

Department of Veterans Affairs

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treatment occurrences for a procedure during the previous fiscal year.

(b) The payment amount for each service paid under Medicare's participating physician fee schedule is the product of three factors: a nationally uniform relative value for the service; a geographic adjustment factor for each physician fee schedule area; and a nationally uniform conversion factor for the service. The conversion factor converts the relative values into payment amounts. For each physician fee schedule service, there are three relative values: An RVU for physician work; an RVU for practice expense; and an RVU for malpractice expense. For each of these components of the fee schedule, there is a geographic practice cost index (GPCI) for each fee schedule area. The GPICs reflect the relative costs of practice expenses, malpractice insurance, and physician work in an area compared to the national average. The GPICs reflect the full variation from the national average in the costs of practice expenses and malpractice insurance, but only one-quarter of the difference in area costs for physician work. The general formula calculating the Medicare fee schedule amount for a given service in a given fee schedule area can be expressed as: Payment = $[(RVU_{work} \times GPCI_{work}) + (RVU_{practice\ expense} \times GPCI_{practice\ expense}) + (RVU_{malpractice} \times GPCI_{malpractice})] \times CF$.

(c) Payment under the 75th percentile methodology is determined for each VA medical facility by ranking all occurrences (with a minimum of eight) under the corresponding code during the previous fiscal year with charges ranked from the highest rate billed to the lowest rate billed and the charge falling at the 75th percentile as the maximum amount to be paid.

(d) Payments made in accordance with this section shall constitute payment in full. Accordingly, the provider or agent for the provider may not impose any additional charge for any services for which payment is made by VA.

(e) Notwithstanding other provisions of this section, VA, for physician services covered by this section, will pay the lesser of the amount determined under paragraphs (a) through (d) of this

section or the amount negotiated with the physician or the physician's agent.

(Authority: 38 U.S.C. 513, 38 U.S.C. 1703, 38 U.S.C. 1728)

[63 FR 39515, July 23, 1998, as amended at 65 FR 66637, Nov. 7, 2000]

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), the Under Secretary for Health may furnish care under this paragraph to any veteran described in 38 U.S.C. 1710(a)(2) 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]

§ 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

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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 daily living activities; and

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

(Authority: 38 U.S.C. 1730)

[54 FR 20842, May 15, 1989. Redesignated and amended at 61 FR 21965, 21966, May 13, 1996]

38 CFR Ch. I (7-1-04 Edition)

§ 17.62 Definitions.

For the purpose of §§17.61 through 17.72:

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

(b) The term *statement of needed care* means a written description of needed assistance in daily living activities devised by VA for each referred veteran in the community residential care program.

(c) The term *daily living activities* includes:

- (1) Walking;
- (2) Bathing, shaving, brushing teeth, combing hair;
- (3) Dressing;
- (4) Eating;
- (5) Getting in or getting out of bed;
- (6) Laundry;
- (7) Cleaning room;
- (8) Managing money;
- (9) Shopping;
- (10) Using public transportation;
- (11) Writing letters;
- (12) Making telephone calls;
- (13) Obtaining appointments;
- (14) Self-administration of medications;
- (15) Recreational and leisure activities; and
- (16) Other similar activities.

(d) The term *paper hearing* means a review of the written evidence of record by the hearing official.

(e) The term *oral hearing* means the in person testimony of representatives of a community residential care facility and of VA before the hearing official and the review of the written evidence of record by that official.

(f) The term *approving official* means the Director or, if designated by the Director, the Associate Director or Chief of Staff of a Department of Veterans Affairs Medical Center or Outpatient Clinic which has jurisdiction to approve a community residential care facility.

(g) The term *hearing official* means the Director or, if designated by the Director, the Associate Director or