Code of Federal Regulations
Title 38. Pensions, Bonuses, and Veterans' Relief
Chapter I. Department of Veterans Affairs (Refs & Annos)
Part 17. Medical (Refs & Annos)
Use of Public or Private Hospitals

38 C.F.R. § 17.52

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

Effective: February 15, 2011
Currentness

(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(j).

(Authority: 38 U.S.C. 1703, 3104; sec. 101, Pub.L. 96–466; sec. 19012, Pub.L. 99–272)

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

(i) A veteran who has a service-connected disability rated at 50 percent or more,

(ii) A veteran who has received VA inpatient care for treatment of nonservice-connected conditions for which treatment was begun during the period of inpatient care. The treatment period (to include care furnished in both facilities of VA and non-VA facilities or any combination of such modes of care) may not continue for a period exceeding 12 months following discharge from the hospital except when it is determined that a longer period is required by virtue of the disabilities being treated, and

(iii) A veteran of the Mexican border period or World War I or who is in receipt of increased pension or additional compensation based on the need for aid and attendance or housebound benefits when it has been determined based on an examination by a physician employed by VA (or, in areas where no such physician is available, by a physician carrying out such function under a contract or fee arrangement), that the medical condition of such veteran precludes appropriate treatment in VA facilities;

(Authority: 38 U.S.C. 1703; sec. 19012, Pub.L. 99–272)

(3) Hospital care or medical services for the treatment of medical emergencies which pose a serious threat to the life or health of a veteran receiving hospital care or medical services in a facility over which the Secretary has direct jurisdiction or government facility with which the Secretary contracts, and for which the facility is not staffed or equipped to perform, and transfer to a public or private hospital which has the necessary staff or equipment is the only feasible means of providing the necessary treatment, until such time following the furnishing of care in the non-VA facility as the veteran can be safely transferred to a VA facility;
(Authority: 38 U.S.C. 1703; sec. 19012, Pub.L. 99–272)

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

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

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

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

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

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

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

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

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

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

(2) If the veteran agrees to pay the United States an amount as determined in § 17.48(e).

(Authority: 38 U.S.C. 1703, 1710 and 1712; sec. 19011–19012, Pub.L. 99–272)

Credits

[33 FR 19010, Dec. 20, 1968, as amended at 35 FR 18198, Nov. 28, 1970; 39 FR 1842, Jan. 15, 1974; 39 FR 20376, June 10, 1974; 45 FR 6936, Jan. 31, 1980; 47 FR 58248, Dec. 30, 1982; 48 FR 19715, May 2, 1983; 49 FR 5616, Feb. 24, 1984; 49 FR 10542, March 21, 1984; 50 FR 4975, Feb. 5, 1985; 51 FR 25066, July 10, 1986; 53 FR 32391, Aug. 25, 1988; 54 FR 34983, Aug. 23, 1989; 54 FR 53057, Dec. 27, 1989; 58 FR 32446, June 10, 1993; 61 FR 21965, 21966, May 13, 1996; 62 FR 17072, April 9, 1997; 75 FR 78915, Dec. 17, 2010]

SOURCE: 54 FR 34978, Aug. 23, 1989; 57 FR 31015–31018, July 13, 1992; 57 FR 38610, Aug. 26, 1992; 57 FR 41701, Sept. 11, 1992; 59 FR 28265, June 1, 1994; 59 FR 49579, Sept. 29, 1994; 59 FR 53355, Oct. 24, 1994; 61 FR 21965, May 13, 1996; 70 FR 71774, Nov. 30, 2005; 73 FR 65553, Nov. 4, 2008; 74 FR 30228, June 25, 2009; 75 FR 69883, Nov. 16, 2010, unless otherwise noted.

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

Notes of Decisions (18)

Current through January 19, 2012; 77 FR 2656.

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38 C.F.R. § 17.53

§ 17.53 Limitations on use of public or private hospitals.

Currentness

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.

Credits

[39 FR 17223, May 14, 1974, as amended at 47 FR 68248, Dec. 30, 1982; 61 FR 21965, May 13, 1996]
SOURCE: 54 FR 34978, Aug. 23, 1989; 57 FR 31015–31018, July 13, 1992; 57 FR 38610, Aug. 26, 1992; 57 FR 41701, Sept. 11, 1992; 59 FR 28265, June 1, 1994; 59 FR 49579, Sept. 29, 1994; 59 FR 53355, Oct. 24, 1994; 61 FR 21965, May 13, 1996; 70 FR 71774, Nov. 30, 2005; 73 FR 65553, Nov. 4, 2008; 74 FR 30228, June 25, 2009; 75 FR 69883, Nov. 16, 2010, unless otherwise noted.

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38 C.F.R. § 17.53a

§ 17.53a [Redesignated]

Currentness

Credits

[61 FR 21965, May 13, 1996]

SOURCE: 54 FR 34978, Aug. 23, 1989; 57 FR 31015–31018, July 13, 1992; 57 FR 38610, Aug. 26, 1992; 57 FR 41701, Sept. 11, 1992; 59 FR 28265, June 1, 1994; 59 FR 49579, Sept. 29, 1994; 59 FR 53355, Oct. 24, 1994; 61 FR 21965, May 13, 1996; 70 FR 71774, Nov. 30, 2005; 73 FR 65553, Nov. 4, 2008; 74 FR 30228, June 25, 2009; 75 FR 69883, Nov. 16, 2010, unless otherwise noted.

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38 C.F.R. § 17.53b

§ 17.53b [Redesignated]

Currentness

Credits

[61 FR 21965, May 13, 1996]

SOURCE: 54 FR 34978, Aug. 23, 1989; 57 FR 31015–31018, July 13, 1992; 57 FR 38610, Aug. 26, 1992; 57 FR 41701, Sept. 11, 1992; 59 FR 28265, June 1, 1994; 59 FR 49579, Sept. 29, 1994; 59 FR 53355, Oct. 24, 1994; 61 FR 21965, May 13, 1996; 70 FR 71774, Nov. 30, 2005; 73 FR 65553, Nov. 4, 2008; 74 FR 30228, June 25, 2009; 75 FR 69883, Nov. 16, 2010, unless otherwise noted.

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38 C.F.R. § 17.53c

§ 17.53c [Redesignated]

Currentness

Credits

[61 FR 21965, May 13, 1996]

SOURCE: 54 FR 34978, Aug. 23, 1989; 57 FR 31015–31018, July 13, 1992; 57 FR 38610, Aug. 26, 1992; 57 FR 41701, Sept. 11, 1992; 59 FR 28265, June 1, 1994; 59 FR 49579, Sept. 29, 1994; 59 FR 53355, Oct. 24, 1994; 61 FR 21965, May 13, 1996; 70 FR 71774, Nov. 30, 2005; 73 FR 65553, Nov. 4, 2008; 74 FR 30228, June 25, 2009; 75 FR 69883, Nov. 16, 2010, unless otherwise noted.

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38 C.F.R. § 17.53d

§ 17.53d [Redesignated]

Currentness

Credits

[61 FR 21965, May 13, 1996]

SOURCE: 54 FR 34978, Aug. 23, 1989; 57 FR 31015–31018, July 13, 1992; 57 FR 38610, Aug. 26, 1992; 57 FR 41701, Sept. 11, 1992; 59 FR 28265, June 1, 1994; 59 FR 49579, Sept. 29, 1994; 59 FR 53355, Oct. 24, 1994; 61 FR 21965, May 13, 1996; 70 FR 71774, Nov. 30, 2005; 73 FR 65553, Nov. 4, 2008; 74 FR 30228, June 25, 2009; 75 FR 69883, Nov. 16, 2010, unless otherwise noted.

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38 C.F.R. § 17.54

§ 17.54 Necessity for prior authorization.

Currentness

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

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

Credits
[42 FR 55212, Oct. 14, 1977; 61 FR 21965, May 13, 1996]
SOURCE: 54 FR 34978, Aug. 23, 1989; 57 FR 31015–31018, July 13, 1992; 57 FR 38610, Aug. 26, 1992; 57 FR 41701, Sept. 11, 1992; 59 FR 28265, June 1, 1994; 59 FR 49579, Sept. 29, 1994; 59 FR 53355, Oct. 24, 1994; 61 FR 21965, May 13, 1996; 70 FR 71774, Nov. 30, 2005; 73 FR 65553, Nov. 4, 2008; 74 FR 30228, June 25, 2009; 75 FR 69883, Nov. 16, 2010, unless otherwise noted.

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

Notes of Decisions (20)

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38 C.F.R. § 17.55

§ 17.55 Payment for authorized public or private hospital care.

Currentness

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

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

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

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

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

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

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

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

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

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

(i) A hospital participating in an alternative payment system that has been granted a Federal waiver from the prospective payment system under the provisions of 42 U.S.C. section 1395f(b)(3) or 42 U.S.C. section 1395ww(c) for the purposes of Medicare payment shall not be subject to the payment methodology set forth in this section so long as such Federal waiver remains in effect.

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

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

Credits
[33 FR 19011, Dec. 20, 1968; 55 FR 42852, Oct. 24, 1990; 61 FR 21965, 21966, May 13, 1996; 62 FR 17072, April 9, 1997; 63 FR 39515, July 23, 1998; 65 FR 66637, Nov. 7, 2000]
SOURCE: 54 FR 34978, Aug. 23, 1989; 57 FR 31015–31018, July 13, 1992; 57 FR 38610, Aug. 26, 1992; 57 FR 41701, Sept. 11, 1992; 59 FR 28265, June 1, 1994; 59 FR 49579, Sept. 29, 1994; 59 FR 53355, Oct. 24, 1994; 61 FR 21965, May 13, 1996; 70 FR 71774, Nov. 30, 2005; 73 FR 65553, Nov. 4, 2008; 74 FR 30228, June 25, 2009; 75 FR 69883, Nov. 16, 2010, unless otherwise noted.

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38 C.F.R. § 17.56

§ 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.

Effective: February 15, 2011
Currentness

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

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

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

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

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

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

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

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

(b) For physician and non-physician professional services rendered in Alaska, VA will pay for services in accordance with a fee schedule that uses the Health Insurance Portability and Accountability Act mandated national standard coding sets. VA will pay a specific amount for each service for which there is a corresponding code. Under the VA Alaska Fee Schedule, the amount paid in Alaska for each code will be 90 percent of the average amount VA actually paid in Alaska for the same services in Fiscal

Year (FY) 2003. For services that VA provided less than eight times in Alaska in FY 2003, for services represented by codes established after FY 2003, and for unit-based codes prior to FY 2004, VA will take the Centers for Medicare and Medicaid Services' rate for each code and multiply it times the average percentage paid by VA in Alaska for Centers for Medicare and Medicaid Services-like codes. VA will increase the amounts on the VA Alaska Fee Schedule annually in accordance with the published national Medicare Economic Index (MEI). For those years where the annual average is a negative percentage, the fee schedule will remain the same as the previous year. Payment for non–VA health care professional services in Alaska shall be the lesser of the amount billed or the amount calculated under this subpart.

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

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

Credits

[63 FR 39515, July 23, 1998; 65 FR 66637, Nov. 7, 2000; 70 FR 5927, Feb. 4, 2005; 75 FR 78915, Dec. 17, 2010]
SOURCE: 54 FR 34978, Aug. 23, 1989; 57 FR 31015–31018, July 13, 1992; 57 FR 38610, Aug. 26, 1992; 57 FR 41701, Sept. 11, 1992; 59 FR 28265, June 1, 1994; 59 FR 49579, Sept. 29, 1994; 59 FR 53355, Oct. 24, 1994; 61 FR 21965, May 13, 1996; 70 FR 71774, Nov. 30, 2005; 73 FR 65553, Nov. 4, 2008; 74 FR 30228, June 25, 2009; 75 FR 69883, Nov. 16, 2010, unless otherwise noted.

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38 C.F.R. § 17.56a

§ 17.56a [Redesignated]

Currentness

Credits

[61 FR 21965, May 13, 1996]

SOURCE: 54 FR 34978, Aug. 23, 1989; 57 FR 31015–31018, July 13, 1992; 57 FR 38610, Aug. 26, 1992; 57 FR 41701, Sept. 11, 1992; 59 FR 28265, June 1, 1994; 59 FR 49579, Sept. 29, 1994; 59 FR 53355, Oct. 24, 1994; 61 FR 21965, May 13, 1996; 70 FR 71774, Nov. 30, 2005; 73 FR 65553, Nov. 4, 2008; 74 FR 30228, June 25, 2009; 75 FR 69883, Nov. 16, 2010, unless otherwise noted.

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