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Title 38, Parts 17, 46, 47, 51–53,
58–64, 70, 71, and 200

Medical

Veterans Benefits Administration

Supplement No. 82

Covering period of *Federal Register* issues
through December 1, 2013

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GENERAL INSTRUCTIONS

Custom Federal Regulations Service™

Supplemental Materials for *Book I*

Code of Federal Regulations

Title 38, Parts 17, 46, 47, 51–53, 58–64, 70, 71, and 200

Medical

Veterans Benefits Administration

Supplement No. 82

5 December 2013

Covering the period of Federal Register issues
through December 1, 2013

When **Book I** was originally prepared, it was current through final regulations published in the *Federal Register* of 15 January 2000. These supplemental materials are designed to keep your regulations up to date. You should file the attached pages immediately, and record the fact that you did so on the *Supplement Filing Record* which is at page I-8 of Book I, *Medical*.

**To ensure accuracy and timeliness of your materials,
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1. Always file your supplemental materials immediately upon receipt.
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3. After filing, enter the relevant information on the Supplement Filing Record sheet (page I-8)—the date filed, name/initials of filer, and date through which the *Federal Register* is covered.
4. If as a result of a failure to file, or an undelivered supplement, you have more than one supplement to file at a time, be certain to file them in chronological order, lower number first.
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FILING INSTRUCTIONS

**Book I, Supplement No. 82
December 5, 2013**

<i>Remove these <u>old pages</u></i>	<i>Add these <u>new pages</u></i>	<i>Section(s) <u>Affected</u></i>
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**Do not file this supplement until you confirm that
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17.169-1 to 17.169-4	17.169-1 to 17.169-4	§17.169
17.111-3 to 17.111-6	17.111-3 to 17.111-6	§17.111

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HIGHLIGHTS

Book I, Supplement No. 82 December 5, 2013

Supplement Highlights references: Where substantive changes are made in the text of regulations, the paragraphs of *Highlights* sections are cited at the end of the relevant section of text. Thus, if you are reading §17.100, you will see a note at the end of that section which reads: “Supplement *Highlights* references—37(1).” This means that paragraph 1 of the *Highlights* section in Supplement No. 37 contains information about the changes made in §17.100. By keeping and filing the *Highlights* sections, you will have a reference source explaining all substantive changes in the text of the regulations.

Supplement frequency: Beginning 1 January 2000, supplements for this Book I will be issued *every month* during which a final rule addition or modification is made to the parts of Title 38 covered by this book. Supplements will be numbered consecutively as issued.

Modifications in this supplement include the following:

1. On 22 October 2013 the VA published a direct final rule effective 23 December 2013, to amend its regulations related to the VA Dental Insurance Program (VADIP), a pilot program to offer premium-based dental insurance to enrolled veterans and certain survivors and dependents of veterans. Specifically, this rule will add language to clarify the limited preemptive effect of certain criteria in the VADIP regulations. Change:

- In §17.169, revised paragraph (g).

2. On 27 November 2013 the VA published a final rule effective 27 December 2013, to amend the definition of “spousal resource protection amount” to reference the Maximum Community Spouse Resource Standard, which is adjusted and published each year by the Centers for Medicare and Medicaid Services (CMS). This change has the immediate effect of increasing the spousal resource protection amount from \$89,280 to \$115,920, and ensures that the spousal resource protection amount will stay consistent with the comparable protection for the spouses of Medicaid recipients. Change:

- In §17.111, revised paragraph (d)(2)(vi) and removed paragraph (g).

3. On 14 November 2013 the VA published a final rule, delay of effective date for the final rule published May 6, 2013. **This rule was executed in supplement #81 for Book I. The effective date of this rule is delayed from November 15, 2013 to April 1, 2014.** The change in this final rule was as follows:

- Revised §17.56 by removing “and except for non-contractual payments for home health services and hospice care”.

spouse (*e.g.*, alimony, child-support); and including the average monthly expenses during the past year for the following: utilities and insurance for the primary residence; out-of-pocket medical care costs not otherwise covered by health insurance; health insurance premiums for the veteran, veteran's spouse, and veteran's dependents; and taxes paid on income and personal property.

(iii) *Fixed Assets* means:

(A) Real property and other non-liquid assets; except that this does not include:

(1) Burial plots;

(2) A residence if the residence is:

(i) The primary residence of the veteran and the veteran is receiving only noninstitutional extended care service; or

(ii) The primary residence of the veteran's spouse or the veteran's dependents (if the veteran does not have a spouse) if the veteran is receiving institutional extended care service.

(3) A vehicle if the vehicle is:

(i) The vehicle of the veteran and the veteran is receiving only noninstitutional extended care service; or

(ii) The vehicle of the veteran's spouse or the veteran's dependents (if the veteran does not have a spouse) if the veteran is receiving institutional extended care service.

(B) [Reserved]

(iv) *Liquid assets* means cash, stocks, dividends received from IRA, 401K's and other tax deferred annuities, bonds, mutual funds, retirement accounts (*e.g.*, IRA, 401Ks, annuities), art, rare coins, stamp collections, and collectibles of the veteran, spouse, and dependents. This includes household and personal items (*e.g.*, furniture, clothing, and jewelry) except when the veteran's spouse or dependents are living in the community.

(v) *Spousal allowance* is an allowance of \$20 per day that is included only if the spouse resides in the community (not institutionalized).

(vi) *Spousal resource protection amount* means the value of liquid assets equal to the Maximum Community Spouse Resource Standard published by the Centers for Medicare and Medicaid Services (CMS) as of January 1 of the current calendar year if the spouse is residing in the community (not institutionalized).

(vii) *Veterans allowance* is an allowance of \$20 per day.

(3) The maximum amount of a copayment for any month equals the copayment amount specified in paragraph (b)(1) of this section multiplied by the number of days in the month. The copayment for any month may be less than the amount specified in paragraph (b)(1) of this section if the veteran provides information in accordance with this section to establish that the copayment should be reduced or eliminated.

(e) Requirement to submit information.

(1) Unless exempted under paragraph (f) of this section, a veteran must submit to a VA medical facility a completed VA Form 10-10EC and documentation requested by the Form at the following times:

(i) At the time of initial request for an episode of extended care services;

(ii) At the time of request for extended care services after a break in provision of extended care services for more than 30 days; and

(iii) Each year at the time of submission to VA of VA Form 10-10EZ.

(2) When there are changes that might change the copayment obligation (i.e., changes regarding marital status, fixed assets, liquid assets, expenses, income (when received), or whether the veteran has a spouse or dependents residing in the community), the veteran must report those changes to a VA medical facility within 10 days of the change.

(f) Veterans and care that are not subject to the copayment requirements. The following veterans and care are not subject to the copayment requirements of this section:

(1) A veteran with a compensable service-connected disability.

(2) A veteran whose annual income (determined under 38 U.S.C. 1503) is less than the amount in effect under 38 U.S.C. 1521(b).

(3) Care for a veteran's noncompensable zero percent service-connected disability.

(4) An episode of extended care services that began on or before November 30, 1999.

(5) Care authorized under 38 U.S.C. 1710(e) for Vietnam-era herbicide-exposed veterans, radiation-exposed veterans, Persian Gulf War veterans, or post-Persian Gulf War combat-exposed veterans.

(6) Care for treatment of sexual trauma as authorized under 38 U.S.C. 1720D.

(7) Care or services authorized under 38 U.S.C. 1720E for certain veterans regarding cancer of the head or neck.

(8) A veteran who VA determines to be catastrophically disabled, as defined in 38 CFR 17.36(e), is exempt from copayments for adult day health care, non-institutional respite care, and non-institutional geriatric care.

(9) A veteran receiving care for psychosis or a mental illness other than psychosis pursuant to §17.109.

[Note: Form 10-10EC will be found on the next three pages.]

(Authority: 38 U.S.C. 101(28), 501, 1701(7), 1710, 1710B, 1720B, 1720D, 1722A)

[67 FR 35040, May 17, 2002, as amended at 69 FR 39846, July 1, 2004; 76 FR 52274, Aug. 22, 2011; 78 FR 28143, May 14, 2013; 78 FR 70864, Nov. 27, 2013]

Supplement *Highlights* references: 9(1), 24(1), 64(1), 77(1), 82(2).

Application for Extended Services, VAF 10-10EC:

<http://www.va.gov/vaforms/medical/pdf/10-10EC.pdf>

§17.169 VA Dental Insurance Program for veterans and survivors and dependents of veterans (VADIP).*(a) General.*

(1) The VA Dental Insurance Program (VADIP) provides premium-based dental insurance coverage through which individuals eligible under paragraph (b) of this section may choose to obtain dental insurance from a participating insurer. Enrollment in VADIP does not affect the insured's eligibility for outpatient dental services and treatment, and related dental appliances, under 38 U.S.C. 1712.

(2) The following definitions apply to this section:

Insured means an individual, identified in paragraph (b) of this section, who has enrolled in an insurance plan through VADIP.

Participating insurer means an insurance company that has contracted with VA to offer a premium-based dental insurance plan to veterans, survivors, and dependents through VADIP. There may be more than one participating insurer.

(b) *Covered veterans and survivors and dependents.* A participating insurer must offer coverage to the following persons:

(1) Any veteran who is enrolled under 38 U.S.C. 1705 in accordance with 38 CFR 17.36.

(2) Any survivor or dependent of a veteran who is eligible for medical care under 38 U.S.C. 1781 and 38 CFR 17.271.

(c) Premiums, coverage, and selection of participating insurer.

(1) *Premiums.* Premiums and copayments will be paid by the insured in accordance with the terms of the insurance plan. Premiums and copayments will be determined by VA through the contracting process, and will be adjusted on an annual basis. The participating insurer will notify all insureds in writing of the amount and effective date of such adjustment.

(2) *Benefits.* Participating insurers must offer, at a minimum, coverage for the following dental care and services:

(i) Diagnostic services.

- (A) Clinical oral examinations.
- (B) Radiographs and diagnostic imaging.
- (C) Tests and laboratory examinations.

(ii) Preventive services.

- (A) Dental prophylaxis.

(B) Topical fluoride treatment (office procedure).

(C) Sealants.

(D) Space maintenance.

(iii) *Restorative services.*

(A) Amalgam restorations.

(B) Resin-based composite restorations.

(iv) *Endodontic services.*

(A) Pulp capping.

(B) Pulpotomy and pulpectomy.

(C) Root canal therapy.

(D) Apexification and recalcification procedures.

(E) Apicoectomy and periradicular services.

(v) *Periodontic services.*

(A) Surgical services.

(B) Periodontal services.

(vi) *Oral surgery.*

(A) Extractions.

(B) Surgical extractions.

(C) Alveoloplasty.

(D) Biopsy.

(vii) *Other services.*

(A) Palliative (emergency) treatment of dental pain.

(B) Therapeutic drug injection.

(C) Other drugs and/or medications.

(D) Treatment of postsurgical complications.

(E) Crowns.

(F) Bridges.

(G) Dentures.

(3) *Selection of participating insurer.* VA will use the Federal competitive contracting process to select a participating insurer, and the insurer will be responsible for the administration of VADIP.

(d) *Enrollment.*

(1) VA, in connection with the participating insurer, will market VADIP through existing VA communication channels to notify all eligible persons of their right to voluntarily enroll in VADIP. The participating insurer will prescribe all further enrollment procedures, and VA will be responsible for confirming that a person is eligible under paragraph (b) of this section.

(2) The initial period of enrollment will be for a period of 12 calendar months, followed by month-to-month enrollment, subject to paragraph (e)(5) of this section, as long as the insured remains eligible for coverage under paragraph (b) of this section and chooses to continue enrollment, so long as VA continues to authorize VADIP.

(3) The participating insurer will agree to continue to provide coverage to an insured who ceases to be eligible under paragraphs (b)(1) through (2) of this section for at least 30 calendar days after eligibility ceased. The insured must pay any premiums due during this 30-day period. This 30-day coverage does not apply to an insured who is disenrolled under paragraph (e) of this section.

(e) *Disenrollment.*

(1) Insureds may be involuntarily disenrolled at any time for failure to make premium payments.

(2) Insureds must be permitted to voluntarily disenroll, and will not be required to continue to pay any copayments or premiums, under any of the following circumstances:

(i) For any reason, during the first 30 days that the beneficiary is covered by the plan, if no claims for dental services or benefits were filed by the insured.

(ii) If the insured relocates to an area outside the jurisdiction of the plan that prevents the use of the benefits under the plan.

(iii) If the insured is prevented by serious medical condition from being able to obtain benefits under the plan.

(iv) If the insured would suffer severe financial hardship by continuing in VADIP.

(v) For any reason during the month-to-month coverage period, after the initial 12-month enrollment period.

(3) All insured requests for voluntary disenrollment must be submitted to the insurer for determination of whether the insured qualifies for disenrollment under the criteria in

paragraphs (e)(2)(i) through (v) of this section. Requests for disenrollment due to a serious medical condition or financial hardship must include submission of written documentation that verifies the existence of a serious medical condition or financial hardship. The written documentation submitted to the insurer must show that circumstances leading to a serious medical condition or financial hardship originated after the effective date coverage began, and will prevent the insured from maintaining the insurance benefits.

(4) If the participating insurer denies a request for voluntary disenrollment because the insured does not meet any criterion under paragraphs (e)(2)(i) through (v) of this section, the participating insurer must issue a written decision and notify the insured of the basis for the denial and how to appeal. The participating insurer will establish the form of such appeals whether orally, in writing, or both. The decision and notification of appellate rights must be issued to the insured no later than 30 days after the request for voluntary disenrollment is received by the participating insurer. The appeal will be decided and that decision issued in writing to the insured no later than 30 days after the appeal is received by the participating insurer. An insurer's decision of an appeal is final.

(5) Month-to-month enrollment, as described in paragraph (d)(2) of this section, may be subject to conditions in insurance contracts, whereby upon voluntarily disenrolling, an enrollee may be prevented from re-enrolling for a certain period of time as specified in the insurance contract.

(f) Other appeals procedures. Participating insurers will establish and be responsible for determination and appeal procedures for all issues other than voluntary disenrollment.

(g) Limited preemption of State and local law. To achieve important Federal interests, including but not limited to the assurance of the uniform delivery of benefits under VADIP and to ensure the operation of VADIP plans at the lowest possible cost to VADIP enrollees, paragraphs (b), (c)(1), (c)(2), (d), and (e)(2) through (5) of this section preempt conflicting State and local laws, including laws relating to the business of insurance. Any State or local law, or regulation pursuant to such law, is without any force or effect on, and State or local governments have no legal authority to enforce them in relation to, the paragraphs referenced in this paragraph or decisions made by VA or a participating insurer under these paragraphs. (Authority: Sec. 510, Pub. L. 111-163)(The Office of Management and Budget has approved the information collection requirement in this section under control number 2900-0789.)

[78 FR 32130; May 29, 2013; as amended at 78 FR 62443, Oct. 22, 2013]

Supplement *Highlights* reference: 77(3), 82(1).