with Indian Tribal Governments, because it does not have a substantial direct effect on one or more Indian tribes, on the relationship between the Federal Government and Indian tribes, or on the distribution of power and responsibilities between the Federal Government and Indian tribes.

Environment

The Coast Guard considered the environmental impact of this rule and concluded that, under figure 2–1, paragraph (32)(e), of Commandant Instruction M16475.lC, this rule is categorically excluded from further environmental documentation. This will change the existing drawbridge operating regulation promulgated by a Coast Guard Bridge Administration Program action. A ''Categorical Exclusion Determination'' is available in the docket where indicated under **ADDRESSES.**

List of Subjects in 33 CFR Part 117

Bridges.

For the reasons set out in the preamble, the Coast Guard amends Part 117 of Title 33, Code of Federal Regulations, as follows:

PART 117—DRAWBRIDGE OPERATION REGULATIONS

1. The authority citation for Part 117 continues to read as follows:

Authority: 33 U.S.C. 499; 49 CFR 1.46; 33 CFR 1.05–1(g); section 117.255 also issued under the authority of Pub. L. 102–587, 106 Stat. 5039.

2. Section 117.301 is added to read as follows:

§ 117.301 Massalina Bayou.

The draw of the Tarpon Dock bascule span bridge, Massalina Bayou, mile 0.0 at Panama City, shall open on signal; except that from 9 p.m. until 11 p.m. on July 4, each year, the draw need not open for the passage of vessels. The draw will open at any time for a vessel in distress.

Dated: June 28, 2001.

Roy J. Casto,

RADM, USCG, Commander, 8th CG District.

[FR Doc. 01–17413 Filed 7–11–01; 8:45 am]

BILLING CODE 4910–15–P

DEPARTMENT OF VETERANS AFFAIRS

38 CFR Part 17

RIN 2900–AK08

Payment or Reimbursement for Emergency Treatment Furnished at Non-VA Facilities

AGENCY: Department of Veterans Affairs.

ACTION: Interim final rule.

SUMMARY: This document amends VA's medical regulations by establishing provisions for payment or reimbursement for certain non-VA emergency services furnished to veterans for nonservice-connected conditions. This is necessary to implement provisions of ''The Veterans Millennium Health Care and Benefits Act.''

DATES: *Effective Date:* This interim final rule is effective on May 29, 2000; except for 38 CFR 17.1004 which is effective July 19, 2001.

Comments Dates: Comments on the rule, including comments on the information collection provisions, must be received on or before September 10, 2001; except that comments on the request for emergency approval of the collection of information provisions must be received on or before July 19, 2001.

ADDRESSES: Mail or hand-deliver written comments to: Director, Office of Regulations Management (02D), Department of Veterans Affairs, 810 Vermont Ave., NW, Room 1154, Washington, DC 20420; or fax comments to (202) 273–9289; or e-mail comments to *OGCRegulations@mail.va.gov.* Comments should indicate that they are submitted in response to ''RIN 2900–AK08.'' All comments received will be available for public inspection in the Office of Regulations Management, Room 1158, between the hours of 8:00 a.m. and 4:30 p.m., Monday through Friday (except holidays). In addition, see the Paperwork Reduction Act heading under the **SUPPLEMENTARY INFORMATION** section of this preamble regarding submission of comments on the information collection provisions.

FOR FURTHER INFORMATION CONTACT: Roscoe Butler, Chief, Policy & Operations, Health Administration Service (10C3), Veterans Health Administration, Department of Veterans Affairs, 810 Vermont Avenue, NW, Washington, DC 20420, (202) 273–8302. (This is not a toll-free number.)

SUPPLEMENTARY INFORMATION: This document amends VA's medical regulations at 38 CFR part 17. The amendments implement provisions of section 111 of Public Law 106–117, The Veterans Millennium Health Care and Benefits Act. These statutory provisions, which are set forth at 38 U.S.C. 1725, authorize VA to establish provisions regarding payment of or reimbursement for the reasonable value of non-VA emergency services provided for nonservice-connected conditions of certain veterans who have no medical insurance and no other recourse for payment.

Conditions for Reimbursement or Payment for Emergency Services

Sections 17.1002 and 17.1003 set forth substantive conditions that must be met for payment or reimbursement for emergency services under 38 U.S.C. 1725. In general, these conditions consist of restatements and interpretations of 38 U.S.C. 1725.

For emergency services other than emergency transportation, we will make payment or reimbursement only for emergency services provided in a hospital emergency department or a similar facility held out as providing emergency care to the public. These are the places that have the capabilities for providing emergency care.

48-Hour Notice

For informational purposes, we have added a note explaining that 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 the veteran begins receiving 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.

Claims

Section 17.1004 sets forth procedures for filing claims. To initiate a claim for emergency treatment a claimant would be required to submit to the VA medical facility of jurisdiction (defined as the nearest VA medical facility to where the emergency service was provided) a completed standard billing form (such as a UB92 or a HCFA 1500). The completed form must also be accompanied by a signed, written statement by the individual or entity claiming the benefit 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 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.''

We believe that this (along with the right to obtain additional information under 17.1004(e)) will be sufficient to make determinations regarding whether the claimant meets the requirements for reimbursement or payment. Claims for payment or reimbursement for ambulance services, including air ambulance services, will not be required to be on a specific form but will be required to include the bill and contain information to establish entitlement to payment or reimbursement for such services.

Consistent with statutory authority in 38 U.S.C. 1725, a claimant 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.

The rule establishes time limits for filing claims and establishes procedures and time limits for the submission of additional information needed by VA to make determinations regarding the claim. This is designed to help ensure that claims are decided in reasonable periods of time.

Also, we note that a claim that is submitted to a VA entity other than the VA medical facility of jurisdiction will be forwarded by the receiving VA entity to the VA medical facility of jurisdiction.

Payment Limitations

The provisions of 38 U.S.C. 1725 state that VA may not pay more than the amount for which the veteran is personally liable. Within this framework, the rule establishes reimbursement or payment rates as the lesser of the amount for which the veteran is personally liable or 70 percent of the amount prescribed under Medicare fee schedules.

Under 38 U.S.C. 1725, VA is authorized for the first time to establish for non-VA providers of emergency treatment a mechanism for obtaining payment for care furnished to veterans who have no health care insurance or other source of payment in whole or in part. Prior to the enactment of this new law, these providers frequently were forced to absorb the costs of this care and pass those costs on to all other paying users of their facilities. With respect to the Congressional intent in authorizing VA to pay or reimburse for emergency treatment, House Report No. 106–237, at pages 39–40, states:

> It is the Committee's view that in setting such payment regulations VA should avoid a policy which gives providers of emergency care a windfall. In that connection, the Committee takes notice of the frequency with which providers of emergency care ''write off'' such debts in cases where the debt is deemed uncollectible or the costs of collection exceed the likely recovery. VA serves a population which is substantially elderly, indigent, and chronically ill. Given that this bill covers a subset of this population which has no private or public medical insurance or coverage, it stands to reason that in most instances under current law providers would write off the debts arising from the provision of emergency care to these veterans. The Committee thus envisions that VA would establish regulations that are significantly below those paid under the Medicare or Medicaid system (or under 38 United States Code, section 1728). Such lower rates should also provide a significant incentive to the providers of care to actively try and obtain reimbursement from those other benefit programs before seeking reimbursement from VA. As a further incentive to the providers of care, the bill also provides that they must accept VA's payment as payment in full.

In accordance with the declared intent of Congress, we will pay or reimburse at a rate discounted from the amounts Medicare pays. Bearing in mind the words in the House report suggesting that VA establish rates ''significantly below'' Medicare or Medicaid rates, VA has established the rate at 70 percent.

Consistent with the provisions of 38 U.S.C. 1725, the rule also states that payment or reimbursement for medical treatment may be made only for the period from the beginning of the treatment until such time as the veteran has ''stabilized'' and could be transferred safely to a VA facility or other Federal facility.

The rule restates statutory provisions that a provider who accepts VA payment for emergency treatment agrees thereby to extinguish all liability on the part of the veteran for that treatment.

Delegations of Authority

Decisions under this rule regarding benefit determinations will be made by Chief of the Health Administration Service or an equivalent official at the VA medical facility of jurisdiction, except that the Fee Service Review Physician or equivalent officer at the VA medical facility of jurisdiction would make determinations regarding § 17.1002(b), (c), and (d). We believe that these are the appropriate individuals to make the determinations assigned. Further, under the rule any decision denying a benefit must be in writing and inform the claimant of VA reconsideration rights and rights of appeal to the Board of Veterans' Appeals.

Independent Right of Recovery

The rule also restates statutory provisions that give the Government an independent right of recovery when any payment is made for the same emergency treatment for which VA had already reimbursed or made payment (this includes statutory liens). The statutory provisions require the veteran or claimant to notify VA and submit documentation regarding the duplicate payment. The rule states that the 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. This will help VA take timely action to recover the amount owed the Government.

Consistent with statutory authority, the rule states that the Chief Financial Officer or equivalent official at the VA medical facility of jurisdiction may waive recovery of a VA payment made to a veteran upon determining that actions to recover the payment would not be cost-effective or would conflict with other litigative interests of the United States.

Retroactive Payments

Because May 29, 2000, is the effective date of 38 U.S.C. 1725, we would make retroactive payments or reimbursements, as appropriate, for qualifying emergency care furnished on or after that date.

Paperwork Reduction Act

The provisions of 38 CFR 17.1004 contain collections of information under the Paperwork Reduction Act of 1995 (44 U.S.C. 3501–3520). Accordingly, under section 3507(d) of the Act, VA has submitted a copy of this rulemaking action to OMB for its review of the collections of information. We have requested OMB to approve the collection of information on an emergency basis by July 19, 2001. If OMB does not approve the collections of information as requested, we will immediately remove § 17.1004 or take such other action as is directed by OMB.

The provisions of 38 CFR 17.1007 and 17.1008 contain collections of information concerning prompt notification of duplicate payments and rejection of VA payments. We expect that fewer than 10 collections of information will occur under any of these provisions in any given year. If VA expects to receive 10 or more collections under any of these provisions in any year, we will seek approval under the

Paperwork Reduction Act for such collections of information.

We are also seeking an approval of the information collection on a non-emergency basis. Accordingly, we are requesting comments on the collection of information provisions contained in § 17.1004. Comments must be submitted by September 10, 2001.

OMB assigns a control number for each collection of information it approves. Except for emergency approvals under 44 U.S.C. 3507(j), VA may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a currently valid OMB control number.

Comments on the collections of information in § 17.1004 should be submitted to the Office of Management and Budget, Attention: Desk Officer for the Department of Veterans Affairs, Office of Information and Regulatory Affairs, Washington, DC 20503, with copies mailed or hand-delivered to: Director, Office of Regulations Management (02D), Department of Veterans Affairs, 810 Vermont Ave., NW, Room 1154, Washington, DC 20420. Comments should indicate that they are submitted in response to ''RIN 2900–AK08.''

Title: Application for Reimbursement/Payment for Emergency Treatment in Non-VA Facilities.

Summary of collection of information: Under the provisions of 38 CFR 17.1004, 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 HCFA 1500). 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 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.''

In addition, § 17.1004 provides that aclaim for payment or reimbursement for emergency transportation does not have to be on a form. The claimant need only submit a signed and dated request for such payment or reimbursement to the VA medical facility of jurisdiction, together with a bill showing the services provided and charges for which the veteran is personally liable and a signed statement explaining who requested such transportation services and why they were necessary.

Description of the need for information and proposed use of information: This information would be needed for VA to decide claims for reimbursement or payment from a veteran, a hospital or other entity that furnished non-VA emergency treatment or transportation to the veteran, or a person or organization that paid for such treatment or transportation on behalf of the veteran. VA would use the information and certifications submitted to process claims for such reimbursement or payment.

Description of likely respondents: Hospital or other entities that furnished the treatment or transportation, the veteran who paid for the treatment or transportation, or the person or organization that paid for such treatment or transportation on behalf of the veteran.

Estimated number of respondents: 241,457.

Estimated frequency of responses: 1.

Estimated total annual reporting and recordkeeping burden: 120,729 hours.

Estimated annual burden per collection: 30 minutes.

The Department considers comments by the public on collections of information in—

- Evaluating whether the collections of information are necessary for the proper performance of the functions of the Department, including whether the information will have practical utility;
- Evaluating the accuracy of the Department's estimate of the burden of the collections of information, including the validity of the methodology and assumptions used;
- Enhancing the quality, usefulness, and clarity of the information to be collected; and
- Minimizing the burden of the collections of information on those who are to respond, including responses through the use of appropriate automated, electronic, mechanical, or other technological collection techniques or other forms of information technology, e.g., permitting electronic submission of responses.

Administrative Procedure Act and Congressional Review Act

We have found good cause to dispense with the notice-and-comment and delayed effective date provisions of the Administrative Procedure Act (5 U.S.C. 553) and the notice and public procedure provisions of the Congressional Review Act (5 U.S.C. 801–808) because compliance with such provisions would be contrary to the public interest. Under the provisions of section 111 of Public Law 106–117, VA was mandated to establish regulations to provide a mechanism for payment or reimbursement for certain non-VA emergency services furnished to veterans for non-service connected conditions. These regulations were to be effective by May 29, 2000. We are aware that because implementing regulations have not become effective, in a number of instances bills for veterans' emergency care that would be covered by this rule have been turned over to collection agencies. This has unnecessarily placed veterans' possessions in jeopardy. Even though we are making § 17.1004 effective immediately, we are soliciting comments for 60 days after publication of the document. We will publish a final document after the comment period ends and we may modify this rule in response to comments.

Compliance With the Congressional Review Act and Executive Order 12866—Cost-Benefit Analysis

This rule is necessary to implement the provisions of section 111 of Public Law 106–117, The Veterans Millennium Health Care and Benefits Act. These provisions, which are set forth at 38 U.S.C. 1725, authorize VA to establish a mechanism for payment of or reimbursement for the reasonable value of non-VA emergency services provided for nonservice-connected conditions of certain veterans who have no medical insurance and no other recourse for payment. This rule would directly impact these veterans positively by avoiding full recourse or payment responsibility for medical care and resulting potential debt collection repercussions. This rule implements a detailed statutory mandate, and we found no potentially effective and reasonably feasible alternatives.

We estimate that the five-year cost of this rule from appropriated funds would be $2.1 billion in benefits costs and $21 million in government operating expenses. Since it is likely that the adoption of the rule may have an annual effect on the economy of $100 million or more, the Office of Management and Budget has designated this rule as a major rule under the Congressional Review Act, 5 U.S.C. 802, and a significant regulatory action under Executive Order 12866, Regulatory Planning and Review. The following information is provided pursuant to the Congressional Review Act and Executive Order 12866.

I. Benefits Costs

The estimated cost for implementation of the emergency care

provisions of the Millennium Act are based on enrollment projections developed by a private actuarial firm and contained in the FY 2001 Enrollment Level Decision Analysis. This baseline population was adjusted, using a survey of enrollees and existing enrollment databases, to calculate the projected number of veterans who had no private or public insurance and who had used VA care within the previous 24 months. These adjustments reflect the criteria contained in the Millennium Act.

Private sector ER-related health care utilization was adjusted to reflect veteran enrollee demographics and relative morbidity, as well as uninsured enrollee reliance on the VA health care system. These utilization estimates, along with Medicare allowable charge levels, were applied to the estimated 990,000 veteran enrollees affected by the emergency care provisions. This resulted in projected estimates for emergency room visits ($93,480,145), ambulance use ($34,108,803), and ER-related inpatient care ($468,221,072). The total of $595,810,019 was then multiplied by the 70 percent reimbursement rate VA will use to pay emergency care providers. This comes to $417,067,014.

This total, however, reflects full implementation of the emergency care provisions. VA believes that it will take time before both providers and eligible veterans are aware of these new benefits and begin to submit acceptable bills to VA for reimbursement. Current experience shows that without widespread dissemination of information, there is limited use of these benefits. VA believes that with the publication of final regulations the submission of claims will increase significantly and could reach 50 percent of the full implementation costs in the first full year after the rule is in effect. Only experience will demonstrate the real demand for this new benefit.

II. Administrative Costs

The administrative workload caused by this rule is expected to be 241,457 claims filed in 2001. Administrative workloads assume that not all claims would be granted; it is probable that non-VA related claims will be received from veterans who are not eligible. Medical Care costs are computed on the average cost of a GS4/5 @ $12/hour × 30 minutes × 241,457 claims/60 which equals $1,448,742.00. In addition, the clinical review costs are estimated at $46/hour × 15 minutes × 241,457 claims/60 which equals $2,776,755.00 for total Medical Care costs of $4,225,497.

OMB Review

This document has been reviewed by the Office of Management and Budget under Executive Order 12866.

Regulatory Flexibility Act

The Secretary hereby certifies that this rule would not have a significant economic impact on a substantial number of small entities as they are defined in the Regulatory Flexibility Act, 5 U.S.C. 601–612. This rule would apply only to an extremely small amount of the business of a hospital or health care provider. Otherwise, the rule would only apply to individuals. Accordingly, pursuant to 5 U.S.C. 605(b), this rule is exempt from the initial and final regulatory flexibility analysis requirements of sections 603 and 604.

Unfunded Mandates Reform Act

The Unfunded Mandates Reform Act requires (in section 202) that agencies prepare an assessment of anticipated costs and benefits before developing any rule that may result in an expenditure by State, local, or tribal governments, in the aggregate, or by the private sector of $100 million or more in any given year. This rule would have no consequential effect on State, local, or tribal governments.

Catalog of Federal Domestic Assistance

The Catalog of Federal Domestic Assistance numbers for the programs affected by this rule are 64.005, 64.007.64.008, 64,009, 64.010, 64.011, 64.012, 64.013, 64.014, 64.015, 64.016, 64.018, 64.019, 64.022, and 64.025.

List of Subjects in 38 CFR Part 17

Administrative practice and procedure, Alcohol abuse, Alcoholism, Claims, Day care, Dental health, Drug abuse, Foreign relations, Government contracts, Grant programs-health, Grant programs-veterans, Health care, Health facilities, Health professions, Health records, Homeless, Medical and dental schools, Medical devices, Medical research, Mental health programs, Nursing homes, Philippines, Reporting and recordkeeping requirements, Scholarships and fellowships, Travel and transportation expenses, Veterans.

Approved: April 9, 2001.

Anthony J. Principi,

Secretary of Veterans Affairs.

For the reasons set out in the preamble, 38 CFR part 17 is amended as set forth below:

PART 17—MEDICAL

1. The authority citation for part 17 continues to read as follows:

Authority: 38 U.S.C. 501, 1721, unless otherwise noted.

2. An undesignated center heading and §§ 17.1000 through 17.1008 are added to read as follows:

Payment or Reimbursement for Emergency Services for Nonservice-Connected Conditions in Non-VA Facilities

Sec.

Payment or Reimbursement for Emergency Services for Nonservice-Connected Conditions in Non-VA Facilities

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

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

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

Note to § 17.1000: 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 the veteran begins receiving 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.

§ 17.1001 Definitions.

For purposes of §§ 17.1000 through 17.1008:

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

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

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

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

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

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

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

(1) A Federal entity;

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

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

(4) An automobile accident reparations insurance carrier; or

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

(c) The term *duplicate payment* means payment made, in whole or in part, for the same emergency services for which VA reimbursed or made payment.

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

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

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

§ 17.1002 Substantive conditions for payment or reimbursement.

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

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

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

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

(d) The claim for payment or reimbursement for any medical care beyond the initial emergency evaluation and treatment is for a continued medical emergency of such a nature that the veteran could not have been safely transferred to a VA or other Federal facility (the medical emergency lasts only until the time the veteran becomes stabilized);

(e) 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;

(f) The veteran is financially liable to the provider of emergency treatment for that treatment;

(g) The veteran has no coverage under a health-plan contract for payment or reimbursement, in whole or in part, 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);

(h) 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 or in part, the veteran's liability to the provider; and

(i) 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)

§ 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 such facility (or payment or reimbursement could have been authorized under 38 U.S.C. 1725 for emergency treatment if 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 has no coverage under a health-plan contract for reimbursement or payment, in whole or in part, for the emergency transportation or any emergency treatment authorized under 38 U.S.C. 1728 (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); and

(d) If the condition for which the emergency transportation was furnished was caused by an accident or work-related injury, the claimant has exhausted without success all claims and remedies reasonably available to the veteran or provider against a third party for payment of such transportation; and the veteran has no contractual or legal recourse against a third party that could reasonably be pursued for the purpose of extinguishing, in whole or in part, the veteran's liability to the provider.

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

§ 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 HCFA 1500). 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 and 17.1003. I am aware

that 38 U.S.C. 6102(b) provides that one who obtains payment without being entitled to it and with intent to defraud the United States shall be fined in accordance with title 18, United States Code, or imprisoned not more than one year, or both.''

Note to § 17.1004(b): These regulations regarding payment or reimbursement for emergency services for nonservice-connected conditions in non-VA facilities also can be found on the internet at *http://www.va.gov/health/elig.*

(c) Notwithstanding the provisions of paragraph (b) of this section, no specific form is required for a claimant (or duly authorized representative) to claim payment or reimbursement for emergency transportation charges under 38 U.S.C. 1725. The claimant need only submit a signed and dated request for such payment or reimbursement to the VA medical facility of jurisdiction, together with a bill showing the services provided and charges for which the veteran is personally liable and a signed statement explaining who requested such transportation services and why they were necessary.

(d) To receive payment or reimbursement for emergency services, a claimant must file a claim within 90 days after the latest of the following:

(1) July 19, 2001.

(2) The date that the veteran was discharged from the facility that furnished the emergency treatment;

(3) 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

(4) 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.

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

§ 17.1005 Payment limitations.

(a) Payment or reimbursement for emergency treatment under 38 U.S.C. 1725 shall be the lesser of the amount for which the veteran is personally liable or 70 percent of the amount under the applicable Medicare fee schedule for such treatment.

(b) Reimbursement or payment for emergency treatment may be made only for the period from the beginning of the treatment until such time as the veteran could be transferred safely to a VA facility or other Federal facility. For purposes of payment or reimbursement under 38 U.S.C. 1725, VA deems it safe for the veteran to be transferred once the veteran has become stabilized.

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

§ 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 Fee Service Review Physician or equivalent officer at the VA medical facility of jurisdiction will make determinations regarding § 17.1002(b), (c), and (d). Any decision denying a benefit must be in writing and inform the claimant of VA reconsideration and appeal rights.

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

§ 17.1007 Independent right of recovery.

(a) VA has the right to recover its payment under this section when, and to the extent that, a third party makes payment for all or part of the same emergency treatment for which VA reimbursed or made payment under this section.

(1) Under 38 U.S.C. 1725(d)(4), the veteran (or the veteran's personal representative, successor, dependents, or survivors) or claimant shall ensure that the Secretary is promptly notified of any payment received from any third party for emergency treatment furnished to the veteran. The veteran (or the veteran's personal representative, successor, dependents, or survivors) or claimant shall immediately forward all documents relating to such payment, cooperate with the Secretary in the investigation of such payment and assist the Secretary in enforcing the United States' right to recover any payment made and accepted under this section. The required notification and submission of documentation must be provided by the veteran or claimant to the VA medical facility of jurisdiction within three working days of receipt of notice of the duplicate payment.

(2) If the Chief Financial Officer or equivalent official at the VA medical facility of jurisdiction concludes that payment from a third party was made for all or part of the same emergency treatment for which VA reimbursed or made payment under this section, such VA official shall, except as provided in paragraph (c) of this section, initiate action to collect or recover the amount of the duplicate payment in the same manner as for any other debt owed the United States.

(b)(1) Any amount paid by the United States to the veteran (or the veteran's personal representative, successor, dependents, or survivors) or to any other person or organization paying for such treatment shall constitute a lien in favor of the United States against any recovery the payee subsequently receives from a third party for the same treatment.

(2) Any amount paid by the United States, and accepted by the provider that furnished the veteran's emergency treatment, shall constitute a lien against any subsequent amount the provider receives from a third party for the same emergency treatment for which the United States made payment.

(c) If it is determined that a duplicate payment was made, the Chief Financial Officer or equivalent official at the VA medical facility of jurisdiction may waive recovery of a VA payment made under this section to a veteran upon determining that the veteran has substantially complied with the provisions of paragraph (a)(1) of this section and that actions to recover the payment would not be cost-effective or would conflict with other litigative interests of the United States.

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

§ 17.1008 Balance billing prohibited.

Payment by VA under 38 U.S.C. 1725 on behalf of a veteran to a provider of emergency treatment shall, unless rejected and refunded by the provider within 30 days of receipt, extinguish all liability on the part of the veteran for that emergency treatment. 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)

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