

payer to Medicare Parts A and B, Medicare supplemental insurance plans, and Medicare HMO plans.

(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.

(Authority: 38 U.S.C. 1713(d))

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]

§ 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 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 (Medicaid excluded), 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.

(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

§ 17.272

38 CFR Ch. I (7-1-08 Edition)

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 (TMJ) syndrome. Authorization is limited to initial radiographs, 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

Department of Veterans Affairs

§ 17.272

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

(26) Services and supplies, to include psychological testing, provided in connection with a specific developmental disorder. The following exception applies: Diagnostic and evaluative services required to arrive at a differential diagnosis for an otherwise eligible child unless the state is required to provide those services under Public Law 94-142, *Education for All Handicapped Children Act of 1975 as amended*, see 20 U.S.C. chapter 33.

(27) Surgery to reverse voluntary surgical sterilization procedures.

(28) 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.

(29) Nonprescription contraceptives.

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

(31) Preventive care (such as routine, annual, or employment-requested physical examinations; routine screening procedures; and immunizations). The following exceptions apply:

(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) Pap smears.

(vi) Mammography tests.

(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.

(32) Chiropractic and naturopathic services.

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

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

(35) 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.

§ 17.272

38 CFR Ch. I (7-1-08 Edition)

(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.

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

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

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

(39) Services of an audiologist or speech therapist, except when prescribed by a physician and rendered as a part of treatment addressed to the physical defect itself and not to any educational or occupational deficit.

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

(41) 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.

(42) 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)(42)(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.

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

(44) Prostheses with the following exceptions:

(i) Artificial limbs.

(ii) Voice prostheses.

(iii) Eyes.

(iv) Items surgically inserted in the body as an integral part of a surgical procedure.

(v) Dental prostheses specifically required in connection with otherwise covered orthodontia directly related to the surgical correction of a cleft palate anomaly.

(45) 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.

(46) Services or advice rendered by telephone are excluded except that 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:

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

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

(iii) 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.

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

(48) Elevators.

(49) Alterations to living spaces or permanent features attached thereto, even when necessary to accommodate installation of covered durable medical

Department of Veterans Affairs

§ 17.272

equipment or to facilitate entrance or exit.

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

(51) Food, food substitutes, vitamins or other nutritional supplements, including those related to prenatal care for a home patient whose condition permits oral feeding.

(52) Enuretic (bed-wetting) devices; enuretic conditioning programs.

(53) Autopsy and post-mortem examinations.

(54) 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.

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

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

(57) Smoking cessation services and supplies.

(58) Megavitamin psychiatric therapy; orthomolecular psychiatric therapy.

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

(60) Inpatient mental health services in excess of 30 days in any fiscal year (or in an admission), in the case of a patient nineteen years of age or older; 45 days in any fiscal year (or in an admission), in the case of a patient under 19 years of age; or 150 days of residential treatment care in any fiscal year (or in an admission) unless a waiver for extended coverage is granted in advance.

(61) Outpatient mental health services in excess of 23 visits in a fiscal year unless a waiver for extended coverage is granted in advance.

(62) Institutional services for partial hospitalization in excess of 60 treatment days in any fiscal year (or in an admission) unless a waiver for extended coverage is granted in advance.

(63) Detoxification in a hospital setting or rehabilitation facility in excess of seven days.

(64) Outpatient substance abuse services in excess of 60 visits during a benefit period. A benefit period begins with the first date of covered service and ends 365 days later.

(65) Family therapy for substance abuse in excess of 15 visits during a benefit period. A benefit period begins with the first date of covered service and ends 365 days later.

(66) 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.

(67) Abortion except when a physician certifies that the life of the mother would be endangered if the fetus were carried to term.

(68) Abortion counseling.

(69) Aversion therapy.

(70) Rental or purchase of biofeedback equipment.

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

(72) Drug maintenance programs where one addictive drug is substituted for another, such as methadone substituted for heroin.

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

(74) 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.

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

(76) Medical photography.

(77) Special tutoring.

(78) Surgery for psychological reasons.

(79) Treatment of premenstrual syndrome (PMS).

(80) Medications not requiring a prescription, except for insulin and related diabetic testing supplies and syringes.

(81) Thermography.

(82) Removal of tattoos.

§ 17.273

38 CFR Ch. I (7-1-08 Edition)

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

(84) 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.

(85) Chemical peeling for facial wrinkles.

(86) Panniculectomy, body sculpting procedures.

(b) CHAMPVA-determined allowable amount.

(1) The term allowable amount is the maximum CHAMPVA-determined level of payment to a hospital or other authorized institutional provider, a physician or other authorized individual professional provider, or other authorized provider for covered services. The CHAMPVA-allowable amount is determined prior to cost sharing and the application of deductibles and/or other health insurance.

(2) A Medicare-participating hospital must accept the CHAMPVA-determined allowable amount for inpatient services as payment-in-full. (Reference 42 CFR parts 489 and 1003).

(3) An authorized provider of covered medical services or supplies must accept the CHAMPVA-determined allowable amount as payment-in-full.

(4) A provider who has collected and not made appropriate refund, or attempts to collect from the beneficiary, any amount in excess of the CHAMPVA-determined allowable amount may be subject to exclusion from Federal benefit programs.

(Authority: 38 U.S.C. 1713)

[63 FR 48102, Sept. 9, 1998, as amended at 67 FR 4359, Jan. 30, 2002]

§ 17.273 Preauthorization.

Preauthorization or advance approval is required for any of the following:

(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) Outpatient mental health visits in excess of 23 per calendar year and/or more than two (2) sessions per week.

(d) Dental care.

(e) Durable medical equipment with a purchase or total rental price in excess of \$300.00.

(f) Organ transplants.

(Authority: 38 U.S.C. 1713)

§ 17.274 Cost sharing.

(a) With the exception of services obtained through VA facilities, CHAMPVA is a cost-sharing program in which the cost of covered services is shared with the beneficiary. CHAMPVA pays the CHAMPVA-determined allowable amount less the deductible, if applicable, and less the beneficiary cost share.

(b) In addition to the beneficiary cost share, an annual (calendar year) outpatient deductible requirement (\$50 per beneficiary or \$100 per family) must be satisfied prior to the payment of outpatient benefits. There is no deductible requirement for inpatient services or for services provided through VA facilities.

(c) To provide financial protection against the impact of a long-term illness or injury, a calendar year cost limit or "catastrophic cap" has been placed on the beneficiary cost-share amount for covered services and supplies. Credits to the annual catastrophic cap are limited to the applied annual deductible(s) and the beneficiary cost-share amount. Costs above the CHAMPVA-allowable amount, as well as costs associated with non-covered services are not credited to the catastrophic cap computation. After a family has paid the maximum cost-share and deductible amounts for a calendar year, CHAMPVA will pay allowable amounts for the remaining covered services through the end of that calendar year.

(i) Through December 31, 2001, the annual cap on cost sharing is \$7,500 per CHAMPVA-eligible family.

(ii) Effective January 1, 2002, the cap on cost sharing is \$3,000 per CHAMPVA-eligible family.

(d) If the CHAMPVA benefit payment is under \$1.00, payment will not be