Department of Veterans Affairs (VA) and Department of Defense (DoD) Memorandum of Agreement (MOA) Regarding Referral of Active Duty Military Personnel Who Sustain Spinal Cord Injury, Traumatic Brain Injury, or Blindness to Veterans Affairs Medical Facilities for Health Care and Rehabilitative Services

1. **PURPOSE**: This document establishes procedures regarding active duty military personnel with spinal cord injury (SCI), traumatic brain injury (TBI), or blindness treated at VA medical facilities under direct resource sharing agreements under the authorities noted in paragraph 2. Active duty military personnel will receive timely and high quality specialty care within a continuum of health care dedicated to the needs of persons with SCI, TBI, and blindness. Note: This MOA does not pertain to the transfer of active duty military personnel to VA facilities for care or treatment related to alcohol or drug abuse or dependence in accordance with Title 38 U.S.C, Section 620A(d)(l). This MOA pertains to direct resource sharing agreements only, and not to agreements between the VA and TRICARE Managed Care Support Contractors (MCSCs).

2. **AUTHORITIES:**

a. Department of Veterans Affairs (VA) and Department of Defense (DoD) Health Resources Sharing and Emergency Operations Act (38 U.S.C. § 8111)
b. Section 3-105 of the VA/DoD Health Care Resource Sharing Guidelines of July 29, 1983.

3. **BACKGROUND**: There has been a long-standing MOA between VA and DoD associated with specialized care for active duty sustaining SCI, TBI, and blindness. VA is known for its integrated system of health care for these conditions. The VA/DoD Health Executive Council has identified the need for referral procedures governing the transfer of active duty military inpatients from military or civilian hospitals to VA medical facilities, and the treatment of active duty military patients at such facilities. This MOA supersedes all previous VA/DoD MOAs relating to active duty military referrals to VA health care facilities for TBI, SCI, and blindness.

4. **DoD RESPONSIBILITIES:**

a. Care management services will be provided by the Military Medical Support Office (MMSO), the appropriate Military Treatment Facility (MTF), and the admitting VAMC as a joint collaboration as appropriate to each individual service member's case. The referring MTF and the VA health care facility shall notify MMSO when a member is referred for care under this agreement. MMSO will provide any required care authorizations relating to care provided under this MOA once the member is admitted to a VA facility.

b. The referring MTF will identify and contact the VA TBI (Appendix A), SCI (Appendix B), or Blind Rehabilitation Center (Appendix C) as soon as possible to begin the referral process, to present the case, and to gain admission approval. The medical and administrative personnel of the MTF must establish immediate contact with their counterparts at the designated VA health care facility to discuss and make specific arrangements. Whenever possible the VA health care facility closest to the active duty member's home of record or location selected by the active duty member,

guardian, conservator, or designee should be contacted first. The service member's command ordinarily determines whether the service members injury and/or condition occurred while in the line of duty and not due to own misconduct which may affect eligibility for VA health care according to provisions of Title 38 U.S.C. Chapter 17.

c. The referring MTF will provide a copy of all pertinent patient medical record documentation requested by the VA health care facility needed to make a medical decision. This includes the patient's history and physical, diagnostics, laboratory findings, hospital course, daily documentation of progress, etc. When the VA facility accepts a patient, the referring DoD/MTF case manager will provide the VA case manager with current clinical information along with the case management plan of care and discharge plan.

d. Pre-requisites for transfer, in addition to identifying an accepting staff physician at the VA health care facility, are stabilization of the patient's injuries and the acute management of the medical and physiological conditions associated with the SCI, TBI, or blindness. Stabilization is an attempt to prevent additional impairments while focusing on prevention of complications. The criteria for the transfer of patients with SCI, TBI, or blindness require:

(1) Attention to airway and adequate oxygenation;

(2) Treatment of hemorrhage, no evidence of active bleeding;

(3) Adequate fluid replacement;

(4) Maintenance of systolic blood pressures (>90 mm mercury hydrargyrum (Hg));

(5) Foley catheter placement, when appropriate, with adequate urine output;

(6) Use of a nasogastric tube, if paralytic ileus develops;

(7) Maintenance of spinal alignment by immobilization of the spine, or adequate stabilization to prevent further neurologic injury (traction, tongs and traction, halo-vest, hard cervical collar, body jacket, etc.); and

(8) Approval by the SCI Center Chief, TBI Center Medical Director or Designee, or Blind Rehabilitation Chief in consultation with other appropriate VA specialty care teams.

e. The referring MTF must notify the VA health care facility of any changes in medical status. Patients are not to be transferred if there is:

(1) Deteriorating neurologic function;

(2) An inability to stabilize the spine, especially if the neurologic injury is incomplete;

(3) Bradyarrhythmias are present;

(4) An inability to maintain systolic blood pressure >90 mm Hg;

(5) Acute respiratory failure is present; or

(6) New onset of fever, infection and/or change in medical status (e.g., deteriorating physiological status).

f. Following the VA health care facility's agreement to accept the patient, the MTF commander or designee is responsible for arranging transportation to the VA facility in accordance with governing policies for movement of patients. This normally will include notifying and submitting a patient movement request to the Global Patient Movement Requirements Center (GPMRC), or when overseas, to the Theater Patient Movement Requirement Center (TPMRC), without regard to weekend or holiday, to schedule the transport of the patient from either an MTF or a civilian hospital. If the patient is moved by other than an Air Force aircraft or is an emergency patient, information reported to GPMRC will be the minimum required to allow GPMRC to develop referral patterns This notification may be made after the fact for emergency patients.

g. The MTF commander and GPMRC are responsible for coordination with the receiving VA facility for ground transportation from the airfield to the VA facility. Whenever possible, the originating MTF should arrange with any MTF within a reasonable distance to provide needed transportation. If that is not possible, the receiving VA health care facility shall obtain appropriate local transportation. NOTE: DoD will be responsible for payment of any costs incurred by VA for the transport of active duty personnel.

h. To ensure optimal care, active duty patients are to go directly to a VA medical facility without passing through a transit military hospital.

i. In emergencies, GPMRC will expedite transfers from MTFs or civilian hospitals to VA facilities through telephone communications. MTFs will report directly to the GPMRC for CONUS transfers, but MTFs will report to the TPMRC at Ramstein Air Base, or to the TPMRC at Yokota Air Base for O-CONUS transfers. The TPMRC will then coordinate with the GPMRC for transportation. An after-the-fact report will be made to GPMRC within 48 hours.

j. DoD will ensure meeting the goal of transfer within three days (four days from overseas), whenever the patient's medical condition permits, but not exceeding twelve days. The ability to complete medical review board processing is not a prerequisite for transfer to a VA medical facility.

k. DoD will assure that each Surgeon General's office or her/his designee provides necessary assistance to VA facilities in the preparation and transmittal of the patient's medical boards or as a point of contact should problems arise.

l. DoD will assure that the appropriate Service provide telephone and written notification to VA facilities when active duty members are discharged or released from active duty. This

notification shall be made before the separation date and will include the date, type of separation, and the periods of active duty served. The DD214 will be provided to VA in a timely manner.

5. VA RESPONSIBILITIES:

a. The Rehabilitation Services Chief Consultant and the Spinal Cord Injury and Disorders Chief Consultant will provide annually to DoD, a list of VA Spinal Cord Injury Centers, Traumatic Brain Injury Lead Centers, and Blind Rehabilitation Centers including their telephone numbers and points of contact. These lists will be updated if changes occur.

b The Veterans Integrated Service Network (VISN) Directors will adhere to policies in this MOA.

c. The designated VA facility with an SCI Center, TBI Center, or Blind Rehabilitation Center will assist military authorities in the following manner:

(1) Respond (following receipt of necessary medical records) to requests for admission from military medical authorities or their designees without regard to weekends or holidays. NOTE: Concurrent notification of the GPMRC will be provided.

(2) Accept appropriate active-duty patients without regard to hour of the day, day of the week, or holidays. NOTE: The acceptance of local transfers from MTFs to VA facilities should be mutually agreed upon. At MTF's where VA staff are assigned, the VA/DoD Social Worker liaison will assist with the transfer.

(3) Coordinate the transfer of active duty patients to VA health care facilities with the MTFs and GPMRC. NOTE: Concurrent notification of the GPMRC will be provided.

(4) Coordinate with civilian hospitals and GPMRC so that active duty patients, who are ready for transfer to a VA specialty care center are transported directly from a civilian hospital to the appropriate VA facility.

(5) Assist the MTF in identifying the most appropriate VA SCI, TBI, or Blind Rehabilitation Center. Active duty patients need to be referred to the designated VA medical facility closest to the active duty member's home of record or location selected by the active duty member, guardian, conservator, or designee, subject to availability of beds. If the preferred Center is unable to accept the patient, that VA medical facility will assist in locating an appropriate placement. NOTE: The Chief Consultant, Rehabilitation Services, or Chief Consultant, SCI&D Services, VA Central Office, 810 Vermont Avenue, NW, Washington, DC 20420, will assist when necessary.

(6) The accepting VA staff physician will review military transportation arrangements and make recommendations if it is believed that the patient's care will be compromised due to delays or other clinical considerations. VA will assist referring military authorities and GPMRC in coordinating the medically indicated mode of transportation and arranging local ground transportation to VA facilities, such as from local airfields.

(7) Provide immediate notification to the appropriate MTF Case Manager and MMSO, when an active duty member is admitted. The VA will assign a case manager responsible for coordinating care through a continuum of health care services for each member admitted. The VA case manager will provide the DoD/MTF case manager periodic updates, no less than once a month depending on the acuity or complexity of the case, until the medical determination or the medical board process is complete. This continued coordination is necessary to aid in communication to the DoD primary care manager, command, other program managers, and medical board personnel.

(8) Coordinate the hospital discharge of an active duty member with the appropriate MTF and the Military Medical Support Office (MMSO).

(9) Assist with medical boards when requested by the military authority having cognizance over the member.

(10) Notify DoD of the active duty member's absences, medical discharge, and change of location.

(11) Prior to discharge, the VAMC where the patient is being treated will facilitate the patient appropriately enrolling to TRICARE in the region of his/her final destination.

6. PROGRAM DESCRIPTIONS:

a. Spinal Cord Injury and Disorders: The mission of the Spinal Cord Injury and Disorders Program within VA is to promote the health, independence, quality of life, and productivity of individuals with spinal cord injury and disorders. There are twenty SCI Centers available throughout VA to provide acute rehabilitative services to persons with new onset SCI (see Appendix B). VA offers a unique system of care through SCI Centers, which includes a full range of health care for eligible persons who have sustained injury to their spinal cord or who have other spinal cord lesions. Persons served in these centers include those with: stable neurological deficit due to spinal cord injury, intraspinal, nonmalignant neoplasms, vascular insult, cauda equina syndrome, inflammatory disease, spinal cord or cauda equina resulting in nonprogressive neurologic deficit, demyelinating disease limited to the spinal cord and of a stable nature, and degenerative spine disease.

b. Traumatic Brain Injury: VA offers a full range of traumatic brain injury rehabilitation to ensure that military and veteran personnel with brain injuries receive coordinated, comprehensive care. The goal is to return the brain injury survivor to the highest level of function and to educate family and caregivers in the long-term needs of the patient. VA has four lead Traumatic Brain Injury Centers (see Appendix A). These facilities provide comprehensive assessment, medical care, TBI specific acute rehabilitation, access to state of the art treatment, clinical trials, and leadership for a nationwide system of TBI care through case management. Each participating medical center has a designated TBI case manager who facilitates patient participation in the program and expedites facility transfers and community placement. Persons served in these Centers and covered under this MOA include individuals sustaining a brain injury caused by an

external physical force resulting in open and closed injuries, and damage to the central nervous system resulting from anoxic/hypoxic episodes, related to trauma or exposure to chemical or environmental toxins that result in brain damage. This MOA does not include brain injuries/insult related to chronic illnesses (i.e., hypertension, tumors, diabetes, etc.). Patients with other acquired brain injury due to chronic disease or infectious processes are not covered under this MOA, but are eligible for care in these centers.

c. Blind Rehabilitation: Blind Rehabilitation Service offers a coordinated educational training and health care service delivery system that provides a continuum of care for veterans with blindness that extends from their home environment, to the local VA facility, to the appropriate rehabilitation setting. These services include adjustment to blindness counseling, patient and family education, benefits analysis, assistive technology, outpatient programs, and residential inpatient training. There are ten residential, inpatient VA Blind Rehabilitation Centers (BRCs) (see Appendix C). The mission of each BRC program is to educate each veteran on all aspects of Blind Rehabilitation and address the expressed needs of each veteran with blindness so they may successfully reintegrate back into their community and family environment. To accomplish this mission, BRCs offer a comprehensive, individualized adjustment-training program along with those services deemed necessary for a person to achieve a realistic level of independence. BRCs offer a variety of skill courses including: orientation and mobility, communication skills, activities of daily living, manual skills, visual skills, leisure skills, and computer access training. The veteran is also assisted in making an emotional and behavioral adjustment to blindness through individual counseling sessions and group therapy meetings. Each VA medical center has a Visual Impairment Services Team Coordinator who has major responsibility for the coordination of all services for visually impaired veterans and their families. Duties include arranging for the provision of appropriate treatment modalities (e.g. referrals to Blind Rehabilitation Centers and/or Blind Rehabilitation Outpatient Specialists) and being a resource for all local service delivery systems in order to enhance the functioning level of veterans with blindness. Referrals can be directed to the Program Analyst in the Blind Rehabilitation Program Office in the VA Central Office at 202-273-8482.

7. DURATION:

a. This MOA will remain in force unless terminated at the request of either party after thirty (30) days written notice. In event this MOA is terminated, DoD shall be liable only for payment in accordance with provisions of this agreement for care provided before the effective termination date.

b. This agreement supersedes all local resource sharing agreements.

8. REIMBURSEMENT:

a. DoD will reimburse CHAMPUS Maximum Allowable Charge (CMAC) rates less 10 percent (CMAC-10%) for outpatient and professional care. Inpatient care will be reimbursed using the VA interagency rates approved by the Office of Management and Budget, which is periodically updated. Updates are provided via a Federal Register Notice. Although the Federal Register Notice indicates that the interagency billing rates do not apply to sharing agreements

between VA and DoD, it has been determined that these rates are appropriate for care provided under this MOA. VAMCs will provide all documentation required for billing medical claims. At a minimum, this will include an itemized bill for each member on Form CMS 1500 for outpatient/professional services and Form UB 92 for inpatient services. Transportation, prosthetics, durable medical equipment, orthotics, dental services, home care, personal care attendants and extended care/nursing home care will be billed at the interagency rate if one exists, or at actual cost as appropriate

b. VA facilities providing care to active duty service members in accordance with this agreement will be paid by the TRICARE Managed Care Support Contractors (MCSCs). Claims should be forwarded to the MCSC for the TRICARE Region to which the member is enrolled in TRICARE Prime. If the member is not enrolled, the claim will be paid by the regional MCSC where the member resides. Prior to paying a claim, MCSCs will verify that the care is payable through MMSO. MMSO can be reached at 888-647-6676, P.O. Box 88699, Great Lakes, IL 60088-6999.

c. The VAMC will obtain authorization for non-network care from MMSO for the billing to go to the VAMC and be forwarded to the MCSC for payment. This is particularly applicable if there are no TRICARE providers, MTFs, or VAMCs/clinics capable of providing the needed services in the destination area.

d. VA facilities should send claims for payment to:

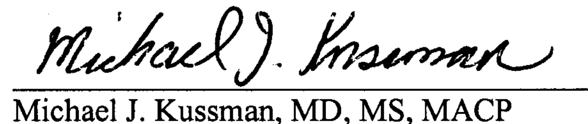
- North Region: North Region Claims, PGBA, P.O. Box 870140, Surfside Beach, SC 29587-9740.
- South Region: TRICARE South Region, Claims Department, P.O. Box 7031, Camden, SC 29020-7031.
- West Region: WPS/West Region Claims, P.O. Box 77028, Madison, WI 53707-7028.

9. EFFECTIVE DATE: This MOA is effective 1 January 2007.

William Winkenwerder, Jr., M.D.

Assistant Secretary for Health Affairs
Department of Defense

Date: 27 Nov. 2006



Michael J. Kussman, MD, MS, MACP

Acting Under Secretary for Health
Department of Veterans Affairs

Date: 13 Dec 2006

TRAUMATIC BRAIN INJURY (TBI) CENTERS ACCEPTING DEPARTMENT OF DEFENSE REFERRALS

1. Minneapolis VA Medical Center (117), One Veterans Drive, Minneapolis, MN 55417, Telephone 612-467-3562.
2. VA Palo Alto HCS (117), 3801 Miranda Avenue, Palo Alto, CA 94304, Telephone 650-447-7114.
3. HH McGuire VA Medical Center (117), 1201 Broad Rock Boulevard, Richmond, VA 23249, Telephone 804-675-5332.
4. James A. Haley VA Medical Center (117), 13000 Bruce B. Downs Blvd., Tampa, FL 33612-4798, Telephone 813-972-7668 or 1-866-659-2156.

SPINAL CORD INJURY (SCI) CENTERS ACCEPTING DEPARTMENT OF DEFENSE REFERRALS

1. Department of Veterans Affairs (VA) New Mexico Health Care System (HCS) (128), 1501 San Pedro Southeast, Albuquerque, NM 87108, Telephone 505-256-2849.
2. Augusta VA Medical Center (128), One Freedom Way, Augusta, GA 30904-6285, Telephone 706-823-2216.
3. VA Boston HCS (128), 1400 VFW Parkway, West Roxbury, MA 02132, Telephone 617-323-7700 Extension 5128.
4. VA Medical Center (128), 130 West Kingsbridge Road, Bronx, NY 10468, Telephone 718-584-9000 Extensions 5423.
5. Louis Stokes VA Medical Center (128W), 10701 East Boulevard, Cleveland, OH 44106, Telephone 216-791-3800 Extension 4731.
6. VA North Texas HCS (128), 4500 South Lancaster Road, Dallas, TX 75216, Telephone 214-857-1757.
7. Edward Hines, Jr. VA Medical Center (128), Fifth Avenue and Roosevelt Road, Hines, IL 60141-5000, Telephone 708-202-2241.
8. Houston VA Medical Center (128), 2002 Holcombe Boulevard, Houston, TX 77030-4298, Telephone 713-794-7128.
9. VA Long Beach HCS (128), 5901 East 7th Street, Long Beach, CA 90822, Telephone 562-826-5701.
10. VA Medical Center (128), 1030 Jefferson Avenue, Memphis, TN 38104, Telephone 901-577-7373.
11. VA Medical Center (128), 1201 Northwest 16th Street, Miami, FL 33125, Telephone 305-324-3174.
12. Clement J. Zablocki VA Medical Center (128), 5000 West National Avenue, Milwaukee, WI 53295, Telephone 414-384-2000 Extension 41230.
13. VA Palo Alto HCS (128), 3801 Miranda Avenue, Palo Alto, CA 94304, Telephone 650-493-5000 Extension 65870.
14. HH McGuire VA Medical Center (128), 1201 Broad Rock Boulevard, Richmond, VA 23249, Telephone 804-675-5282.
15. South Texas Veterans HCS (128), 7400 Meront Minter Blvd., San Antonio, TX 78284, Telephone 210-617-5257.
16. VA San Diego HCS (128), 3350 La Jolla Village Drive, San Diego, CA 92161, Telephone 858-642-3117.
17. VA Medical Center (128), 10 Casia Street, San Juan, PR 00921-3201, Telephone 787-641-7582 Extension 14130.
18. VA Puget Sound HCS (128), 1660 South Columbian Way, Seattle, WA 98108-1597, Telephone 206-764-2332.
19. Saint Louis VA Medical Center (128JB), One Jefferson Barracks Drive, St. Louis, MO 63125, Telephone 314-894-6677.
20. James A. Haley VA Medical Center (128), 13000 Bruce B. Downs Blvd., Tampa, FL 33612-4798, Telephone 813-972-7517.

BLIND REHABILITATION CENTERS (BRC) ACCEPTING DEPARTMENT OF DEFENSE REFERRALS

1. Augusta VA Medical Center (324), One Freedom Way, Augusta, GA 30904-6285, Telephone 706-733-0188 Extension 6660.
2. Birmingham VA Medical Center (124), 700 South 19th Street, Birmingham, AL 35233, Telephone 205-933-8101.
3. Edward Hines, Jr. VA Medical Center (124), Fifth Avenue and Roosevelt Road, Hines, IL 60141-5000, Telephone 708-202-8387 Extension 22112.
4. Central Texas VA Health Care System, 1901 Veterans Memorial Drive, Temple, TX 76504, Telephone 254-297-3755. Blind Rehabilitation Center, 4800 Memorial Drive, Waco, TX 76711. Telephone 254-297-3755.
5. San Juan VA Medical Center (124), 10 Casia Street, San Juan, PR 00921-3201, Telephone 787-641-8325.
6. Southern Arizona VA Health Care System (3-124), 3601 South 6th Avenue, Tucson, AZ 85723, Telephone 520-629-4643.
7. VA Connecticut Health Care System (124), West Haven Campus, 950 Campbell Avenue, West Haven, CT 06516, Telephone 203-932-5711 Extension 2247.
8. VA Palo Alto HCS (124), 3801 Miranda Avenue, Palo Alto, CA 94304, Telephone 650-493-5000 Extension 64218.
9. VA Puget Sound HCS (124), 1660 South Columbian Way, Seattle, WA 98108-1597, Telephone 253-583-1203. (A-112-BRC), American Lake Division, 9600 Veterans Drive, Tacoma, WA 98493, Telephone: 253-983-1299.
10. West Palm Beach VA Medical Center (124), 7305 North Military Trail, West Palm Beach, FL 33410-6400, Telephone 561-422-8425.

OFFICE OF MANAGEMENT AND BUDGET

Charges to Tortiously Liable Third Parties for Hospital, Medical, Surgical, and Dental Care and Treatment Furnished by the United States (Department of Veterans Affairs)

AGENCY: Office of Management and Budget, Executive Office of the President.

ACTION: Notification of charges to tortiously liable third parties for hospital, medical, surgical, and dental care and treatment furnished by the Department of Veterans Affairs.

SUMMARY: By virtue of the authority vested in the President by section 2(a) of the Federal Medical Care Recovery Act, Public Law 87–693 (76 Stat. 593; 42 U.S.C. 2652), and delegated to the Director of the Office of Management and Budget by Executive Order No. 11541 of July 1, 1970 (35 FR 10737), the charges to tortiously liable third parties for hospital, medical, surgical, and dental care and treatment (including prostheses and medical appliances) furnished by the Department of Veterans Affairs are the "reasonable charges" generated by the methodology set forth in 38 CFR 17.101 and published from time to time in the **Federal Register**, most recently on April 29, 2003 (68 FR 22774). These charges are for use in connection with the recovery from tortiously liable third persons of the reasonable value of hospital, medical, surgical, and dental care and treatment furnished by the United States through the Department of Veterans Affairs (28 CFR 43.1–43.4). These charges have been established in accordance with the requirements of OMB Circular A–25, which requires charges that are at least as great as the full cost of the services provided

There are two basic reasons for this change. First, VA's community-based "reasonable charges" more accurately reflect the reasonable value of the medical care and treatment furnished by VA to the injured person, consistent with 42 U.S.C. 2651 and 2652, than do VA's cost-based *per-diem* tort rates.

Second, VA's present dual-rate billing system (tort feasor and health plan), using significantly different charges, is confusing and difficult to justify. VA claims, for example, may be made both against the tort feasor who caused the injury, using the current FMCRA *per-diem* rates, and against the veteran's health plan, using the significantly higher reasonable charges, for the same VA medical care. This not only is confusing to VA billing officials and makes settling claims more difficult, but such dual billing also may disadvantage veterans by providing a *per-diem* rate bill to assert against the tort feasor while exposing veterans to subrogation claims from their health plans who paid at the higher reasonable charges rates. Making the charges billed to all liable parties in FMCRA cases uniform will eliminate confusion and remove an impediment to allowing injured veterans to assert the higher reasonable charges rates for their causally related health care as a necessary and proper element of damages in their cases against the responsible tort feasors.

Beginning on January 7, 2004, the charges prescribed herein supercede those established by the Director of the Office of Management and Budget for the Department of Veterans Affairs on November 1, 1999 (64 FR 58862).

Joshua B. Bolten,
Director.

[FR Doc. 04–317 Filed 1–6–04; 8:45 am]
BILLING CODE 3110–01–P

OFFICE OF MANAGEMENT AND BUDGET

DEPARTMENT OF VETERANS AFFAIRS

Cost-Based and Interagency Billing Rates for Medical Care or Services Provided by the Department of Veterans Affairs

AGENCIES: Office of Management and Budget, Executive Office of the President and the Department of Veterans Affairs.

ACTION: Notice.

SUMMARY: This document provides cost-based and interagency billing rates for medical care or services provided by the Department of Veterans Affairs (VA):

(a) In error or on tentative eligibility;
(b) In a medical emergency;
(c) To pensioners of allied nations;
(d) For research purposes in circumstances under which VA medical care appropriation is to be reimbursed by VA research appropriation; and
(e) To beneficiaries of the Department of Defense or other Federal agencies, when the care or service provided is not covered by an applicable sharing agreement.

In addition, until such time as charges for outpatient dental care and prescription drugs are implemented under the provisions of 38 CFR 17.101, the applicable cost-based billing rates provided in this notice will be used for collection or recovery by VA for outpatient dental care and prescription drugs provided under circumstances covered by that section. This notice is issued jointly by the Office of Management and Budget and the Department of Veterans Affairs.

EFFECTIVE DATE: The rates set forth herein are effective January 7, 2004, and until further notice.

FOR FURTHER INFORMATION CONTACT: David Cleaver, Chief Business Office (168), Veterans Health Administration, Department of Veterans Affairs, 810 Vermont Avenue, NW., Washington, DC 20420, (202) 254–0361. (This is not a toll free number.)

SUPPLEMENTARY INFORMATION: VA's medical regulations at 38 CFR 17.102(h) set forth a methodology for computing rates for medical care or services provided by VA:

(a) In error or on tentative eligibility;
(b) In a medical emergency;
(c) To pensioners of allied nations;
(d) For research purposes in circumstances under which VA medical care appropriation is to be reimbursed by VA research appropriation; and
(e) To beneficiaries of the Department of Defense or other Federal agencies, when the care or service provided is not covered by an applicable sharing agreement.

Two sets of rates are obtained via application of this methodology: Cost-Based Rates, for use for purposes (a) through (d), above, and Interagency Rates, for use for purpose (e), above. Government employee retirement benefits and return on fixed assets are not included in the Interagency Rates, and the Interagency Rates are not broken down into three components (Physician; Ancillary; and Nursing, Room, and Board), but in all other respects the Interagency Rates are the same as the Cost-Based Rates.

When medical care or service is obtained at the expense of the Department of Veterans Affairs from a non-VA source under circumstances in which the Cost-Based or Interagency Rates would apply if the care or service had been provided by VA, then the charge for such care or service will be the actual amount paid by VA for that care or service.

Inpatient charges will be at the per diem rates shown for the type of bed section or discrete treatment unit providing the care. Prescription Filled charge in lieu of the Outpatient Visit rate will be charged when the patient receives no service other than the Pharmacy outpatient service. This charge applies whether the patient receives the prescription in person or by mail.

Current rates obtained via the above methodology are as follows:

	Cost-based rates	Interagency rates
A. Hospital Care, Rates Per Inpatient Day		
General Medicine:		
All Inclusive Rate	$1,815	$1,668
Physician	217	
Ancillary	473	
Nursing, Room, and Board	1,125	
Neurology:		
All Inclusive Rate	2,289	2,098
Physician	335	
Ancillary	604	
Nursing, Room, and Board	1,350	
Rehabilitation Medicine:		
All Inclusive Rate	1,723	1,574
Physician	196	
Ancillary	526	
Nursing, Room, and Board	1,001	
Blind Rehabilitation:		
All Inclusive Rate	1,254	1,162
Physician	101	
Ancillary	623	
Nursing, Room, and Board	530	
Spinal Cord Injury:		
All Inclusive Rate	1,237	1,136
Physician	153	
Ancillary	311	
Nursing, Room, and Board	773	
Surgery:		
All Inclusive Rate	3,513	3,255
Physician	387	
Ancillary	1,065	
Nursing, Room, and Board	2,061	
General Psychiatry:		
All Inclusive Rate	971	888
Physician	92	
Ancillary	153	
Nursing, Room, and Board	726	
Substance Abuse (Alcohol and Drug Treatment):		
All Inclusive Rate	1,206	1,106
Physician	115	
Ancillary	279	
Nursing, Room, and Board	812	
Psychosocial Residential Rehabilitation Treatment Programs:		
All Inclusive Rate	276	252
Physician	17	
Ancillary	29	
Nursing, Room, and Board	230	
Intermediate Medicine:		
All Inclusive Rate	801	733
Physician	39	
Ancillary	118	
Nursing, Room, and Board	644	
B. Nursing Home Care, Rates Per Day		
All Inclusive Rate	451	411
Physician	14	
Ancillary	61	
Nursing, Room, and Board	376	
C. Outpatient Medical and Dental Treatment		
Outpatient Visit (other than Emergency Dental)	300	282
Emergency Dental Outpatient Visit	185	167
D. Prescription Filled, Per Prescription	45	45

Beginning on the effective date indicated herein, these rates supercede those established for the Department of Veterans Affairs by the Director of the Office of Management and Budget on November 1, 1999 (64 FR 58862).

Approved: September 17, 2003.

Anthony J. Principi,

Secretary, Department of Veterans Affairs.

Approved: December 30, 2003.

Joshua B. Bolten,

Director, Office of Management and Budget.

[FR Doc. 04–318 Filed 1–6–04; 8:45 am]

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