match during the applicant's senior year of medical or osteopathic school. Once the applicant is matched with a residency specialty stated in § 17.525 and upon selection of the SELRP, VA must offer the applicant participation in the SELRP no later than 28 days after:

(1) The applicant is matched with the residency; and

(2) VA has published the residency in a Notice in the *FEDERAL REGISTER*. Such notices are published on a yearly basis until vacancies are filled.

(c) *Preferences.* VA will give preference to eligible participants who:

(1) Are, or will be, participating in residency programs in health care facilities that are:

(i) Located in rural areas;

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- (ii) Operated by Indian tribes, tribal organizations, or the Indian Health Services; or
- (iii) Are affiliated with underserved health care facilities of VA; or
- (2) Veterans.

§ 17.528 Application.

(a) *General.* A complete application for the SELRP 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:

(1) One letter of reference from the Program Director of the core program in which the applicant is training, which indicates that the applicant is in good to excellent standing, or, for individuals who have yet to initiate training, a letter of reference from a faculty member or dean;

(2) One or more letters of reference from faculty members under which the applicant trained; and

(3) One letter of reference from a peer colleague who is familiar with the 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 medical specialty and underserved area;

(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) A summary of the applicant's educational loan, which includes the total loan amount and when the loan was acquired. The educational loan must be specific to the education that was required and used to qualify the applicant for appointment as a physician.

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- (ii) The name of the lending agency that provided the educational loan.
- (3) A full curriculum vitae.

(The Office of Management and Budget has approved the information collection requirement in this section under control number 2900-0879)

[85 FR 45535, July 29, 2020, as amended at 88 FR 13034, Mar. 2, 2023]

§ 17.529 Award procedures.

(a) *Repayment amount.* (1) VA may pay no more than \$40,000 in educational loan repayment for each year of obligated service for a period not to exceed four years for a total payment of \$160,000.00.

(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 agreement. 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.

(c) *Waiver of maximum amount of payment.* VA may waive the limitations under paragraph (a)(1) of this section to participants of the SELRP if VA determines that there is a shortage of qualified employees due to either the location of where the participant will serve the period of obligated service or the requirements of the position that the participant will hold in VA. However, the waiver may not exceed the actual amount of the principal and the interest on the participant's loans payable to or for that participant.

§ 17.530 Agreement and obligated service.

(a) *General.* In addition to any requirements under section 5379(c) of title 5, a participant in the SELRP

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must agree, in writing, to the following:

- (1) Obtain a license to practice medicine in a State;
- (2) Successfully complete post-graduate training leading to eligibility for board certification in a medical specialty;
- (3) Serve as a full-time clinical practice employee of VA for 12 months for every \$40,000.00 that the participant receives payment through the SELRP, however, the participant must serve for a period of no fewer than 24 months; and
- (4) Except as provided in paragraph (b) of this section, begin obligated service as a full-time VA employee no later than 60 days after completing residency in the medical specialty described in § 17.527(a)(1).

(b) *Obligated service.* (1) *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 qualifying field of 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.

(2) *Location and position of obligated service.* VA will provide SELRP participants a list of qualifying medical facility locations. A participant may select a service location from that list. However, VA reserves the right to make final decisions on the location and position of the obligated service.

(c) *Exception to commencement of obligated service.* If a participant receives an accredited fellowship in a medical specialty other than the specialty described in § 17.27(a)(1), the participant may request, in writing, a delayed commencement of the period of obligated service until after the participant completes the fellowship. However, the period of obligated service will begin no later than 60 days after completion of such fellowship in the medical specialty described in § 17.527(a)(1).

§ 17.531 Failure to comply with terms and conditions of agreement.

A participant of the SELRP who fails to satisfy the period of obligated service will owe the United States govern-

ment an amount determined by the formula $A = B \times ((T - S) \div T)$, where:

- (a) "A" is the amount the participant owes the United States government.
- (b) "B" is the sum of all payments to or for the participant under the SELRP.
- (c) "T" is the number of months in the period of obligated service of the participant.
- (d) "S" is the number of whole months of such period of obligated service served by the participant.

EDUCATIONAL ASSISTANCE FOR CERTAIN FORMER MEMBERS OF THE ARMED FORCES

SOURCE: Sections 17.535 through 17.539 appear at 86 FR 56651, Oct. 12, 2021, unless otherwise noted.

§ 17.535 Purpose.

The purpose of §§ 17.535 through 17.539 is to establish the Educational Assistance for Certain Former Members of the Armed Forces (EACFMAF). The EACFMAF will provide a scholarship to certain former members of the Armed Forces for the education and training leading to employment as a VA physician assistant.

§ 17.536 Eligibility.

(a) *Military and Training requirements.* An individual is eligible to participate in the EACFMAF if such individual is a former member of the Armed Forces who was discharged or released therefrom under conditions other than dishonorable and meets one of the following criteria:

(1) Has medical or military health experience gained while serving as a member of the Armed Forces;

(2) Has received a certificate, associate degree, baccalaureate degree, master's degree, or post baccalaureate training in a science relating to health care; or

(3) Has participated in the delivery of health care services or related medical services, including participation in military training relating to the identification, evaluation, treatment, and prevention of disease and disorders.

(b) *School and Individual requirements.* To be eligible for the EACFMAF, an applicant must:

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(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 leading to employment as a physician assistant;

(3) Be a citizen of the United States; and

(4) Submit an application to participate in the Scholarship Program together with a signed agreement as specified in § 17.538.

§ 17.537 Award procedures.

(a) *Priority.* In awarding EACFMAF, VA will give priority to eligible individuals who agree to be employed as physician assistants in a VA medical facility that:

(1) Is located in a community that is designated as a medically underserved population under 42 U.S.C. 254b(b)(3)(A);

(2) Is designated by VA as a medically underserved facility; and

(3) Is in a State with a per capita population of veterans of more than five percent, according to the National Center for Veterans Analysis and Statistics and the United States Census Bureau.

(b) *Amount of funds.* VA will provide a scholarship to individuals who participate in the EACFMAF to cover the costs of such individuals obtaining a master's degree in physician assistant studies or similar master's degree for a period of one to three years. All such payments to scholarship participants are exempt from Federal taxation. The payments will consist of:

(1) Tuition and required fees;

(2) Other educational expenses, including books and laboratory equipment.

§ 17.538 Agreement and obligated service.

(a) *Agreement.* Each eligible individual who accepts funds from the EACFMAF will enter into an agreement with VA where the eligible individual agrees to the following:

(1) Maintain enrollment, attendance, and acceptable level of academic standing as defined by the school;

(2) Complete a master's degree in physician assistant studies or similar master's degree; and

(3) Be employed as a full-time clinical practice employee in VA as a physician assistant for a period of obligated service for one calendar year for each school year or part thereof for which the EACFMAF was awarded, but for no less than three years.

(b) *Obligated service—(1) General.* An eligible individual's obligated service will begin on the date on which the eligible individual begins full-time permanent employment with VA as a clinical practice employee as a physician assistant, but no later than 90 days after the date that the eligible individual completes a master's degree in physician assistant studies or similar master's degree, or the date the eligible individual becomes licensed in a State and certified as required by the Secretary, whichever is later. VA will actively assist and monitor eligible individuals to ensure State licenses and certificates are obtained in a minimal amount of time following graduation. If an eligible individual 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 eligible individual is considered to be in breach of the acceptance agreement.

(2) *Location and position of obligated service.* VA will publish a list of VA medical facilities where the participants may perform their period of obligated service in a notice in the FEDERAL REGISTER on a yearly basis. Participants of the EACFMAF may select their preference for service from this list to serve the period of obligated service. VA reserves the right to make final decisions on the location and position of the obligated service. An eligible individual who receives an EACFMAF must be willing to relocate to another geographic location to carry out their service obligation.

(The Office of Management and Budget has approved the information collection requirements in this section under control number 2900-0793)

§ 17.539 Failure to comply with terms and conditions of agreement.

(a) *Participant fails to satisfy terms of agreement.* If an eligible individual who accepts funding for the EACFMAF fails to satisfy the terms of agreement, the

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United States is entitled to recover damages in an amount equal to the total amount of EACFMAF funding paid or is payable to or on behalf of the individual, reduced by the total number of obligated service days the individual has already served minus the total number of days in the individual's period of obligated service.

(b) *Repayment period.* The eligible individual 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 one year after the date of the breach of the agreement.

READJUSTMENT COUNSELING SERVICE SCHOLARSHIP PROGRAM

SOURCE: Sections 17.545 through 17.553 appear at 87 FR 71256, Nov. 22, 2022 unless otherwise noted.

§ 17.545 Purpose.

The purpose of §§ 17.545 through 17.553 is to establish the Readjustment Counseling Service Scholarship Program (RCSSP) as part of VA's Educational Assistance Program. For purposes of the RCSSP, the term Vet Center has the meaning given that term in 38 U.S.C. 1712A(h).

§ 17.547 Eligibility.

An individual is eligible to participate in the RCSSP if the individual meets the following requirements:

(a) Is accepted for enrollment or be currently enrolled on a full-time basis in a program of study at an accredited educational institution, school, or training program leading to a terminal doctorate degree in psychology, or a terminal masters degree in social work, marriage and family therapy, or mental health counseling that would meet the education requirements for appointment to a position in one of those fields under 38 U.S.C. 7402(b); and

(b) Enters into an agreement with the Secretary under § 17.551.

§ 17.548 Application procedures.

(a) *Availability.* VA will make awards under the RCSSP only when VA determines it is necessary to assist in alleviating shortages of psychologists, social workers, marriage and family

therapists, or mental health counseling professionals in Vet Centers. VA's determination of the number of RCSSP scholarships to be awarded in a fiscal year is subject to the availability of appropriations.

(b) *Application-general.* Each individual desiring a RCSSP scholarship must submit an accurate and complete application, including a signed written acceptance agreement.

(c) *VA's duties.* VA will notify applicants prior to acceptance in the RCSSP 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) A full description of the terms and conditions that apply to participation in the RCSSP and service in VA.

(The Office of Management and Budget has approved the information collection requirements in this section under control number 2900-0899.)

§ 17.549 Award procedures.

(a) *Priority.* In selecting individuals to participate in the RCSSP, VA will give priority to the following individuals:

(1) An individual who agrees to be employed by Vet Centers located in communities that are:

(i) Designated as a medically underserved population under section 330(b)(3) of the Public Health Service Act (42 U.S.C. 254b(b)(3)); and

(ii) In States with a per capita population of more than five percent veterans according to the National Center for Veterans Analysis and Statistics and the Bureau of the Census.

(2) A veteran.

(b) *Placement criteria.* When determining which Vet Center a scholarship recipient will be placed to carry out their service obligation, VA will consider the priority criteria in paragraph (a) of this section and the size and professional makeup of the current Vet Center staff to ensure that the Vet Center staff has health care professionals that are licensed to supervise participants of the RCSSP from the same health care profession as required by VA professional qualification standards and a requirement of some State

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licensure boards for some disciplines for each of the four professions.

(c) *Amount of funds.* VA will provide a scholarship to individuals who participate in the RCSSP to cover the actual costs of such individuals obtaining a terminal degree in psychology, social work, marriage and family therapy, or professional mental health counseling for a maximum of two years. If a participant completes their terminal degree in less than two years, the period of obligated service remains unchanged.

(1) Social work, marriage and family therapy, and professional mental health counseling are master level programs that require approximately a two-year period for achieving the terminal degree. VA will fund RCSSP social work, marriage and family therapy, and professional mental health counseling participants for a maximum of two years.

(2) Psychology is a doctoral level program requiring approximately five years for completion of the terminal academic degree. In addition, psychology graduates are required to undergo a one-year internship at either an American Psychology Association (APA) or Canadian Psychological Association (CPA) accredited internship program prior to qualifying for full time VA employment. VA will fund psychology participants for the last two years of their five-year academic training to obtain a terminal doctorate degree. VA will not provide funding for the one-year APA or CPA internship under the RCSSP.

(d) *Payment of funds.* All such payments to scholarship participants are exempt from Federal taxation. The payments will consist of the actual cost of:

(1) Tuition and required fees;

(2) Other educational expenses, including books and laboratory equipment; and

(3) A monthly stipend, for the duration of the scholarship award. The Secretary may determine the amount of the stipend paid to participants, but that amount may not exceed the maximum amount provided for in 38 U.S.C. 7613(b).

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§ 17.551 Agreement and obligated service.

(a) *Agreement.* Each participant who accepts funds from the RCSSP will enter into an agreement with VA where the participant agrees to the following:

(1) Maintain enrollment, attendance, and an acceptable level of academic standing as defined by the school;

(2) Obtain a terminal degree in psychology, social work, marriage and family therapy, or professional mental health counseling; and

(3) Be employed as a full-time VA employee at a Vet Center for a period of six-years as a psychologist, social worker, marriage and family therapist, or professional mental health counselor following the completion of such program of study.

(4) Psychologists must complete a one-year internship at either an American Psychological Association (APA) or Canadian Psychological Association (CPA) accredited program. Obtaining an APA or CPA accredited internship requires that an individual participate in the Association of Psychology Postdoctoral and Internship Centers (APPIC) process. If a scholarship participant does not participate in an APA or CPA accredited internship, they are in breach of their agreement.

(b) *Obligated service*—(1) *Determination of service commencement date.* VA will notify the participant of the commencement date of the period of obligated service no later than 60 days before such date.

(2) *Commencement date of obligated service*—(i) *General.* A participant's period of obligated service will begin on the date the participant begins full-time permanent employment at a Vet Center as a psychologist, social worker, marriage and family therapist, or professional mental health counselor, but no later than 180 days after the date that the participant completes a terminal degree in one of the identified disciplines. Psychology participants will commence their period of obligated service no later than 180 days after completion of their one-year APA or CPA internship, which requires completion of all academic requirements to obtain a terminal doctorate degree.

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(ii) *Independent practice.* Upon receipt of the terminal degree, participants will enter VA employment at the entry level until full licensure at the independent practice level has been attained. Independent practice licensure is a requirement for all scholarship participants. Non-licensed psychologists, social workers, marriage and family therapists, and professional mental health counselors are required to serve under the supervision of a licensed health care professional of their profession and must be independently licensed by a State within the time frame specified in VA qualification standards.

(iii) *VA monitoring of participants.* VA will actively assist and monitor participants to ensure State licenses are obtained in a minimal amount of time following graduation and the required period of supervision for their profession. If a participant fails to obtain their terminal degree or fails to obtain licensure in a State at the independent practice level no later than 180 days after the required period of supervision for their profession, the participant is considered to be in breach of the acceptance agreement.

(3) *Location and position of obligated service.* VA reserves the right to make final decisions on the location and position of the obligated service. A participant who receives an RCSSP must be willing to relocate to another geographic location to carry out their service obligation in accordance with the participant's agreement. The requirement for participants to receive supervision from a licensed staff within their respective professions, as a condition for their own licensure, is a critical point for the consideration of the potential location of the obligated service.

(The Office of Management and Budget has approved the information collection requirements in this section under control number 2900-0899.)

§ 17.553 Failure to comply with terms and conditions of agreement.

(a) *Liquidated damages.* Except as provided in paragraph (b) of this section, a participant of the RCSSP who fails to accept payment or instructs the educational institution in which the par-

ticipant is enrolled not to accept payment, in whole or in part, of a scholarship under the agreement entered into under §17.551 will be liable to the United States for liquidated damages in the amount of \$1,500.

(b) *Liability during program of study.* Liability under this section is in lieu of any service obligation arising under the agreement. Except as provided in paragraph (d) of this section, a participant of the RCSSP will be liable to the United States for the amount that has been paid to or on behalf of the participant under the agreement if any of the following occurs:

(1) The participant fails to maintain an acceptable level of academic standing in the educational institution in which the participant is enrolled, as determined by the educational institution;

(2) The participant is dismissed from the educational institution for disciplinary reasons; or

(3) The participant voluntarily terminates the program of study in the educational institution before the completion of the program of study for which the RCSSP was awarded.

(c) *Liability during period of obligated service.* Except as provided in paragraph (d) of this section, if a participant of the RCSSP does not complete their period of obligated service, the United States will be entitled to recover from the participant an amount determined in accordance with the following formula: $A = 3\Phi(t-s/t)$, where:

(1) 'A' is the amount the United States is entitled to recover;

(2) 'Φ' is the sum of:

(i) The amounts paid under this subchapter to or on behalf of the participant, and

(ii) 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.

(3) 't' is the total number of months in the period of obligated service of the participant; and

(4) 's' is the number of months of such period served by the participant.

(d) *Limitation on liability for reductions-in-force.* Liability will not arise under paragraph (c) of this section if

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the participant fails to maintain employment as a VA employee due to a staffing adjustment.

(e) *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 one year after the date of the breach of the agreement.

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.

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(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

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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

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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 2900-0793)

[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; 89 FR 51446, June 18, 2024]

§ 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

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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—*(1) *Physicians and dentists*—(i) VA will award not less than 50 HPSP scholarships each year to individuals who are accepted for enrollment or are enrolled in a program of education or training leading to employment as a physician or dentist until such date as VA determines that the staffing shortage of physicians and dentists in VA is less than 500.

(ii) Once the staffing shortage of physicians and dentists is less than 500, VA will award HPSP scholarships to individuals in an amount equal to not less than ten percent of the staffing shortage of physicians and dentists in VA.

(2) *Mental health disciplines.* Notwithstanding paragraphs (b)(1) and (3) of this section, VA will award not less than 83 HPSP scholarships each year to individuals who are accepted for or are enrolled in a program of education or training leading to employment in a mental health discipline, including, but limited to, advanced practice nursing (with a focus on mental health or substance use disorder), psychology, or social work.

(3) *Other health care professions.* VA will grant HPSP scholarships in a course of study in those disciplines or programs other than physician or dentist where recruitment is necessary for the improvement of health care of veterans as 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, as amended at 85 FR 13053, Mar. 6, 2020; 89 FR 51446, June 18, 2024]

§ 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]

Department of Veterans Affairs**§ 17.606****§ 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

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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-absence 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-

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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*—(i) *Physician or dentist*. A participant who attended school as a full-time student will agree to serve as a full-time physician or dentist in the Veterans Health Administration for 18 months for each school year or part thereof for which a scholarship was awarded.

(ii) *Other health care profession*. A participant who attended school as a full-time student in a health care profession other than physician or dentist 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; 85 FR 13053, Mar. 6, 2020]

§ 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

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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

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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) Who is enrolled in a program or education or training leading to employment as a physician, fails to successfully complete post-graduate training leading to eligibility for board certification in a specialty.

(5) 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

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from the date such person becomes eligible to apply for State licensure; or

(Authority: 38 U.S.C. 7617(b)(4))

(6) 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 pe-

riod 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; 85 FR 13053, Mar. 6, 2020]

§ 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.

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(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]

VETERANS HEALING VETERANS MEDICAL ACCESS AND SCHOLARSHIP PROGRAM

SOURCE: Sections 17.613 through 17.618 appear at 84 FR 61551, Nov. 13, 2019, unless otherwise noted.

§ 17.613 Purpose.

The purpose of §§ 17.613 through 17.618 is to establish the requirement for the Veterans Healing Veterans Medical Access and Scholarship Program (VHVMASP). The VHVMASP will provide funding for the medical education of two eligible veterans from each covered medical school.

§ 17.614 Definitions.

The following definitions apply to §§ 17.613 through 17.618.

Acceptable level of academic standing means:

(1) Maintaining a cumulative grade point average at or above passing, as determined by the medical school;

(2) Completing all required courses with a passing grade;

(3) Successfully completing the required course of study for graduation within four academic years;

(4) Successfully passing the required United States Medical Licensing Examinations steps 1 and 2, within the timeframe for graduation from medical school; and

(5) Having no final determinations of unprofessional conduct or behavior.

Covered medical school means any of the following:

(1) Texas A&M College of Medicine.

(2) Quillen College of Medicine at East Tennessee State University.

(3) Boonshoft School of Medicine at Wright State University.

(4) Joan C. Edwards School of Medicine at Marshall University.

(5) University of South Carolina School of Medicine.

(6) Charles R. Drew University of Medicine and Science.

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(7) Howard University College of Medicine.

(8) Meharry Medical College.

(9) Morehouse School of Medicine.

VA means the Department of Veterans Affairs.

VHVMASP means the Veterans Healing Veterans Medical Access and Scholarship Program authorized by section 304 of the VA MISSION Act of 2018, Public Law 115-182.

§ 17.615 Eligibility.

A veteran is considered eligible to receive funding for the VHVMASP if such veteran meets the following criteria.

(a) Has been discharged or released, under conditions other than dishonorable, from the Armed Forces for not more than 10 years before the date of application for admission to a covered medical school;

(b) Is not concurrently receiving educational assistance under chapter 30, 31, 32, 33, 34, or 35 of title 38 United States Code or chapter 1606 or 1607 of title 10 United States Code at the time the veteran would be receiving VHVMASP funding;

(c) Applies for admission to a covered medical school for the entering class of 2020;

(d) Indicates on the application to the covered medical school that they would like to be considered for the VHVMASP;

(e) Meets the minimum admissions criteria for the covered medical school to which the eligible veteran applies; and

(f) Agrees to the terms stated in § 17.617.

§ 17.616 Award procedures.

(a) *Distribution of funds.* (1) Each covered medical school that opts to participate in the VHVMASP will reserve two seats in the entering class of 2020 for eligible veterans who receive funds for the VHVMASP. Funding will be awarded to two eligible veterans with the highest admissions ranking among veteran applicants for such entering class for each covered medical school.

(2) If two or more eligible veterans do not apply for admission at a covered medical school for the entering class of 2020, VA will distribute the available funding to eligible veterans who ap-

plied, and are accepted, for admission at other covered medical schools.

(b) *Amount of funds.* An eligible veteran will receive funding from the VHVMASP equal to the actual cost of the following:

(1) Tuition at the covered medical school for which the veteran enrolls for a period of not more than 4 years;

(2) Books, fees, and technical equipment;

(3) Fees associated with the National Residency Match Program;

(4) Two away rotations, performed during the fourth year of school, at a VA medical facility; and

(5) A monthly stipend for the four-year period during which the eligible veteran is enrolled in a covered medical school in an amount to be determined by VA.

§ 17.617 Agreement and obligated service.

(a) *Agreement.* Each eligible veteran who accepts funds from the VHVMASP will enter into an agreement with VA where the eligible veteran agrees to the following:

(1) Maintain enrollment, attendance, and acceptable level of academic standing as defined by the covered medical school;

(2) Complete post-graduate training leading to eligibility for board certification in a physician specialty applicable to VA;

(3) After completion of medical school and post-graduate training, obtain and maintain a license to practice medicine in a State. Eligible veterans must ensure that State licenses are obtained in a minimal amount of time following completion of residency, or fellowship, if the veteran is enrolled in a fellowship program approved by VA. If a participant fails to obtain his or her degree, or fails to become licensed in a State no later than 90 days after completion of residency, or fellowship, if applicable, the participant is considered to be in breach of the acceptance agreement; and

(4) Serve as a full-time clinical practice employee in VA for a period of four years.

(b) *Obligated service—(1) General.* An eligible veteran's obligated service will begin on the date on which the eligible

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veteran begins full-time permanent employment with VA as a clinical practice employee. VA will appoint the participant to such position as soon as possible, but no later than 90 days after the date that the participant completes residency, or fellowship, if applicable, or the date the participant becomes licensed in a State, whichever is later.

(2) *Location and position of obligated service.* VA reserves the right to make final decisions on the location and position of the obligated service.

(The Office of Management and Budget has approved the information collection requirements in this section under control number 2900-0793.)

§ 17.618 Failure to comply with terms and conditions of agreement.

(a) *Participant fails to satisfy terms of agreement.* If an eligible veteran who accepts funding for the VHVMASP breaches the terms of the agreement stated in § 17.617, the United States is entitled to recover damages in an amount equal to the total amount of VHVMASP funding received by the eligible veteran.

(b) *Repayment period.* The eligible veteran 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.

(c) *Waivers.* The Under Secretary for Health, or designee, may waive or suspend any service or financial liability incurred by a participant whenever compliance by the participant is impossible, due to circumstances beyond the control of the participant, or whenever the Under Secretary for Health, or designee, concludes that a waiver or suspension of compliance is in the VA's best interest.

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

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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))

Department of Veterans Affairs**§ 17.631****§ 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

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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 partici-

pant. 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

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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 serv-

ice 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(e))

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.

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§ 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

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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

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(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.

(The Office of Management and Budget has approved the information collection requirement in this section under control number 2900-0879)

[81 FR 66820, Sept. 29, 2016, as amended at 82 FR 4795, Jan. 17, 2017; 88 FR 13034, Mar. 2, 2023]

§ 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;

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(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 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 pay-

ments 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

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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

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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]

Department of Veterans Affairs**§ 17.703****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

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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

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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

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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)

38 CFR Ch. I (7-1-25 Edition)**§ 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

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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,

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(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

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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.

Department of Veterans Affairs**§ 17.900****§ 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 con-

tinence-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 home-maker 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, rehabilitative 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

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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

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(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; home-maker 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, fac-

simile, 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

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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

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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

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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.

(a) This section applies only to legacy claims.

(b) 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; 87 FR 43748, July 22, 2022]

§ 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

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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

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

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

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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 by VA; 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

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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; 88 FR 10841, Feb. 22, 2023]

§ 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 serv-

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ices 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 February 1, 2010 but more than 90 days before February 22, 2023, if the claimant was eligible for partial payment from a health-plan contract for the emergency treatment and the claimant files a claim for reimbursement no later than 1 year after February 22, 2023.

(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; 88 FR 10841, Feb. 22, 2023]

Department of Veterans Affairs**§ 17.1005****§ 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, 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

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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; 88 FR 10842, Feb. 22, 2023]

§ 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 appeal rights.

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

[66 FR 36470, July 12, 2001, as amended at 76 FR 79072, Dec. 21, 2011; 87 FR 43748, July 22, 2022]

§ 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

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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,

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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]

EMERGENT SUICIDE CARE

SOURCE: Sections 17.1200 through 17.1230 appear at 88 FR 2536, Jan. 17, 2023, unless otherwise noted.

§ 17.1200 Purpose and scope.

(a) **Purpose.** Sections 17.1200 through 17.1230 implement VA's authority under 38 U.S.C. 1720J to provide emergent suicide care.

(b) **Scope.** If an individual is eligible under § 17.1210, VA will provide emergent suicide care under §§ 17.1200 through 17.1230 and not under other regulations in title 38 CFR through which emergent or other care could be provided. Eligibility under § 17.1210, however, does not affect eligibility for other care under chapter 17 of title 38, U.S.C.

§ 17.1205 Definitions.

For purposes of sections §§ 17.1200 through 17.1230:

Acute suicidal crisis means an individual was determined to be at imminent risk of self-harm by a trained crisis responder or health care provider.

Crisis residential care means emergent suicide care provided in a residential facility other than a hospital (that is not a personal residence) that provides 24-hour medical supervision.

Crisis stabilization care means, with respect to an individual in acute suicidal crisis, care that ensures, to the extent practicable, immediate safety and reduces: the severity of distress; the need for urgent care; or the likelihood that the severity of distress or need for urgent care will increase during the transfer of that individual from a facil-

ity at which the individual has received care for that acute suicidal crisis.

Emergent suicide care means crisis stabilization care provided to an individual eligible under § 17.1210 pursuant to a recommendation from the Veterans Crisis Line or when such individual has presented at a VA or non-VA facility in an acute suicidal crisis.

Health care provider means a VA or non-VA provider who is licensed to practice health care by a State and who is performing within the scope of their practice as defined by a State or VA practice standard.

Health-plan contract has the same meaning as that term is defined in 38 U.S.C. 1725(f)(2).

Inpatient care means care received by an individual during their admission to a hospital.

Non-VA facility means a facility that meets the definition in 38 U.S.C. 1701(4).

Outpatient care means care received by an individual that is not described within the definition of "inpatient care" under this section to include telehealth, and without the provision of room or board.

Provide, provided, or provision means furnished directly by VA, paid for by VA, or reimbursed by VA.

Trained crisis responder means an individual who responds to emergency situations in the ordinary course of their employment and therefore can be presumed to possess adequate training in crisis intervention.

VA facility means a facility that meets the definition in 38 U.S.C. 1701(3).

Veterans Crisis Line means the hotline under 38 U.S.C. 1720F(h).

§ 17.1210 Eligibility.

(a) An individual is eligible for emergent suicide care if they were determined to be in acute suicidal crisis and are either of the following:

- (1) A veteran as that term is defined in 38 U.S.C. 101; or
- (2) An individual described in 38 U.S.C. 1720I(b).

(b) VA may initiate provision of emergent suicide care for an individual in acute suicidal crisis prior to that individual's status under paragraphs

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(a)(1) or (2) of this section being confirmed. If VA is unable to confirm an individual's status under paragraph (a)(1) or (2) of this section, VA shall bill that individual for the emergent suicide care provided consistent with 38 CFR 17.102(a) and (b)(1).

§ 17.1215 Periods of emergent suicide care.

(a) Unless extended under paragraph (b) of this section, emergent suicide care will be provided to an individual eligible under §17.1210 from the date acute suicidal crisis is determined to exist:

(1) Through inpatient care or crisis residential care, as long as the care continues to be clinically necessary, but not to exceed 30 calendar days; or

(2) If care under paragraph (a)(1) of this section is unavailable, or if such care is not clinically appropriate, through outpatient care, as long as the care continues to be clinically necessary, but not to exceed 90 calendar days.

(b) VA may extend a period under paragraph (a) of this section if such period is ending and VA determines that an individual continues to require care to address the effects of the acute suicidal crisis.

§ 17.1220 Provision of emergent suicide care.

(a) Emergent suicide care will be provided to individuals eligible under §17.1210 only if it is determined by a health care provider to be clinically necessary and in accord with generally accepted standards of medical practice.

(b) Prescription drugs, biologicals, and medical devices that may be provided during a period of emergent suicide care under §17.1215 must be approved by the Food and Drug Administration, unless the treating VA facility or non-VA facility is conducting formal clinical trials under an Investigational Device Exemption or an Investigational New Drug application, or the drugs, biologicals, or medical devices are prescribed under a compassionate use exemption.

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(a) VA will not charge individuals eligible under §17.1210 who receive care under §17.1215 any costs for such care.

(1) For care furnished in a VA facility, VA will not charge any copayment or other costs that would otherwise be applicable under 38 CFR chapter 17.

(2) For care furnished in a non-VA facility, VA will either:

(i) Pay for the care furnished, subject to paragraphs (b) through (d) of this section; or

(ii) Reimburse an individual eligible under §17.1210 for the costs incurred by the individual for the care received, subject to paragraph (e) of this section.

(b) The amounts paid by VA for care furnished under paragraph (a)(2)(i) of this section will:

(1) Be established pursuant to contracts, or agreements, or

(2) If there is no amount determinable under paragraph (b)(1) of this section, VA will pay the following amounts:

(i) For care furnished in Alaska for which a VA Alaska Fee Schedule (see 38 CFR 17.56(b)) code and amount exists: The lesser of billed charges or the VA Alaska Fee Schedule amount. The VA Alaska Fee Schedule only applies to physician and non-physician professional services. The schedule uses the Health Insurance Portability and Accountability Act mandated national standard coding sets.

(ii) For care not within the scope of paragraph (b)(2)(i) of this section, and for which an applicable Medicare fee schedule or prospective payment system amount exists for the period in which the service was provided (without any changes based on the subsequent development of information under Medicare authorities) (hereafter "Medicare rate"): The lesser of billed charges or the applicable Medicare rate.

(iii) For care not within the scope of paragraph (b)(2)(i) of this section, furnished by a facility currently designated as a Critical Access Hospital (CAH) by CMS, and for which a specific amount is determinable under the following methodology: The lesser of billed charges or the applicable CAH rate verified by VA. Data requested by

VA to support the applicable CAH rate shall be provided upon request. Billed charges are not relevant for purposes of determining whether a specific amount is determinable under the above methodology.

(iv) For care not within the scope of paragraphs (b)(2)(i) through (iii) of this section and for which there exists a VA Fee Schedule amount for the period in which the service was performed: The lesser of billed charges or the VA Fee Schedule amount for the period in which the service was performed, as posted on *VA.gov*.

(v) For care not within the scope of paragraphs (b)(2)(i) through (iv) of this section: Billed charges.

(c) Payment by VA under paragraph (a)(2)(i) of this section shall, unless rejected and refunded within 30 calendar days of receipt, extinguish all liability on the part of the individual who received care. 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 this requirement.

(d) To obtain payment under paragraph (a)(2)(i) of this section, a health care provider or non-VA facility must:

(1) If the care was provided pursuant to a contract, follow all applicable provisions and instructions in such contract to receive payment.

(2) If the care was not provided pursuant to a contract with VA, submit to VA a standard billing form and other information as required no later than 180 calendar days from the date services were furnished. Submission instructions, to include required forms and other information, can be found at *www.va.gov*.

(e) To obtain reimbursement under paragraph (a)(2)(ii) of this section, an individual eligible under § 17.1210 must submit to VA a standard billing form and other information as required no later than 180 calendar days from the date the individual paid for emergent suicide care. Submission instructions, to include required forms and other information, can be found at *www.va.gov*.

(f) VA may recover costs of care it has paid or reimbursed under paragraphs (a)(2)(i) and (ii) of this section,

other than for such care for a service-connected disability, if the individual who received the care is entitled to the care (or payment of the care) under a health plan contract. Such recovery procedures will generally comply with 38 CFR 17.100–17.106.

§ 17.1230 Payment or reimbursement of emergency transportation.

(a) VA will pay or reimburse for the costs of emergency transportation (*i.e.*, ambulance or air ambulance) to a VA facility or non-VA facility for the provision of emergent suicide care to an eligible individual under § 17.1210.

(1) For claims submitted by providers of emergency transportation, rates of payment for emergency transportation under paragraph (a) of this section will be calculated as they are under 38 CFR 17.1005(a)(1) through (3). For purposes of this section, the term “emergency treatment” in § 17.1005(a) should be read to mean “emergency transportation.”

(2) For claims submitted by an individual eligible under § 17.1210, VA will reimburse for emergency transportation under paragraph (a) of this section the costs such individual incurred for the emergency transportation.

(b) To obtain payment for emergency transportation furnished under paragraph (a) of this section, the provider of such transportation must submit to VA a standard billing form and other information as required no later than 180 calendar days from the date transportation was furnished. Submission instructions, to include required forms and other information, can be found at *www.va.gov*.

(c) To obtain reimbursement for emergency transportation under paragraph (a) of this section, an individual eligible under § 17.1210 must submit to VA a standard billing form and other information as required no later than 180 calendar days from the date the individual paid for such transportation. Submission instructions, to include required forms and other information, can be found at *www.va.gov*.

(d) Payment by VA under paragraph (a) of this section shall, unless rejected and refunded within 30 calendar days of receipt, extinguish all liability on the part of the individual who received

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care. No provision of a contact, agreement, or assignment to the contrary shall operate to modify, limit, or negate this requirement.

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.

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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

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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

§ 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

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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

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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

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(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

§ 17.3100

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]

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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

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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

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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.

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(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.

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(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)

PROSTHETIC AND REHABILITATIVE ITEMS AND SERVICES

SOURCE: Sections 17.3200 through 17.3250, appear at 85 FR 84259, Dec. 28, 2020 unless otherwise noted.

§ 17.3200 Purpose and scope.

(a) *Purpose.* The purpose of this section and §§ 17.3210 through 17.3250 is to establish eligibility and other criteria for the provision to veterans of the prosthetic and rehabilitative items and services, listed in § 17.3230, authorized as medical services under 38 U.S.C. 1701(6)(F) and 38 U.S.C. 1710(a).

(b) *Scope.* This section and §§ 17.3210 through 17.3250 apply only to items and services listed in § 17.3230(a) and authorized to be provided as medical services under 38 U.S.C. 1701(6)(F) and 38 U.S.C. 1710(a). The provision of the items or services and payments in table 1 to this paragraph (b) are authorized in whole or in part by separate statutes and controlled by other implementing regulations:

TABLE 1 TO PARAGRAPH (B)

Item or service	Statute	Regulation(s)
Clothing allowance	38 U.S.C. 1162	38 CFR 3.810
Service and guide dog benefits	38 U.S.C. 1714(b) & (c)	38 CFR 17.148
Sensori-neural aids	38 U.S.C. 1707(b)	38 CFR 17.149
Patient lifts and other rehabilitative devices.	38 U.S.C. 1717(b)	38 CFR 17.151
Devices for deaf veterans	38 U.S.C. 1717(c)	38 CFR 17.152
Equipment for blind veterans	38 U.S.C. 1714(b)	38 CFR 17.154
Automobile adaptive equipment	38 U.S.C. 3901 <i>et seq.</i>	38 CFR 17.155 through 17.159
Home improvements and structural alterations.	38 U.S.C. 1717(a)(2)	38 CFR 17.3100 through 17.3130

Department of Veterans Affairs**§ 17.3210****§ 17.3210 Definitions.**

For the purposes of §§ 17.3200 through 17.3250:

Activities of daily living (ADL) means specific personal care activities that are required for basic daily maintenance and sustenance, to include eating, toileting, bathing, grooming, dressing and undressing, and mobility.

Adaptive household item means a durable household item that has been adapted to compensate for, or that by design compensates for, loss of physical, sensory, or cognitive function and is necessary to complete one or more ADLs in the home or other residential setting. Adaptive household items include but are not limited to adaptive eating utensils, shower stools or chairs, hooks to assist in buttoning clothing, or shoe horns. This definition does not include household furniture or furnishings, improvements or structural alterations, or household appliances, unless a household appliance is necessary to complete an ADL in the home or other residential setting. VA will not furnish such items or services in such a manner as to relieve any other person or entity of a contractual obligation to furnish these items or services to the veteran.

Adaptive recreation equipment means an item that is designed to compensate for, or that by design compensates for, loss of physical, sensory, or cognitive function and is necessary for the veteran to actively and regularly participate in a sport, recreation, or leisure activity to achieve the veteran's rehabilitation goals as documented in the veteran's medical record.

Cognitive device means an item that compensates for a cognitive impairment and that is used to maintain or improve a veteran's functional capabilities, including but not limited to technological equipment such as tablets and smart phones, and associated technological equipment, applications or software that can assist veterans in maintaining daily scheduling of important tasks or navigating their surroundings (e.g., global positioning system, or GPS).

Communication device means an item that compensates for a communication deficiency and allows participation in daily communication activities, in-

cluding but not limited to picture or symbol communication boards and an electro larynx.

Durable means capable of, and intended for, repeat use.

Home exercise equipment means an item used in a home or residential setting that compensates for a loss of physical, sensory, or cognitive function and that is necessary for the veteran to actively and regularly participate in aerobic, fitness, strength, or flexibility activities to achieve the veteran's rehabilitation goals as documented in the veteran's medical record, when there is no other means for the veteran to exercise to achieve the veteran's rehabilitation goals. Such equipment includes but is not limited to an upper body ergometer and a functional electrical stimulation cycle.

Home medical equipment means an item that is a movable and durable medical device that is used in a home or residential setting to treat or support treatment of specific medical conditions. Such equipment includes but is not limited to hospital beds, portable patient lifts, portable ramps, ventilators, home dialysis equipment, and infusion, feeding, or wound therapy pumps. This definition does not include household furniture or furnishings, improvements or structural alterations, or household appliances. VA will not furnish home medical equipment in such a manner as to relieve any other person or entity of a contractual obligation to furnish these items or services to the veteran.

Home respiratory equipment means an item used to provide oxygen therapy or to support or enhance respiratory function, including but not limited to compressed oxygen, oxygen concentrators, and continuous positive airway pressure machines.

Household appliance means an item used in the home for performance of domestic chores or other domestic tasks, including but not limited to a refrigerator, stove, washing machine, and vacuum cleaner.

Household furniture or furnishing means an item commonly used to make a home habitable or otherwise used to ornament a home, including but not limited to tables, chairs, desks, lamps,

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cabinets, non-hospital beds, curtains, and carpet(s).

Implant means any biological or non-biological material that:

- (1) Is manufactured or processed to be placed into a surgically or naturally formed cavity on the human body;
- (2) Is covered with tissue, has the potential to be covered with tissue, or is permanently embedded in tissue;
- (3) Does not dissolve or dissipate within the body; and
- (4) Is not a living organ, embryonic tissue, blood, or blood product.

Improvements or structural alterations 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.

Mobility aid means an item that compensates for a mobility impairment and that is used to maintain or improve a veteran's functional capabilities to be mobile. Mobility aids include but are not limited to manual and motorized wheelchairs, canes, walkers, and equipment to assist a veteran to reach for or grasp items. This definition does not include a service or guide dog.

Orthotic device means an item fitted externally to the body that is used to support, align, prevent, or correct deformities or to improve the function of movable parts of the body. Orthotic devices include but are not limited to leg braces, upper extremity splints and braces, and functional stimulation devices.

Primary residence means the personal domicile or residential setting in which the veteran resides the majority of the year.

Prosthetic device means an item that replaces a missing or defective body part. Prosthetic devices include but are not limited to artificial limbs and artificial eyes.

Replacement item means an item that is similar or identical to an item provided under § 17.3230(a), and that takes the place of such an item.

VA-authorized vendor means a vendor that has been authorized by VA to provide items and services under § 17.3230.

38 CFR Ch. I (7-1-25 Edition)**§ 17.3220 Eligibility.**

A veteran is eligible to receive items and services described in § 17.3230 if:

(a) The veteran is enrolled under § 17.36 or exempt from enrollment under § 17.37(a) through (c); and

(b) The veteran is otherwise receiving care or services under chapter 17 of title 38 U.S.C. If a VA provider or an eligible entity or provider as defined in § 17.4005 prescribes an item or service for the veteran, the veteran is considered to otherwise be receiving care or services under chapter 17 of title 38 U.S.C.

§ 17.3230 Authorized items and services.

(a)(1) VA will provide veterans eligible under § 17.3220 with the following items and services if VA determines that such items and services are needed under § 17.38(b), serve as a direct and active component of the veteran's medical treatment and rehabilitation, and do not solely support the comfort or convenience of the veteran:

- (i) Adaptive household items.
- (ii) Adaptive recreation equipment.
- (iii) Cognitive devices.
- (iv) Communication devices.

(v) Home exercise equipment, where such equipment will only be provided for one location, the veteran's primary residence, unless it is clinically determined that the equipment should be provided at the veteran's non-primary residence instead of the veteran's primary residence. Prior to any installation of home exercise equipment, the owner of the residence must agree to the installation. Such equipment will only be provided to achieve the veteran's rehabilitation goals as documented in the veteran's medical record.

(vi) Home medical equipment, and if required, installation that does not amount to an improvement or structural alteration to a veteran's residence. Such equipment will only be provided for one location, the veteran's primary residence, unless it is clinically determined that the equipment should be provided at the veteran's non-primary residence instead of the veteran's primary residence. Prior to any installation of home medical

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equipment, the owner of the residence must agree to the installation.

(vii) Home respiratory equipment.

(viii) Implants.

(ix) Mobility aids.

(x) Orthotic devices.

(xi) Prosthetic devices.

(xii) Repairs to items provided under paragraph (a) of this section, even if the item was not initially prescribed by VA, unless VA determines to replace the item for cost or clinical reasons.

(xiii) Replacement items, if items provided under this section have been damaged, destroyed, lost, or stolen, or if replacement is clinically indicated, subject to the following: Items that are serviceable, and that still meet the veteran's need, will not be replaced for the sole purpose of obtaining a newer model of the same or similar item.

(xiv) Specialized clothing made necessary by the wearing of a prosthetic device.

(xv) Training with and fitting of prescribed items.

(2) Paragraph (a)(1) of this section supplements the requirement in § 17.38(b) for a determination of need but only with respect to the provision of items and services listed in paragraph (a)(1) of this section. The exclusions under § 17.38(c) will apply to the items and services provided under this section. While VA will generally provide only one item under this section, the provision of spare items may be authorized based on a clinical determination of need using the criteria set forth in this section.

(b) Unless an item provided under § 17.3230(a) is loaned to the veteran based on a clinical determination that a loan is more beneficial for the veteran, such items become the property of the veteran once the veteran takes possession of those items. If the determination is that the item will be loaned to a veteran, the veteran must agree to the terms of the loan in order to receive the item.

§ 17.3240 Furnishing authorized items and services.

(a)(1) VA providers, or eligible entities and providers as defined in § 17.4005, will prescribe items and services in accordance with § 17.3230(a) and

will do so in consultation with the veteran.

(2) Once the item or service is prescribed under paragraph (a)(1) of this section, VA will either fill such prescriptions directly or will pay for such prescriptions to be furnished through a VA-authorized vendor.

(3) The determination under paragraph (a)(2) of this section of whether a prescription will be filled by VA directly or will be furnished by a VA-authorized vendor will be based on, but not limited to, such factors as the veteran's clinical needs, VA capacity and availability, geographic availability, and cost.

(b) Except for emergency care under §§ 17.120 through 17.132, §§ 17.1000 through 17.1008, or § 17.4020(c), or urgent care under § 17.4600, prior authorization of items and services under § 17.3230 is required for VA to reimburse VA-authorized vendors for furnishing such items or services to veterans.

§ 17.3250 Veteran responsibilities.

(a) Veterans must use items provided under §§ 17.3230 and 17.3240 as they are prescribed, and consistent with the manufacturer's instructions and any training provided. Failure to do so may result in the item not being replaced under § 17.3230(a)(13).

(b) Except for emergency care under §§ 17.120 through 17.132, §§ 17.1000 through 17.1008, or § 17.4020(c), or urgent care under § 17.4600, veterans obtaining items and services provided under § 17.3230 must obtain prior authorization from VA in order to obtain VA reimbursement for such items and services obtained from a VA-authorized vendor. VA will not be responsible for the cost of items and services provided that are not preauthorized by VA or not covered as emergency care under §§ 17.120 through 17.132, §§ 17.1000 through 17.1008, or § 17.4020(c), or urgent care under § 17.4600.

CLINICAL LABORATORY STANDARDS**§ 17.3500 VA application of 42 CFR part 493 standards for clinical laboratory operations.**

Laboratory testing within VA performed for the diagnosis, prevention, or

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treatment of any disease or impairment of, or health assessment of, human beings must meet, at a minimum, requirements established under the following subparts of 42 CFR part 493 as implemented by VA. Except as noted below, functions and responsibilities assigned to the Centers for Medicare & Medicaid Services (CMS) in 42 CFR part 493 are implemented by VA at VA laboratories and outreach clinics, as well as with contracted laboratory services performed on site at VA laboratories or other testing sites. Provisions that are specific to oversight by state licensure programs are not applicable. VA administers the application of the relevant provisions of 42 CFR part 493 to VA laboratories as follows:

(a) *General provisions.* All provisions in subpart A of 42 CFR part 493 apply to VA with the following exceptions:

(1) Functions assigned to HHS in this subpart are performed by VA.

(2) While 42 CFR part 493 requires laboratories that perform waived, moderate and high complexity tests to meet the regulations, VA requires VA laboratories meet or exceed the requirements of 42 CFR part 493.

(b) *Certificate of waiver.* All provisions in subpart B of 42 CFR part 493 apply to VA, except that:

(1) Certificates issued by HHS under this subpart are instead issued by VA pursuant to an agreement between CMS and VA.

(2) CMS does not require remittance of a fee from laboratories for any certificate issued by VA under this subpart.

(c) *Registration certificate, certificate for provider-performed microscopy procedures, and certificate of compliance.* All provisions in subpart C of 42 CFR part 493 apply to VA, except that:

(1) Certificates issued by HHS under this subpart are instead issued by VA pursuant to an agreement between CMS and VA.

(2) CMS does not require remittance of a fee from laboratories for any certificate issued by VA under this subpart.

(d) *Certificates of accreditation.* All provisions in subpart D of 42 CFR part 493 apply to VA, except that:

(1) Certificates issued by HHS under this subpart are instead issued by VA

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pursuant to an agreement between CMS and VA.

(2) CMS does not require remittance of a fee from laboratories for any certificate issued by VA under this subpart.

(e) *Accreditation by a private, nonprofit accreditation organization or exemption under an approved state laboratory program.* All provisions in subpart E of 42 CFR part 493 apply to VA, to the extent that this subpart addresses accreditation by a private, nonprofit accreditation organization. VA applies this subpart as follows:

(1) VA relies on CMS to grant deeming authority for accreditation organizations. VA uses only an accreditation agency with deeming authority to determine whether a laboratory is in compliance with standards established by the accreditation organization. VA determines whether the laboratory is in compliance with any additional standard established by VA which is:

(i) More stringent than that required for accreditation purposes, or

(ii) Not addressed by accreditation standards or 42 CFR part 493.

(2) VA uses only CMS-approved proficiency testing providers.

(3) Proficiency testing providers release proficiency testing results directly to VA.

(4) VA, rather than CMS, performs inspections of VA laboratories.

(5) Oversight and enforcement functions under this subpart are performed by VA.

(f) *General administration.* Subpart F of 42 CFR part 493 sets forth the methodology for determining the amount of the fees for issuing the appropriate certificate, and for determining compliance with the applicable standards of the Public Health Service Act and the Federal validation of accredited laboratories and of CLIA-exempt laboratories. This subpart is inapplicable to VA, as CMS does not collect fees for certification of VA laboratories.

(g) *Participation in proficiency testing for laboratories performing nonwaived testing.* All provisions in subpart H of 42 CFR part 493 apply to VA, except that all enforcement and oversight functions related to proficiency testing which are assigned to HHS in this subpart are performed by VA.

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(h) *Proficiency testing programs for nonwaived testing.* All provisions in subpart I of 42 CFR part 493 apply to VA, and VA employs scoring criteria under this subpart. VA uses only CMS approved proficiency testing providers. Enforcement and oversight functions related to proficiency testing which are assigned to HHS in this subpart are performed by VA.

(i) *Facility administration for nonwaived testing.* VA applies standards established in Subpart J of 42 CFR part 493.

(j) *Quality system for nonwaived testing.* VA applies standards established in Subpart K of 42 CFR part 493.

(k) *Personnel for nonwaived testing.* VA applies standards established in subpart M of 42 CFR part 493, except that requirements regarding maintaining a license in the state where the laboratory is located are not applicable.

(l) *Inspection.* VA applies standards established in subpart Q of 42 CFR part 493, except that all enforcement and oversight functions, which are assigned to HHS in this subpart are performed by VA.

(m) *Enforcement procedures.* VA applies standards established in subpart R of 42 CFR part 493, except:

(1) Enforcement and oversight functions which are assigned to HHS in this subpart are performed by VA.

(2) Due process protections afforded by CMS to CMS certified laboratories facing sanctions are not applicable to laboratories operating under this section.

(3) Suspension of the right to Medicare or Medicaid payments as an available sanction is not applicable. VA does not participate in these programs.

(4) State onsite monitoring and monetary penalties imposed by CMS as an alternate sanction under 42 CFR 493.1806(c) are not applicable.

(5) VA may cease laboratory testing immediately at any site subject to this section upon notification of immediate jeopardy to patients.

(6) VA does not participate in laboratory registry under 42 CFR 493.1850. VA may disclose laboratory information useful in evaluating the performance of laboratories under 5 U.S.C. 552.

(n) *Consultations.* Subpart T of 42 CFR part 493 requires HHS to establish a

Clinical Laboratory Improvement Advisory Committee (CLIA) to advise and make recommendations on technical and scientific aspects of the provisions of part 493. This subpart does not apply to VA.

[86 FR 24498, May 7, 2021]

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).

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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.

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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.

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(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

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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.

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(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.

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(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,

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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 agree-

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ment 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;

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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 re-

lated 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.

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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.

(Office of Management and Budget approved the collection of information under control number 2900-0872)

[84 FR 21678, May 14, 2019, as amended at 86 FR 50861, Sept. 13, 2021]

§ 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

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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 Fed-

eral 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.

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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:

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- (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.

(Office of Management and Budget approved the collection of information under control number 2900–0872)

[84 FR 21678, May 14, 2019, as amended at 86 FR 50861, Sept. 13, 2021]

§ 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

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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

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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.

(Office of Management and Budget approved the collection of information under control number 2900-0872)

[84 FR 21678, May 14, 2019, as amended at 86 FR 50861, Sept. 13, 2021]

§ 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

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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) Eligible veterans may receive urgent care under this section without prior approval from VA.

(ii) 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) through (4) 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.

(4)(i) If an eligible veteran meets the definition of Indian or urban Indian, as defined in 25 U.S.C. 1603(13) and (28), they are exempt from copayments for all urgent care visits. 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)(4)(i)(A) through (F) of this section:

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

(B) 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;

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

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

(E) 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

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

(1) 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;

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- (2) Is an Eskimo or Aleut or other Alaska Native;
- (3) Is considered by DOI to be an Indian for any purpose; or
- (4) Is considered by HHS to be an Indian under that Department's regulations.

(ii) After VA determines the submitted documentation meets paragraph (d)(4)(i) of this section and updates the veteran's record to reflect the veteran's status as an Indian or urban Indian, VA will reimburse eligible veterans exempt under paragraph (d)(4)(i) for any copayments that were paid to VA for urgent care visits provided on or after January 5, 2022, if they would have been exempt from making such copayments if paragraph (d)(4)(i) had been in effect.

(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, in-

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cluding 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.

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

[84 FR 26018, June 5, 2019, as amended at 88 FR 13034, Mar. 2, 2023; 88 FR 19873, Apr. 4, 2023; 88 FR 21478, Apr. 11, 2023]