This document is scheduled to be published in the
Federal Register on 12/03/2013 and available online at
http://federalregister.gov/a/2013-28858, and on **FDsys.gov**

DEPARTMENT OF VETERANS AFFAIRS 8320-01

38 CFR Part 17

RIN 2900-A021

Criteria for a Catastrophically Disabled Determination for Purposes of Enrollment

AGENCIES: Department of Veterans Affairs.

ACTION: Final rule.

SUMMARY: The Department of Veterans Affairs (VA) is amending its regulation concerning the manner in which VA determines that a veteran is catastrophically disabled for purposes of enrollment in priority group 4 for VA health care. As amended by this rulemaking, the regulation articulates the clinical criteria that identify an individual as catastrophically disabled, instead of using the corresponding International Classification of Diseases, Ninth Revision, Clinical Modification (ICD–9–CM) and Current Procedural Terminology (CPT®) codes. The revisions ensure that the regulation is not out of date when new versions of those codes are published. The revisions also broaden some of the descriptions for a finding of catastrophic disability. Additionally, the final rule does not rely on the Folstein Mini Mental State Examination (MMSE) as a criterion for determining whether a veteran meets the definition of catastrophically disabled, because we have determined that the MMSE is no longer a necessary clinical assessment tool.

DATES: Effective Date: This rule is effective July 1, 2014.

FOR FURTHER INFORMATION CONTACT: Rajiv Jain, MD, Assistant Deputy Under Secretary for Health for Patient Care Services (10P4), Veterans Health Administration, Department of Veterans Affairs, 810 Vermont Avenue NW., Washington, DC 20420, (202) 461–7800. (This is not a toll-free number.)

SUPPLEMENTARY INFORMATION: Pursuant to 38 U.S.C. 1705, VA established eight enrollment categories (in order of priority) for veterans eligible to enroll in VA's health care system. Under 38 CFR 17.36(b)(4), ''veterans who are determined to be catastrophically disabled'' are to be enrolled in enrollment priority group 4. For enrollment purposes, § 17.36(e) defines ''catastrophically disabled'' and, prior to this final rulemaking, § 17.36(e)(1) identified the covered conditions for catastrophically disabled in part by assignment of particular tabular diagnosis codes from Volume 1 of the ICD–9–CM, associated supplementary codes (V Codes), tabular procedure codes from Volume 3 of ICD–9–CM, and procedure codes from the CPT®. (CPT is a trademark of the American Medical Association. CPT codes and descriptions are copyrighted by the American Medical Association. All rights reserved.) This approach will soon be outdated; the ICD–9–CM and CPT® will no longer be used for disease and inpatient procedure coding after October 1, 2014, when they will be replaced by updated tabular diagnosis and supplementary codes from the International Classification of Diseases, Tenth Revision, Clinical Modification (ICD–10–CM) and by procedure codes from the International Classification of Diseases, Tenth Revision, Procedure Coding System (ICD–10–PCS). For this reason, and because these codes are subject to regular update and revision in the future, we published on February 22,

2013 (78 FR 12264), a proposed rule to rely on the clinical and diagnostic information that formed the basis for the codes listed in the regulation, rather than relying on the codes by number. We also proposed to eliminate the MMSE as a criterion for determining whether a veteran meets the definition of catastrophically disabled. The use of the MMSE is redundant of the Katz scale, the Global Assessment of Functioning, and the Functional Independence Measure, which are referred to in the current regulation as tools to measure an individual's ability to carry out the Activities of Daily Living. We provided a 60-day comment period, which ended on April 23, 2013. We received 2 comments from members of the general public.

One commenter was generally in support of the rulemaking. The commenter had one concern regarding the "criteria by which an amputee may be able to attain Priority Group 4 benefits." Specifically, the commenter was concerned with amputation, detachment, or reamputation of the forearm at or through the radius and ulna. The commenter stated that this amendment narrows the definition of catastrophically disabled instead of the intended purpose of the proposed rulemaking, which was to broaden the criteria. The commenter further stated: "Specificity of injury narrows the range of those that can claim benefits, but the differen[ce] between a veteran having a catastrophic injury because some part of his forearm has been amputated versus an amputation that occurred between the radius and ulna seems to impose an arbitrary restriction." Also, the commenter stated that "[i]f a veteran's hand were crushed, for example, it is disabled in the same way an amputated hand would be. However, under these precise definitions, he would be denied coverage under Priority Group 4."

VA considers a veteran to be catastrophically disabled if the veteran has a condition resulting from two of the procedures listed in § 17.36(e)(1)(i) through (e)(1)(xvi). The amputation, detachment, or reamputation of the veteran's forearm at or through the radius and the ulna does not by itself render a veteran catastrophically disabled. However, if a veteran's forearm was amputated, detached, or reamputated at any point, VA would consider this condition as one of the veteran's qualifying conditions for a determination of catastrophically disabled. VA does not limit this definition to one specific point in the forearm as the commenter suggests. The commenter also stated that if the veteran had a crushed hand this would be the same as amputation. Depending on the severity of the crushed hand a clinician would determine whether the injury would meet a criterion under paragraph (e)(1). Only a clinician may determine if a veteran is catastrophically disabled based on the veteran's disabilities. We are not making any changes based on this commenter's concerns.

Another commenter was also partially in agreement with the proposed rule. The commenter was concerned, however, that by eliminating the need to update ICD codes VA would not have a mechanism in place to update the way VA determines that a veteran is catastrophically disabled. The elimination of the ICD–9–CM and CPT® codes does not mean that if the classification of conditions that render a veteran catastrophically disabled were to change in the future, VA would not amend its regulations to conform with this change. On the contrary, VA will continue to comply

with the national and international standards of care and provide veterans with the most up-to-date health care.

The commenter further stated that not relying on the numbered codes will cause physicians to use a greater level of discretion when determining who is considered to be catastrophically disabled. The commenter indicated that while there are terminological clarifications for blindness, such clarifications do not exist for persistent vegetative state, "which seems like it would be equally open to a variety of understandings by different physicians across the country." Although the proposed rule did not provide "terminological clarifications" for persistent vegetative state, this condition has a medical definition. A vegetative state is present when the body preserves the ability to maintain blood pressure, respiration, and cardiac function, but not cognitive function. Kenneth Maiese, MD, "Vegetative State and Minimally Conscious State," http://www.merckmanuals.com/professional/neurologic_disorders/coma_and_impaired_consciousness/vegetative_state_and_minimally_conscious_state.html?qt=persistent%20vegitative%20state&alt=sh (last updated Nov. 2012). A vegetative state is considered persistent if it lasts more than 1 month. Id. Persistent vegetative state is a term of art that is recognized in the medical community and requires no further clarifiers. Also, clinicians must always exercise clinical judgment in the context of a shared vocabulary, and, even when assigning a particular code, there will be discretion and occasional deviation within expected and accepted medical limits.

The commenter was also concerned that the proposed rule stated that there were no costs or savings associated with the rulemaking. The commenter indicated that the number of veterans who would be considered catastrophically disabled would increase in the coming years as veterans return from the war in Iraq and Afghanistan. VA acknowledges that the number of catastrophically disabled veterans may increase as veterans and servicemembers return from combat areas. By stating in the proposed rulemaking that there would be no costs or savings associated with the rulemaking, we meant that by amending § 17.36(e) VA would not incur additional costs in the diagnosis of a catastrophic disability by eliminating the ICD–9–CM and CPT® codes. We are not making any changes based on any of this commenter's concerns.

In order for the clinicians to properly codify a veteran as catastrophically disabled under the provisions of this rulemaking and for VA to properly codify a veteran in the correct enrollment category, VA must update its computer system. Because this computer update will not be in place until next year, we are delaying the applicability date of this rulemaking until July 1, 2014.

We are making a technical edit to § 17.36(e)(1)(vi) to remove an inadvertent duplication of the phrase "of the".

Based on the rationale set forth in the Supplementary Information to the proposed rule and in this final rule, VA is adopting the proposed rule as a final rule with one editorial change.

Effect of rulemaking

Title 38 of the Code of Federal Regulations, as revised by this final rulemaking, represents VA's implementation of its legal authority on this subject. Other than future amendments to this regulation or governing statutes, no contrary guidance or procedures are authorized. All existing or subsequent VA guidance must be read to conform with this rulemaking if possible or, if not possible, such guidance is superseded by this rulemaking.

Paperwork Reduction Act

This final rule contains no provisions constituting a collection of information under the Paperwork Reduction Act of 1995 (44 U.S.C. 3501-3521).

Regulatory Flexibility Act

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. This final rule will directly affect only individuals and will not directly affect small entities. Therefore, pursuant to 5 U.S.C. 605(b), this rulemaking is exempt from the initial and final regulatory flexibility analysis requirements of sections 603 and 604.

Executive Orders 12866 and 13563

Executive Orders 12866 and 13563 direct agencies to assess the costs and benefits of available regulatory alternatives and, when regulation is necessary, to select regulatory approaches that maximize net benefits (including potential economic, environmental, public health and safety effects, and other advantages; distributive impacts; and equity). Executive Order 13563 (Improving Regulation and Regulatory Review) emphasizes the importance of quantifying both costs and benefits, reducing costs, harmonizing rules, and promoting flexibility. Executive Order 12866 (Regulatory Planning and Review) defines a "significant regulatory action," which requires review by the Office of Management and Budget (OMB) unless OMB waives such review, as "any regulatory action that is likely to result in a rule that may: (1) Have an annual effect on the economy of $100 million or more or adversely affect in a material way the economy, a sector of the economy, productivity, competition, jobs, the environment, public health or safety, or State, local, or tribal governments or communities; (2) Create a serious inconsistency or otherwise interfere with an action taken or planned by another agency; (3) Materially alter the budgetary impact of entitlements, grants, user fees, or loan programs or the rights and obligations of recipients thereof; or (4) Raise novel legal or policy issues arising out of legal mandates, the President's priorities, or the principles set forth in this Executive Order."

The economic, interagency, budgetary, legal, and policy implications of this regulatory action have been examined, and it has been determined not to be a significant regulatory action under Executive Order 12866. VA's impact analysis can be found as a supporting document at http://www.regulations.gov, usually within 48 hours after the rulemaking document is published. Additionally, a copy of the rulemaking and

its impact analysis are available on VA's Web site at http://www1.va.gov/orpm/, by following the link for "VA Regulations Published."

Unfunded Mandates

The Unfunded Mandates Reform Act of 1995 requires, at 2 U.S.C. 1532, that agencies prepare an assessment of anticipated costs and benefits before issuing any rule that may result in the expenditure by State, local, and tribal governments, in the aggregate, or by the private sector, of $100 million or more (adjusted annually for inflation) in any given year. This final rule will have no such effect on State, local, and tribal governments, or on the private sector.

Catalog of Federal Domestic Assistance Numbers

The Catalog of Federal Domestic Assistance numbers and titles for the programs affected by this document are 64.007, Blind Rehabilitation Centers; 64.008, Veterans Domiciliary Care; 64.009, Veterans Medical Care Benefits; 64.010, Veterans Nursing Home Care; 64.011, Veterans Dental Care; 64.012, Veterans Prescription Service; 64.013, Veterans Prosthetic Appliances; 64.014, Veterans State Domiciliary Care; 64.015, Veterans State Nursing Home Care; 64.018, Sharing Specialized Medical Resources; 64.019, Veterans Rehabilitation Alcohol and Drug Dependence; and 64.022, Veterans Home Based Primary Care.

Signing Authority

The Secretary of Veterans Affairs, or designee, approved this document and authorized the undersigned to sign and submit the document to the Office of the Federal Register for publication electronically as an official document of the Department of Veterans Affairs. Jose D. Riojas, Chief of Staff, Department of Veterans Affairs, approved this document on October 31, 2013, for publication.

List of Subjects in 38 CFR Part 17

Administrative practice and procedure, Alcohol abuse, Alcoholism, Day care, Dental health, Drug abuse, Health care, Health facilities, Health professions, Health records, Homeless, Medical and dental schools, Medical devices, Medical research, Mental health programs, Nursing homes, Veterans.

Dated: November 27, 2013

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Robert C. McFetridge, Director,
Regulation Policy and Management,
Office of the General Counsel,
Department of Veterans Affairs.

For the reasons set forth in the preamble, the Department of Veterans Affairs amends 38 CFR part 17 as follows:

PART 17 – MEDICAL

1. The authority citation for part 17 continues to read as follows:

AUTHORITY: 38 U.S.C. 501, and as noted in specific sections.

2. Amend § 17.36 as follows:

a. Revise paragraph (e)(1).

b. Remove paragraph (e)(2)(ii).

c. Redesignate paragraphs (e)(2)(iii) and (iv) as new paragraphs (e)(2)(ii) and (iii), respectively.

The revisions read as follows:

§ 17.36 Enrollment—provision of hospital and outpatient care to veterans.

* * * * *

(e) * * *

(1) Quadriplegia and quadriparesis; paraplegia; legal blindness defined as visual impairment of 20/200 or less visual acuity in the better seeing eye with corrective lenses, or a visual field restriction of 20 degrees or less in the better seeing eye with corrective lenses; persistent vegetative state; or a condition resulting from two of the following procedures, provided the two procedures were not on the same limb:

(i) Amputation, detachment, or reamputation of or through the hand;

(ii) Disarticulation, detachment, or reamputation of or through the wrist;

(iii) Amputation, detachment, or reamputation of the forearm at or through the radius and ulna;

(iv) Amputation, detachment, or disarticulation of the forearm at or through the elbow;

(v) Amputation, detachment, or reamputation of the arm at or through the humerus;

(vi) Disarticulation or detachment of the arm at or through the shoulder;

(vii) Interthoracoscapular (forequarter) amputation or detachment;

(viii) Amputation, detachment, or reamputation of the leg at or through the tibia and fibula;

(ix) Amputation or detachment of or through the great toe;

(x) Amputation or detachment of or through the foot;

(xi) Disarticulation or detachment of the foot at or through the ankle;

(xii) Amputation or detachment of the foot at or through malleoli of the tibia and fibula;

(xiii) Amputation or detachment of the lower leg at or through the knee;

(xiv) Amputation, detachment, or reamputation of the leg at or through the femur;

(xv) Disarticulation or detachment of the leg at or through the hip; and

(xvi) Interpelviaabdominal (hindquarter) amputation or detachment.

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[FR Doc. 2013-28858 Filed 12/02/2013 at 8:45 am; Publication Date: 12/03/2013]