upon motion granted by the Board, or upon order of the Board. If a motion for an extension is denied, the time for responding to the motion may remain as specified under this section. The Board, may in its discretion, consider a reply brief. Except as provided in paragraph (e)(1) of this section, a reply brief, if filed, shall be filed within 15 days from the date of service of the brief in response to the motion. The time for filing a reply brief will not be extended. No further papers in support of or in opposition to a motion will be considered by the Board. Briefs shall be submitted in typewritten or printed form, double spaced, in at least pica or eleven-point type, on letter-size paper. The brief in support of the motion and the brief in response to the motion shall not exceed 25 pages in length; and a reply brief shall not exceed 10 pages in length. Exhibits submitted in support of or in opposition to the motion shall not be deemed to be part of the brief for purposes of determining the length of the brief. When a party fails to file a brief in response to a motion, the Board may treat the motion as conceded. An oral hearing will not be held on a motion except on order by the Board.

(b) Any request for reconsideration or modification of an order or decision issued on a motion must be filed within one month from the date thereof. A brief in response must be filed within 15 days from the date of service of the request.

* * * * *

(d) When any party files a motion to dismiss, or a motion for judgment on the pleadings, or a motion for summary judgment, or any other motion which is potentially dispositive of a proceeding, the case will be suspended by the Trademark Trial and Appeal Board with respect to all matters not germane to the motion and no party should file any paper which is not germane to the motion except as otherwise specified in the Board's suspension order. If the case is not disposed of as a result of the motion, proceedings will be resumed pursuant to an order of the Board when the motion is decided.

(e)(1) A motion for summary judgment may not be filed until notification of the proceeding has been sent to the parties by the Trademark Trial and Appeal Board. A motion for summary judgment, if filed, should be filed prior to the commencement of the first testimony period, as originally set or as reset, and the Board, in its discretion, may deny as untimely any motion for summary judgment filed thereafter. A motion under Rule 56(f) of the Federal Rules of Civil Procedure, if filed in response to a motion for summary judgment, shall be filed within 30 days from the date of service of the summary judgment motion. The time for filing a motion under Rule 56(f) will not be extended. If no motion under Rule 56(f) is filed, a brief in response to the motion for summary judgment shall be filed within 30 days from the date of service of the motion unless the time is extended by stipulation of the parties approved by the Board, or upon motion granted by the Board, or upon order of the Board. If a motion for an extension is denied, the time for responding to the motion for summary judgment may remain as specified under this section. The Board may, in its discretion, consider a reply brief. A reply brief, if filed, shall be filed within 15 days from the date of service of the brief in response to the motion. The time for filing a reply brief will not be extended. No further papers in support of or in opposition to a motion for summary judgment will be considered by the Board.

* * * * *

(f) The Board will not hold any person in contempt, or award attorneys' fees or other expenses to any party.

16. Section 2.134 is amended by revising paragraph (a) to read as follows:

§ 2.134 Surrender or voluntary cancellation of registration.

(a) After the commencement of a cancellation proceeding, if the respondent applies for cancellation of the involved registration under section 7(e) of the Act of 1946 without the written consent of every adverse party to the proceeding, judgment shall be entered against the respondent. The written consent of an adverse party may be signed by the adverse party or by the adverse party's attorney or other authorized representative.

* * * * *

17. Section 2.146 is amended by revising paragraph (e)(1) to read as follows:

§ 2.146 Petitions to the Commissioner.

* * * * *

(e)(1) A petition from the grant or denial of a request for an extension of time to file a notice of opposition shall be filed within fifteen days from the date of mailing of the grant or denial of the request. A petition from the grant of a request shall be served on the attorney or other authorized representative of the potential opposer, if any, or on the potential opposer. A petition from the denial of a request shall be served on the attorney or other authorized representative of the applicant, if any, or on the applicant. Proof of service of the petition shall be made as provided by § 2.119(a). The potential opposer or the applicant, as the case may be, may file a response within fifteen days from the date of service of the petition and shall serve a copy of the response on the petitioner, with proof of service as provided by § 2.119(a). No further paper relating to the petition shall be filed.

* * * * *

PART 3—RULES OF PRACTICE IN TRADEMARK CASES

18. The authority citation for part 3 continues to read as follows:

Authority: 15 U.S.C. 1123; 35 U.S.C. 6.

19. Section 3.41 is revised to read as follows:

§ 3.41 Recording fees.

All requests to record documents must be accompanied by the appropriate fee. A fee is required for each application, patent and registration against which the document is recorded as identified in the cover sheet. The recording fee is set in § 1.21(h) of this chapter for patents and in § 2.6(b)(6) of this chapter for trademarks.

Dated: August 27, 1998.

Bruce A. Lehman,

Assistant Secretary of Commerce and Commissioner of Patents and Trademarks.

[FR Doc. 98–23680 Filed 9–8–98; 8:45 am]

BILLING CODE 3510–16–P

DEPARTMENT OF VETERANS AFFAIRS

38 CFR Part 17

RIN 2900–AE64

Civilian Health and Medical Program of the Department of Veterans Affairs (CHAMPVA)

AGENCY: Department of Veterans Affairs.

ACTION: Final rule.

SUMMARY: This document amends the medical regulations concerning medical care for survivors and dependents of certain veterans. These regulations establish basic policies and procedures governing the administration of the Civilian Health and Medical Program of the Department of Veterans Affairs (CHAMPVA), including CHAMPVA claims processing procedures, benefits and services.

DATES: *Effective Date:* October 9, 1998.

FOR FURTHER INFORMATION CONTACT: Susan Schmetzer, Health Administration Center (formerly CHAMPVA Center), P.O. Box 65023, Denver, CO 80206–9023, telephone (303) 331–7552.

SUPPLEMENTARY INFORMATION: In a document published in the **Federal Register** (61 FR 56486) on November 1, 1996, we proposed to amend the medical regulations (38 CFR part 17) by including CHAMPVA claims processing procedures and a description of benefits and services.

The provisions of 38 U.S.C. 1713 authorize VA to provide medical care to the dependents and survivors of certain veterans ''in the same or similar manner and subject to the same or similar limitations'' as medical care is furnished by the Department of Defense (DoD) to certain dependents and survivors of active duty and retired members of the Armed Forces under 10 United States Code, Chapter 55, Civilian Health and Medical Program of the Uniformed Services (CHAMPUS/TRICARE). Previously, VA had an agreement with DoD to contract with commercial claims processors (fiscal intermediaries) for the processing of VA claims. However, in an effort to both contain costs and to improve services to the beneficiaries, VA now conducts its own claims processing services and has consolidated the operations in Denver, Colorado.

Interested parties were invited to submit written comments on or before December 31, 1996. We received comments from two organizations, the American Academy of Dermatology and the American Podiatric Medical Association, Inc. All comments submitted by these two organizations were in reference to excluded benefits under § 17.272.

It was recommended that we clarify the exclusion for cosmetic surgery found at § 17.272(19) to distinguish it from reconstructive surgery. We agree and have added clarifying language to assist in distinguishing between covered and noncovered benefits.

A recommendation was made to change the term ''podiatry services'' in § 17.272(25) to ''foot care services.'' We concur with this recommendation as it clarifies that the exclusion is applicable to all medical providers who may treat certain foot conditions, not just podiatrists.

A commenter recommended that § 17.272(35) be modified to allow for wigs and hairpieces for conditions other than alopecia. No changes were made based on this comment. 38 U.S.C. 1713 requires that CHAMPVA benefits be subject to the same or similar limitations as medical care furnished to Department of Defense dependents through the CHAMPUS/TRICARE program. In accordance with section 744 of Public Law 96–527, CHAMPUS/TRICARE wig and hairpiece benefits are specifically limited to alopecia resulting from treatment of malignant disease.

The exclusion at § 17.272(46) of service or advice rendered by telephone or telephonic device with the exception of cardiac pacemaker monitoring was suggested as presenting a roadblock to cost-saving technology. For the same reason, the commenter also objected to the exclusion at § 17.272(75) of services performed when a patient is not physically present. These exclusions promote a quality of care standard that is established for diagnosis and treatment through face-to-face contact between a provider and patient. For this reason, no changes are made to § 17.272(75). However, we do recognize that remote monitoring can be an efficient alternative to certain outpatient hospital or physician office visits. Additionally, CHAMPUS/TRICARE has recently revised their regulations on this issue to allow for remote monitoring under specific circumstances. As CHAMPVA is to be administered in a similar manner, the final rule was modified to include the applicable criteria to consider an exception to the exclusion cited under § 17.272(46) for services rendered by telephone.

It was recommended that the exclusion of benefits for autopsy and post-mortem examinations found at § 17.272(53) be eliminated. The commenter stated that accrediting bodies look at autopsy rates as a quality assurance measure. Although quality assurance is important, the CHAMPVA program was established to provide healthcare benefits. Autopsies and post-mortem examinations do not come within the scope of a healthcare benefit. For this reason, no change was made to the regulation.

One comment asserted that limiting immunotherapy for malignant diseases to Stage A and Stage O of the bladder under § 17.272(73) was too restrictive as there are some promising treatments being researched. No change was made based on this comment. CHAMPVA benefits do not include coverage for treatments that are experimental or investigational and the stated exclusion is consistent with CHAMPUS/TRICARE policy.

A commenter suggested that the exclusion of medical photography at § 17.272(76) is inappropriate as it is a procedure utilized by dermatologists to document skin disease progression. Medical photography, however, is not considered medically essential for the treatment of skin diseases and, therefore, no change was made based on this comment.

A recommendation was made to modify the exclusion of dermabrasion at § 17.272(84) to allow for treatment related to premalignant changes or for patients who are allergic to 5-fluorouracil. Although dermabrasion is not a covered benefit in the cases cited by the commenter, it is a benefit under limited circumstances. Coverage may be extended following authorized reconstructive or plastic surgery if it is required to restore body form or revise disfiguring and extensive scars resulting from neoplastic surgery. As a result, the language relating to this exclusion has been modified.

Subsequent to the publication of the proposed regulations for the Civilian Health and Medical Program of the Department of Veterans Affairs (CHAMPVA), the name of the administrating organization for the Program was changed from CHAMPVA Center to the Health Administration Center. As a result, a modification to 38 CFR 17.270, General Provisions, has been made to reflect this change.

Additional changes were made to the final rule for purposes of clarification as well as standardization with other VA programs for dependents. These changes, which expand benefits available under CHAMPVA, are described below.

A note was added to 38 CFR 17.271 clarifying that eligibility criteria specific to dependency and indemnity are not applicable to CHAMPVA eligibility determinations.

Consistent with CHAMPUS/TRICARE policy, wheelchair lifts were removed as an excluded benefit from § 17.272(a).

Consistent with CHAMPUS/TRICARE policy, the exception to excluded coverage of shoes and inserts in § 17.272(a)(45) was modified to include medically necessary therapeutic shoes and inserts for diabetics as a covered benefit.

Preauthorization for durable medical equipment detailed in § 17.273(a)(5) was clarified to note that the requirement is applicable to rentals and purchases.

For clarification, § 17.274, Cost Sharing, was modified from ''With the exception of services obtained directly from VA medical facilities * * *'' to ''With the exception of services obtained directly through VA medical facilities* * *'' This modification was made to clarify that cost-sharing is not required for services that are provided by VA, whether directly, through sharing agreements or through services provided by the VA's Consolidated Mail Outpatient Pharmacy. In these cases the services are an extension of VA services although a physical examination within the VA may not occur.

The proposed regulations provided that if there were disagreement with a

determination concerning covered services or calculation of benefits, a request for reconsideration may be submitted within one year of the initial determination. If there continues to be disagreement with the reconsideration decision, a request for written review may be made to the Center Director within 30 days. The final rule has been changed from allowing 30 days to submit the request for review to the Center Director to 90 days. This action provides consistency in the reconsideration procedures between CHAMPVA and other VA health benefit programs for dependents.

In addition to the above modifications, three Public Laws were enacted which impact the proposed regulations. As noted earlier, under the provisions of 38 U.S.C. 1713, the CHAMPVA program is to provide the same/similar benefits as those provided under CHAMPUS. The Public Laws expand available benefits under CHAMPUS/TRICARE. Accordingly, we are making these same changes to the CHAMPVA regulations.

Public Law 103–322, section 230202, effective September 13, 1994, states that, notwithstanding any other law, if a Federal program or Federally financed State or local program would otherwise pay benefits which are also available under an eligible crime victim compensation plan, (1) such crime compensation program must not pay that compensation; and (2) the other program must make its payments without regard to the existence of the crime victim compensation program. This provision, therefore, mandates that CHAMPVA assume primary payer status to State Victims of Crime Compensation Programs. As a result, the final rule at § 17.272(a)(3) has been modified to indicate that CHAMPVA is the primary payer when benefits are also available through the State Victims of Crime Compensation Program.

Public Law 103–337, section 705, enacted October 5, 1994, added voice prostheses to the benefits available under CHAMPUS/TRICARE. 38 U.S.C. 1713 requires that CHAMPVA benefits be subject to the same or similar limitations as medical care furnished to Department of Defense dependents through the CHAMPUS/TRICARE program. As a result, the regulations at § 17.272(a)(44) were modified to include voice prostheses as a covered benefit.

Public Law 104–106, section 701, enacted February 10, 1996, expands pediatric coverage under the CHAMPUS/TRICARE program. Previously, coverage for well-baby visits and immunizations was provided to children up to age two. With the enactment of the Public Law, this coverage was extended for children up to age six. As 38 U.S.C. 1713 requires that CHAMPVA benefits be subject to the same or similar limitations as medical benefits furnished to Department of Defense dependents through the CHAMPUS/TRICARE program, the regulations at § 17.272(a)(31)(i) were modified to provide for well child care up to age six.

This final rule has been reviewed by OMB under Executive Order 12866.

The Secretary hereby certifies that this final rule will 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. These amendments would not cause significant economic impact on healthcare providers, suppliers, or entities since only a small portion of their business concerns CHAMPVA beneficiaries. The final rule would mostly impact individuals who are VA beneficiaries. Pursuant to 5 U.S.C. 605(b), these amendments are exempt from the initial and final regulatory flexibility analyses requirements of §§ 603 and 604.

The Catalog of Federal Domestic Assistance Program numbers are 64.009, 64.010, 64.011.

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, Grants programs—veterans, Health care, Health facilities, Health professions, Health records, Homeless, Medical and dental schools, Medical devices, Medical research, Mental health programs, Nursing home care, Philippines, Reporting and record-keeping requirements, Scholarships and fellowships, Travel and transportation expenses, Veterans.

Approved: May 8, 1998.

Togo D. West, Jr.,

Secretary.

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

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.

§ 17.84 [Removed]

2. Section 17.84 is removed.

3. A new center heading and §§ 17.270 through 17.278 are added to read as follows:

Civilian Health and Medical Program of the Department of Veterans Affairs (CHAMPVA)—Medical Care for Survivors and Dependents of Certain Veterans

Sec.

§ 17.270 General provisions.

(a) CHAMPVA is the Civilian Health and Medical Program of the Department of Veterans Affairs and is administered by the Health Administration Center, Denver, Colorado. Pursuant to 38 U.S.C. 1713, VA is authorized to provide medical care in the same or similar manner and subject to the same or similar limitations as medical care furnished to certain dependents and survivors of active duty and retired members of the Armed Forces. The CHAMPVA program is designed to accomplish this purpose. Under CHAMPVA, VA shares the cost of medically necessary services and supplies for eligible beneficiaries as set forth in §§ 17.271 through 17.278.

(b) For purposes of this section, the definitions of ''child,'' ''service-connected condition/disability,'' ''spouse,'' and ''surviving spouse'' must be those set forth further in 38 U.S.C. 101. The term ''fiscal'' year refers to October 1, through September 30.

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

§ 17.271 Eligibility.

(a) The following persons are eligible for CHAMPVA benefits provided that they are not eligible for CHAMPUS/TRICARE or Medicare Part A (except as noted in § 17.271).

(1) The spouse or child of a veteran who has been adjudicated by VA as having a permanent and total service-connected disability;

(2) The surviving spouse or child of a veteran who died as a result of an adjudicated service-connected condition(s); or who at the time of death was adjudicated permanently and totally disabled from a service-connected condition(s);

(3) The surviving spouse or child of a person who died on active military service and in the line of duty and not

due to such person's own misconduct; and

(4) An eligible child who is pursuing a full-time course of instruction approved under 38 U.S.C. Chapter 36, and who incurs a disabling illness or injury while pursuing such course (between terms, semesters or quarters; or during a vacation or holiday period) that is not the result of his or her own willful misconduct and that results in the inability to continue or resume the chosen program of education must remain eligible for medical care until:

(i) The end of the six-month period beginning on the date the disability is removed; or

(ii) The end of the two-year period beginning on the date of the onset of the disability; or

(iii) The twenty-third birthday of the child, whichever occurs first.

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

(b) Persons who lose eligibility for CHAMPVA by becoming potentially eligible for Medicare Part A as a result of reaching age 65 or who qualify for Medicare Part A benefits on the basis of a disability, including end stage renal disease, may re-establish CHAMPVA eligibility by submitting documentation from the Social Security Administration (SSA) certifying their non-entitlement to or exhaustion of Medicare Part A benefits. Persons under age 65 who are enrolled in both Medicare Part A and B may become potentially eligible for CHAMPVA as a secondary payer to Medicare. In cases where CHAMPVA eligibility is restored upon exhaustion of Medicare benefits, CHAMPVA coverage will extend even during subsequent periods of Medicare eligibility. When both CHAMPVA and Medicare eligibility exist, CHAMPVA must be the secondary payer.

(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.

§ 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 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 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.

(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.

(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 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 nonskilled 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.

(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)

§ 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 medical facilities, CHAMPVA is a cost-sharing program in which the cost of covered services is shared with the beneficiary. 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 for inpatient services. CHAMPVA pays the CHAMPVA-determined allowable amount less the deductible, if applicable, and less the beneficiary cost share. To provide financial protection against the impact of a long-term illness or injury, an annual cost limit or ''catastrophic cap'' has been placed on the beneficiary cost-share amount for covered services and supplies. This annual cap on cost sharing is $7,500 per CHAMPVA-eligible family. 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 noncovered services are not credited to the catastrophic cap computation.

(b) If the CHAMPVA benefit payment is under $1.00, payment will not be issued. Catastrophic cap and deductible will, however, be credited.

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

§ 17.275 Claim filing deadline.

(a) Unless an exception is granted under paragraph (b) of this section, claims for medical services and supplies must be filed with the Center no later than:

(1) One year after the date of service; or

(2) In the case of inpatient care, one year after the date of discharge; or

(3) In the case of retroactive approval for medical services/supplies, 180 days following beneficiary notification of authorization; or

(4) In the case of retroactive approval of CHAMPVA eligibility, 180 days following notification to the beneficiary of authorization for services occurring on or after the date of first eligibility.

(b) Requests for an exception to the claim filing deadline must be submitted, in writing, to the Center and include a complete explanation of the circumstances resulting in late filing along with all available supporting documentation. Each request for an exception to the claim filing deadline will be reviewed individually and considered on its own merit. The Center Director may grant exceptions to the requirements in paragraph (a) if he or she determines that there was good cause for missing the filing deadline. For example, when dual coverage exists CHAMPVA payment, if any, cannot be determined until after the primary insurance carrier has adjudicated the claim. In such circumstances an exception may be granted provided that the delay on the part of the primary insurance carrier is not attributable to the beneficiary. Delays due to provider billing procedures do not constitute a valid basis for an exception.

§ 17.276 Appeal/review process.

Notice of the initial determination regarding payment of CHAMPVA benefits will be provided to the beneficiary on a CHAMPVA Explanation of Benefits (EOB) form. The EOB form is generated by the CHAMPVA automated payment processing system. If a beneficiary disagrees with the determination concerning covered services or calculation of benefits, he or she may request reconsideration. Such requests must be submitted to the Center in writing within one year of the date of the initial determination. The request must state why the beneficiary believes the decision is in error and must include any new and relevant information not previously considered. Any request for reconsideration that does not identify the reason for dispute will be returned to the claimant without further consideration. After reviewing the claim and any relevant supporting documentation, a CHAMPVA benefits advisor will issue a written determination to the beneficiary that affirms, reverses or modifies the previous decision. If the beneficiary is still dissatisfied, within 90 days of the date of the decision he or she may make a written request for review by the Center Director. The Director will review the claim, and any relevant supporting documentation, and issue a decision in writing that affirms, reverses or modifies the previous decision. The decision of the Director with respect to benefit coverage and computation of benefits is final.

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

Note to § 17.276: Denial of CHAMPVA benefits based on legal eligibility requirements may be appealed to the Board of Veterans' Appeals in accordance with 38 CFR part 20. Medical determinations are not appealable to the Board. 20 CFR 20.101.

§ 17.277 Third-party liability/Medicare cost recovery.

The Center will actively pursue third-party liability/medical care cost recovery in accordance with applicable law.

§ 17.278 Confidentiality of records.

Confidentiality of records will be maintained in accordance with 38 CFR 1.460 through 1.582.

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ENVIRONMENTAL PROTECTION AGENCY

40 CFR Part 52

[NM 22–1–7103a; FRL–6152–4]

Approval and Promulgation of Implementation Plan for New Mexico: General Conformity Rules

AGENCY: Environmental Protection Agency (EPA).

ACTION: Final rule.

SUMMARY: This action conditionally approves a revision to the New Mexico State Implementation Plan (SIP) that contains regulations for implementing and enforcing the general conformity rules which the EPA promulgated on November 30, 1993 (58 FR 63214). Specifically, the general conformity rules enable the New Mexico Environment Department to review conformity of all Federal actions (*See* 40 CFR part 51, subpart W—Determining Conformity of General Federal Actions to State or Federal Implementation Plans) with the control strategy SIPs