DEPARTMENT OF VETERANS AFFAIRS

38 CFR Part 17

RIN 2900–AJ30

Medical Care Collection or Recovery

AGENCY: Department of Veterans Affairs.

ACTION: Proposed rule.

SUMMARY: This document proposes to amend VA's medical regulations concerning collection or recovery by VA for medical care or services provided or furnished to a veteran:

For a non-service connected disability for which the veteran is entitled to care (or the payment of expenses of care) under a health-plan contract;

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

Previously, by statute VA was authorized to charge ''reasonable costs'' for such care or services. However, amended statutory provisions now authorize VA to charge ''reasonable charges.'' Accordingly, this document proposes to establish methodology for charging ''reasonable charges'' consistent with the statutory amendment. Under the proposal, the charges billed using this methodology, as appropriate, would consist of inpatient facility charges, skilled nursing facility/sub-acute inpatient facility charges, outpatient facility charges, physician charges, and non-physician provider charges. Reasonable charges for outpatient dental care and prescription drugs not administered during treatment would continue to be billed using the existing cost-based methodology.

Pursuant to statutory authority, VA has the right to recover or collect the charges from a third party to the extent that a provider of the care or services would be eligible to receive payment therefor from that third party if the care or services had not been furnished by a department or agency of the United States. With respect to a third-party payer liable under a health plan contract, consistent with the statutory authority, the third-party payer would have 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.

Using the methodology in this proposed rule, the data for calculating actual amounts for the various inpatient facility charges, skilled nursing facility/sub-acute inpatient facility charges, outpatient facility charges, and physician charges at individual VA facilities for the period August 1998 through September 1999 are set forth in a companion document published in the ''Notices'' section of this issue of the **Federal Register**.

Also, under the proposal, the regulations would be clarified to state specifically that billing methodology based on costs will continue to be applied to establish charges for medical care furnished in error or on tentative eligibility, furnished in a medical emergency, furnished to certain beneficiaries of the Department of Defense or other Federal agencies, furnished to pensioners of allied nations, and furnished to military retirees with chronic disability.

DATES: Comments must be received on or before December 14, 1998.

ADDRESSES: Mail or hand-deliver written comments to: Director, Office of Regulations Management (02D), Department of Veterans Affairs, 810 Vermont Ave., NW, Room 1154, Washington, DC 20420. Comments should indicate that they are submitted in response to ''RIN: 2900–AJ30.'' All written comments received will be available for public inspection at the above address in the Office of Regulations Management, Room 1158, between the hours of 8:00 a.m. and 4:30 p.m., Monday through Friday (except holidays).

FOR FURTHER INFORMATION CONTACT: David Cleaver, VHA Office of Finance (174), Veterans Health Administration, Department of Veterans Affairs, 810 Vermont Avenue, NW, Washington, DC 20420, (202) 273–8210. (This is not a toll free number.)

SUPPLEMENTARY INFORMATION:

Background

This document proposes to amend VA's medical regulations which are set forth at 38 CFR part 17. More specifically, it is proposed to amend the regulations concerning collection or recovery by VA for medical care or services provided or furnished to a veteran:

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

Pub. L. 105–33 amended the statutory provisions (38 U.S.C. 1729) to authorize VA to bill ''reasonable charges'' instead of ''reasonable cost.'' In this regard, the legislative history for these amendments includes the following statement from the House Conference Report (H. Rep. No. 105–217, July 30, 1997, at pp. 974–975):

> These amendments would allow VA to move away from a cost-based medical care recovery system to one that more appropriately resembles market pricing for health care services; the Committee envisions VA would establish health care charges that would allow it to recover amounts needed to help preserve the viability of the health care system for all veterans and that also reflect the substantial advantages to VA patients both in having the quality services provided by that system available and in using them. The amendments reflect the expectation that VA would establish reasonable charges that are responsive to market prices—charges that are not constrained to recovery of costs, but which may yield net revenues. (The concept of ''market price'' here refers to the price for a service that is based on competition in open markets. When a substantial competitive demand exists for a service, its market price normally is determined using commercial practices, such as by reference to prevailing prices and payments in competitive markets for services the same or similar to those provided by the Government.)

Accordingly, this document proposes to establish methodology for charging ''reasonable charges'' consistent with the statutory amendment. Under the proposal, as appropriate, the amount billed using this methodology would consist of inpatient facility charges, skilled nursing facility/sub-acute inpatient facility charges, outpatient facility charges, physician charges, and non-physician provider charges.

Amount of Recovery or Collection—Third Party Liability

Under the provisions of 38 U.S.C. 1729, VA has the right to recover or collect its reasonable charges 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 not been furnished by a department or agency of the United States. With respect to a third-party payer liable under a health plan contract, consistent with the statutory authority, the third-party payer would have 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.

General

One way to establish ''reasonable'' inpatient facility charges, skilled nursing facility/sub-acute inpatient facility charges, outpatient facility charges, physician charges, and non-physician provider charges would be to use available data to determine prevailing charges for services in the locality of each VA facility, and bill those prevailing charges. However, this is impractical because there is insufficient data for some services at a number of localities. Therefore, we are proposing formulas designed to establish baseline reasonable charges for each provided service, commensurate with charges in each local market, and to enable VA to project from the baseline the charges applicable to medical care and services provided during subsequent relevant periods.

We are proposing separate formulas for inpatient facility charges, skilled nursing facility/sub-acute inpatient facility charges, outpatient facility charges, physician charges, and non-physician provider charges. These formulas, developed for VA by Milliman & Robertson, Inc., Actuaries and Consultants, reflect inherent differences in the structure and available information for each of these categories of charges.

Inpatient Facility Charges

The proposed inpatient facility charges consist of per diem charges for room and board and for ancillary services that vary by VA facility and by diagnosis related group (DRG). These charges are calculated based on the following formula.

To establish a baseline, two nationwide average per diem charges for each DRG were calculated for Calendar Year 1995 (the latest available data), one from the Medicare Standard Analytical File 5% Sample and one from the MedStat claim database, a claim database of nationwide commercial insurance (two widely used data bases that, among other things, are used for analyzing industry charges). Results obtained from these two databases were then combined into a single weighted average per diem charge for each DRG. Using both databases in this way strengthens the statistical basis for the resulting nationwide average per diem charges by providing additional data for all DRGs, especially those that occur infrequently in one or the other database.

The resulting weighted average per diem charge for each DRG was then separated into its two components, a room and board component and an ancillary component. This was done to make subsequent calculations more accurate and to conform with standard industry billing practices. Consistent with billing practices of many providers, the resulting amounts for room and board and ancillary services for each DRG were then adjusted to reflect 80th percentile charges. Since the resulting nationwide 80th percentile charges represent amounts applicable for calendar year 1995, the formula includes trending provisions to update the charges to reflect appropriate economic changes for future periods. Finally, to account for locality variations, the formula provides for the trended nationwide 80th percentile charges for room and board and ancillary services to be multiplied by geographic area adjustment factors to set charges commensurate with the local market for each VA facility.

Skilled Nursing Facility/Sub-Acute Inpatient Facility Charges

Under the proposal, skilled nursing facility/sub-acute inpatient facility charges would be per diem charges that vary by VA facility. The proposed charges would cover care, including skilled rehabilitation services (e.g., physical therapy, occupational therapy, and speech therapy), 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 therapists, and audiologists. The skilled nursing facility/sub-acute inpatient facility charges would incorporate charges for ancillary services associated with care provided in these settings. The proposed charges would be calculated based on the following formula.

To establish a baseline, a nationwide average per diem billed charge for skilled nursing facility care for July 1, 1998, was obtained from the 1998 Milliman & Robertson, Inc. Health Cost Guidelines, a publication that includes nationwide skilled nursing facility charges (skilled nursing facility charges are also representative of sub-acute inpatient facility charges). Consistent with billing practices of many providers, the nationwide average per diem billed charge then was adjusted to reflect the nationwide 80th percentile charge level. The resulting nationwide 80th percentile charges represent amounts applicable for calendar year 1998. Accordingly, the formula includes trending provisions to update the charges to reflect appropriate economic changes for future periods. The formula provides for the trended nationwide charges to be multiplied by geographic area adjustment factors to set charges commensurate with the local market for each VA facility.

Outpatient Facility Charges

Under the proposal, outpatient facility charges, as appropriate, will include separate charges for prosthetic devices and durable medical equipment that reflect actual costs to VA. It is industry practice to purchase the devices and provide them at actual cost. Accordingly, ''actual costs'' and ''reasonable charges'' are the same for prosthetic devices and durable medical equipment. Otherwise, the proposed outpatient facility charges consist of charges for outpatient facility services that vary by VA facility and by CPT procedure code. These charges are calculated based on the following formula.

Using the 1995 MedStat claims database of nationwide commercial insurance, the median billed facility charge was calculated for each CPT procedure code for which outpatient facility charges apply. All outpatient facility CPT procedure codes were then separated into outpatient facility CPT procedure code groups that were both subject-matter-related and statistically-related, resulting in 37 such groups. This step was designed to ensure that there were sufficient relevant data for each CPT procedure code, using the smallest number of groups necessary to obtain this information. Then, for each CPT procedure code in each of the 37 groups, consistent with billing practices of many providers, the median charge was adjusted to the 80th percentile. The formula includes trending provisions to update the 80th percentile charges to reflect appropriate economic changes for future periods. Using the resulting charges and 1998 practice expense relative value units (RVUs), the mathematical approximation methodology of least squares then was applied to the data for each outpatient facility CPT procedure code group to

derive two charge factors. The first factor represents the charge for each incremental RVU in the CPT procedure code group and the second factor represents a fixed amount adjustment for the CPT procedure code group. Then for each CPT procedure code, the outpatient facility RVU was multiplied by the incremental charge factor and the resulting charge was adjusted by the fixed amount.

The results constitute nationwide trended 80th percentile outpatient facility charges. The resulting charges then were multiplied by geographic area adjustment factors to set charges commensurate with the local market for each VA facility.

Also, the proposed rule contains special provisions for multiple surgical procedures performed during the same outpatient encounter by a provider or provider team. Charges for the second and subsequent surgical procedures during the same outpatient encounter are reduced consistent with industry practice.

Further, the proposed rule clarifies that outpatient facility charges would not be made for services customarily performed in an independent clinician's office since such services would not usually create significant outpatient facility expenses.

Physician Charges

The proposed physician charges consist of charges for the services of physicians which vary by VA facility and by CPT procedure code. These charges are calculated based on the following formula.

For each CPT procedure code except those for anesthesia and pathology, the total facility-adjusted RVU (sum of RVU components, with each component adjusted by the facility's geographic area adjustment factors) was multiplied by the facility-adjusted conversion factor (nationwide conversion factor multiplied by the facility's geographic area adjustment factor). This provides a charge for each CPT procedure code that reflects the local market for each VA facility. For CPT procedure codes other than those specifically addressed below in this paragraph, the calculations by which the total facility-adjusted RVUs were derived consist of separate calculations for physician work expense and physician practice expense to obtain more accurate charge components. The RVU calculations for radiology, pathology, and anesthesia differ from other physician charges to reflect industry practice. For radiology CPT procedure codes, the calculation of physician charges does not include separately identified technical component RVUs. For each anesthesia and pathology CPT procedure code, RVUs were multiplied by a nationwide conversion factor to obtain the nationwide charge. The nationwide charge was multiplied by a geographic area adjustment factor to obtain the physician charge for each anesthesia and pathology CPT procedure code at a particular VA facility. Separate calculations of RVUs also were required for CPT procedure codes which had only total RVUs (these CPT procedure codes do not have separate information for physician work expense and physician practice expense).

To obtain the conversion factors referred to in the preceding paragraph, CPT procedure codes were separated into physician CPT procedure code groups that were both subject-matter-related and statistically-related, resulting in 24 such groups. This step was designed to ensure that there were sufficient relevant data for each CPT procedure code, using the smallest number of groups necessary to obtain this information. Separate conversion factors were calculated for each of the 24 different physician CPT procedure code groups. Consistent with billing practices of many providers, the conversion factors, reflecting nationwide median physician charges, were then adjusted to reflect nationwide 80th percentile charges. The formula then provides for multiplying the resulting conversion factors by the appropriate geographic area adjustment factors to establish conversion factors commensurate with the local market for each VA facility.

The charges resulting from these calculations represent amounts applicable for 1996–1997, the latest available data (see paragraph (e)(3) of proposed § 17.101). Accordingly, the formula includes trending provisions to update the charges to reflect appropriate economic changes for future periods.

Certain Non-Physician Provider Charges

The proposal at § 17.101(f) includes non-physician provider charges for certain non-physician services covered by CPT procedure codes. The charges consist of percentages of physician charges. The percentages for a nurse practitioner, clinical nurse specialist, physician assistant, certified registered nurse anesthetist, clinical psychologist, and clinical social worker are based on Medicare percentages. The percentages for a podiatrist, chiropractor, dietitian, clinical pharmacist, and optometrist are based on the MedStat nationwide insurance database. We used the Medicare percentages when available because of their extensive use for billing and payment of claims. However, all of the percentages are consistent with industry practice.

Publication of Data for Calculating Actual Amounts for Inpatient Facility Charges, Skilled Nursing Facility/Sub-Acute Inpatient Facility Charges, Outpatient Facility Charges, and Physician Charges

We have set forth in a companion document published in the ''Notices'' section of this issue of the **Federal Register**, data (derived from the methodology explained above) for calculating inpatient facility charges, skilled nursing facility/sub-acute inpatient facility charges, outpatient facility charges, and physician charges at individual VA facilities. Should the methodology set forth in this proposal be adopted, the data in the companion document would be used for inpatient facility charges, skilled nursing facility/sub-acute inpatient facility charges, outpatient facility charges, and physician charges from the effective date of the final rule through September 1999. Accordingly, interested parties may wish to retain the ''Notices'' document for future reference. Under the proposal, VA would update annually in the ''Notices'' section of the **Federal Register** the data for calculating the charges at individual VA facilities.

Billing Reasonable Costs for Various Hospital Care or Medical Services not Covered Under Proposed § 17.101

The regulations at current § 17.101 (proposed § 17.102) contain provisions for billing reasonable costs for hospital care or medical services. Paragraph (h) includes the following methodology for billing for hospital care or medical services furnished veterans for non-service connected disabilities:

The method for computing the charges for medical care and services is based on the Cost Distribution Report, which sets forth the actual basic costs and per diem rates by type of inpatient care and outpatient visit. Factors for depreciation of buildings and equipment and Central Office overhead are added, based on accounting manual instructions. Additional factors are added for interest on capital investment and for standard fringe benefit costs covering government employee retirement and disability costs. The current year billing rates are projected on prior year actual rates by applying the budgeted percentage increase. In addition, based on the detail available in the Cost Distribution Report, VA intends to, on each bill break down the all-inclusive rate into its three principal components; namely, physician cost, ancillary services cost, and nursing, room and board cost. The rates generated by the foregoing methodology are the same rates prescribed by the Office of Management and

Budget and published in the **Federal Register** for use under the Federal Medical Care Recovery Act, 42 U.S.C. 2651–2653.

The adoption of this proposed rule would supersede these quoted provisions insofar as they relate to charges to third parties liable under health plan contracts, liable under worker's compensation laws or plans, or liable as a result of a motor vehicle accident when VA provides or furnishes hospital care or medical services to veterans for non-service connected disabilities. However, the proposal would amend the regulations to provide specifically that this billing methodology based on costs would continue to apply to charging for medical care furnished in error or on tentative eligibility, furnished in a medical emergency, furnished to beneficiaries of the Department of Defense or other Federal agencies, furnished to pensioners of allied nations, and furnished to military retirees with chronic disability.

Outpatient Dental Charges and Prescription Drugs not Administered During Treatment

The proposal at § 17.101(g) includes charges for outpatient dental care and prescription drugs not administered during treatment. Under the proposal, these charges would continue to be billed based on VA costs as set forth in proposed § 17.102. However, in the future, we intend to consider whether, based on information to be acquired, we should amend the regulations to reflect a different ''reasonable charge'' methodology for these charges.

Technical Changes

The proposed rule also proposes to make a number of technical amendments to the medical regulations for purposes of consistency.

Paperwork Reduction Act of 1995

Under the Paperwork Reduction Act of 1995 (44 U.S.C. 3501–3520), a collection of information is set forth in proposed 38 CFR 17.101(a)(2). Accordingly, under section 3507(d) of the Act, VA has submitted a copy of this rulemaking action to the Office of Management and Budget (OMB) for its review of the proposed collection of information.

OMB assigns a control number for each collection of information it approves. VA may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a currently valid OMB control number.

Comments on the proposed collection of information should be submitted to the Office of Management and Budget, Attention: Desk Officer for the Department of Veterans Affairs, Office of Information and Regulatory Affairs, Washington, DC 20503, with copies mailed or hand-delivered to: Director, Office of Regulations Management (02D), Department of Veterans Affairs, 810 Vermont Ave., NW, Room 1154, Washington, DC 20420. Comments should indicate that they are submitted in response to ''RIN 2900–AJ30.''

Title: Submission of Evidence.

Summary of collection of information: Under the provisions of proposed § 17.101(a)(2), a third-party payer that is liable for reimbursing VA for health care VA provided to veterans with non-service-connected conditions continues to have the option of paying either the billed charges as described in proposed § 17.101 or the amount the health plan demonstrates it would pay to providers other than entities of the United States for the same care or services in the same geographic area. If the amount submitted for payment is less than the amount billed, VA will accept the submission as payment, subject to verification at VA's discretion. A VA employee having responsibility for collection of such charges may request that the third party payer submit evidence or information to substantiate the appropriateness of the payment amount (e.g., health plan policies, provider agreements, medical evidence, proof of payment to other providers demonstrating the amount paid for the same care and services VA provided).

Description of need for information and proposed use of information: This information would be needed to determine whether the third-party payer has met the test of properly demonstrating its equivalent private sector provider payment amount for the same care or services and within the same geographic area as provided by VA.

Description of likely respondents: Third-party payers who are liable under health plan contracts for reimbursing VA for healthcare it provides to veterans with non-service-connected conditions.

Estimated number of respondents: 400 per year.

Estimated frequency of responses: Once per year.

Estimated average burden per collection: 2 hours.

Estimated total annual reporting and recordkeeping burden: 800 hours.

The Department considers comments by the public on proposed collections of information in—

- Evaluating whether the proposed collections of information are necessary for the proper performance of the functions of the Department, including whether the information will have practical utility;
- Evaluating the accuracy of the Department's estimate of the burden of the proposed collections of information, including the validity of the methodology and assumptions used;
- Enhancing the quality, usefulness, and clarity of the information to be collected; and
- Minimizing the burden of the collections of information on those who are to respond, including through the use of appropriate automated, electronic, mechanical, or other technological collection techniques or other forms of information technology, e.g., permitting electronic submission of responses.

OMB is required to make a decision concerning the collection of information contained in this proposed rule between 30 and 60 days after publication of this document in the **Federal Register**. Therefore, a comment to OMB is best assured of having its full effect if OMB receives it within 30 days of publication. This does not affect the deadline for the public to comment on the proposed regulations.

Regulatory Flexibility Act

The Secretary hereby certifies that this proposed rule would 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 rulemaking proceeding mostly would affect large insurance companies. Further, the provisions of the proposed rule would not impose a significant economic impact on any entities since VA billing would not constitute a significant portion of an insurance company's business. Accordingly, pursuant to 5 U.S.C. 605(b), this proposed rule is exempt from the initial and final regulatory flexibility analyses requirements of sections 603 and 604.

OMB Review

This document has been reviewed by OMB pursuant to Executive Order 12866.

The Catalog of Federal Domestic Assistance numbers for the programs affected by this document 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: September 21, 1998.

Togo D. West, Jr.,

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.

§§ 17.101 and 17.102 [Redesignated as §§ 17.102 and 17.101, respectively]

2. Sections 17.101 and 17.102 are redesignated as §§ 17.102 and 17.101, respectively.

3. Newly redesignated § 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 non-service 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 non-service 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 non-service 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 non-service connected disability incurred as a result of a motor vehicle accident in a State that requires automobile accident reparations insurance.

(2) *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).

(3) *Methodology.* Based on the methodology set forth in this section, the charges billed will include, as appropriate, inpatient facility charges, skilled nursing facility/sub-acute inpatient facility charges, outpatient facility charges, physician charges, and non-physician provider charges. In addition, the charges billed for prosthetic devices and durable medical equipment provided on an outpatient basis will be VA's actual cost and the charges billed for prescription drugs not administered during treatment will bill a single nationwide average. Data for calculating actual amounts for inpatient facility charges, skilled nursing facility/sub-acute inpatient facility charges, outpatient facility charges, and physician charges will be published annually in the ''Notices'' section of the **Federal Register**.

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

Consolidated MSA means a consolidated Metropolitan Statistical Area.

CPI means Consumer Price Index.

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

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

CPT procedure code means a 5 digit-identifier for a specified physician service or procedure.

DRG means diagnosis related group.

Geographic area means Metropolitan Statistical Area (MSA) or the local market, if the VA facility is not located in an MSA.

RVU means relative value unit.

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

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

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

(2) *Per diem charges.* To establish a baseline, two nationwide average per diem charges for each DRG are calculated for Calendar Year 1995, one from the Medicare Standard Analytical File 5% Sample and one from the MedStat claim database, a claim database of nationwide commercial insurance. Results obtained from these two databases are then combined into a single weighted average per diem charge for each DRG. The resulting weighted average per diem charge for each DRG is then separated into its two components, a room and board component and an ancillary component, with the amount for each component calculated to reflect the corresponding percentage set forth in paragraph (b)(2)(i) of this section. The resulting amounts for room and board and ancillary services for each DRG are then each multiplied by the final ratio set forth in paragraph (b)(2)(ii) of this section to reflect the 80th percentile charges. Finally, the resulting charges are each trended forward from their 1995 base to the effective time period for the charges, as set forth in paragraph (b)(2)(iii) of this section. The results

constitute the room and board per diem charge and the ancillary per diem charge.

(i) *Charge component percentages.* Using only those cases from the Medicare Standard Analytical File 5% Sample for which a distinction between room and board charges and ancillary charges can be determined, the percentage of the total charges for room and board compared to the combined total charges for room and board and ancillary services, and the percentage of the total charges for ancillary services compared to the combined total charges for room and board and ancillary services, are calculated by DRG.

(ii) *80th percentile.* Using the medical and surgical admissions in the Medicare Standard Analytical File 5% Sample, obtain for each consolidated MSA 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. The consolidated MSA ratios are averaged to obtain a final 80th percentile ratio.

(iii) *Trending forward.* For each DRG, the 80th percentile charges, representing calculations for calendar year 1995, are trended forward for the period August 1998 through September 1999, and for each 12-month period thereafter, beginning October 1, 1999, based on changes to the CPI. The projected total CPI trend from 1995 to the midpoint of the effective charge period is calculated as the composite of three components. The first component trends from 1995 to January 1997, using the Hospital Room component of the CPI–W for room and board charges and using the Other Hospital component of the CPI–W for ancillary charges. The second component trends from January 1997 to the latest available month, based on the Inpatient Hospital component of the CPI–U for room and board and ancillary charges. The third component trends from the latest available month to the midpoint of the effective charge period, based on the latest three-month average annual trend rate from the Inpatient Hospital component of the CPI–U. The projected total CPI trends are then applied to the 1995-base 80th percentile charges.

(3) *Geographic area adjustment factors.* For each VA facility location, the average per diem room and board charges and ancillary charges from the 1995 Medicare Standard Analytical File 5% Sample are calculated for each DRG. The DRGs are separated into two groups, surgical and non-surgical. For each of these groups of DRGs, for each geographic area, average room and board per diem charges and ancillary per diem charges are calculated for 1995, weighted by FY 1997 nationwide VA discharges and by average lengths of stay from the combined Medicare Standard Analytical File 5% Sample and the MedStat claim data base. This results in four average per diem charges for each geographic area: room and board for surgical DRGs, ancillary for surgical DRGs, room and board for non-surgical DRGs, and ancillary for non-surgical DRGs. Four corresponding national average per diem charges are obtained from the 1995 Medicare Standard Analytical File 5% Sample, weighted by FY 1997 nationwide VA discharges and by average lengths of stay from the combined Medicare Standard Analytical File 5% Sample and the MedStat claim data base. Four geographic area adjustment factors are then calculated for each geographic area by dividing each geographic area average per diem charge by the corresponding national average per diem charge.

(c) *Skilled nursing facility/sub-acute inpatient facility charges.* When VA provides or furnishes skilled nursing/sub-acute inpatient services within the scope of care referred to in paragraph (a)(1) of this section, skilled nursing facility/sub-acute inpatient facility charges billed for such services will be determined in accordance with the provisions of this paragraph. The skilled nursing facility/sub-acute inpatient facility charges are per diem charges that vary by VA facility. The facility charges cover care, including skilled rehabilitation services (e.g., physical therapy, occupational therapy, and speech therapy), 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 therapists, and audiologists. The skilled nursing facility/sub-acute inpatient facility charges also incorporate charges for ancillary services associated with care provided in these settings. The charges are calculated as follows:

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

(2) *Per diem charge.* To establish a baseline, a nationwide average per diem billed charge for July 1, 1998, was obtained from the 1998 Milliman & Robertson, Inc. Health Cost Guidelines, a publication that includes nationwide skilled nursing facility charges (Milliman & Robertson, Inc, 1305 5th Ave., Suite 3800, Seattle, WA 98101–2605). That average per diem billed charge is then multiplied by the 80th percentile adjustment factor set forth in paragraph (c)(2)(i) of this section to obtain a nationwide 80th percentile charge level. Finally, the resulting charge is trended forward to the effective time period for the charges, as set forth in paragraph (c)(2)(ii) of this section.

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

(ii) *Trending forward.* The 80th percentile charge, representing charge levels for July 1, 1998, is trended forward to the midpoint of the period August 1998 through September 1999, and to the midpoint of each 12-month period thereafter, beginning October 1, 1999, based on the projected change in Medicare reimbursement from the Annual Report of the Board of Trustees of the Federal Hospital Insurance Trust Fund (this report can be found on the Health Care Financing Administration Internet site at *http://www.hcfa.gov* under the headings ''Publications and Forms'' and ''Professional/ Technical Publications'').

(3) *Geographic area adjustment factors.* A ratio of the average per diem charge for each State to the nationwide average per diem charge is obtained (these ratios are set forth in the 1998 Milliman & Robertson, Inc. Health Cost Guidelines, a data base of nationwide commercial insurance charges and relative costs) (Milliman & Robertson, Inc., 1301 5th Ave., Suite 3800, Seattle, WA 98101–2605). The geographic area adjustment factor for charges for each VA facility is the ratio for the State in which the facility is located.

(d) *Outpatient facility charges.* When VA provides or furnishes outpatient services that are within the scope of care referred to in paragraph (a)(1) of this section and are not customarily performed in an independent clinician's office, the outpatient facility charges billed for such services will be

determined in accordance with the provisions of this paragraph. Except for prosthetic devices and durable medical equipment, whose charges will be made separately at actual cost to VA, charges for outpatient facility services will vary by VA facility and by CPT procedure code. These charges will be calculated as follows:

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

(2) *Nationwide 80th percentile charges by CPT procedure code.* For each CPT procedure code for which outpatient facility charges apply, the 1998 practice expense RVUs (these RVUs can be found in the *1998 St. Anthony's Complete RBRVS,* Relative Value Studies, Inc., St. Anthony Publishing, 11410 Isaac Newton Square, Reston, VA 20190) are used as the outpatient facility RVUs. For each CPT procedure code, the outpatient facility RVU is multiplied by the charge amount for each incremental RVU as set forth in paragraph (d)(3) of this section. The resulting charge is adjusted by a fixed charge amount as also set forth in paragraph (d)(3) of this section to obtain the nationwide 80th percentile charge.

(3) *Charge factor.* Using the 1995 MedStat claims database of nationwide commercial insurance, the median billed facility charge is calculated for each applicable CPT procedure code. All outpatient facility CPT procedure codes are then separated into one of the 37 outpatient facility CPT procedure code groups as set forth in paragraph (d)(3)(i) of this section. Then, for each CPT procedure code in each such group, the median charge is adjusted to the 80th percentile as set forth in paragraph (d)(3)(ii) of this section. The resulting 80th percentile charge for each CPT procedure code is trended forward to the effective time period for the charges as set forth in paragraph (d)(3)(iii) of this section. Using the resulting charges and the RVUs, the mathematical approximation methodology of least squares is applied to the data for each CPT procedure code group to derive two charge factors. The first factor represents the charge amount for each incremental RVU in the CPT procedure code group and the second factor represents a fixed charge amount adjustment for the CPT procedure code group.

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

(A) Surgery—Integumentery System—Skin, Subcutaneous & Accessory Structures/Nails;

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

(C) Surgery—Integumentery System—Not Otherwise Classified;

(D) Surgery—Musculoskeletal System—Not Otherwise Classified;

(E) Surgery—Musculoskeletal System—Limbs—Incisions/Excisions/Insertion/Removal;

(F) Surgery—Musculoskeletal System—Limbs—Shoulders/Humerus & Elbow/Pelvis & Hip Joint/Femur & Knee Joint—Other than Incisions/Excisions/Insertion/Removal;

(G) Surgery—Musculoskeletal System—Limbs—Forearm & Wrist—Other than Incisions/Excisions/Insertion/Removal;

(H) Surgery—Musculoskeletal System—Limbs—Tibia/Fibula & Ankle Joint'' Other than Incisions/Excisions/Insertion/Removal;

(I) Surgery—Musculoskeletal System—Limbs—Hand & Fingers/Foot & Toes—Other than Incisions/Excisions/Insertion/Removal;

(J) Surgery—Musculoskeletal System—Arthroscopy;

(K) Surgery—Respiratory System;

(L) Surgery—Cardiovascular System;

(M) Surgery—Hemic & Lymphatic Systems;

(N) Surgery—Digestive System—Not Otherwise Classified;

(O) Surgery—Digestive System—Endoscopy;

(P) Surgery—Urinary System;

(Q) Surgery—Male Genital System;

(R) Surgery—Laparoscopy/Hysteroscopy;

(S) Surgery—Maternity Care & Delivery;

(T) Surgery—Endocrine System;

(U) Surgery—Eye/Ocular Adnexa;

(V) Surgery—Auditory System;

(W) Radiology—Diagnostic—Head & Neck/Chest/Spine & Pelvis;

(X) Radiology—Diagnostic—Extremities/Abdomen/Gastrointestinal Tract/Urinary Tract/Gynecological & Obstetrical/Heart;

(Y) Radiology—Diagnostic—Aorta & Arteries/Veins & Lymphatics;

(Z) Radiology—Diagnostic Ultrasound;

(AA) Radiology—Radiation Oncology/Nuclear Medicine/Therapeutic;

(BB) Radiology—Diagnostic—CAT Scans;

(CC) Radiology—Diagnostic—Magnetic Resonance Imaging (MRI);

(DD) Medicine—Global—Not Otherwise Classified;

(EE) Medicine—Global—Dialysis;

(FF) Medicine—Technical Component—Gastroenterology;

(GG) Medicine—Technical Component—Cardiovascular;

(HH) Medicine—Technical Component—Pulmonary;

(II) Medicine—Technical Component—Neurology & Neuromuscular Procedures;

(JJ) Medicine—Observation Care; and

(KK) Medicine—Emergency.

(ii) *80th percentile.* For each of the 37 outpatient facility CPT procedure code groups set forth in paragraph (d)(3)(i) of this section, the median charge is increased by the ratio of the 80th percentile charge to median charge (the data for CPT procedure code groups listed at paragraphs (d)(3)(i)(DD), (EE), (JJ), and (KK) of this section are obtained from the MedStat database of nationwide charges; the data for the other groups are obtained from the Outpatient Facility UCR module of the Comprehensive Healthcare Payment System from MediCode, Inc., a 1997 release from a nationwide database of outpatient facility charges) (MediCode, Inc., 5225 Wiley Post Way, Suite 500, Salt Lake, UT 84116). To mitigate the impact of the variation in the intensity of services by CPT procedure code, the percent increase from the median to the 80th percentile in outpatient charges is compared to the percent increase from the median to the 80th percentile in inpatient semi-private room and board charges. Any percent increase in outpatient charges in excess of the inpatient semi-private room and board percent increase is multiplied by a factor of 0.50. The 80th percentile outpatient facility charge is reduced accordingly.

(iii) *Trending forward.* The charges for each CPT procedure code, representing calculations for calendar year 1995, are trended forward for the period August 1998 through September 1999, and for each 12-month period thereafter, beginning October 1, 1999, based on changes to the Outpatient Hospital component of the CPI–U. Actual CPI–U changes are used through the latest available month. The three-month average annual trend rate as of the latest available month is held constant to the midpoint of the effective charge period. The projected total CPI–U change from 1995 to this midpoint of the effective charge period is then applied to the 1995 80th percentile charges.

(4) *Geographic area adjustment factors.* For each VA outpatient facility

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

(5) *Multiple surgical procedures.* When multiple surgical procedures are performed during the same outpatient encounter by a provider or provider team as indicated by multiple surgical CPT procedure codes, then the highest charge will be billed at 100% of the charges established under this section; the second highest charge will be billed at 25% of the charges established under this section; the third highest charge will be billed at 15% of the charges established under this section; and no outpatient facility charges will be billed for any additional surgical procedures.

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

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

(2)(i) *Total facility-adjusted RVUs for physician services other than anesthesia, pathology, and specified CPT procedure codes.* The work expense and practice expense components of the RVUs for CPT procedure codes (other than anesthesia, pathology, and those CPT procedure codes set forth at paragraphs (e)(2)(ii) and (e)(2)(iii) of this section) are compiled (information concerning the RVUs and their components can be obtained from Veterans Health Administration, Office of Finance, Department of Veterans Affairs, 810 Vermont Ave., NW, Washington, DC 20420). For radiology CPT procedure codes, these compilations do not include separately identified technical component RVUs. For CPT procedure codes that generate an outpatient facility charge, the facility practice expense RVU is substitute for the non-facility practice expense RVU (information concerning facility practice expense RVUs can be obtained from Veterans Health Administration, Office of Finance, Department of Veterans Affairs, 810 Vermont Ave., NW, Washington, DC 20420). For Medicine and Surgery CPT procedure codes with separate professional and technical components that also generate an outpatient facility charge, only the professional component is compiled. The sum of the facility-adjusted work expense RVU as set forth in paragraph (e)(2)(i)(A) of this section and the facility-adjusted practice expense RVU as set forth in paragraph (e)(2)(i)(B) of this section equals the total facility-adjusted RVUs.

(A) *Facility-adjusted work expense RVUs.* For each CPT procedure code for each geographic area, the 1998 work expense RVU is multiplied by the 1998 Medicare work adjuster (0.917) and the results are further multiplied by the work expense 1998 Medicare Geographic Practice Cost Index. The result constitutes the facility-adjusted work expense RVU.

(B) *Facility-adjusted practice expense RVUs.* For each CPT procedure code for each geographic area, the 1998 practice expense RVU is multiplied by the practice expense 1998 Medicare Geographic Practice Cost Index. The result constitutes the facility-adjusted practice expense RVU.

(ii) *RVUs for specified CPT procedure codes.* For the following CPT procedure codes, obtain the nationwide 80th percentile billed charges from the nationwide commercial insurance data base compiled by the Health Insurance Association of America (Health Insurance Association of America, 555 13th Street, NW, Suite 600E, Washington, DC 20004): 20930, 20936, 22841, 48160, 48550, 54440, 79900, 80050, 80055, 80103, 80500, 80502, 85060, 85095, 85097, 85102, 86077, 86078, 86079, 86485, 86490, 86510, 86580, 86585, 86586, 86850, 86860, 86870, 86890, 86891, 86901, 86910, 86911, 86915, 86920, 86921, 86922, 86927, 86930, 86931, 86932, 86945, 86950, 86965, 86970, 86971, 86972, 86975, 86977, 86978, 86985, 88000, 88005, 88012, 88014, 88016, 88036, 88037, 88104, 88106, 88107, 88108, 88125, 88160, 88161, 88162, 88170, 88171, 88172, 88173, 88180, 88182, 88300, 88302, 88304, 88305, 88307, 88309, 88311, 88312, 88313, 88314, 88318, 88319, 88321, 88323, 88325, 88329, 88331, 88332, 88342, 88346, 88347, 88348, 88349, 88355, 88356, 88358, 88362, 88365, 89100, 89105, 89130, 89132, 89135, 89140, 89141, 89250, 89350, 89360, 92390, 92391, 94642, 94772, 99024, 99071, 99078, 99080, 99082, 99100, 99116, 99135, 99140, 99420, 99450, 99455, 99456. For the following CPT procedure codes, obtain the nationwide 80th percentile billed charges from the Medicare Standard Analytical File 5% Sample: 99070, M0076, M0300. Then divide the nationwide 80th percentile billed charges by the untrended nationwide conversion factor for the corresponding physician CPT procedure code group as set forth in paragraphs (e)(3) and (e)(3)(i). The resulting nationwide total RVUs are multiplied by the geographic adjustment factors as set forth in paragraph (e)(2)(iv) of this section to obtain the facility-specific total RVUs.

(iii) *RVUs for specified CPT procedure codes.* For the following list of CPT procedure codes, the nationwide total RVU is calculated by multiplying the 1998 Medicare work adjuster (0.917) by the work expense RVU and adding the practice expense RVU (the work expense RVU and the practice expense RVU for these CPT procedure codes can be found in the *1998 St. Anthony's Complete RBRVS,* Relative Value Studies, Inc., St. Anthony Publishing, 11410 Isaac Newton Square, Reston, VA 20190): 15824, 15825, 15826, 15828, 15829, 15876, 15877, 15878, 15879, 17380, 21088, 24940, 26587, 32850, 33930, 33940, 36415, 36468, 36469, 41820, 41821, 41850, 41870, 47133, 48554, 50300, 58974, 65760, 65765, 65767, 65771, 69090, 69710, 75556, 76092, 76140, 76350, 78608, 78609, 90700, 90701, 90702, 90703, 90704, 90705, 90706, 90707, 90708, 90709, 90710, 90711, 90712, 90713, 90714, 90716, 90717, 90718, 90179, 90720, 90721, 90724, 90725, 90726, 90727, 90728, 90730, 90732, 90733, 90735,

90737, 90741, 90742, 90744, 90745, 90746, 90747, 90882, 90889, 90989, 90993, 92531, 92532, 92533, 92534, 92551, 92559, 92560, 92590, 92591, 92592, 92593, 92594, 92595, 92992, 92993, 93760, 93762, 93784, 93786, 93788, 93790, 95120, 95125, 95130, 95131, 95132, 95133, 95134, 96110, 96545, 97545, 97546, 99000, 99001, 99002, 99025, 99050, 99052, 99054, 99056, 99058, 99075, 99090, 99190, 99191, 99192, 99288, 99358, 99359, 99360, 99361, 99362, 99371, 99372, 99373. The resulting nationwide total RVUs are multiplied by the geographic adjustment factors as set forth in paragraph (e)(2)(iv) of this section to obtain the facility-specific total RVUs.

(iv) *RVU geographic area adjustment factors for specified CPT procedure codes.* The geographic area adjustment factor for each facility location consists of the weighted average of the 1998 work expense and practice expense Medicare Geographic Practice Cost Indices for each facility location using charge data for representative CPT procedure codes statistically selected and weighted for work expense and practice expense.

(3) *Facility-adjusted 80th percentile conversion factors.* CPT procedure codes are separated into the following 24 physician CPT procedure code groups: allergy immunotherapy, allergy testing, anesthesia, cardiovascular, chiropractor, consults, emergency room visits and observation care, hearing/ speech exams, immunizations, inpatient visits, maternity/cesarean deliveries, maternity/non-deliveries, maternity/ normal deliveries, miscellaneous medical, office/home urgent care visits, outpatient psychiatry/alcohol and drug abuse, pathology, physical exams, physical medicine, radiology, surgery, therapeutic injections, vision exams, and well baby exams. For each of the 24 physician CPT procedure code groups, representative CPT procedure codes were statistically selected and weighted so as to give a weighted average RVU comparable to the weighted average RVU of the entire physician CPT procedure code group (the selected CPT procedure codes are set forth in the 1998 Milliman & Robertson, Inc., Health Cost Guidelines fee survey) (Milliman &n Robertson, Inc., 1301 5th Ave., Suite 3800, Seattle, WA 98101–2605). The 80th percentile charge for each selected CPT procedure code is obtained (this is contained in the nationwide commercial insurance data base compiled by the Health Insurance Association of America, 555 13th Street, NW, Suite 600E, Washington, DC 20004 (medical data for 5/1/96–4/30/97, including radiology and pathology; surgical data for 3/1/96-2/28/97; anesthesia data for 3/1/96-2/28/97)). A nationwide conversion factor (a monetary amount) is calculated for each physician CPT procedure code group as set forth in paragraph (e)(3)(i) of this section. The nationwide conversion factors for each of the 24 physician CPT procedure code groups are trended forward as set forth in paragraph (e)(3)(ii) of this section. The resulting amounts for each of the 24 groups are multiplied by geographic area adjustment factors as set forth in paragraph (3)(3)(iii) of this section, resulting in facility-adjusted 80th percentile conversion factors for each VA facility geographic area for the 24 physician CPT procedure code groups for the effective charge period.

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

(ii) *Trending forward.* The nationwide conversion factor for each of the 24 physician CPT procedure code groups, representing charges for time periods detailed in paragraph (e)(3) of this section, are trended forward for the period August 1998 through September 1999, and for each 12-month period thereafter, beginning October 1, 1999, based on changes to the Physician component of the CPI–U. Actual CPI–U changes are used through the latest available month. The three-month average annual trend rate as of the latest available month is held constant to the midpoint of the effective charge period. The projected total CPI–U change from the midpoint of the source data collection period to the midpoint of the effective charge period is then applied to the 24 conversion factors.

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

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

(i) *RVUs for anesthesia.* The 1998 base unit value for each anesthesia CPT procedure code is compiled (the base unit values can be found in the *1998 St. Anthony's Complete RBRVS,* Relative Value Studies, Inc., St. Anthony Publishing, 11410 Isaac Newton Square, Reston, VA 20190). The average time unit value for each anesthesia CPT procedure code is compiled from a Health Care Financing Administration study concerning average time unit values for anesthesia CPT procedure codes (these values can be obtained from Veterans Health Administration, Office of Finance, Department of Veterans Affairs, 810 Vermont Ave., NW, Washington, DC 20420). For each anesthesia CPT procedure code introduced since the HCFA study, the time unit value is calculated as the average time unit value for all other anesthesia CPT procedure codes with the same base unit value. The sum of the anesthesia base unit value and the anesthesia time unit value equals the total anesthesia RVUs.

(ii) *RVUs for pathology.* For each pathology CPT procedure code, the 1998 Medicare payment amount is used as the RVU for the corresponding CPT procedure code (the payment amounts can be found on the Health Care Financing Administration public use files Internet site at *http://www.hcfa.gov/stats/pufiles.htm* under the heading ''Payment Rates/ Non-Institutional Providers'' and the title ''Clinical Diagnostic Laboratory Fee Schedule.''

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

(1) Nurse practitioner: 85%.

(2) Clinical nurse specialist: 85%.
(3) Physician Assistant: 65% for assistance at surgery; 75% for other hospital care and 85% for other non-hospital care.
(4) Certified registered nurse anesthetist: 50% when physician supervised; 100% when not physician supervised.
(5) Clinical psychologist: 80%.
(6) Clinical social worker: 75%.
(7) Podiatrist: 95%.
(8) Chiropractor: 100%.
(9) Dietitian: 75%.
(10) Clinical pharmacist: 80%.
(11) Optometrist: 90%.

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

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

§ 17.102 [Amended]

4. In newly redesignated § 17.102, the first sentence of the introductory text is amended by removing ''Charges'' and adding in its place ''Except as provided in § 17.101, charges'', paragraph (h) is amended by removing the heading and adding, in its place, ''Computation of charges.''; by removing paragraphs (h)(1), (2), and (4) through (6); and by removing ''(3) The method of computing the charges for medical care and services'' and by adding, in its place, ''The method for computing the charges under paragraphs (a), (b), (d), (f), and (g), and the last sentence of paragraph (c) of this section''.

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