



# Federal Register

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**Thursday,  
October 2, 2003**

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## **Part II**

### **Department of Veterans Affairs**

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**38 CFR Part 17**

**Reasonable Charges for Medical Care or  
Services; 2003 Methodology Changes;  
Proposed Rule and Notice**

**DEPARTMENT OF VETERANS  
AFFAIRS**

**38 CFR Part 17**

**RIN 2900-AL06**

**Reasonable Charges for Medical Care  
or Services; 2003 Methodology  
Changes**

**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 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 methodologies 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 proposes to amend the regulations regarding VA's reasonable charges methodologies for the following purposes: to establish charges for medical care, procedures, services, durable medical equipment (DME), drugs, injectables, medical items, and supplies for which we currently do not have charges; to replace certain charges currently based on VA costs with charges based on community charges; to establish separate charges for medical care, procedures, services, DME, drugs, injectables, medical items, and supplies whose charges are presently combined with other charges; to bring our charge structures and associated billing practices closer to industry standard charge structures and billing practices; and to provide certain clarifications.

**DATES:** Comments must be received on or before November 3, 2003.

**ADDRESSES:** Mail or hand-deliver written comments to: Director,

Regulations Management (00REG1), Department of Veterans Affairs, 810 Vermont Avenue, NW, Room 1068, Washington, DC 20420; or fax comments to (202) 273-9026; or e-mail comments to [OGCRegulations@mail.va.gov](mailto:OGCRegulations@mail.va.gov).

Comments should indicate that they are submitted in response to "RIN 2900-AL06." All written comments received will be available for public inspection in the Office of Regulations 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:**

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

**SUPPLEMENTARY INFORMATION:** This document proposes to amend VA's medical regulations that are set forth in 38 CFR part 17. More specifically, we are proposing to amend the regulations that establish methodologies 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.

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 therefor 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.

The methodologies for establishing reasonable charges are 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. An exception is that charges for prescription drugs are based on VA costs in accordance with the methodology set forth in § 17.102.

This document proposes to amend VA's reasonable charges regulations to make significant changes to our charge development methodologies and charge structures, to provide charges for 2003 Current Procedural Terminology (CPT) codes, and to provide certain clarifications. These proposed changes are described in more detail in the following paragraphs.

**Data for Calculating Actual Charge Amounts**

As we have done in the past, we are publishing data for calculating actual charge amounts based on the methodologies set forth in this proposed rule in an accompanying notice in this same edition of the **Federal Register**. However, this document proposes that in the future this information will either be published in a notice in the **Federal Register** or will be posted on the Internet site of the Veterans Health Administration Chief Business Office at <http://www.va.gov/revenue>, under "Charge Data." We are proposing this change because we believe posting this information on the Internet will make it more readily available to the public, while at the same time greatly reducing the volume of information and associated taxpayer expense of publishing it in the **Federal Register**.

**Data Sources**

Presently, the regulations identify data sources used to calculate charges by name and edition (for example, 2001 Medicare MedPAR file). In addition, the regulations give specific information on where various databases can be obtained (for example, the Internet site where the Medicare Clinical Diagnostic Laboratory Fee Schedule can be found). This document proposes that data sources will hereafter be identified in these regulations only by name, and that the editions used and information on where these data sources may be obtained will be presented along with the data for calculating actual charge amounts, either in notices in the **Federal Register** or on the Internet site of the Veterans Health Administration Chief Business Office at <http://www.va.gov/revenue>,

under "Charge Data." We are proposing this change so that a change in the edition of a data source or in the information on where a database may be obtained will not, by itself, require any change to the regulations.

#### **Definitions—Additions, Changes, and Deletions**

This document proposes to add definitions for APC (Ambulatory Payment Classification), CMS (Centers for Medicare and Medicaid Services), DME, HCPCS (Healthcare Common Procedure Coding System) code, ICU (Intensive Care Unit), non-provider-based, provider-based, and RBRVS (Resource-Based Relative Value Scale). We are proposing to amend the definition of the term "CPT procedure code" to indicate that the same definition applies equally to the term "CPT code."

Presently, geographic area is defined, for acute inpatient facility charges and skilled nursing facility/sub-acute inpatient facility charges, as Metropolitan Statistical Area (MSA) or the local market, if the VA facility is not located in an MSA; and is defined, for outpatient facility charges and physician charges, as three-digit ZIP Code locality. We are proposing to amend the definition of geographic area to mean simply a three-digit ZIP Code area. This change reflects the fact that we are proposing to use three-digit ZIP Code areas as the geographic areas for all of our charge types. We are proposing this change for acute inpatient facility charges and skilled nursing facility/sub-acute inpatient facility charges because, due to the variability of charges within MSA and non-MSA areas, changing to three-digit ZIP Code areas will produce charges that are more accurate for the location in which the care was provided.

We are proposing to delete the definition for CPI-W (Consumer Price Index—Urban Wage Earners and Clerical Workers) because we have not used CPI-W information anywhere in the regulations, and have no plans to do so. We are also proposing to delete the separate definition for CPI (Consumer Price Index), because that term appears in the regulations only as part of the defined term CPI-U (Consumer Price Index—All Urban Consumers).

#### **Provider-Based and Non-Provider-Based Entities and Charges**

For a specific item of medical care or service provided on an outpatient basis, we may have a professional charge, or an outpatient facility charge, or both. Presently, for all outpatient services for which we have both a professional

charge and an outpatient facility charge, these charges are developed so as to be mutually exclusive, with the expectation that both charges will be billed for the same occasion of service. In addition, most of our outpatient facility charges are expected to be billed by all VA facilities that perform the applicable service, regardless of the type of facility. In other words, these charges are equally available to be billed by the outpatient departments of VA medical centers (VAMCs), by VA community-based outpatient clinics (CBOCs) operating similar to private-sector ambulatory surgery centers, by VA CBOCs operating like private-sector doctors' offices, etc. Presently, the only outpatient facility charges not available to be billed by all VA facilities are those for office or other outpatient evaluation and management (E&M) services CPT codes 99201 through 99215. Billing of the outpatient facility charges for the ten services covered by these codes is presently restricted to the outpatient departments of 169 VAMCs.

This document proposes to amend the regulations to provide that each VA healthcare entity will be designated as either provider-based (entitled to bill outpatient facility charges) or non-provider-based (not entitled to bill outpatient facility charges), based on CMS criteria for provider-based and non-provider-based entities. Further, application of the proposed methodologies presented in this document will provide two sets of charges for outpatient care, one set for use by provider-based entities and one for use by non-provider-based entities. For those outpatient services that have both a professional charge and an outpatient facility charge, the professional charge for use by provider-based entities will be lower, based on Medicare's lower facility practice expense Relative Value Units (RVUs), in consideration of the fact that both the professional charge and the outpatient facility charge will be billed. For the same services, the professional charge for use by non-provider-based entities will be higher, based on Medicare's higher non-facility practice expense RVUs, in consideration of the fact that only the professional charge will be billed. We are proposing these changes because they will result in VA charge structures and billing practices that more closely approximate industry standard charge structures and billing practices.

#### **Charges for Medical Care or Services Provided by Non-VA Providers at VA Expense**

Presently, the phrase in the regulations, "medical care or services provided or furnished by VA," is understood to include medical care or services provided by non-VA providers at VA expense, and the charges billed for such care are those determined according to this section. This document proposes to amend the regulations by adding language to confirm this understanding.

#### **Charges for Medical Care or Services for Which VA Does Not Have an Established Charge**

Presently, the regulations do not address the issue of charges for medical care or services for which VA does not have an established charge or does not specifically make other provision for charges. The result has been that VA has not been charging for such care or services. This document proposes to amend the regulations by adding language to provide for charges, under specified circumstances, when we do not have established charges.

Under the proposed change, when VA provides or furnishes medical care or services and VA does not have an established charge for such care or services, then the charges billed for such care or services will be determined according to the provisions of the proposed new paragraph (a)(8) of the regulations, which sets forth four criteria for establishing a charge and provides that, if none apply, then no charge will be made. We believe that these proposed changes provide a fair and reasonable basis for such charges. We are proposing these changes to provide appropriate charges, under these specified circumstances, where presently we have no charges.

#### **Unlisted and Unspecified Procedures, Services, and Supplies**

Both the American Medical Association and CMS, in compiling CPT and HCPCS Level II, respectively, recognize that there may be procedures, services, or supplies provided by physicians and other healthcare professionals which have not yet been defined. Accordingly, both CPT and HCPCS Level II provide specific codes for reporting unlisted and unspecified procedures, services, and supplies. Presently, the regulations do not provide charges for unlisted CPT codes or for any HCPCS Level II codes. This document proposes methodologies that will enable us to provide charges for unlisted and unspecified procedures,

services, and supplies. We are proposing this change so that we will be able to bill for these procedures, services, and supplies when we provide or furnish them to our patients, and so that our charge structures and billing practices will more closely approximate industry standard charge structures and billing practices.

#### Charge Types

Presently, the reasonable charges regulations set forth methodologies for four basic types of charges, as follows:

- Acute inpatient facility charges;
- Skilled nursing facility/sub-acute inpatient facility charges;
- Outpatient facility charges; and
- Physician charges.

Under the above organization of charge types, facility charges for observation care are included under outpatient facility charges, and charges for pathology/laboratory and anesthesia services are included under physician charges. This document proposes to amend the regulations to describe separate charge types for observation care, pathology/laboratory, and anesthesia.

Presently, we do not have partial hospitalization facility charges. This document proposes to amend the regulations to establish partial hospitalization facility charges.

Presently, we do not have separate charges for HCPCS Level II codes. This document proposes to amend the regulations to establish charges for HCPCS Level II codes.

Presently, our charges for prosthetic devices and DME provided on an outpatient basis are VA's actual cost, and our charges for outpatient dental care are based on VA costs in accordance with the methodology set forth in § 17.102. In place of these cost-related charges, this document proposes to amend the regulations to establish reasonable charges for prosthetic devices, DME, and outpatient dental care by establishing charges for the associated HCPCS Level II codes.

Presently, we do not have charges for ambulance or other emergency transportation services. This document proposes to amend the regulations to establish reasonable charges for ambulance and other emergency transportation services by establishing charges for the associated HCPCS Level II codes.

Associated with these changes, we are proposing to amend the regulations to organize reasonable charges into the following eleven charge types:

- Acute inpatient facility charges;
- Skilled nursing facility/sub-acute inpatient facility charges;

- Partial hospitalization facility charges;
- Outpatient facility charges;
- Physician and other professional charges except for anesthesia services and certain dental services;
- Professional charges for anesthesia services;
- Professional charges for dental services identified by HCPCS Level II codes;
- Pathology and laboratory charges;
- Observation care facility charges;
- Ambulance and other emergency transportation charges; and
- Charges for durable medical equipment, drugs, injectables, and other medical services, items, and supplies identified by HCPCS Level II codes.

The reasons we are proposing these changes are (1) to enable us to bill for medical care, procedures, services, DME, drugs, injectables, medical items, and supplies for which we currently do not have charges; (2) to replace certain charges currently based on VA costs with charges based on community charges; (3) to enable us to bill separately for medical care, procedures, services, DME, drugs, injectables, medical items, and supplies whose charges are presently combined with other charges; and (4) to bring our charge structures and billing practices closer to industry standard charge structures and billing practices.

Additional information regarding each of the above charge types is provided in the following paragraphs.

#### Acute Inpatient Facility Charges

Presently, the regulations provide methodologies for calculating two per diem charges for each diagnosis related group (DRG), one for room and board and one for ancillary services. These same per diem charges are used for both ICU days and non-ICU days. This document proposes to amend the regulations by providing methodologies for calculating different room and board per diem charges for ICU days and non-ICU days. With these changes, each DRG will have three per diem charges: a room and board per diem charge for ICU days, a different room and board per diem charge for non-ICU days, and an ancillary services per diem charge that applies to both ICU and non-ICU days. We are proposing these changes because they will result in charges for each patient that will be more specific to the care and services the patient received, and will result in VA charge structures and billing practices that more closely approximate industry standard charge structures and billing practices.

As noted earlier, we are proposing to change from MSAs to three-digit ZIP

Codes for geographic areas for acute inpatient facility charges. Presently, we calculate 80th percentile factors and geographic area adjustment factors for acute inpatient facility charges by MSA, based on charge data from the Medicare Standard Analytical File 5% Sample. Associated with the change to three-digit ZIP Codes, we are proposing to amend the regulations to base the calculation of these factors on the MedPAR file, which provides a complete record of all Medicare hospital admissions. This change from 5% to 100% of Medicare hospital admissions will produce more accurate 80th percentile factors and geographic area adjustment factors for the smaller three-digit ZIP Code areas.

#### Skilled Nursing Facility/Sub-Acute Inpatient Facility Charges

Presently, we calculate skilled nursing facility/sub-acute inpatient facility all-inclusive per diem charges based on the nationwide average per diem charge presented in annual releases of the Milliman USA, Inc., Health Cost Guidelines. We are proposing to change the regulations to base these charges on the actual average per diem billed charge derived from the MedPAR skilled nursing facility file. This will more directly and accurately measure the nationwide baseline charge, and enable calculation of a more accurate nationwide 80th percentile charge. We are also proposing to change the trending methodology from one based on trends in Medicare reimbursement rates, as presented in the Annual Report of the Boards of Trustees of the Federal Supplementary Medical Insurance Trust Funds, to trends based on the inpatient hospital services component of the CPI-U. This change will result in trending that more accurately reflects changes in billed charge levels.

Presently, we calculate 80th percentile adjustment factors and geographic area adjustment factors based on the Medicare Standard Analytical File 5% Sample and the Milliman USA, Inc., Health Cost Guidelines, respectively. We are proposing to amend the regulations to base calculation of these factors on the MedPAR skilled nursing facility file. These changes will produce more accurate 80th percentile adjustment factors and geographic area adjustment factors.

#### Partial Hospitalization Facility Charges

Presently, we do not have a per diem facility charge that is specific to partial hospitalization, nor do we have charges for any of the HCPCS Level II codes,

including those associated with partial hospitalization. We are proposing to amend the regulations to provide a methodology for establishing partial hospitalization facility charges. We are proposing this change so that we will be able to bill for these services when we provide or furnish them to our patients.

#### **Outpatient Facility Charges**

Presently, we calculate outpatient facility charges utilizing a statistical method based on 1998 Medicare practice expense RVUs, which we adopted as a proxy weighting system for the calculation of outpatient facility charges. We are proposing to amend the methodology to base nationwide average outpatient facility charges on Medicare Ambulatory Payment Classification (APC) groups, using data from the Medicare Standard Analytical File 5% Sample. This will provide the basis for a more accurate calculation, because APC payment groups are based on actual outpatient facility charge data, whereas the 1998 Medicare practice expense RVUs were based on physician charge data for overhead expenses.

One consequence of adopting APC groups for this purpose is that the statistical methodology we presently use to bundle CPT codes into CPT code groups will no longer be needed, because APCs provide appropriate groupings of codes. We are also proposing to amend the regulations to adjust APC charges, which represent Medicare average reimbursement levels, to nationwide 80th percentile billed charge levels. This adjustment will result in charges that more accurately reflect market-level charges.

For outpatient facility services which do not have APC assignments, we propose to calculate outpatient facility charges using data from the MDR database, the MedStat claims database, and the Medicare Standard Analytical File 5% Sample.

These changes to the regulations will result in VA charge structures and billing practices that more closely approximate industry standard charge structures and billing practices.

#### **Physician and Other Professional Charges Except for Anesthesia Services and Certain Dental Services**

Presently, the regulations incorporate the methodologies for charges for pathology/laboratory and anesthesia services in the methodology for physician charges. We are proposing to restructure the regulations so that pathology/laboratory charges and professional charges for anesthesia services are identified as separate charge types. We are also proposing to specify

in the regulations that charges for professional dental services identified by CPT code are determined in accordance with the same methodology as for physician charges, while professional dental services identified by HCPCS Level II code are treated as a separate charge type, with charges determined using a different methodology as discussed below. We are proposing these changes so that different charge types and different charge development methodologies will be separately identified and described in the regulations.

Presently, our charges are not influenced by the presence or absence of CPT code modifiers. This document proposes to amend the regulations to add methodology for developing charge adjustment factors for specified CPT/HCPCS code modifiers, using data from the Medicare Standard Analytical File 5% Sample. Some charge adjustment factors will act to increase the charge (for example, modifier 22, Unusual Procedural Services). Other charge adjustment factors will act to decrease the charge (for example, modifier 52, Reduced Services). This change will result in VA charge structures and billing practices that more closely approximate industry standard charge structures and billing practices.

Presently, language in the regulations is interpreted to mean that we do not have professional charges for categories of providers other than physicians unless the provider category is specifically named in the regulations. This document proposes to amend the regulations to set forth charge methodologies for physicians and other professionals that apply to all professional provider categories. This change will result in VA charge structures and billing practices that more closely approximate industry standard charge structures and billing practices.

#### **Professional Charges for Anesthesia Services**

Presently, professional charges for anesthesia services are based in part on average time units compiled from a Health Care Financing Administration study. Applying this methodology, the professional charge for a given anesthesia procedure is the same, regardless of the length of time the patient received anesthesia. This document proposes to amend the methodology so that professional charges for anesthesia services will vary according to the length of time the patient received anesthesia. This change will result in VA charge structures and billing practices that more closely

approximate industry standard charge structures and billing practices.

#### **Professional Charges for Dental Services Identified by HCPCS Level II Codes**

Presently, charges for outpatient dental care are based on VA costs in accordance with the methodology set forth in § 17.102. This document proposes to amend the methodology to establish reasonable charges for dental services identified by HCPCS Level II codes, using data from the Prevailing Healthcare Charges System, the National Dental Advisory Service nationwide pricing index, the Dental UCR (Usual, Customary, or Reasonable) Module of the Ingenix Comprehensive Healthcare Payment System, the Milliman USA, Inc., Dental Health Cost Guidelines, and the dental services component of the CPI-U. This change will result in VA charge structures and billing practices that more closely approximate industry standard charge structures and billing practices.

#### **Pathology and Laboratory Charges**

Presently, the regulations provide that for each pathology and laboratory CPT code, the technical component RVUs are added to the professional component RVUs, if any, resulting in only one charge for each pathology and laboratory CPT code. This document proposes to amend the methodology so that those pathology and laboratory procedures which require a professional interpretation will have two separate charges: a professional component charge determined according to the methodology set forth in the Physician and Other Professional Charges paragraph in the regulations, and a technical component charge determined according to the methodology set forth in the Pathology and Laboratory Charges paragraph in the regulations. This change will result in VA charge structures and billing practices that more closely approximate industry standard charge structures and billing practices.

#### **Observation Care Facility Charges**

Presently, our facility charges for observation care consist of outpatient facility charges for three observation care CPT codes, 99218, 99219, and 99220. These charges are per occurrence, regardless of the number of hours the patient received observation care. This document proposes to amend the regulations to provide a methodology for establishing observation care facility charges that will vary according to the number of hours the patient receives observation

care. For this purpose, we propose to use data from the outpatient facility component of the Medicare Standard Analytical File 5% Sample, trend the charges forward using the outpatient hospital services component of the CPI-U, and use the geographic area adjustment factors computed for outpatient facility charges. This change will result in VA charge structures and billing practices that more closely approximate industry standard charge structures and billing practices.

#### **Ambulance and Other Emergency Transportation Charges**

Ambulance and other emergency transportation services are identified by HCPCS Level II codes. Presently, we do not have charges for any HCPCS Level II codes. This document proposes to amend the regulations to provide a methodology for establishing charges for ambulance and other emergency transportation services by HCPCS Level II code. For this purpose, we propose to use data from the outpatient facility component of the Medicare Standard Analytical File 5% Sample, trend the charges forward using the outpatient hospital services component of the CPI-U, and use the geographic area adjustment factors computed for outpatient facility charges. We are proposing this change so that we will be able to bill and be reimbursed for these services when we provide or furnish them to our patients.

#### **Charges for Durable Medical Equipment, Drugs, Injectables, and Other Medical Services, Items, and Supplies Identified By HCPCS Level II Codes**

Presently, we do not have charges for any HCPCS Level II codes. This document proposes to amend the regulations to provide a methodology for establishing charges for DME, drugs, injectables, and other medical services, items, and supplies identified by HCPCS Level II code. For this purpose, we propose to use the following data sources: Ingenix/St. Anthony's RBRVS; Medicare DME Fee Schedule; Medicare Parenteral and Enteral Nutrition Fee Schedule; Part B and DME components of the Medicare Standard Analytical File 5% Sample; MDR database; Milliman USA, Inc., Optimized HMO (Health Maintenance Organization) Data Sets; Milliman USA, Inc., Health Cost Guidelines; and a VA nationwide distribution of procedures, services, items, and supplies. We propose to trend these charges forward using the medical care commodities component of the CPI-U. We are proposing this change so that we will be able to bill

and be reimbursed for these services, items, and supplies when we provide or furnish them to our patients.

#### **Responses to Comments**

In response to our interim final rule published in the **Federal Register** on May 8, 2001 (66 FR 23326, RIN 2900-AK73), we received two comments, both from the same commenter, that we have not previously resolved.

The commenter stated that we should add charges for codes G0193 through G0201 (HCPCS Level II codes). In this document, we are proposing to add charges for nearly all HCPCS Level II codes, including codes G0193 through G0201.

The same commenter also 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.

With respect to our charge development methodology, our charge for a given service reflects the actual amounts billed by the providers of that service. Therefore, our charge for a service performed solely by audiologists will reflect the actual amounts billed by audiologists, not by physicians. However, we agree that including these and other services not performed by physicians under the general category of "physician charges" may be confusing. Therefore, in this document, we are proposing to change from the term "physician services" to the term "physician and other professional services" so as to allow for the fact that many professional medical services are performed by audiologists and other healthcare professionals instead of, or in addition to, physicians.

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

#### **Paperwork Reduction Act**

This document contains provisions at 38 CFR 17.101(a)(4) constituting a collection of information under the Paperwork Reduction Act (44 U.S.C. 3501-3521). The Office of Management and Budget (OMB) has approved the information collection requirements for

§ 17.101(a)(4) under OMB control number 2900-0606.

#### **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 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, 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 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 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 recordkeeping requirements, Scholarships and fellowships, Travel and transportation expenses, Veterans.

Approved: August 8, 2003.

**Anthony J. Principi,**

*Secretary of Veterans Affairs.*

For the reasons set out in the preamble, 38 CFR part 17 is proposed to be 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) *Methodologies.* Based on the methodologies set forth in this section, the charges billed will include the following types of charges, as appropriate: acute inpatient facility charges; skilled nursing facility/sub-acute inpatient facility charges; partial hospitalization facility charges; outpatient facility charges; physician and other professional charges, including professional charges for anesthesia services and dental services; pathology and laboratory charges; observation care facility charges; ambulance and other emergency transportation charges; and charges for durable medical equipment, drugs, injectables, and other medical services, items, and supplies identified by HCPCS Level II codes. In addition, 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 charge amounts based on the methodologies set forth in this section will either be published in a notice in the **Federal Register** or will be posted on the Internet site of the Veterans Health Administration Chief Business Office at <http://www.va.gov/revenue>, under "Charge Data." For care for which VA has established a charge, VA will bill using its most recent published or posted charge. For care for which VA has not established a charge, VA will bill according to the methodology set forth in paragraph (a)(8) of this section.

(3) *Data sources.* In this section, data sources are identified by name. The specific editions of these data sources used to calculate actual charge amounts, and information on where these data

sources may be obtained, will be presented along with the data for calculating actual charge amounts, either in notices in the **Federal Register** or on the Internet site of the Veterans Health Administration Chief Business Office at <http://www.va.gov/revenue>, under "Charge Data."

(4) *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).

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

*APC* means Medicare Ambulatory Payment Classification.

*CMS* means the Centers for Medicare and Medicaid Services.

*CPI-U* means Consumer Price Index—All Urban Consumers.

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

*DME* means Durable Medical Equipment.

*DRG* means Diagnosis Related Group.

*Geographic area* means a three-digit ZIP Code area.

*HCPCS code* means a Healthcare Common Procedure Coding System Level II identifier, consisting of a letter followed by four digits, defined by CMS for a specified physician service, procedure, test, supply, or other medical service.

*ICU* means Intensive Care Unit, including coronary care units.

*MDR* means Medical Data Research, a medical charge database published by Ingenix, Inc.

*MedPAR* means the Medicare Provider Analysis and Review file.

*Non-provider-based* means a VA healthcare entity (such as a small VA community-based outpatient clinic) that functions as the equivalent of a doctor's office or for other reasons does not meet CMS provider-based criteria, and, therefore, is not entitled to bill outpatient facility charges.

*Provider-based* means the outpatient department of a VA hospital or any other VA healthcare entity that meets CMS provider-based criteria. Provider-based entities are entitled to bill outpatient facility charges.

*RBRVS* means Resource-Based Relative Value Scale.

*RVU* means Relative Value Unit.

*Unlisted procedures* mean procedures, services, items, and supplies that have not been defined or specified by the American Medical Association or CMS, and the CPT and HCPCS codes used to report such procedures, services, items, and supplies.

(6) *Provider-based and non-provider-based entities and charges.* Each VA healthcare entity (medical center, hospital, community-based outpatient clinic, independent outpatient clinic, etc) is designated as either provider-based or non-provider-based. Provider-based entities are entitled to bill outpatient facility charges; non-provider-based entities are not. The charges for physician and other professional services provided at non-provider-based entities will be billed as professional charges only. Professional charges for both provider-based entities and non-provider-based entities are produced by the methodologies set forth in this section, with professional charges for provider-based entities based on facility practice expense RVUs, and professional charges for non-provider-based entities based on non-facility practice expense RVUs.

(7) *Charges for medical care or services provided by non-VA providers at VA expense.* When medical care or services are furnished at the expense of the VA by non-VA providers, the charges billed for such care or services will be the higher of the charges determined according to this section, or the amount VA paid to the non-VA provider.

(8) *Charges for medical care or services for which VA does not have an established charge.* When medical care or services are provided or furnished at VA expense by either VA or non-VA providers, and VA does not have an established charge for such care or services, then the charges billed for such care or services will be according to the first of the following subparagraphs that applies:

(i) In the event that a new identifier (DRG, CPT code, or HCPCS code) is assigned to a particular type or item of medical care or service, then until such time as VA establishes a charge for the new identifier, VA's charge for such care or service will be VA's most recent established charge for the identifier previously assigned to that type or item of medical care or service; otherwise,

(ii) In the event that the medical care or service is provided or furnished at VA expense by a non-VA provider, then VA's charge for such care or service will be the amount VA paid to the non-VA provider; otherwise,

(iii) VA's charges for prosthetic devices and durable medical equipment will be VA's actual cost; otherwise,

(iv) If a Medicare allowed charge amount can be determined for the care or service, then VA's charge will be the Medicare participating provider allowed charge amount geographically adjusted using the applicable geographic area adjustment factors determined pursuant to this section; otherwise,

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

(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 geographic area 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, the total acute inpatient facility charge is the sum of the applicable charges determined pursuant to paragraphs (b)(1)(i), (ii), and (iii) of this section. For purposes of this section, standard room and board days and ICU room and board days are mutually exclusive: VA will bill either a standard room and board per diem charge or an ICU room and board per diem charge, as applicable, for each day of a given acute inpatient stay.

(i) *Standard room and board charges.* Multiply the nationwide standard room and board per diem charge determined pursuant to paragraph (b)(2) of this section by the appropriate geographic area adjustment factor determined pursuant to paragraph (b)(3) of this section. The result constitutes the area-specific standard room and board per diem charge. Multiply this amount by the number of days for which standard

room and board charges apply to obtain the total acute inpatient facility standard room and board charge.

(ii) *ICU room and board charges.* Multiply the nationwide ICU room and board per diem charge determined pursuant to paragraph (b)(2) of this section by the appropriate geographic area adjustment factor determined pursuant to paragraph (b)(3) of this section. The result constitutes the area-specific ICU room and board per diem charge. Multiply this amount by the number of days for which ICU room and board per diem charges apply to obtain the total acute inpatient facility ICU room and board charge.

(iii) *Ancillary charges.* Multiply the nationwide ancillary per diem charge determined pursuant to paragraph (b)(2) of this section by the appropriate geographic area adjustment factor determined pursuant to paragraph (b)(3) of this section. The result constitutes the area-specific ancillary per diem charge. Multiply this amount by the number of days of acute inpatient care to obtain the total acute inpatient facility ancillary 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 calculations of acute inpatient facility charges 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 amounts for each DRG are calculated, one from the MedPAR file and one from the MedStat claims database, a database of nationwide commercial insurance claims. Average per diem charges are calculated based on all available charges, except for care reported for emergency room, ambulance, professional, and observation care. These two data sources may report charges for two differing periods of time; when this occurs, the data source charges with the earlier center date are trended forward to the center date of the other data source, based on changes to the inpatient hospital services component of the CPI-U. Results obtained from these two data sources are then combined into a single weighted average per diem charge for each DRG. The resulting charge for each DRG is then separated into its two components, a room and board component and an ancillary component, with the per diem

charge for each component calculated by multiplying the weighted average per diem charge by the corresponding percentage determined pursuant to paragraph (b)(2)(i) of this section. The room and board per diem charge is further differentiated into a standard room and board per diem charge and an ICU room and board per diem charge by multiplying the average room and board charge by the corresponding DRG-specific ratios determined pursuant to paragraph (b)(2)(ii) of this section. The resulting per diem charges for standard room and board, ICU room and board, and ancillary services for each DRG are then each multiplied by the final ratio determined pursuant to paragraph (b)(2)(iii) of this section to reflect the nationwide 80th percentile charges. Finally, the resulting amounts are each trended forward from the center date of the trended data sources to the effective time period for the charges, as set forth in paragraph (b)(2)(iv) of this section. The results constitute the nationwide 80th percentile standard room and board, ICU room and board, and ancillary per diem charges.

(i) *Room and board charge and ancillary 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) *Standard room and board per diem charge and ICU room and board per diem charge ratios.* Using only those cases from the MedPAR file for which a distinction between room and board and ancillary charges can be determined, overall average per diem room and board charges are calculated by DRG. Then, using the same cases, an average standard room and board per diem charge is calculated by dividing total non-ICU room and board charges by total non-ICU room and board days. Similarly, an average ICU room and board per diem charge is calculated by dividing total ICU room and board charges by total ICU room and board days. Finally, ratios of standard room and board per diem charges to average overall room and board per diem charges are calculated by DRG, as are ratios of ICU room and board per diem charges to average overall room and board per diem charges.



(iii) *80th percentile.* Using cases from the MedPAR file with separately identifiable semi-private room rates, 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 geographic area. The geographic area-based ratios are averaged to obtain a final 80th percentile ratio.

(iv) *Trending forward.* 80th percentile charges for each DRG, obtained as described in paragraph (b)(2) of this section, are trended forward based on changes to the inpatient hospital services component of the CPI-U. Actual CPI-U changes are used from the center date of the trended data sources through the latest available month as of the time the calculations are performed. The three-month average annual trend rate as of the latest available month is then held constant to the midpoint of the calendar year in which the charges are primarily expected to be used. The projected total CPI-U change so obtained is then applied to the 80th percentile charges.

(3) *Geographic area adjustment factors.* For each geographic area, the average per diem room and board charges and ancillary charges from the MedPAR file 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, weighted by nationwide VA discharges and by average lengths of stay from the combined MedPAR file and 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 MedPAR file, weighted by nationwide VA discharges and by average lengths of stay from the combined MedPAR file and 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 geographic area. The facility charges cover care, including room and board, nursing care, pharmaceuticals, supplies, and skilled rehabilitation services (e.g., physical therapy, inhalation 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. These charges are calculated as follows:

(1) *Formula.* For each stay, multiply the nationwide per diem charge determined pursuant to paragraph (c)(2) of this section by the appropriate geographic area adjustment factor determined pursuant to paragraph (c)(3) of this section. The result constitutes the area-specific per diem charge. Finally, multiply the area-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 is calculated based on charges reported in the MedPAR skilled nursing facility file. For this purpose, the following MedPAR charge categories are included: room and board (private, semi-private, and ward), physical therapy, occupational therapy, inhalation therapy, speech-language pathology, pharmacy, medical/surgical supplies, and "other" services. The following MedPAR charge categories are excluded from the calculation of the per diem charge and will be billed separately, using the charges determined as set forth in other applicable paragraphs of this section, when these services are provided to skilled nursing patients or sub-acute inpatients: ICU and CCU room and board, laboratory, radiology, cardiology, dialysis, operating room, blood and blood administration, ambulance, MRI, anesthesia, durable medical equipment, emergency room, clinic, outpatient, professional, lithotripsy, and organ acquisition services. The resulting average per diem billed charge is then multiplied by the 80th percentile adjustment factor determined pursuant to paragraph (c)(2)(i) of this section to obtain a nationwide 80th percentile charge level. Finally, the resulting amount 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 adjustment factor.* Using the MedPAR skilled nursing facility file, the ratio of the day-weighted 80th percentile room and board per diem charge to the day-weighted average room and board per diem charge is obtained for each geographic area. The geographic area-based ratios are averaged to obtain the 80th percentile adjustment factor.

(ii) *Trending forward.* The 80th percentile charge is trended forward based on changes to the inpatient hospital services component of the CPI-U. Actual CPI-U changes are used from the time period of the source data through the latest available month as of the time the calculations are performed. The three-month average annual trend rate as of the latest available month is then held constant to the midpoint of the calendar year in which the charges are primarily expected to be used. The projected total CPI-U change so obtained is then applied to the 80th percentile charge.

(3) *Geographic area adjustment factors.* The average billed per diem charge for each geographic area is calculated from the MedPAR skilled nursing facility file. This amount is divided by the nationwide average billed charge calculated in paragraph (c)(2) of this section. The geographic area adjustment factor for charges for each VA facility is the ratio of the geographic area in which the facility is located.

(d) *Partial hospitalization facility charges.* When VA provides or furnishes partial hospitalization services that are within the scope of care referred to in paragraph (a)(1) of this section, the facility charges billed for such services will be determined in accordance with the provisions of this paragraph. Partial hospitalization facility charges are per diem charges that vary by geographic area. These charges are calculated as follows:

(1) *Formula.* For each partial hospitalization stay, multiply the nationwide per diem charge determined pursuant to paragraph (d)(2) of this section by the appropriate geographic area adjustment factor determined pursuant to paragraph (d)(3) of this section. The result constitutes the area-specific per diem charge. Finally, multiply the area-specific per diem charge by the number of days of care to obtain the total partial hospitalization facility charge.

(2) *Per diem charge.* To establish a baseline, a nationwide median per diem billed charge is calculated based on

charges associated with partial hospitalization from the outpatient facility component of the Medicare Standard Analytical File 5% Sample. That median per diem billed charge is then multiplied by the 80th percentile adjustment factor determined pursuant to paragraph (d)(2)(i) of this section to obtain a nationwide 80th percentile charge level. Finally, the resulting amount is trended forward to the effective time period for the charges, as set forth in paragraph (d)(2)(ii) of this section.

(i) *80th percentile adjustment factor.* The 80th percentile adjustment factor for partial hospitalization facility charges is the same as that computed for skilled nursing facility/sub-acute inpatient facility charges under paragraph (c)(2)(i) of this section.

(ii) *Trending forward.* The 80th percentile charge is trended forward based on changes to the outpatient hospital services component of the CPI-U. Actual CPI-U changes are used from the time period of the source data through the latest available month as of the time the calculations are performed. The three-month average annual trend rate as of the latest available month is then held constant to the midpoint of the calendar year in which the charges are primarily expected to be used. The projected total CPI-U change so obtained is then applied to the 80th percentile charges, as described in paragraph (d)(2) of this section.

(3) *Geographic area adjustment factors.* The geographic area adjustment factors for partial hospitalization facility charges are the same as those computed for outpatient facility charges under paragraph (e)(4) of this section.

(e) *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, the charges billed for such services will be determined in accordance with the provisions of this paragraph. Charges for outpatient facility services vary by geographic area and by CPT/HCPCS code. These charges apply in the situations set forth in paragraph (e)(1) of this section and are calculated as set forth in paragraph (e)(2) of this section.

(1) *Settings and circumstances in which outpatient facility charges apply.* Outpatient facility charges consist of facility charges for procedures, diagnostic tests, evaluation and management services, and other medical services, items, and supplies provided in the following settings and circumstances:

(i) Outpatient departments and clinics at VA medical centers;

(ii) Other VA provider-based entities; and

(iii) VA non-provider-based entities, for procedures and tests for which no corresponding professional charge is established under the provisions of paragraph (f) of this section.

(2) *Formula.* For each outpatient facility charge CPT/HCPCS code, multiply the nationwide 80th percentile charge determined pursuant to paragraph (e)(3) of this section by the appropriate geographic area adjustment factor determined pursuant to paragraph (e)(4) of this section. The result constitutes the area-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 (e)(5) of this section.

(3) *Nationwide 80th percentile charges by CPT/HCPCS code.* For each CPT/HCPCS code for which outpatient facility charges apply, the nationwide 80th percentile charge is calculated as set forth in either paragraph (e)(3)(i) or (e)(3)(ii) of this section. The resulting amount is trended forward to the effective time period for the charges, as set forth in paragraph (e)(3)(iii) of this section. The results constitute the nationwide 80th percentile outpatient facility charges by CPT/HCPCS code.

(i) *Nationwide 80th percentile charges for CPT/HCPCS codes which have APC assignments.* Using the outpatient facility charges reported in the outpatient facility component of the Medicare Standard Analytical File 5% Sample, claim records are selected for which all charges can be assigned to an APC. Using this subset of the 5% Sample data, nationwide median charge to Medicare APC payment amount ratios, by APC, and nationwide 80th percentile to median charge ratios, by APC, are computed according to the methodology set forth in paragraphs (e)(3)(i)(A) and (e)(3)(i)(B) of this section, respectively. The product of these two ratios by APC is then computed, resulting in a composite nationwide 80th percentile charge to Medicare APC payment amount ratio. This ratio is then compared to the alternate nationwide 80th percentile charge to Medicare APC payment amount ratio computed in paragraph (e)(3)(i)(C) of this section, and the lesser amount is selected and multiplied by the current Medicare APC payment amount. The resulting product is the APC-specific nationwide 80th percentile charge amount for each applicable CPT/HCPCS code.

(A) *Nationwide median charge to Medicare APC payment amount ratios.* For each CPT/HCPCS code, the ratio of median billed charge to Medicare APC payment amount is determined. The weighted average of these ratios for each APC is then obtained, using the reported 5% Sample frequencies as weights. In addition, corresponding ratios are calculated for each of the APC categories set forth in paragraph (e)(3)(i)(D) of this section, again using the reported 5% Sample frequencies as weights. For APCs where the 5% Sample frequencies provide a statistically credible result, the APC-specific weighted average nationwide median charge to Medicare APC payment amount ratio so obtained is accepted without further adjustment. However, if the 5% Sample data do not produce statistically credible results for any specific APC, then the APC category-specific ratio is applied for that APC.

(B) *Nationwide 80th percentile to median charge ratios.* For each CPT/HCPCS code, a geographically normalized nationwide 80th percentile billed charge amount is divided by a similarly normalized nationwide median billed charge amount. The weighted average of these ratios for each APC is then obtained, using the reported 5% Sample frequencies as weights. In addition, corresponding ratios are calculated for each of the APC categories set forth in paragraph (e)(3)(i)(D) of this section, again using the reported 5% Sample frequencies as weights. For APCs where the 5% Sample frequencies provide a statistically credible result, the APC-specific weighted average nationwide 80th percentile to median charge ratio so obtained is accepted without further adjustment. However, if the 5% Sample data do not produce statistically credible results for any specific APC, then the APC category-specific ratio is applied for that APC.

(C) *Alternate nationwide 80th percentile charge to Medicare APC payment amount ratios.* A minimum 80th percentile charge to Medicare APC payment amount ratio is set at 2.0 for APCs with Medicare APC payment amounts of \$25 or less. A maximum 80th percentile charge to Medicare APC payment amount ratio is set at 6.5 for APCs with Medicare APC payment amounts of \$10,000 or more. Using linear interpolation with these endpoints, the alternate APC-specific nationwide 80th percentile charge to Medicare APC payment amount ratio is then computed, based on the Medicare APC payment amount.

(D) *APC categories for the purpose of establishing 80th percentile to median factors.* For the purpose of the statistical methodology set forth in paragraph (e)(3)(i) of this section, APCs are assigned to the following APC categories:

- (1) Radiology.
- (2) Drugs.
- (3) Office, Home, and Urgent Care Visits.
- (4) Cardiovascular.
- (5) Emergency Room Visits.
- (6) Outpatient Psychiatry, Alcohol and Drug Abuse.
- (7) Pathology.
- (8) Surgery.
- (9) Allergy Immunotherapy, Allergy Testing, Immunizations, and Therapeutic Injections.
- (10) All APCs not assigned to any of the above groups.

(ii) *Nationwide 80th percentile charges for CPT/HCPCS codes which do not have APC assignments.* Nationwide 80th percentile billed charge levels by CPT/HCPCS code are computed from the outpatient facility component of the MDR database, from the MedStat claims database, and from the outpatient facility component of the Medicare Standard Analytical File 5% Sample. If the MDR database contains sufficient data to provide a statistically credible 80th percentile charge, then that result is retained for this purpose. If the MDR database does not provide a statistically credible 80th percentile charge, then the result from the MedStat database is retained for this purpose, provided it is statistically credible. If neither the MDR nor the MedStat databases provide statistically credible results, then the nationwide 80th percentile billed charge computed from the 5% Sample data is retained for this purpose. The nationwide 80th percentile charges retained from each of these data sources are trended forward to the effective time period for the charges, as set forth in paragraph (e)(3)(iii) of this section.

(iii) *Trending forward.* The charges for each CPT/HCPCS code, obtained as described in paragraph (e)(3) of this section, are trended forward based on changes to the outpatient hospital services component of the CPI-U. Actual CPI-U changes are used from the time period of the source data through the latest available month as of the time the calculations are performed. The three-month average annual trend rate as of the latest available month is then held constant to the midpoint of the calendar year in which the charges are primarily expected to be used. The projected total CPI-U change so obtained is then applied to the 80th

percentile charges, as described in paragraph (e)(3) of this section.

(4) *Geographic area adjustment factors.* For each geographic area, a single adjustment factor is calculated as the arithmetic average of the outpatient geographic area adjustment factor published in the Milliman USA, Inc., Health Cost Guidelines (this factor constitutes the ratio of the level of charges for each geographic area to the nationwide level of charges), and a geographic area adjustment factor developed from the MDR database. See paragraph (a)(3) of this section for data sources. The MDR-based geographic area adjustment factors are calculated as the ratio of the CPT/HCPCS code weighted average charge level for each geographic area to the nationwide CPT/HCPCS code 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/HCPCS procedure codes, then the CPT/HCPCS procedure code with the highest facility charge will be billed at 100% of the charges established under this section; the CPT/HCPCS procedure code with the second highest facility charge will be billed at 25% of the charges established under this section; the CPT/HCPCS 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.

(f) *Physician and other professional charges except for anesthesia services and certain dental services.* When VA provides or furnishes physician and other professional services, other than professional anesthesia services and certain professional dental services, within the scope of care referred to in paragraph (a)(1) of this section, physician and other professional charges billed for such services will be determined in accordance with the provisions of this paragraph. Charges for professional dental services identified by CPT code are determined in accordance with the provisions of this paragraph; charges for professional dental services identified by HCPCS Level II code are determined in accordance with the provisions of paragraph (h) of this section. Physician and other professional charges consist of charges for professional services that vary by geographic area, by CPT/HCPCS code, by site of service, and by modifier, where applicable. These charges are calculated as follows:

(1) *Formula.* For each CPT/HCPCS code or, where applicable, each CPT/HCPCS code and modifier combination, multiply the total geographically-adjusted RVUs determined pursuant to paragraph (f)(2) of this section by the applicable geographically-adjusted conversion factor (a monetary amount) determined pursuant to paragraph (f)(3) of this section to obtain the physician charge for each CPT/HCPCS code in a particular geographic area. Then, multiply this charge by the appropriate factors for any charge-significant modifiers, determined pursuant to paragraph (f)(4) of this section.

(2)(i) *Total geographically-adjusted RVUs for physician services that have Medicare RVUs.* The work expense and practice expense RVUs for CPT/HCPCS codes, other than the codes described in paragraphs (f)(2)(ii) and (f)(2)(iii) of this section, are compiled using Medicare Physician Fee Schedule RVUs. The sum of the geographically-adjusted work expense RVUs determined pursuant to paragraph (f)(2)(i)(A) of this section and the geographically-adjusted practice expense RVUs determined pursuant to paragraph (f)(2)(i)(B) of this section equals the total geographically-adjusted RVUs.

(A) *Geographically-adjusted work expense RVUs.* For each CPT/HCPCS code for each geographic area, the Medicare Physician Fee Schedule work expense RVUs are multiplied by the work expense Medicare Geographic Practice Cost Index. The result constitutes the geographically-adjusted work expense RVUs.

(B) *Geographically-adjusted practice expense RVUs.* For each CPT/HCPCS code for each geographic area, the Medicare Physician Fee Schedule practice expense RVUs are multiplied by the practice expense Medicare Geographic Practice Cost Index. The result constitutes the geographically-adjusted practice expense RVUs. In these calculations, facility practice expense RVUs are used to obtain geographically-adjusted practice expense RVUs for use by provider-based entities, and non-facility practice expense RVUs are used to obtain geographically-adjusted practice expense RVUs for use by non-provider-based entities.

(ii) *RVUs for CPT/HCPCS codes that do not have Medicare RVUs and are not designated as unlisted procedures.* For CPT/HCPCS codes that are not assigned RVUs in paragraphs (f)(2)(i) or (f)(2)(iii) of this section, total RVUs are developed based on various charge data sources. For these CPT/HCPCS codes, the nationwide 80th percentile billed charges are obtained, where statistically

credible, from the MDR database. For any remaining CPT/HCPCS codes, the nationwide 80th percentile billed charges are obtained, where statistically credible, from the Part B component of the Medicare Standard Analytical File 5% Sample. For any remaining CPT/HCPCS codes, the nationwide 80th percentile billed charges are obtained, where statistically credible, from the Prevailing Healthcare Charges System nationwide commercial insurance database. For each of these CPT/HCPCS codes, nationwide total RVUs are obtained by taking the nationwide 80th percentile billed charges obtained using the preceding three databases and dividing by the untrended nationwide conversion factor for the corresponding CPT/HCPCS code group determined pursuant to paragraphs (f)(3) and (f)(3)(i) of this section. For any remaining CPT/HCPCS codes that have not been assigned RVUs using the preceding data sources, the nationwide total RVUs are calculated by summing the work expense and non-facility practice expense RVUs found in Ingenix/St. Anthony's RBRVS. The resulting nationwide total RVUs obtained using these four data sources are multiplied by the geographic area adjustment factors determined pursuant to paragraph (f)(2)(iv) of this section to obtain the area-specific total RVUs.

(iii) *RVUs for CPT/HCPCS codes designated as unlisted procedures.* For CPT/HCPCS codes designated as unlisted procedures, total RVUs are developed based on the weighted median of the total RVUs of CPT/HCPCS codes within the series in which the unlisted procedure code occurs. A nationwide VA distribution of procedures and services is used for the purpose of computing the weighted median. The resulting nationwide total RVUs are multiplied by the geographic area adjustment factors determined pursuant to paragraph (f)(2)(iv) of this section to obtain the area-specific total RVUs.

(iv) *RVU geographic area adjustment factors for CPT/HCPCS codes that do not have Medicare RVUs, including codes that are designated as unlisted procedures.* The adjustment factor for each geographic area consists of the weighted average of the work expense and practice expense Medicare Geographic Practice Cost Indices for each geographic area using charge data for representative CPT/HCPCS codes statistically selected and weighted for work expense and practice expense.

(3) *Geographically-adjusted 80th percentile conversion factors.* CPT/HCPCS codes are separated into the following 23 CPT/HCPCS code groups:

allergy immunotherapy, allergy testing, 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 23 CPT/HCPCS code groups, representative CPT/HCPCS codes are statistically selected and weighted so as to give a weighted average RVU comparable to the weighted average RVU of the entire CPT/HCPCS code group (the selected CPT/HCPCS codes are set forth in the Milliman USA, Inc., Health Cost Guidelines fee survey; see paragraph (a)(3) of this section for data sources). The 80th percentile charge for each selected CPT/HCPCS code is obtained from the MDR database. A nationwide conversion factor (a monetary amount) is calculated for each CPT/HCPCS code group as set forth in paragraph (f)(3)(i) of this section. The nationwide conversion factors for each of the 23 CPT/HCPCS code groups are trended forward to the effective time period for the charges, as set forth in paragraph (f)(3)(ii) of this section. The resulting amounts for each of the 23 groups are multiplied by geographic area adjustment factors determined pursuant to paragraph (f)(3)(iii) of this section, resulting in geographically-adjusted 80th percentile conversion factors for each geographic area for the 23 CPT/HCPCS code groups for the effective charge period.

(i) *Nationwide conversion factors.* Using the nationwide 80th percentile charges for the selected CPT/HCPCS codes from paragraph (f)(3) of this section, a nationwide conversion factor is calculated for each of the 23 CPT/HCPCS code groups by dividing the weighted average charge by the weighted average RVU.

(ii) *Trending forward.* The nationwide conversion factors for each of the 23 CPT/HCPCS code groups, obtained as described in paragraph (f)(3)(i) of this section, are trended forward based on changes to the physicians' services component of the CPI-U. Actual CPI-U changes are used from the time period of the source data through the latest available month as of the time the calculations are performed. The three-month average annual trend rate as of the latest available month is then held constant to the midpoint of the calendar year in which the charges are primarily

expected to be used. The projected total CPI-U change so obtained is then applied to the 23 conversion factors.

(iii) *Geographic area adjustment factors.* Using the 80th percentile charges for the selected CPT/HCPCS codes from paragraph (f)(3) of this section for each geographic area, a geographic area-specific conversion factor is calculated for each of the 23 CPT/HCPCS code groups by dividing the weighted average charge by the weighted average geographically-adjusted RVU. The resulting conversion factor for each geographic area for each of the 23 CPT/HCPCS code groups is divided by the corresponding nationwide conversion factor determined pursuant to paragraph (f)(3)(i) of this section. The resulting ratios are the geographic area adjustment factors for the conversion factors for each of the 23 CPT/HCPCS code groups for each geographic area.

(4) *Charge adjustment factors for specified CPT/HCPCS code modifiers.* Surcharges or charge discounts are calculated in the following manner: from the Part B component of the Medicare Standard Analytical File 5% 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 or discount factors for specified charge-significant CPT/HCPCS code modifiers.

(5) *Certain charges for providers other than physicians.* When services for which charges are established according to the preceding provisions of this paragraph (f) are performed by providers other than physicians, the charges for those services will be as determined by the preceding provisions of this paragraph, except as follows:

(i) *Outpatient facility charges.* When the services of providers other than physicians are furnished in outpatient facility settings or in other facilities designated as provider-based, and outpatient facility charges for those services have been established under paragraph (e) of this section, then the outpatient facility charges established under paragraph (e) will apply instead of the charges established under this paragraph (f).

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

- (A) Nurse practitioner: 85%.
- (B) Clinical nurse specialist: 85%.
- (C) Physician assistant: 85%.
- (D) Clinical psychologist: 80%.
- (E) Clinical social worker: 75%.
- (F) Dietitian: 75%.
- (G) Clinical pharmacist: 80%.

(g) *Professional charges for anesthesia services.* When VA provides or furnishes professional anesthesia services within the scope of care referred to in paragraph (a)(1) of this section, professional anesthesia charges billed for such services will be determined in accordance with the provisions of this paragraph. Charges for professional anesthesia services provided by physicians or by certified registered nurse anesthetists when not medically directed by an anesthesiologist will be 100% of the charges determined as set forth in this paragraph. Charges for professional anesthesia services provided by a certified registered nurse anesthetist when medically directed by an anesthesiologist will be 50% of the charges otherwise determined as set forth in this paragraph, and shall be in addition to the charges for the anesthesiologist. Professional anesthesia charges consist of charges for professional services that vary by geographic area, by CPT/HCPCS code base units, and by number of time units. These charges are calculated as follows:

(1) *Formula.* For each anesthesia CPT/HCPCS code, multiply the total anesthesia RVUs determined pursuant to paragraph (g)(2) of this section by the applicable geographically-adjusted conversion factor (a monetary amount) determined pursuant to paragraph (g)(3) of this section to obtain the professional anesthesia charge for each CPT/HCPCS code in a particular geographic area.

(2) *Total RVUs for professional anesthesia services.* The total anesthesia RVUs for each anesthesia CPT/HCPCS code are the sum of the base units (as compiled by CMS) for that CPT/HCPCS code and the number of time units reported for the anesthesia service, where one time unit equals 15 minutes. For anesthesia CPT/HCPCS codes designated as unlisted procedures, base units are developed based on the weighted median base units for anesthesia CPT/HCPCS codes within the series in which the unlisted procedure code occurs. A nationwide VA distribution of procedures and services is used for the purpose of computing the weighted median base units.

(3) *Geographically-adjusted 80th percentile conversion factors.* A nationwide 80th percentile conversion factor is calculated according to the methodology set forth in paragraph

(g)(3)(i) of this section. The nationwide conversion factor is then trended forward to the effective time period for the charges, as set forth in paragraph (g)(3)(ii) of this section. The resulting amount is multiplied by geographic area adjustment factors determined pursuant to paragraph (g)(3)(iii) of this section, resulting in geographically-adjusted 80th percentile conversion factors for each geographic area for the effective charge period.

(i) *Nationwide conversion factor.* Preliminary 80th percentile conversion factors for each area are compiled from the MDR database. Then, a preliminary nationwide weighted-average 80th percentile conversion factor is calculated, using as weights the population (census) frequencies for each geographic area as presented in the Milliman USA, Inc., Health Cost Guidelines (see paragraph (a)(3) of this section for data sources). A nationwide 80th percentile fee by CPT/HCPCS code is then computed by multiplying this conversion factor by the MDR base units for each CPT/HCPCS code. An adjusted 80th percentile conversion factor by CPT/HCPCS code is then calculated by dividing the nationwide 80th percentile fee for each procedure code by the anesthesia base units (as compiled by CMS) for that CPT/HCPCS code. Finally, a nationwide weighted average 80th percentile conversion factor is calculated using combined frequencies for billed base units and time units from the Part B component of the Medicare Standard Analytical File 5% Sample as weights.

(ii) *Trending forward.* The nationwide conversion factor, obtained as described in paragraph (g)(3)(i) of this section, is trended forward based on changes to the physicians' services component of the CPI-U. Actual CPI-U changes are used from the time period of the source data through the latest available month as of the time the calculations are performed. The three-month average annual trend rate as of the latest available month is then held constant to the midpoint of the calendar year in which the charges are primarily expected to be used. The projected total CPI-U change so obtained is then applied to the conversion factor.

(iii) *Geographic area adjustment factors.* The preliminary 80th percentile conversion factors for each geographic area described in paragraph (g)(3)(i) of this section are divided by the corresponding preliminary nationwide 80th percentile conversion factor also described in paragraph (g)(3)(i). The resulting ratios are the adjustment factors for each geographic area.

(h) *Professional charges for dental services identified by HCPCS Level II codes.* When VA provides or furnishes outpatient dental professional services within the scope of care referred to in paragraph (a)(1) of this section, and such services are identified by HCPCS code rather than CPT code, the charges billed for such services will be determined in accordance with the provisions of this paragraph. The charges for dental services vary by geographic area and by HCPCS code.

These charges are calculated as follows:

(1) *Formula.* For each HCPCS dental code, multiply the nationwide 80th percentile charge determined pursuant to paragraph (h)(2) of this section by the appropriate geographic area adjustment factor determined pursuant to paragraph (h)(3) of this section. The result constitutes the area-specific dental charge.

(2) *Nationwide 80th percentile charges by HCPCS code.* For each HCPCS dental code, 80th percentile charges are extracted from three independent data sources: Prevaling Healthcare Charges System database; National Dental Advisory Service nationwide pricing index; and the Dental UCR Module of the Comprehensive Healthcare Payment System, a release from Ingenix from a nationwide database of dental charges (see paragraph (a)(3) of this section for data sources). Charges for each database are then trended forward to a common date, based on actual changes to the dental services component of the CPI-U. Charges for each HCPCS dental code from each data source are combined into an average 80th percentile charge by means of the methodology set forth in paragraph (h)(2)(i) of this section. HCPCS dental codes designated as unlisted are assigned 80th percentile charges by means of the methodology set forth in paragraph (h)(2)(ii) of this section. Finally, the resulting amounts are each trended forward to the effective time period for the charges, as set forth in paragraph (h)(2)(iii) of this section. The results constitute the nationwide 80th percentile charge for each HCPCS dental code.

(i) *Averaging methodology.* The average charge for any particular HCPCS dental code is calculated by first computing a preliminary mean average of the three charges for each code. Statistical outliers are identified and removed by testing whether any charge differs from the preliminary mean charge by more than 50% of the preliminary mean charge. In such cases, the charge most distant from the preliminary mean is removed as an outlier, and the average charge is

calculated as a mean of the two remaining charges. In cases where none of the charges differ from the preliminary mean charge by more than 50% of the preliminary mean charge, the average charge is calculated as a mean of all three reported charges.

(ii) *Nationwide 80th percentile charges for HCPCS dental codes designated as unlisted procedures.* For HCPCS dental codes designated as unlisted procedures, 80th percentile charges are developed based on the weighted median 80th percentile charge of HCPCS dental codes within the series in which the unlisted procedure code occurs. The distribution of procedures and services from the Prevailing Healthcare Charges System nationwide commercial insurance database is used for the purpose of computing the weighted median.

(iii) *Trending forward.* 80th percentile charges for each dental procedure code, obtained as described in paragraph (h)(2) of this section, are trended forward based on the dental services component of the CPI-U. Actual CPI-U changes are used from the time period of the source data through the latest available month as of the time the calculations are performed. The three-month average annual trend rate as of the latest available month is then held constant to the midpoint of the calendar year in which the charges are primarily expected to be used. The projected total CPI-U change so obtained is then applied to the 80th percentile charges.

(3) *Geographic area adjustment factors.* A geographic adjustment factor (consisting of the ratio of the level of charges in a given geographic area to the nationwide level of charges) for each geographic area and dental class of service is obtained from Milliman USA, Inc., Dental Health Cost Guidelines, a database of nationwide commercial insurance charges and relative costs; and a normalized geographic adjustment factor computed from the Dental UCR Module of the Comprehensive Healthcare Payment System compiled by Ingenix, as follows: Using local and nationwide average charges reported in the Ingenix data, a local weighted average charge for each dental class of procedure codes is calculated using utilization frequencies from the Milliman USA, Inc., Dental Health Cost Guidelines as weights (*see* paragraph (a)(3) of this section for data sources). Similarly, using nationwide average charge levels, a nationwide average charge by dental class of procedure codes is calculated. The normalized geographic adjustment factor for each dental class of procedure codes and for each geographic area is the ratio of the

local average charge divided by the corresponding nationwide average charge. Finally, the geographic area adjustment factor is the arithmetic average of the corresponding factors from the data sources mentioned in the first sentence of this paragraph (h)(3).

(i) *Pathology and laboratory charges.* When VA provides or furnishes pathology and laboratory services within the scope of care referred to in paragraph (a)(1) of this section, charges billed for such services will be determined in accordance with the provisions of this paragraph. Pathology and laboratory charges consist of charges for services that vary by geographic area and by CPT/HCPCS code. These charges are calculated as follows:

(1) *Formula.* For each CPT/HCPCS code, multiply the total geographically-adjusted RVUs determined pursuant to paragraph (i)(2) of this section by the applicable geographically-adjusted conversion factor (a monetary amount) determined pursuant to paragraph (i)(3) of this section to obtain the pathology/laboratory charge for each CPT/HCPCS code in a particular geographic area.

(2)(i) *Total geographically-adjusted RVUs for pathology and laboratory services that have Medicare-based RVUs.* Total RVUs are developed based on the Medicare Clinical Diagnostic Laboratory Fee Schedule (CLAB). The CLAB payment amounts are upwardly adjusted such that the adjusted payment amounts are, on average, equivalent to Medicare Physician Fee Schedule payment levels, using statistical comparisons to the 80th percentile derived from the MDR database. These adjusted payment amounts are then divided by the corresponding Medicare conversion factor to derive RVUs for each CPT/HCPCS code. The resulting nationwide total RVUs are multiplied by the geographic adjustment factors determined pursuant to paragraph (i)(2)(iv) of this section to obtain the area-specific total RVUs.

(ii) *RVUs for CPT/HCPCS codes that do not have Medicare-based RVUs and are not designated as unlisted procedures.* For CPT/HCPCS codes that are not assigned RVUs in paragraphs (i)(2)(i) or (i)(2)(iii) of this section, total RVUs are developed based on various charge data sources. For these CPT/HCPCS codes, the nationwide 80th percentile billed charges are obtained, where statistically credible, from the MDR database. For any remaining CPT/HCPCS codes, the nationwide 80th percentile billed charges are obtained, where statistically credible, from the Part B component of the Medicare Standard Analytical File 5% Sample.

For any remaining CPT/HCPCS codes, the nationwide 80th percentile billed charges are obtained, where statistically credible, from the Prevailing Healthcare Charges System nationwide commercial insurance database. For each of these CPT/HCPCS codes, nationwide total RVUs are obtained by taking the nationwide 80th percentile billed charges obtained using the preceding three databases and dividing by the untrended nationwide conversion factor determined pursuant to paragraphs (i)(3) and (i)(3)(i) of this section. For any remaining CPT/HCPCS codes that have not been assigned RVUs using the preceding data sources, the nationwide total RVUs are calculated by summing the work expense and non-facility practice expense RVUs found in Ingenix/St. Anthony's RBRVS. The resulting nationwide total RVUs obtained using these four data sources are multiplied by the geographic area adjustment factors determined pursuant to paragraph (i)(2)(iv) of this section to obtain the area-specific total RVUs.

(iii) *RVUs for CPT/HCPCS codes designated as unlisted procedures.* For CPT/HCPCS codes designated as unlisted procedures, total RVUs are developed based on the weighted median of the total RVUs of CPT/HCPCS codes within the series in which the unlisted procedure code occurs. A nationwide VA distribution of procedures and services is used for the purpose of computing the weighted median. The resulting nationwide total RVUs are multiplied by the geographic area adjustment factors determined pursuant to paragraph (i)(2)(iv) of this section to obtain the area-specific total RVUs.

(iv) *RVU geographic area adjustment factors for CPT/HCPCS codes that do not have Medicare RVUs, including codes that are designated as unlisted procedures.* The adjustment factor for each geographic area consists of the weighted average of the work expense and practice expense Medicare Geographic Practice Cost Indices for each geographic area using charge data for representative CPT/HCPCS codes statistically selected and weighted for work expense and practice expense.

(3) *Geographically-adjusted 80th percentile conversion factors.* Representative CPT/HCPCS codes are statistically selected and weighted so as to give a weighted average RVU comparable to the weighted average RVU of the entire pathology/laboratory CPT/HCPCS code group (the selected CPT/HCPCS codes are set forth in the Milliman USA, Inc., Health Cost Guidelines fee survey). The 80th percentile charge for each selected CPT/

HCPCS code is obtained from the MDR database. A nationwide conversion factor (a monetary amount) is calculated as set forth in paragraph (i)(3)(i) of this section. The nationwide conversion factor is trended forward to the effective time period for the charges, as set forth in paragraph (i)(3)(ii) of this section. The resulting amount is multiplied by a geographic area adjustment factor determined pursuant to paragraph (i)(3)(iv) of this section, resulting in the geographically-adjusted 80th percentile conversion factor for the effective charge period.

(i) *Nationwide conversion factors.* Using the nationwide 80th percentile charges for the selected CPT/HCPCS codes from paragraph (i)(3) of this section, a nationwide conversion factor is calculated by dividing the weighted average charge by the weighted average RVU.

(ii) *Trending forward.* The nationwide conversion factor, obtained as described in paragraph (i)(3) of this section, is trended forward based on changes to the physicians' services component of the CPI-U. Actual CPI-U changes are used from the time period of the source data through the latest available month as of the time the calculations are performed. The three-month average annual trend rate as of the latest available month is then held constant to the midpoint of the calendar year in which the charges are primarily expected to be used. The projected total CPI-U change so obtained is then applied to the pathology/laboratory conversion factor.

(iii) *Geographic area adjustment factor.* Using the 80th percentile charges for the selected CPT/HCPCS codes from paragraph (i)(3) of this section for each geographic area, a geographic area-specific conversion factor is calculated by dividing the weighted average charge by the weighted average geographically-adjusted RVU. The resulting geographic area conversion factor is divided by the corresponding nationwide conversion factor determined pursuant to paragraph (i)(3)(i) of this section. The resulting ratios are the geographic area adjustment factors for pathology and laboratory services for each geographic area.

(j) *Observation care facility charges.* When VA provides observation care within the scope of care referred to in paragraph (a)(1) of this section, the facility charges billed for such care will be determined in accordance with the provisions of this paragraph. The charges for this care vary by geographic area and number of hours of care. These charges are calculated as follows:

(1) *Formula.* For each occurrence of observation care, add the nationwide

base charge determined pursuant to paragraph (j)(2) of this section to the product of the number of hours in observation care and the hourly charge also determined pursuant to paragraph (j)(2) of this section. Then multiply this amount by the appropriate geographic area adjustment factor determined pursuant to paragraph (j)(3) of this section. The result constitutes the area-specific observation care facility charge.

(2)(i) *Nationwide 80th percentile observation care facility charges.* To calculate nationwide base and hourly facility charges, all claims with observation care line items are selected from the outpatient facility component of the Medicare Standard Analytical File 5% Sample. Then, using the 80th percentile observation line item charges for each unique hourly length of stay, a standard linear regression technique is used to calculate the nationwide 80th percentile base charge and 80th percentile hourly charge. Finally, the resulting amounts are each trended forward to the effective time period for the charges, as set forth in paragraph (j)(2)(ii) of this section. The results constitute the nationwide 80th percentile base and hourly facility charges for observation care.

(ii) *Trending forward.* The nationwide 80th percentile base and hourly facility charges for observation care, obtained as described in paragraph (j)(2)(i) of this section, are trended forward based on changes to the outpatient hospital services component of the CPI-U. Actual CPI-U changes are used from the time period of the source data through the latest available month as of the time the calculations are performed. The three-month average annual trend rate as of the latest available month is then held constant to the midpoint of the calendar year in which the charges are primarily expected to be used. The projected total CPI-U change so obtained is then applied to the 80th percentile charges.

(3) *Geographic area adjustment factors.* The geographic area adjustment factors for observation care facility charges are the same as those computed for outpatient facility charges under paragraph (e)(4) of this section.

(k) *Ambulance and other emergency transportation charges.* When VA provides ambulance and other emergency transportation services that are within the scope of care referred to in paragraph (a)(1) of this section, the charges billed for such services will be determined in accordance with the provisions of this paragraph. The charges for these services vary by HCPCS code, length of trip, and

geographic area. These charges are calculated as follows:

(1) *Formula.* For each occasion of ambulance or other emergency transportation service, add the nationwide base charge for the appropriate HCPCS code determined pursuant to paragraph (k)(2)(i) of this section to the product of the number of miles traveled and the appropriate HCPCS code mileage charge determined pursuant to paragraph (k)(2)(ii) of this section. Then multiply this amount by the appropriate geographic area adjustment factor determined pursuant to paragraph (k)(3) of this section. The result constitutes the area-specific ambulance or other emergency transportation service charge.

(2)(i) *Nationwide 80th percentile all-inclusive base charge.* To calculate a nationwide all-inclusive base charge, all ambulance and other emergency transportation claims are selected from the outpatient facility component of the Medicare Standard Analytical File 5% Sample. Excluding professional and mileage charges, as well as all-inclusive charges which are reported on such claims, the total charge per claim, including incidental supplies, is computed. Then, the 80th percentile amount for each HCPCS code is computed. Finally, the resulting amounts are each trended forward to the effective time period for the charges, as set forth in paragraph (k)(2)(iii) of this section. The results constitute the nationwide 80th percentile all-inclusive base charge for each HCPCS base charge code.

(ii) *Nationwide 80th percentile mileage charge.* To calculate a nationwide mileage charge, all ambulance and other emergency transportation claims are selected from the outpatient facility component of the Medicare Standard Analytical File 5% Sample. Excluding professional, incidental, and base charges, as well as claims with all-inclusive charges, the total mileage charge per claim is computed. This amount is divided by the number of miles reported on the claim. Then, the 80th percentile amount for each HCPCS code, using miles as weights, is computed. Finally, the resulting amounts are each trended forward to the effective time period for the charges, as set forth in paragraph (k)(2)(iii) of this section. The results constitute the nationwide 80th percentile mileage charge for each HCPCS mileage code.

(iii) *Trending forward.* The nationwide 80th percentile charge for each HCPCS code, obtained as described in paragraphs (k)(2)(i) and (k)(2)(ii) of this section, is trended forward based on

changes to the outpatient hospital services component of the CPI-U. Actual CPI-U changes are used from the time period of the source data through the latest available month as of the time the calculations are performed. The three-month average annual trend rate as of the latest available month is then held constant to the midpoint of the calendar year in which the charges are primarily expected to be used. The projected total CPI-U change so obtained is then applied to the 80th percentile charges.

(3) *Geographic area adjustment factors.* The geographic area adjustment factors for ambulance and other emergency transportation charges are the same as those computed for outpatient facility charges under paragraph (e)(4) of this section.

(l) *Charges for durable medical equipment, drugs, injectables, and other medical services, items, and supplies identified by HCPCS Level II codes.*

When VA provides DME, drugs, injectables, or other medical services, items, or supplies that are identified by HCPCS Level II codes and that are within the scope of care referred to in paragraph (a)(1) of this section, the charges billed for such services, items, and supplies will be determined in accordance with the provisions of this paragraph. The charges for these services, items, and supplies vary by geographic area, by HCPCS code, and by modifier, when applicable. These charges are calculated as follows:

(1) *Formula.* For each HCPCS code, multiply the nationwide charge determined pursuant to paragraphs (l)(2), (l)(3), and (l)(4) of this section by the appropriate geographic area adjustment factor determined pursuant to paragraph (l)(5) of this section. The result constitutes the area-specific charge.

(2) *Nationwide 80th percentile charges for HCPCS codes with RVUs.* For each applicable HCPCS code, RVUs are compiled from the data sources set forth in paragraph (l)(2)(i) of this section. The RVUs are multiplied by the charge amount for each incremental RVU determined pursuant to paragraph (l)(2)(ii) of this section, and this amount is added to the fixed charge amount also determined pursuant to paragraph (l)(2)(ii) of this section. Then, for each HCPCS code, this charge is multiplied by the appropriate 80th percentile to median charge ratio determined pursuant to paragraph (l)(2)(iii) of this section. Finally, the resulting amount is trended forward to the effective time period for the charges, as set forth in paragraph (l)(2)(iv) of this section to

obtain the nationwide 80th percentile charge.

(i) *RVUs for DME, drugs, injectables, and other medical services, items, and supplies.* For the purpose of the statistical methodology set forth in paragraph (l)(2)(ii) of this section, HCPCS codes are assigned to the following HCPCS code groups. For the HCPCS codes in each group, the RVUs or amounts indicated constitute the RVUs:

(A) Chemotherapy Drugs: Ingenix/St. Anthony's RBRVS Practice Expense RVUs.

(B) Other Drugs: Ingenix/St. Anthony's RBRVS Practice Expense RVUs.

(C) DME—Hospital Beds: Medicare DME Fee Schedule amounts.

(D) DME—Medical/Surgical Supplies: Medicare DME Fee Schedule amounts.

(E) DME—Orthotic Devices: Medicare DME Fee Schedule amounts.

(F) DME—Oxygen and Supplies: Medicare DME Fee Schedule amounts.

(G) DME—Wheelchairs: Medicare DME Fee Schedule amounts.

(H) Other DME: Medicare DME Fee Schedule amounts.

(I) Enteral/Parenteral Supplies: Medicare Parenteral and Enteral Nutrition Fee Schedule amounts.

(J) Surgical Dressings and Supplies: Medicare DME Fee Schedule amounts.

(K) Vision Items—Other Than Lenses: Medicare DME Fee Schedule amounts.

(L) Vision Items—Lenses: Medicare DME Fee Schedule amounts.

(M) Hearing Items: Ingenix/St. Anthony's RBRVS Practice Expense RVUs.

(ii) *Charge amounts.* Using combined Part B and DME components of the Medicare Standard Analytical File 5% Sample, the median billed charge is calculated for each HCPCS code. A mathematical approximation methodology based on least squares techniques is applied to the RVUs specified for each of the groups set forth in paragraph (l)(2)(i) of this section, yielding two charge amounts for each HCPCS code group: a charge amount per incremental RVU, and a fixed charge amount.

(iii) *80th Percentile to median charge ratios.* Two ratios are obtained for each HCPCS code group set forth in paragraph (l)(2)(i) of this section by dividing the weighted average 80th percentile charge by the weighted average median charge derived from two data sources: Medicare data, as represented by the combined Part B and DME components of the Medicare Standard Analytical File 5% Sample; and the MDR database. Charge frequencies from the Medicare data are

used as weights when calculating all weighted averages. For each HCPCS code group, the smaller of the two ratios is selected as the adjustment from median to 80th percentile charges.

(iv) *Trending forward.* The charges for each HCPCS code, obtained as described in paragraph (l)(2)(iii) of this section, are trended forward based on changes to the medical care commodities component of the CPI-U. Actual CPI-U changes are used from the time period of the source data through the latest available month as of the time the calculations are performed. The three-month average annual trend rate as of the latest available month is then held constant to the midpoint of the calendar year in which the charges are primarily expected to be used. The projected total CPI-U change so obtained is then applied to the 80th percentile charges, as described in paragraph (l)(2)(iii) of this section.

(3) *Nationwide 80th percentile charges for HCPCS codes without RVUs.* For each applicable HCPCS code, 80th percentile charges are extracted from three independent data sources: the MDR database; Medicare, as represented by the combined Part B and DME components of the Medicare Standard Analytical File 5% Sample; and Milliman USA, Inc., Optimized HMO (Health Maintenance Organization) Data Sets (see paragraph (a)(3) of this section for data sources). Charges from each database are then trended forward to the effective time period for the charges, as set forth in paragraph (l)(3)(i) of this section. Charges for each HCPCS code from each data source are combined into an average 80th percentile charge by means of the methodology set forth in paragraph (l)(3)(ii) of this section. The results constitute the nationwide 80th percentile charge for each applicable HCPCS code.

(i) *Trending forward.* The charges from each database for each HCPCS code, obtained as described in paragraph (l)(3) of this section, are trended forward based on changes to the medical care commodities component of the CPI-U. Actual CPI-U changes are used from the time period of each source database through the latest available month as of the time the calculations are performed. The three-month average annual trend rate as of the latest available month is then held constant to the midpoint of the calendar year in which the charges are primarily expected to be used. The projected total CPI-U change so obtained is then applied to the 80th percentile charges, as described in paragraph (l)(3) of this section.



(ii) *Averaging methodology.* The average 80th percentile trended charge for any particular HCPCS code is calculated by first computing a preliminary mean average of the three charges for each HCPCS code. Statistical outliers are identified and removed by testing whether any charge differs from the preliminary mean charge by more than 5 times the preliminary mean charge, or by less than 0.2 times the preliminary mean charge. In such cases, the charge most distant from the preliminary mean is removed as an outlier, and the average charge is calculated as a mean of the two remaining charges. In cases where none of the charges differ from the preliminary mean charge by more than 5 times the preliminary mean charge, or less than 0.2 times the preliminary mean charge, the average charge is calculated as a mean of all three reported charges.

(4) *Nationwide 80th percentile charges for HCPCS codes designated as unlisted or unspecified.* For HCPCS codes designated as unlisted or unspecified procedures, services, items, or supplies, 80th percentile charges are developed based on the weighted median 80th percentile charges of HCPCS codes within the series in which the unlisted or unspecified code occurs. A nationwide VA distribution of procedures, services, items, and supplies is used for the purpose of computing the weighted median.

(5) *Geographic area adjustment factors.* For the purpose of geographic adjustment, HCPCS codes are combined into two groups: drugs and DME/supplies, as set forth in paragraph

(l)(5)(i) of this section. The geographic area adjustment factor for each of these groups is calculated as the ratio of the area-specific weighted average charge determined pursuant to paragraph (l)(5)(ii) of this section divided by the nationwide weighted average charge determined pursuant to paragraph (l)(5)(iii) of this section.

(i) *Combined HCPCS code groups for geographic area adjustment factors for DME, drugs, injectables, and other medical services, items, and supplies.* For the purpose of the statistical methodology set forth in paragraph (l)(5) of this section, each of the HCPCS code groups set forth in paragraph (l)(2)(i) of this section is assigned to one of two combined HCPCS code groups, as follows:

- (A) Chemotherapy Drugs: Drugs.
- (B) Other Drugs: Drugs.
- (C) DME—Hospital Beds: DME/supplies.
- (D) DME—Medical/Surgical Supplies: DME/supplies.
- (E) DME—Orthotic Devices: DME/supplies.
- (F) DME—Oxygen and Supplies: DME/supplies.
- (G) DME—Wheelchairs: DME/supplies.
- (H) Other DME: DME/supplies.
- (I) Enteral/Parenteral Supplies: DME/supplies.
- (J) Surgical Dressings and Supplies: DME/supplies.
- (K) Vision Items—Other Than Lenses: DME/supplies.
- (L) Vision Items—Lenses: DME/supplies.
- (M) Hearing Items: DME/supplies.

(ii) *Area-specific weighted average charges.* Using the median charges by

HCPCS code from the MDR database for each geographic area and utilization frequencies by HCPCS code from the combined Part B and DME components of the Medicare Standard Analytical File 5% Sample, an area-specific weighted average charge is calculated for each combined HCPCS code group.

(iii) *Nationwide weighted average charges.* Using the area-specific weighted average charges determined pursuant to paragraph (l)(5)(ii) of this section, a nationwide weighted average charge is calculated for each combined HCPCS code group, using as weights the population (census) frequencies for each geographic area as presented in the Milliman USA, Inc., Health Cost Guidelines (*see* paragraph (a)(3) of this section for data sources).

(m) *Charges for prescription drugs not administered during treatment.* Notwithstanding other provisions of this section, when VA provides or furnishes 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 prescription drugs 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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