DEPARTMENT OF VETERANS AFFAIRS

38 CFR Part 17

RIN 2900–AL57

Reasonable Charges for Medical Care or Services; 2003 Update

AGENCY: Department of Veterans Affairs.

ACTION: Interim final rule.

SUMMARY: This document amends the Department of Veterans Affairs (VA) medical regulations concerning ''reasonable charges'' for medical care or services provided or furnished by VA to a veteran:

—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;

—For 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

—For a nonservice-connected disability incurred as a result of a motor vehicle accident in a State that requires automobile accident reparations insurance.

The regulations contain a methodology designed to establish VA charges that replicate, insofar as possible, the 80th percentile of community charges, adjusted to the market areas in which VA facilities are located, and trended forward to the time period during which the charges will be used. This document amends the regulations to update databases and other provisions for the purpose of providing more current and more precise charges.

DATES: *Effective Date:* These amendments are effective April 29, 2003. Comments must be submitted by June 30, 2003.

ADDRESSES: Mail or hand-deliver written comments to: Director, Office of Regulations Management (02D), Department of Veterans Affairs, 810 Vermont Avenue, NW., Room 1154, Washington, DC 20420; or fax comments to (202) 273–9289; or e-mail comments to *OGCRegulations@mail.va.gov.* Comments should indicate that they are submitted in response to ''RIN 2900-AL57.'' All comments received will be available for public inspection in the Office of Regulations Management, Room 1158, between the hours of 8 a.m. and 4:30 p.m., Monday through Friday (except holidays).

FOR FURTHER INFORMATION CONTACT: David Cleaver, Chief Business Office (161), 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 amends VA's medical regulations that are set forth in 38 CFR part 17. More specifically, we are amending the regulations that establish a methodology for determining ''reasonable charges'' for medical care or services provided or furnished by VA to a veteran:

(i) 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;

(ii) For 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

(iii) For a nonservice-connected disability incurred as a result of a motor vehicle accident in a State that requires automobile accident reparations insurance.

The methodology for establishing ''reasonable charges'' covers inpatient facility charges, skilled nursing facility/sub-acute inpatient facility charges, outpatient facility charges, physician charges, and other provider charges. The methodology for these charges is designed to replicate, insofar as possible, the 80th percentile of community charges, adjusted to the market areas in which VA facilities are located, and trended forward to the time period during which the charges will be used. Charges for outpatient dental care and prescription drugs are based on a reasonable cost methodology, while charges for prosthetic devices and durable medical equipment are based on VA's actual cost.

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 therefore from that third party if the care or services had been furnished by a provider other than a department or agency of the United States. However, consistent with that statutory authority, 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.

This document amends VA's reasonable charges regulations to provide charges for 2002 Current Procedural Terminology (CPT) codes, to provide charges for 2002 and 2003 Diagnosis Related Groups (DRGs), to update source databases to more recent versions, and to provide certain clarifications. These changes will not have a significant impact on any affected party, but will make VA's charge system more current and more precise.

Acute Inpatient Facility Charges

Previously, the regulations provided for ''inpatient facility charges.'' We are changing the term ''inpatient facility charges'' to ''acute inpatient facility charges.'' This change reflects that acute inpatient facility charges do not include sub-acute inpatient facility charges. Sub-acute inpatient facility charges are included in the charges for skilled nursing facility/sub-acute inpatient facility care.

Definitions—Additions and Clarifications

This document adds definitions for MDR (Medical Data Research) and MedPAR (Medicare Provider Analysis and Review file). We are amending the definition of CPT procedure code to identify the American Medical Association as the entity that defines CPT procedure codes, and we are amending the definition of geographic area to specify acute inpatient facility charges.

Updated Databases and Associated Changes

Our previous charges were implemented with an interim final rule and notice published in the **Federal Register** on May 8, 2001 (66 FR 23326). The acute inpatient facility charges in that update were based on the Medicare DRG grouper in effect in 2001. This document updates our charges to be based on the current Medicare DRG grouper. With this change, our acute inpatient facility charges will be based on current industry-standard DRGs.

In the formulas for acute inpatient facility charges, we have updated the Medicare MedPAR database from the 1999 release to the 2001 release, which allows us to readily calculate acute inpatient facility charges for the newest DRG grouper. We have also updated the MedStat claims database from 1997 data

to 1999 data, and 1997 VA discharge data to 2001 data. We did not update databases related to geographic area adjustment factors and 80th percentile factors; in both cases, our experience indicates that updating these databases would not produce a material difference in charge levels.

The regulations regarding ''reasonable charges'' identify various charge databases utilized for the calculation of skilled nursing facility/sub-acute inpatient facility charges. This document updates the data source for per diem charges to the 2003 Milliman USA, Inc., Health Cost Guidelines. With this change, the regulations will have the latest available estimate of average billed charges for skilled nursing facility/sub-acute inpatient facility services. We do not update the data source for geographic area adjustment factors, as the Milliman USA, Inc., Health Cost Guidelines do not provide for a 2003 release of this particular data source. Also, we do not update databases related to 80th percentile factors; as with acute inpatient facility charges, our experience indicates that updating these databases would not produce a material difference in charge levels.

The regulations identify various charge databases utilized for the calculation of outpatient facility charges. At this time, we are preparing a more thorough update of these charges, to be based on Medicare Ambulatory Payment Classifications. Therefore, this interim final rule provides a trended update to charges published in 2001, without updating the basic underlying data sources.

The regulations identify various charge databases utilized for the calculation of professional charges. This document utilizes the latest appropriate versions of the various databases available to us at the time of calculation. In particular, we have relied on 2002 Medicare Physician Fee Schedule Relative Value Units (RVU) and geographic practice cost indices, 2002 Medicare Clinical Diagnostic Laboratory Fee Schedule, 2001 Medicare conversion factor, 2002 St. Anthony's Resource Based RelativeValue Scale RVUs, 2001 MDR database, 2000 Medicare Standard Analytical File 5% Sample database, 2001 Prevailing Healthcare Charges System database, and 2001 Milliman USA, Inc., Health Cost Guidelines fee survey. Note that due to corporate changes, the MDR database previously owned by MediCode is now owned by Ingenix; we previously referred to it as the MediCode database, but due to its change of ownership, we refer to it in this document by its more specific designation of MDR database. Also note that the database previously compiled by the Health Insurance Association of America (HIAA) was sold by HIAA to Ingenix, who renamed it the Prevailing Healthcare Charges System database; it is a continuation of the same database under a new owner and new name.

In accordance with the methodology in the regulations, acute inpatient facility charges, outpatient facility charges, and physician charges are updated based on changes to the consumer price index. Under this methodology, charges are trended to the midpoint of the calendar year in which the charges will be effective.

All of the above changes made by this document are for the purpose of providing more current and more precise charges.

In addition to the above changes, dates have been added to various data sources for purposes of clarification.

Previous Interim Final Rules and Responses to Comments

This document supersedes two previous interim final rules, one published in the **Federal Register** on November 2, 2000 (65 FR 65906, RIN 2900–AK39), and the other published in the **Federal Register** on May 8, 2001 (66 FR 23326, RIN 2900–AK73). We received no comments in response to the November 2, 2000, document. We received two comments in response to the May 8, 2001, document. These comments are discussed below.

One commenter stated that the terms ''speech therapy'' and ''speech therapists'' should be changed to ''speech-language pathology'' and ''speech-language pathologists,'' respectively. We agree, and we have made these changes in this interim final rule.

The same commenter also stated that we should add charges for codes G0193 through G0201 (these are HCPCS Level II codes). In addition, the commenter stated that we have identified audiology services furnished in conjunction with a hearing aid, CPT codes 92590 through 92595, as physician services, when in fact these services are performed solely by audiologists and should not be designated as physician services. We are developing a proposed rule to address these issues.

The second commenter submitted information regarding the work of certified registered nurse anesthetists (CRNAs) and recommended changes to the wording regarding VA's charges for the services of CRNAs. Section 17.101(f) states the amounts that will be charged for certain providers as percentages of the amounts that will be charged if the services had been provided by physicians. Previously, the wording for CRNAs was as follows:

Certified registered nurse anesthetist:
50% when physician supervised;
100% when not physician supervised.

For clarity, we are amending the wording to the following:

Certified registered nurse anesthetist:
50% when medically directed by an anesthesiologist;
100% when not medically directed by an anesthesiologist.

Other Changes and Clarifications

The regulations make two references to charges for prescription drugs, but the previous language in these paragraphs was different: § 17.101(a)(2) stated that these charges ''will be a single nationwide average,'' while § 17.101(g) stated that these charges ''will be based on VA costs in accordance with the methodology set forth in § 17.102 of this part.'' For consistency, the language in paragraph (a)(2) is being amended to read the same as in paragraph (g).

The methodology at § 17.101(e)(2) for the calculation of Relative Value Units (RVUs) for physician charges establishes a priority of data sources for RVUs. Except as noted earlier regarding updated data sources, we are not amending this methodology, but rather than listing information regarding specific CPT procedure codes in the regulations, we are including this information in the applicable **Federal Register** notice when the results of these calculations are released.

Administrative Procedure Act

This document amends the reasonable charges regulations to update databases and other provisions for the purpose of providing more precise charges. Although some charges will be slightly different, overall these changes would at most result in a very minor change in VA charges. Under these circumstances, we have concluded under 5 U.S.C. 553 that there is good cause for dispensing with prior notice and comment and a delayed effective date based on the conclusion that such procedure is impracticable, unnecessary, and contrary to the public interest.

Unfunded Mandates

The Unfunded Mandates Reform Act requires, at 2 U.S.C. 1532, that agencies prepare an assessment of anticipated costs and benefits before developing any rule that may result in an expenditure by State, local, or tribal governments, in the aggregate, or by the private sector of $100 million or more in any given year.

This rule would have no consequential effect on State, local, or tribal governments.

Paperwork Reduction Act

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

Executive Order 12866

This document has been reviewed by the Office of Management and Budget under Executive Order 12866.

Regulatory Flexibility Act

The Secretary hereby certifies that this regulatory amendment 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 amendment would affect mainly large insurance companies, and where small entities are involved, they would not be impacted significantly since most of their business is not with VA. Accordingly, pursuant to 5 U.S.C. 605(b), this amendment 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 for the programs affected by this rule are 64.005, 64.007, 64.008, 64.009, 64.010, 64.011, 64.012, 64.013, 64.014, 64.015, 64.016, 64.018, 64.019, 64.022, and 64.025.

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 record-keeping requirements, Scholarships and fellowships, Travel and transportation expenses, Veterans.

Approved: March 20, 2003.

Anthony J. Principi,

Secretary of Veterans Affairs.

■ For the reasons set out in the preamble, 38 CFR part 17 is amended 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 is revised 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)(1) *General.* This section covers collection or recovery by VA, under 38 U.S.C. 1729, for medical care or services provided or furnished to a veteran:

(i) 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;

(ii) For 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

(iii) For a nonservice-connected disability incurred as a result of a motor vehicle accident in a State that requires automobile accident reparations insurance.

(2) *Methodology.* Based on the methodology set forth in this section, the charges billed will include, as appropriate, acute inpatient facility charges, skilled nursing facility/sub-acute inpatient facility charges, outpatient facility charges, physician charges, and non-physician provider charges. In addition, the charges billed for prosthetic devices and durable medical equipment provided on an outpatient basis will be VA's actual cost, and the charges billed for prescription drugs not administered during treatment will be based on VA costs in accordance with the methodology set forth in § 17.102. Data for calculating actual amounts for acute inpatient facility charges, skilled nursing facility/sub-acute inpatient facility charges, outpatient facility charges, and physician charges will be published annually in the ''Notices'' section of the **Federal Register**. In those cases in which the effective period for published charges has expired and new charges have not yet become effective, VA will continue to bill using the most recently published charges until new charges are published and become effective (for example, if the most recently published charges state that they are effective through December and new charges are not published and effective until February 1, then the charges set forth for the period through December will continue to be used through January 31).

(3) *Amount of recovery or collection—third party liability.* A third-party payer liable under a health plan contract has the option of paying either the billed charges described in this section or the amount the health plan demonstrates is the amount 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. If the amount submitted by the health plan for payment is less than the amount billed, VA will accept the submission as payment, subject to verification at VA's discretion in accordance with this section. A VA employee having responsibility for collection of such charges may request that the third party health plan submit evidence or information to substantiate the appropriateness of the payment amount (*e.g.*, health plan or insurance policies, provider agreements, medical evidence, proof of payment to other providers in the same geographic area for the same care and services VA provided).

(4) *Definitions.* For purposes of this section:

Consolidated MSA means a consolidated Metropolitan Statistical Area.

CPI means Consumer Price Index.

CPI–U means Consumer Price Index—All Urban Consumers.

CPI–W means Consumer Price Index—Urban Wage Earners and Clerical Workers.

CPT procedure code means Current Procedural Terminology code, a five-digit identifier defined by the American Medical Association for a specified physician service or procedure.

DRG means Diagnosis Related Group.

Geographic area, for purposes of acute inpatient facility and skilled nursing facility/sub-acute inpatient facility charges, means Metropolitan Statistical Area (MSA) or the local market, if the VA facility is not located in an MSA; and for outpatient facility charges and physician charges, means a three-digit ZIP Code locality.

MDR means Medical Data Research, a medical charge database published by Ingenix Publishing Group.

MedPAR means the Medicare Provider Analysis and Review file.

RVU means Relative Value Unit.

(b) *Acute inpatient facility charges.* When VA provides or furnishes acute inpatient services within the scope of care referred to in paragraph (a)(1) of this section, acute inpatient facility charges billed for such services will be determined in accordance with the provisions of this paragraph. Acute inpatient facility charges consist of per diem charges for room and board and for ancillary services that vary by VA

facility and by DRG. These charges are calculated as follows:

(1) *Formula.* For each acute inpatient stay, or portion thereof, for which a particular DRG assignment applies, multiply the nationwide room and board per diem charge as set forth in paragraph (b)(2) of this section by the appropriate geographic area adjustment factor as set forth in paragraph (b)(3) of this section. The result constitutes the facility-specific room and board per diem charge. Also, for each inpatient stay, multiply the nationwide ancillary per diem charge as set forth in paragraph (b)(2) of this section by the appropriate geographic area adjustment factor as set forth in paragraph (b)(3) of this section. The result constitutes the facility-specific ancillary per diem charge. Then add the facility-specific room and board per diem charge to the facility-specific ancillary per diem charge. This constitutes the facility-specific combined per diem facility charge. Finally, multiply the facility-specific combined per diem facility charge by the number of days of inpatient care to obtain the total acute inpatient facility charge.

Note to paragraph (b)(1): If there is a change in a patient's condition and/or treatment during a single acute inpatient stay such that the DRG assignment changes (for example, a psychiatric patient who develops a medical or surgical problem), then the calculations will be made separately for each DRG, according to the number of days of care applicable for each DRG, and the total acute inpatient facility charge will be the sum of the total acute inpatient facility charges for the different DRGs.

(2) *Per diem charges.* To establish a baseline, two nationwide average per diem charges for each DRG are calculated, one from the 2001 Medicare MedPAR file and one from the 1999 MedStat claims database, a database of nationwide commercial insurance claims (available from the MedStat Group, 777 E. Eisenhower Parkway, Ann Arbor, MI 48108). Because these two data sources report charges for two differing periods of time, the MedStat claims database was trended forward to the center date of the MedPAR data based on changes to the Inpatient Hospital component of the CPI–U. Results obtained from these two databases are then combined into a single weighted average per diem charge for each DRG. The resulting weighted average per diem charge for each DRG is then separated into its two components, a room and board component and an ancillary component, with the amount for each component calculated to reflect the corresponding percentage set forth in paragraph (b)(2)(i) of this section. The resulting amounts for room and board and ancillary services for each DRG are then each multiplied by the final ratio set forth in paragraph (b)(2)(ii) of this section to reflect the 80th percentile charges. Finally, the resulting charges are each trended forward to the effective time period for the charges, as set forth in paragraph (b)(2)(iii) of this section. The results constitute the room and board per diem charge and the ancillary per diem charge.

(i) *Charge component percentages.* Using only those cases from the MedPAR file for which a distinction between room and board charges and ancillary charges can be determined, the percentage of the total charges for room and board compared to the combined total charges for room and board and ancillary services, and the percentage of the total charges for ancillary services compared to the combined total charges for room and board and ancillary services, are calculated by DRG.

(ii) *80th percentile.* Using the medical and surgical admissions in the 1995 Medicare Standard Analytical File 5% Sample, the ratio of the day-weighted 80th percentile semi-private room and board per diem charge to the average semi-private room and board per diem charge is obtained for each consolidated MSA. The consolidated MSA ratios are averaged to obtain a final 80th percentile ratio.

(iii) *Trending forward.* 80th percentile charges for each DRG, representing charge levels described in paragraph (b)(2) of this section, are trended forward based on changes to the hospital inpatient component of the CPI-U. Actual CPI-U changes are used through the latest available month for room/board and ancillary charges. Trends from the latest available month to the midpoint of the calendar year in which charges become effective are based on the latest three-month average annual trend rate from the Inpatient Hospital component of the CPI–U. The projected total CPI trend is then applied to the 80th percentile charges.

(3) *Geographic area adjustment factors.* For each VA facility location, the average per diem room and board charges and ancillary charges from the 1995 Medicare Standard Analytical File 5% Sample are calculated for each DRG. The DRGs are separated into two groups, surgical and non-surgical. For each of these groups of DRGs, for each geographic area, average room and board per diem charges and ancillary per diem charges are calculated for 1995, weighted by FY 2001 nationwide VA discharges and by average lengths of stay from the combined Medicare Standard Analytical File 5% Sample and the MedStat claims database. This results in four average per diem charges for each geographic area: room and board for surgical DRGs, ancillary for surgical DRGs, room and board for non-surgical DRGs, and ancillary for non-surgical DRGs. Four corresponding national average per diem charges are obtained from the 1995 Medicare Standard Analytical File 5% Sample, weighted by FY 2001 nationwide VA discharges and by average lengths of stay from the combined Medicare Standard Analytical File 5% Sample and the MedStat claims database. Four geographic area adjustment factors are then calculated for each geographic area by dividing each geographic area average per diem charge by the corresponding national average per diem charge.

(c) *Skilled nursing facility/sub-acute inpatient facility charges.* When VA provides or furnishes skilled nursing/sub-acute inpatient services within the scope of care referred to in paragraph (a)(1) of this section, skilled nursing facility/sub-acute inpatient facility charges billed for such services will be determined in accordance with the provisions of this paragraph. The skilled nursing facility/sub-acute inpatient facility charges are per diem charges that vary by VA facility. The facility charges cover care, including skilled rehabilitation services (*e.g.*, physical therapy, occupational therapy, and speech-language pathology), that is provided in a nursing home or hospital inpatient setting, is provided under a physician's orders, and is performed by or under the general supervision of professional personnel such as registered nurses, licensed practical nurses, physical therapists, occupational therapists, speech-language pathologists, and audiologists. The skilled nursing facility/sub-acute inpatient facility charges also incorporate charges for ancillary services associated with care provided in these settings. The charges are calculated as follows:

(1) *Formula.* For each stay, multiply the nationwide per diem charge as set forth in paragraph (c)(2) of this section by the appropriate geographic area adjustment factor as set forth in paragraph (c)(3) of this section. The result constitutes the facility-specific per diem charge. Finally, multiply the facility-specific per diem charge by the number of days of care to obtain the total skilled nursing facility/sub-acute inpatient facility charge.

(2) *Per diem charge.* To establish a baseline, a nationwide average per diem billed charge for July 1, 2003, was

obtained from the 2003 Milliman USA, Inc., Health Cost Guidelines, a publication that includes nationwide skilled nursing facility charges (Milliman USA, Inc., 1301 5th Avenue, Suite 3800, Seattle, WA 98101–2605). That average per diem billed charge is then multiplied by the 80th percentile adjustment factor set forth in paragraph (c)(2)(i) of this section to obtain a nationwide 80th percentile charge level. Finally, the resulting charge is trended forward to the effective time period for the charges, as set forth in paragraph (c)(2)(ii) of this section.

(i) *80th percentile.* Using the 1995 Medicare Standard Analytical File 5% Sample, the median per diem accommodation charge is calculated for each provider. For each State, the ratio of the 80th percentile of provider median charges to the average statewide charges for accommodations is calculated. The State ratios are averaged to produce a nationwide 80th percentile adjustment factor.

(ii) *Trending forward.* The 80th percentile charge is trended forward to the midpoint of the calendar year in which the charges will be effective, based on the projected change in Medicare reimbursement from the Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds (this report can be found on the Internet site of the Centers for Medicare & Medicaid Services (CMS) at *http://www.cms.gov/publications/trusteesreport*).

(3) *Geographic area adjustment factors.* A ratio of the average per diem charge for each State to the nationwide average per diem charge is obtained (these ratios are set forth in the 2002 Milliman USA, Inc., Health Cost Guidelines, a database of nationwide commercial insurance charges and relative costs) (Milliman USA, Inc., 1301 5th Avenue, Suite 3800, Seattle, WA 98101–2605). The geographic area adjustment factor for charges for each VA facility is the ratio for the State in which the facility is located.

(d) *Outpatient facility charges.* When VA provides or furnishes outpatient facility services that are within the scope of care referred to in paragraph (a)(1) of this section and are not customarily performed in an independent clinician's office, the outpatient facility charges billed for such services will be determined in accordance with the provisions of this paragraph. This consists of outpatient facility charges for procedures, tests, and evaluation and management services, including the subset of evaluation and management codes which are designated as ''Office or Other Outpatient Services'' when those evaluation and management services are provided in the outpatient department of a hospital. Except for prosthetic devices and durable medical equipment, whose charges will be made separately at actual cost to VA, charges for outpatient facility services will vary by VA facility and by CPT procedure code. These charges will be calculated as follows:

(1) *Formula.* For each outpatient facility charge CPT procedure code, multiply the nationwide charge as set forth in paragraph (d)(2) of this section by the appropriate geographic area adjustment factor as set forth in paragraph (d)(4) of this section. The result constitutes the facility-specific outpatient facility charge. When multiple surgical procedures are performed during the same outpatient encounter by a provider or provider team, the outpatient facility charges for such procedures will be reduced as set forth in paragraph (d)(5) of this section.

(2) *Nationwide 80th percentile charges by CPT procedure code.* For each CPT procedure code for which outpatient facility charges apply, the 1998 practice expense RVUs (these RVUs can be found in the 1998 St. Anthony's Complete RBRVS, available from Ingenix Publishing Group, 5225 Wiley Post Way, Salt Lake City, UT 84116) are used as the outpatient facility RVUs. For each CPT procedure code, the outpatient facility RVU is multiplied by the charge amount for each incremental RVU as set forth in paragraph (d)(3) of this section. The resulting charge is adjusted by a fixed charge amount as also set forth in paragraph (d)(3) of this section to obtain the nationwide 80th percentile charge.

(3) *Charge factors.* Using the 1997 MedStat claims database of nationwide commercial insurance (available from the MedStat Group, 777 E. Eisenhower Parkway, Ann Arbor, MI 48108), the median billed facility charge is calculated for each applicable CPT procedure code. All outpatient facility CPT procedure codes are then separated into one of the 45 outpatient facility CPT procedure code groups as set forth in paragraph (d)(3)(i) of this section. Then, for each CPT procedure code in each such group, the median charge is adjusted to the 80th percentile as set forth in paragraph (d)(3)(ii) of this section. The resulting 80th percentile charge for each CPT procedure code is trended forward to the effective time period for the charges as set forth in paragraph (d)(3)(iii) of this section. Using the resulting charges and the RVUs, mathematical approximation methodology based on least squares techniques are applied to the data for each CPT procedure code group to derive outpatient facility charges. For each CPT procedure code, the charge amount is calculated as an amount per incremental RVU and a fixed charge amount adjustment.

(i) *Outpatient facility CPT procedure code groups.*

(A)—Surgery—Integumentary System—Skin, Subcutaneous and Accessory Structures—Incision and Drainage, Excision-Debridement, Paring or Cutting, Biopsy, Removal of Skin Tags, Shaving of Epidermal or Dermal Lesions, and Surgery—Integumentary System—Nails;

(B) Surgery—Integumentary System—Skin, Subcutaneous & Accessory Structures—Excision-Benign Lesions, Excision-Malignant Lesions; and Surgery—Integumentary System—Nails—Introduction;

(C) Surgery—Integumentary System—Repair—Simple, Intermediate, Complex, Adjacent Tissue Transfer or Rearrangement;

(D) Surgery—Integumentary System—Repair—Free Skin Grafts, Flaps, Other Flaps and Grafts, Other Procedures, Pressure Ulcers;

(E) Surgery—Integumentary System—Repair—Burns, Local Treatment;

(F) Surgery—Integumentary System—Destruction;

(G) Surgery—Integumentary System—Breast;

(H) Surgery—Musculoskeletal System—All Body Regions—Incision, Excision, Introduction or Removal;

(I) Surgery—Musculoskeletal System—All Body Regions—Repair, Revision and/or Reconstruction, Arthrodesis, Manipulation, Amputation, Wound Exploration, Replantation, Grafts, Spinal Instrumentation;

(J) Surgery—Musculoskeletal System—All Body Regions—Fracture and/or Dislocation—Closed Treatments (Except for Head, Neck [Soft Tissues] and Thorax);

(K) Surgery—Musculoskeletal System—All Body Regions—Fracture and/or Dislocation—Open Treatments, and Surgery—Musculoskeletal System—Head, Neck (Soft Tissues) and Thorax—Fracture and/or Dislocation—Closed Treatments;

(L) Surgery—Musculoskeletal System—Application of Casts and Strapping;

(M) Surgery—Musculoskeletal System—Endoscopy/Arthroscopy;

(N) Surgery—Respiratory System;

(O) Surgery—Cardiovascular System;

(P) Surgery—Digestive System—All Body Regions—All procedures except Endoscopy;

(Q) Surgery—Digestive System—All Body Regions—Endoscopy;
(R) Surgery—Urinary System;
(S) Surgery—Male Genital System;
(T) Surgery—Female Genital System;
(U) Surgery—Maternity Care and Delivery—Antepartum Services;
(V) Surgery—Maternity Care and Delivery—Excision, Introduction, Repair, Vaginal Delivery, Antepartum and Postpartum Care, Cesarean Delivery, Delivery After Previous Cesarean Delivery, Abortion, Other Procedures;
(W) Surgery—Endocrine System, Nervous System;
(X) Surgery—Eye and Ocular Adnexa;
(Y) Surgery—Auditory System;
(Z) Radiology—Diagnostic—Head and Neck, Chest, Spine and Pelvis—All Except CAT Scans and Magnetic Resonance Imaging (MRI);
(AA) Radiology—Diagnostic—Upper Extremities, Lower Extremities, Abdomen, Gastrointestinal Tract, Urinary Tract, Gynecological and Obstetrical, Heart—All Except CAT Scans and Magnetic Resonance Imaging (MRI);
(BB) Radiology—Diagnostic—Aorta and Arteries, Veins and Lymphatics—All Except CAT Scans and Magnetic Resonance Imaging (MRI);
(CC) Radiology—Diagnostic Ultrasound;
(DD) Radiology—Radiation Oncology, Nuclear Medicine, Therapeutic;
(EE) Radiology—Diagnostic—CAT Scans in All Categories;
(FF) Radiology—Diagnostic—Magnetic Resonance Imaging (MRI) in All Categories;
(GG) Medicine—Vaccines, Toxoids;
(HH) Medicine—Therapeutic or Diagnostic Infusions (Excluding Chemotherapy), Therapeutic, Prophylactic, or Diagnostic Injections;
(II) Medicine—Psychiatry, Biofeedback;
(JJ) Medicine—Dialysis;
(KK) Medicine—Gastroenterology;
(LL) Medicine—Ophthalmology—Special Ophthalmological Services, and Medicine—Special Otorhinolaryngologic Services;
(MM) Medicine—Cardiovascular—Other Vascular Studies;
(NN) Medicine—Cardiovascular—Therapeutic Services, Echocardiography, Cardiac Catheterization, Intracardiac Electrophysiological Procedures, and Medicine—Non-Invasive Vascular Diagnostic Studies;
(OO) Medicine—Pulmonary;
(PP) Medicine—Neurology and Neuromuscular Procedures, Central Nervous System Assessments and Tests;
(QQ) Medicine—Chemotherapy Administration;
(RR) Medicine—Special Dermatological Procedures;
(SS) Medicine—Physical Medicine and Rehabilitation—Evaluation, Modalities; and Medicine—Photodynamic Therapy;
(TT) Medicine—Physical Medicine and Rehabilitation—Therapeutic Procedures, Tests and Measurements, Other Procedures, Medicine—Osteopathic Manipulative Treatment, Medicine—Chiropractic Manipulative Treatment, Medicine—Special Services, Procedures, and Reports, and Medicine—Other Services and Procedures;
(UU) Medicine—Evaluation & Management—Consultations;
(VV) Medicine—Evaluation & Management—Hospital Observation Services;
(WW) Medicine—Evaluation & Management—Emergency Department Services, Critical Care Services; and
(XX) Medicine—Evaluation & Management—Office or Other Outpatient Services, Prolonged Services, and Medicine—Ophthalmology—General Ophthalmological Services.

(ii) *80th percentile.* For each of the 45 outpatient facility CPT procedure code groups set forth in paragraph (d)(3)((i) of this section, the median charge is increased by the ratio of the 80th percentile charge to median charge obtained from the 1997 MedStat claims database. To mitigate the impact of the variation in the intensity of services by CPT procedure code, the percent increase from the median to the 80th percentile in outpatient charges is compared to the percent increase from the median to the 80th percentile in inpatient semi-private room and board charges. Any percent increase in outpatient charges in excess of the inpatient semi-private room and board percent increase is multiplied by a factor of 0.50. The 80th percentile outpatient facility charge is reduced accordingly.

(iii) *Trending forward.* The charges for each CPT procedure code, representing charge levels described in paragraph (d)(3) of this section, are trended forward to the midpoint of the calendar year in which the charges will be effective. The trend factors are based on changes to the Outpatient Hospital component of the CPI–U. Actual CPI–U changes are used through the latest available month. The three-month average annual trend rate as of the latest available month is held constant to the midpoint of the effective charge period. The projected total CPI–U change from the source data period to the effective period is then applied to the 80th percentile charges, as described in paragraph (d)(3) of this section.

(4) *Geographic area adjustment factors.* For each VA outpatient facility location, a single geographic area adjustment factor is calculated as the arithmetic average of the outpatient geographic area adjustment factor (this factor constitutes the ratio of the level of charges for each geographic area to the nationwide level of charges) published in the 2001 Milliman USA, Inc., Health Cost Guidelines (Milliman USA, Inc., 1301 5th Avenue, Suite 3800, Seattle, WA 98101–2605), and a geographic area adjustment factor developed from the 2000 MediCode data. The MediCode-based geographic area adjustment factors are calculated as the ratio of the CPT-weighted average charge level for each VA outpatient facility location to the nationwide CPT-weighted average charge level.

(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 procedure codes, then the CPT procedure code with the highest facility charge will be billed at 100% of the charges established under this section; the CPT procedure code with the second highest facility charge will be billed at 25% of the charges established under this section; the CPT procedure code with the third highest facility charge will be billed at 15% of the charges established under this section; and no outpatient facility charges will be billed for any additional surgical procedures.

(e) *Physician charges.* When VA provides or furnishes physician services within the scope of care referred to in paragraph (a)(1) of this section, physician charges billed for such services will be determined in accordance with the provisions of this paragraph. Physician charges consist of charges for professional services that vary by VA facility and by CPT procedure code. These charges are calculated as follows:

(1) *Formula.* For each CPT procedure code except those for anesthesia, multiply the total facility-adjusted RVU as set forth in paragraph (e)(2) of this section by the applicable facility-adjusted conversion factor (facility-adjusted conversion factors are expressed in monetary amounts) set forth in paragraph (e)(3) of this section to obtain the physician charge for each CPT procedure code at a particular VA facility. For each anesthesia CPT procedure code, multiply the nationwide physician charge as set forth in paragraph (e)(4) of this section by the geographic area adjustment factor as set

forth in paragraph (e)(3)(iii) of this section to obtain the physician charge for each anesthesia CPT procedure code at a particular VA facility.

(2)(i) *Total facility-adjusted RVUs for physician services other than anesthesia and specified CPT procedure codes.* The work expense and practice expense components of the RVUs for CPT procedure codes (other than anesthesia and those CPT procedure codes set forth in paragraphs (e)(2)(ii) through (e)(2)(iv) of this section) are compiled using 2002 Medicare RVUs. For radiology CPT procedure codes, these compilations do not include separately identified technical component RVUs. For CPT procedure codes that generate an outpatient facility charge, the facility practice expense RVUs are substituted for the non-facility practice expense RVUs. For medicine and surgery CPT procedure codes with separate professional and technical components that also generate an outpatient facility charge, only the professional component is compiled. The sum of the facility-adjusted work expense RVU as set forth in paragraph (e)(2)(i)(A) of this section and the facility-adjusted practice expense RVU as set forth in paragraph (e)(2)(i)(B) of this section equals the total facility-adjusted RVUs.

(A) *Facility-adjusted work expense RVUs.* For each CPT procedure code for each geographic area, the 2002 work expense RVU is multiplied by the work expense 2002 Medicare Geographic Practice Cost Index. The result constitutes the facility-adjusted work expense RVU.

(B) *Facility-adjusted practice expense RVUs.* For each CPT procedure code for each geographic area, the 2002 practice expense RVU is multiplied by the practice expense 2002 Medicare Geographic Practice Cost Index. The result constitutes the facility-adjusted practice expense RVU.

(ii) *RVUs for laboratory and pathology CPT procedure codes based on Medicare's Clinical Diagnostic Laboratory Fee Schedule.* For CPT procedure codes without modifiers that are not assigned separately identified work and practice expense RVUs in paragraph (e)(2)(i) of this section, laboratory fee RVUs are developed based on the 2002 edition of the Medicare Clinical Diagnostic Laboratory Fee Schedule (found in the files-for-download section of the Centers for Medicare & Medicaid Services (CMS) Internet site at *http://www.cms.gov/providers/pufdownload/*). The Medicare Clinical Diagnostic Laboratory Fee Schedule payment amounts are upwardly adjusted so that the payment levels are, on average, equivalent to Medicare Physician Fee Schedule payment levels, using statistical comparisons to the 80th percentile derived from the 2001 MDR charge database. These adjusted payment amounts are then divided by the 2001 Medicare conversion factor to derive a laboratory fee RVU corresponding to each CPT code. These RVUs are added to the 2002 work and practice expense RVUs for the corresponding professional component (if any) of a given CPT procedure code to derive nationwide total RVUs. The resulting nationwide total RVUs are multiplied by the geographic adjustment factors as set forth in paragraph (e)(2)(v) of this section to obtain the facility-specific total RVUs.

(iii) *RVUs for specified CPT procedure codes.* For CPT procedure codes without modifiers that are not assigned RVUs in (e)(2)(i) or (e)(2)(ii) of this section, total RVUs are developed based on various charge databases. For these CPT procedure codes, the nationwide 80th percentile billed charges are obtained, where statistically credible, from the 2001 MDR charge database (available from Ingenix Publishing Group, 5225 Wiley Post Way, Salt Lake City, UT 84116). Then for remaining CPT procedure codes, the nationwide 80th percentile billed charges are obtained, where statistically credible, from the 2000 Part B Medicare Standard Analytical File 5% Sample. For any remaining CPT procedure codes, the nationwide 80th percentile billed charges are obtained, where statistically credible, from the 2001 Prevailing Healthcare Charges System, a nationwide commercial insurance database compiled by Ingenix (Ingenix Publishing Group, 5225 Wiley Post Way, Salt Lake City, UT 84116). The nationwide 80th percentile billed charges so obtained are divided by the untrended nationwide conversion factor for the corresponding physician CPT procedure code group as set forth in paragraphs (e)(3) and (e)(3)(i) of this section. The resulting nationwide total RVUs are multiplied by the geographic adjustment factors as set forth in paragraph (e)(2)(v) of this section to obtain the facility-specific total RVUs.

(iv) *RVUs for specified CPT procedure codes.* For CPT procedure codes without modifiers that are not assigned RVUs in paragraphs (e)(2)(i), (e)(2)(ii), or (e)(2)(iii) of this section, the nationwide total RVUs are calculated by summing the work expense and practice expense RVUs found in the 2002 St. Anthony's RBRVS (available from Ingenix Publishing Group, 5225 Wiley Post Way, Salt Lake City, UT 84116). The resulting nationwide total RVUs are multiplied by the geographic adjustment factors as set forth in paragraph (e)(2)(v) of this section to obtain the facility-specific total RVUs.

(v) *RVU geographic area adjustment factors for specified CPT procedure codes.* The geographic area adjustment factor for each facility location consists of the weighted average of the 2002 work expense and practice expense Medicare Geographic Practice Cost Indices for each facility location using charge data for representative CPT procedure codes statistically selected and weighted for work expense and practice expense.

(3) *Facility-adjusted 80th percentile conversion factors.* CPT procedure codes are separated into the following 24 physician CPT procedure code groups: allergy immunotherapy, allergy testing, anesthesia, cardiovascular, chiropractor, consults, emergency room visits and observation care, hearing/speech exams, immunizations, inpatient visits, maternity/cesarean deliveries, maternity/non-deliveries, maternity/normal deliveries, miscellaneous medical, office/home urgent care visits, outpatient psychiatry/alcohol and drug abuse, pathology, physical exams, physical medicine, radiology, surgery, therapeutic injections, vision exams, and well baby exams. For each of the 24 physician CPT procedure code groups, representative CPT procedure codes were statistically selected and weighted so as to give a weighted average RVU comparable to the weighted average RVU of the entire physician CPT procedure code group (the selected CPT procedure codes are set forth in the 2001 Milliman USA, Inc., Health Cost Guidelines fee survey, available from Milliman USA, Inc., 1301 5th Avenue, Suite 3800, Seattle, WA 98101–2605). The 80th percentile charge for each selected CPT procedure code is obtained from the 2001 MDR charge database (available from Ingenix Publishing Group, 5225 Wiley Post Way, Suite 500, Salt Lake City, Utah 84116). A nationwide conversion factor (a monetary amount) is calculated for each physician CPT procedure code group as set forth in paragraph (e)(3)(i) of this section. The nationwide conversion factors for each of the 24 physician CPT procedure code groups are trended forward as set forth in paragraph (e)(3)(ii) of this section. The resulting amounts for each of the 24 groups are multiplied by geographic area adjustment factors as set forth in paragraph (e)(3)(iii) of this section, resulting in facility-adjusted 80th percentile conversion factors for each VA facility geographic area for the 24

physician CPT procedure code groups for the effective charge period.

(i) *Nationwide conversion factors.* Using the nationwide 80th percentile charges for the selected CPT procedure codes from paragraph (e)(3) of this section, a nationwide conversion factor is calculated for each of the 24 physician CPT procedure code groups by dividing the weighted average charge by the weighted average RVU. To correspond with the charge data, for medicine and surgery CPT procedure codes, the total RVUs are used even when separate professional and technical components are specified.

(ii) *Trending forward.* The nationwide conversion factor for each of the 24 physician CPT procedure code groups, representing charge levels described in paragraph (e)(3) of this section, are trended forward based on changes to the Physician component of the CPI–U. Actual CPI–U changes are used through the latest available month. The three-month average annual trend rate as of the latest available month is held constant to the midpoint of the calendar year in which charges will be effective. The projected total CPI–U change from the midpoint of the source data collection period to the midpoint of the effective charge period is then applied to the 24 conversion factors.

(iii) *Geographic area adjustment factors.* Using the 80th percentile charges for the selected CPT procedure codes from paragraph (e)(3) of this section for each VA facility geographic area, a geographic area-specific conversion factor is calculated for each of the 24 physician CPT procedure code groups by dividing the weighted average charge by the weighted average facility-adjusted RVU. The resulting geographic area conversion factor for each facility geographic area for each physician CPT procedure code group is divided by the corresponding nationwide conversion factor as set forth in paragraph (e)(3)(i). The resulting ratios are the geographic area adjustment factors for each of the 24 physician CPT procedure code groups for each facility geographic area.

(4) *Nationwide 80th percentile charges for anesthesia CPT procedure codes.* The nationwide charges are calculated by multiplying the RVUs as set forth in paragraph (e)(4)(i) of this section by the appropriate nationwide trended 80th percentile conversion factors as set forth in paragraph (e)(3) of this section.

(i) *RVUs for anesthesia.* The 2002 base unit value for each anesthesia CPT procedure code is compiled (the base unit values can be found in the 2002 St. Anthony's RBRVS, available from Ingenix Publishing Group, 5225 Wiley Post Way, Salt Lake City, UT 84116). The average time unit value for each anesthesia CPT procedure code is compiled from a Health Care Financing Administration study concerning average time unit values for anesthesia CPT procedure codes (these values can be obtained from the Chief Business Office (161), Veterans Health Administration, Department of Veterans Affairs, 810 Vermont Avenue, NW, Washington, DC 20420). For each anesthesia CPT procedure code introduced since the Health Care Financing Administration study, the time unit value is calculated as the average time unit value for all other anesthesia CPT procedure codes with the same base unit value. The sum of the anesthesia base unit value and the anesthesia average time unit value equals the total anesthesia RVUs.

(ii) [Reserved]

(f) *Other provider charges.* When the following providers provide or furnish VA care within the scope of care referred to in paragraph (a)(1) of this section, charges for that care covered by a CPT procedure code will be determined based on the following indicated percentages of the amount that would be charged if the care had been provided by a physician under paragraph (e) of this section:

(1) Nurse practitioner: 85%.

(2) Clinical nurse specialist: 85%.

(3) Physician Assistant: 85%.

(4) Certified registered nurse anesthetist: 50% when medically directed by an anesthesiologist; 100% when not medically directed by an anesthesiologist.

(5) Clinical psychologist: 80%.

(6) Clinical social worker: 75%.

(7) Podiatrist: 100%.

(8) Chiropractor: 100%.

(9) Dietitian: 75%.

(10) Clinical pharmacist: 80%.

(11) Optometrist: 100%.

(g) *Outpatient dental care and prescription drugs not administered during treatment.* Notwithstanding other provisions of this section, when VA provides or furnishes outpatient dental care or prescription drugs not administered during treatment, within the scope of care referred to in paragraph (a)(1) of this section, charges billed separately for such care will be based on VA costs in accordance with the methodology set forth in § 17.102 of this part.

(The Office of Management and Budget has approved the information collection requirements in this section under control number 2900–0606.)

(Authority: 38 U.S.C. 101, 501, 1701, 1705, 1710, 1721, 1722, 1729)

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