

Proposed Rules

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This section of the FEDERAL REGISTER contains notices to the public of the proposed issuance of rules and regulations. The purpose of these notices is to give interested persons an opportunity to participate in the rule making prior to the adoption of the final rules.

DEPARTMENT OF VETERANS AFFAIRS

38 CFR Part 17

RIN 2900-AM35

Reasonable Charges for Medical Care or Services

AGENCY: Department of Veterans Affairs.

ACTION: Proposed rule.

SUMMARY: This document proposes to amend the Department of Veterans Affairs (VA) medical regulations concerning "reasonable charges" for medical care or services provided or furnished by VA to certain veterans for nonservice-connected disabilities. We propose to change the process for determining interim billing charges when a new Diagnosis Related Group (DRG) code or Current Procedure Terminology/Healthcare Common Procedure Coding System (CPT/HCPCS) code identifier is assigned to a particular type or item of medical care or service and VA has not yet established a charge for the new identifier. This process is designed to provide interim billing charges that are very close to what the new billing charges would be when the charges for the new identifiers are established in accordance with the regulations. We also propose to change the regulations by removing all of the provisions for discounts of billed charges. This is expected to reduce or eliminate duplicate discounting and thereby prevent unintended underpayments to the government.

DATES: Comments must be received on or before March 15, 2007.

ADDRESSES: Written comments may be submitted by: Mail or hand delivery to Director, Regulations Management (OOREG1), Department of Veterans Affairs, 810 Vermont Ave., NW., Room 1068, Washington, DC 20420; fax to (202) 273-9026; e-mail through <http://www.Regulations.gov>. Comments should indicate that they are submitted in response to "RIN 2900-AM35." All

comments received will be available for public inspection in the Office of Regulation Policy and Management, Room 1063B, between the hours of 8 a.m. and 4:30 p.m., Monday through Friday (except holidays). Please call (202) 273-9515 for an appointment.

FOR FURTHER INFORMATION CONTACT:

Romona Greene, Manager of Rates and Charges, VHA 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: This document proposes to amend VA's medical regulations that were established under the authority of 38 U.S.C. 1729 and are set forth in 38 CFR 17.101 (referred to below as the regulations). The regulations establish methodologies for determining reasonable charges for medical care or services provided or furnished by VA to certain veterans.

Under the provisions of 38 U.S.C. 1729, VA has the right to recover or collect reasonable charges for such medical care and services from a third party to the extent that the veteran or a provider of the care or services would be eligible to receive payment for:

- A nonservice-connected disability for which the veteran is entitled to care (or the payment of expenses of care) under a health plan contract,
- A nonservice-connected disability incurred incident to the veteran's employment and covered under a worker's compensation law or plan that provides reimbursement or indemnification for such care and services, or
- A nonservice-connected disability incurred as a result of a motor vehicle accident in a State that requires automobile accident reparations (no-fault) insurance.

However, consistent with the statutory authority at 38 U.S.C. 1729(c)(2)(B), a third-party payer liable for such medical care and services under a health plan contract has the option of paying, to the extent of its coverage, either the billed charges or the amount the third-party payer demonstrates it would pay for care or services furnished by providers other than entities of the United States for the same care or services in the same geographic area.

Except for charges for prescription drugs, the regulations were promulgated to contain methodologies to establish VA charges that replicate, insofar as possible, the 80th percentile of community charges (see 68 FR 56876). VA's methodologies to determine reasonable charges for prescription drugs are based on VA costs and contained in 38 CFR 17.102.

Charges When a New DRG or CPT/HCPCS Code Identifier Does Not Have an Established Charge

The methodology for certain charges is based on adjustments to average charges developed from a national data base for DRG codes and CPT/HCPCS codes. The current regulations at § 17.101(a)(8) provide for the development of charges when VA does not have an established charge for a new DRG or CPT/HCPCS code. We propose to revise § 17.101(a)(8) to make it more clear and accurate. The proposed changes are explained below.

The current regulations at § 17.101(a)(8), provide that when VA does not have an established charge for new DRG codes or CPT/HCPCS, then a charge would be developed by using the first option out of the five specified options for which a charge could be determined. Accordingly, if an applicable charge could be determined under the first option then that would be used without considering any other option. If a charge could not be determined under the first option but could be determined under the second option then the second option would be used, and so on.

We do not propose to change the substance of the first two options which would continue to be set forth at § 17.101(a)(8)(i) and (ii) (they are included in the text portion of this document with nonsubstantive changes for purposes of clarity). We also do not propose to change the substance of the last option (it would be moved from § 17.101(a)(8)(v) to § 17.101(a)(8)(viii) and is included in the text portion of this document with nonsubstantive changes for purposes of clarity).

The proposed third option would continue to be located at § 17.101(a)(8)(iii). It concerns prosthetic devices and durable equipment. Under the current regulations for this option, VA's charges for prosthetic devices and durable equipment reflect the actual cost to VA. We propose to change this

option to provide that the charge would be 1 and 1/2 times VA's actual cost. As noted above, the regulations were intended to contain methodologies to establish VA charges that replicate, insofar as possible, the 80th percentile of community charges. However, billing charges under the current third option fall short of this mark. Based on our expertise and experience with charging trend analyses, we have concluded that these proposed changes would provide interim billing charges that would be as close as possible to what the new billing charges will be when the charges for the new identifiers are established in accordance with the regulations.

Under the current regulations involving the fourth option, VA's charges for care or services consist of the Medicare participating provider allowed charge amount (if one could be determined), geographically adjusted using the applicable geographic area adjustment factors that are described in the regulations. We propose to change this option to consist of four different parts, two for new identifier DRG codes and two for new identifier CPT/HCPCS codes, as stated in the text portion of this document at § 17.101(a)(8)(iv) through (vii). Based on our expertise and experience with charging trend analyses, we have concluded that these proposed changes would provide interim billing charges that would be as close as possible to what the new billing charges will be when the charges for the new identifiers are established in accordance with the regulations.

Discounts

The current regulations at § 17.101(e)(5), (f)(4), (f)(5)(ii), and (g) include provisions to discount billing and thereby reflect industry standards. As explained below, we are proposing to change the regulations to discontinue applying discounts for billed charges by removing all of the provisions in the regulations that provide for such discounts.

The current regulations at § 17.101(e)(5) provide discounts when multiple surgical procedures were performed during the same outpatient encounter by a provider or provider team as indicated by multiple surgical CPT/HCPCS procedure codes. Under these provisions, the surgical procedure with the highest facility charge under the CPT/HCPCS procedure code is billed at 100 percent of the charges established under the regulations, the second highest at 25 percent, the third highest at 15 percent, and the rest at no charge.

The current regulations at § 17.101(f)(4) set forth a mechanism to

establish discount factors for specified charge-significant CPT/HCPCS code modifiers. Under this authority, discounts are based on multipliers as follows:

- 51—Multiplier procedures 0.94,
- 52—Reduced services 0.70,
- 53—Discontinued procedure 0.97,
- 62—Two surgeons 0.92, and
- 80—Assistant surgeon 0.31.

The current regulations at § 17.101(f)(5)(ii) set forth discounts for charges for the professional services of certain providers. In this regard, the regulations provide that the charges for care would be the indicated percentages of the amount that would be charged if the care had been provided by a physician:

- Nurse practitioner: 85 percent.
- Clinical nurse specialist: 85 percent.
- Physician Assistant: 85 percent.
- Clinical psychologist: 80 percent.
- Clinical social worker: 75 percent.
- Dietitian: 75 percent.
- Clinical pharmacist: 80 percent.

The current regulations at § 17.101(g) provide for a 50 percent discount of the charges for professional anesthesia services provided by medically directed certified registered nurse anesthetists.

All of the discounts explained above, which are the same discounts that apply to billing under the Medicare program, reflect industry practices for billing. This is the same rationale described in the **Federal Register** for establishing paragraphs (f)(4), and (f)(5)(ii) (see 63 FR 54758). However, after the discounts are applied to the billed charges, virtually all third party payers apply the same discounts a second time (discounts are included in industry software), thereby reducing the billed charges below what was intended by the regulations. We believe that the duplicate discounting would cause unintended underpayments to the government of approximately \$24 million annually. Accordingly, to eliminate duplicate discounting and to help ensure that the regulations work as intended, we propose to remove all of the provisions in the regulations that provide for such discounts. These amendments would not affect discounts applied by third party payers under industry billing practices.

Comment Period

We are providing a 30-day comment period instead of a 60-day comment period. We wish to consider any relevant comments prior to taking any regulatory action. However, subject to consideration of comments, it appears that it is necessary to take expeditious action on the proposed rule. As noted

above, the regulations were promulgated to contain methodologies to establish VA charges that replicate, insofar as possible, the 80th percentile of community charges. The proposed changes regarding interim charges based on new DRG code or CPT/HCPCS code identifiers are intended to make the interim charges as close as possible to what the new billing charges will be when the charges for the new identifiers are established in accordance with the regulations, and, consequently, to make the interim charges as close as possible to the 80th percentile of community charges. With respect to the proposed changes regarding discounts, it is necessary to take expeditious action to prevent unintended underpayments to the government. Under the current regulations discounts are applied by VA to the billed charges. However, inconsistent with the intent of the regulations, virtually all third party payers apply the same discounts a second time (discounts are included in industry software), thereby reducing the billed charges below what was intended by the regulations.

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 an 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 proposed rule would have no such effect on State, local, and tribal governments, or on the private sector.

Paperwork Reduction Act

This document contains no collections of information under the Paperwork Reduction Act (44 U.S.C. 3501–3521).

Executive Order 12866

Executive Order 12866 directs agencies to assess all 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, and other advantages; distributive impacts; and equity). The Order classifies a rule as a significant regulatory action requiring review by the Office of Management and Budget if it meets any one of a number of specified conditions, including: Having an annual effect on the economy of \$100 million or more, creating a serious inconsistency or interfering with an

action of another agency, materially altering the budgetary impact of entitlements or the rights of entitlement recipients, or raising novel legal or policy issues. VA has examined the economic, legal, and policy implications of this proposed rule and has concluded that it is a significant regulatory action under Executive Order 12866.

Regulatory Flexibility Act

The Secretary hereby certifies that this proposed 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 proposed rule would affect mainly large insurance companies. The proposed rule might have an insignificant impact on a few small entities that do an inconsequential amount of their business with VA. Accordingly, pursuant to 5 U.S.C. 605(b), this proposed rule is exempt from the initial and final regulatory flexibility analysis requirements of sections 603 and 604.

Catalog of Federal Domestic Assistance Numbers

The Catalog of Federal Domestic Assistance numbers and titles for the programs affected by this document are 64.005, Grants to States for Construction of State Home Facilities; 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; 64.016, Veterans State Hospital Care; 64.018, Sharing Specialized Medical Resources; 64.019, Veterans Rehabilitation Alcohol and Drug Dependence; 64.022, Veterans Home Based Primary Care.

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, Grant programs—veterans, Health care, Health facilities, Health professions, Health records, Homeless, Medical and dental schools, Medical devices, Medical research, Mental health programs, Nursing homes, Philippines, Reporting and recordkeeping requirements, Scholarships and fellowships, Travel and transportation expenses, Veterans.

Approved: November 3, 2006.

Gordon H. Mansfield,

Deputy Secretary of Veterans Affairs.

Editorial Note: This document was received at the Office of the Federal Register on February 7, 2007.

For the reasons set out in the preamble, VA proposes to amend 38 CFR part 17 as set forth below:

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.

2. Section 17.101, paragraph (g) introductory text is amended by removing “50 percent” and adding in its place “100 percent”; and by revising paragraphs (a)(8), (e)(5), (f)(4), and (f)(5)(ii) to read as follows:

§ 17.101 Collection or recovery by VA for medical care or services provided or furnished to a veteran for a nonservice-connected disability.

(a) * * *

(8) *Charges when a new DRG or CPT/HCPSC code identifier does not have an established charge.* When VA does not have an established charge for a new DRG or CPT/HCPSC code to be used in determining a billing charge under the applicable methodology in this section, then VA will establish an interim billing charge or establish an interim charge to be used for determining a billing charge under the applicable methodology in paragraphs (a)(8)(i) through (a)(8)(viii) of this section.

(i) If a new DRG or CPT/HCPSC code identifier replaces a DRG or CPT/HCPSC code identifier, the most recently established charge for the identifier being replaced will continue to be used for determining a billable charge under paragraphs (b), (e), (f), (g), (h), (i), (k), or (l) of this section until such time as VA establishes a charge for the new identifier.

(ii) If medical care or service is provided or furnished at VA expense by a non-VA provider and a charge cannot be established under paragraph (a)(8)(i) of this section, then VA’s billing charge for such care or service will be the amount VA paid to the non-VA provider without additional calculations under this section.

(iii) If a new CPT/HCPSC code has been established for a prosthetic device or durable medical equipment subject to paragraph (l) of this section and a charge cannot be established under paragraphs (a)(8)(i) or (ii) of this section, VA’s charge for such prosthetic device or durable medical equipment will be 1

and ½ times VA’s average actual cost without additional calculations under this section.

(iv) If a new medical identifier DRG code has been assigned to a particular type of medical care or service and a charge cannot be established under paragraphs (a)(8)(i) through (iii) of this section, then until such time as VA establishes a charge for the new medical identifier DRG code, the interim charge for use in paragraph (b) of this section will be the average charge of all medical DRG codes that are within plus or minus 10 of the numerical relative weight assigned to the new medical identifier DRG code.

(v) If a new surgical identifier DRG code has been assigned to a particular type of medical care or service and a charge cannot be established under paragraphs (a)(8)(i) through (iv) of this section, then until such time as VA establishes a charge for the new surgical identifier DRG code, the interim charge for use in paragraph (b) of this section will be the average charge of all surgical DRG codes that are within plus or minus 10 of the numerical relative weight assigned to the new surgical identifier DRG code.

(vi) If a new identifier CPT/HCPSC code is assigned to a particular type or item of medical care or service and a charge cannot be established under paragraphs (a)(8)(i) through (v) of this section, then until such time as VA establishes a charge for the new identifier for use in paragraphs (e), (f), (g), (h), (i), (k), or (l) of this section, VA’s billing charge will be the Medicare allowable charge multiplied by 1 and ½, without additional calculations under this section.

(vii) If a new identifier CPT/HCPSC code is assigned to a particular type or item of medical care or service and a charge cannot be established under paragraphs (a)(8)(i) through (vi) of this section, then until such time as VA establishes a charge for the new identifier, VA’s interim charge for use in paragraphs (e), (f), (g), (h), (i), (k), or (l) of this section, will be the charge for the CPT/HCPSC code that is closest in characteristics to the new CPT/HCPSC code.

(viii) If a charge cannot be established under paragraphs (a)(8)(i) through (a)(8)(vii) of this section, then VA will not charge for the care or service.

* * * * *

(e) * * *

(5) Multiple surgical procedures. When multiple surgical procedures are performed during the same outpatient encounter by a provider or provider team as indicated by multiple surgical

CPT/HCPCS procedure codes, then each CPT/HCPCS procedure code will be billed at 100 percent of the charges established under this section.

(f) * * *

(4) *Charge adjustment factors for specified CPT/HCPCS code modifiers.* Surcharges are calculated in the following manner: From the Part B component of the Medicare Standard Analytical File 5 percent Sample, the ratio of weighted average billed charges for CPT/HCPCS codes with the specified modifier to the weighted average billed charge for CPT/HCPCS codes with no charge modifier is calculated, using the frequency of procedure codes with the modifier as weights in both weighted average calculations. The resulting ratios constitute the surcharge factors for specified charge-significant CPT/HCPCS code modifiers.

(5) * * *

(ii) *Charges for professional services.* Charges for the professional services of the following providers will be 100 percent of the amount that would be charged if the care had been provided by a physician:

- (A) Nurse practitioner.
- (B) Clinical nurse specialist.
- (C) Physician Assistant.
- (D) Clinical psychologist.
- (E) Clinical social worker.
- (F) Dietitian.
- (G) Clinical pharmacist.

* * * * *

[FR Doc. E7-2391 Filed 2-12-07; 8:45 am]

BILLING CODE 8320-01-P

DEPARTMENT OF THE INTERIOR

Fish and Wildlife Service

50 CFR Part 17

Endangered and Threatened Wildlife and Plants; 90-Day Finding on a Petition To List the Jollyville Plateau Salamander as Endangered

AGENCY: Fish and Wildlife Service, Interior.

ACTION: Notice of 90-day petition finding and initiation of status review.

SUMMARY: We, the U.S. Fish and Wildlife Service (Service), announce a 90-day finding on a petition to list the Jollyville Plateau salamander (*Eurycea tonkawae*) as endangered under the Endangered Species Act of 1973, as amended (Act). We find that the petition presents substantial scientific or commercial information indicating that listing the Jollyville Plateau salamander may be warranted. Therefore, with the publication of this notice, we are

initiating a status review to determine if listing the species is warranted. To ensure that the status review of the Jollyville Plateau salamander is comprehensive, we are soliciting information and data regarding this species.

DATES: The finding announced in this document was made on February 13, 2007. To be considered in the 12-month finding for this petition, comments and information should be submitted to us by April 16, 2007.

ADDRESSES: The complete supporting file for this finding is available for public inspection, by appointment, during normal business hours at the Austin Ecological Services Field Office, U.S. Fish and Wildlife Service, 10711 Burnet Road, Suite 200, Austin, TX 78758 or via electronic mail at <http://www.fws.gov/southwest/es/Library/>. The petition is available at <http://www.fws.gov/southwest/es/Library/>. Submit new information, materials, comments, or questions concerning this petition and our finding to the above address.

FOR FURTHER INFORMATION CONTACT: Robert Pine, Field Supervisor, Austin Ecological Services Field Office (see **ADDRESSES** section) (telephone 512/490-0057; facsimile 512/490-0974). Persons who use a telecommunications device for the deaf (TDD) may call the Federal Information Relay Service (FIRS) at 800-877-8339.

SUPPLEMENTARY INFORMATION:

Public Information Solicited

When we make a finding that substantial information is presented to indicate that listing a species may be warranted, we are required to promptly commence a review of the status of the species. To ensure that the status review is complete and based on the best available scientific and commercial information, we are soliciting information on the Jollyville Plateau salamander. We request any additional information, comments, and suggestions from the public, other concerned governmental agencies, Tribes, the scientific community, industry, or any other interested parties concerning the status of the Jollyville Plateau salamander. We are seeking information regarding the species' historical and current status and distribution, its biology and ecology, ongoing conservation measures for the species and its habitat, and threats to the species and its habitat.

We will base our 12-month finding on a review of the best scientific and commercial information available, including all information received

during the public comment period. If you wish to comment or provide information, you may submit your comments and materials concerning this finding to the Field Supervisor, Austin Ecological Services Field Office (see **ADDRESSES** section). Please note that comments merely stating support or opposition to the actions under consideration without providing supporting information, although noted, will not be considered in making a determination, as section 4(b)(1)(A) of the Act directs that determinations as to whether any species is a threatened or endangered species shall be made "solely on the basis of the best scientific and commercial data available." At the conclusion of the status review, we will issue the 12-month finding on the petition, as provided in section 4(b)(3)(B) of the Act.

Our practice is to make comments, including names and home addresses of respondents, available for public review during normal business hours. Individual respondents may request that we withhold their names and home addresses, etc., but if you wish us to consider withholding this information, you must state this prominently at the beginning of your comments. In addition, you must present rationale for withholding this information. This rationale must demonstrate that disclosure would constitute a clearly unwarranted invasion of privacy. Unsupported assertions will not meet this burden. In the absence of exceptional, documentable circumstances, this information will be released. We will always make submissions from organizations or businesses, and from individuals identifying themselves as representatives of or officials of organizations or businesses, available for public inspection in their entirety.

Background

Section 4(b)(3)(A) of the Endangered Species Act of 1973, as amended (16 U.S.C. 1531 *et seq.*), requires that we make a finding on whether a petition to list, delist, or reclassify a species presents substantial scientific or commercial information to indicate that the petitioned action may be warranted. We base this finding on information provided in the petition, supporting information submitted with the petition, and information otherwise available in our files at the time we make the determination. To the maximum extent practicable, we make this finding within 90 days of receipt of the petition, and publish our notice of this finding promptly in the **Federal Register**.