DEPARTMENT OF VETERANS AFFAIRS

38 CFR Part 17

RIN 2900–AK73

Reasonable Charges for Medical Care or Services

AGENCY: Department of Veterans Affairs.

ACTION: Interim final rule.

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

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

—For a nonservice-connected disability incurred incident to the veteran's employment and covered under a worker's compensation law or plan that provides reimbursement or indemnification for such care and services; or

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

This document amends the regulations to update databases and other provisions for the purpose of providing more precise charges.

DATES: *Effective Date:* These amendments are effective May 8, 2001. Comments must be submitted by July 9, 2001.

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; or fax comments to (202) 273–9289; or e-mail comments to *OGCRegulations@mail.va.gov.*. Comments should indicate that they are submitted in response to ''RIN 2900–AK73''. All comments received will be available for public inspection in the Office of Regulations Management, Room 1158, between the hours of 8 a.m. and 4:30 p.m., Monday through Friday (except holidays).

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

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

(ii) For a nonservice-connected disability incurred incident to the veteran's employment and covered under a worker's compensation law or plan that provides reimbursement or indemnification for such care and services; or

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

The methodology for establishing such ''reasonable charges'' covers inpatient facility charges, skilled nursing facility/sub-acute inpatient facility charges, outpatient facility charges, physician charges, and other provider charges.

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 not been furnished by 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 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.

This document changes the previous regulations to provide charges for updated 2001 Current Procedural Terminology (CPT) codes, and to update some of the databases to more recent versions. These changes are described in greater detail in the following paragraphs. These changes will not have a significant impact on any affected party, but will make VA's charge system more current and more accurate.

The formulas for skilled nursing/sub-acute inpatient charges, outpatient facility charges and physician charges were designed to replicate, insofar as possible, the 80th percentile charge for a particular service in a specific location. We have made changes to ensure that the information used in the methodology is as current and precise as possible. As an example, the formula for physician charges included factors based on the 1999 Medicode database. We now are able to use the 2000 Medicode database.

The formula for skilled nursing facility/sub-acute inpatient facility charges includes per diem charges that are based on nationwide data concerning skilled nursing facility charges contained in the 2000 Milliman & Robertson, Inc., Health Cost Guidelines. We are amending the formula to use the data, which has been updated by Milliman & Robertson through July 1, 2001. With this change, the formula will use the latest available data for calculating per diem charges.

The formula for outpatient facility charges included 45 CPT code groups from which the median charge was used for calculating the charge factors. We are amending the formula to use 50 CPT code groups instead of the previous 45 to better group together those CPT codes with similar characteristics. This will help ensure more accurate results for the charge factors.

For physician charges other than anesthesia charges, in general, we have established several methods for determining charges depending on the availability of information. Under the existing regulations, we employ methodology to provide the most precise charges. If Relative Value Units (RVUs) are established under Medicare, we employ methodology utilizing these factors. This enables us to use three geographic area adjustment factors (GAAFs) in calculating charges for each of these CPT procedure codes: One for the work expense RVUs, one for the practice expense RVUs, and one for the conversion factor. When work expense and practice expense RVUs are not available from Medicare, we use methodology based on total RVUs derived from Medicare's Clinical Diagnostic Laboratory Fee Schedule. For each of these CPT procedure codes, we are able to use two GAAFs in calculating the charges: One for the total RVUs and one for the conversion factor. If neither of these sources for relative values is available, we use methodology based directly on billed charge data. We have made changes to the relative order in which each data source is used in order to ensure that the most recent charge data are utilized. Specifically, the regulation utilizes 2000 Medicode data first. If charges are lacking in Medicode, 1998 Medicare charge data are used. Finally, for codes not included in these two sources, we use 1997

Health Insurance Association of America (HIAA) charge data. For each of these CPT procedure codes, we develop total RVUs and a conversion factor, using one GAAF for RVUs and one GAAF for the conversion factor. As a last resort, if none of the above are available, we use methodology based on work expense and practice expense RVUs obtained from St. Anthony's RBRVS (Resource Based Relative Value Scale). For each of these CPT procedure codes, we develop total RVUs and a conversion factor, using one GAAF for RVUs and one GAAF for the conversion factor. Consistent with these principles, we have made changes to reflect that the American Medical Association (AMA) has established new CPT codes, and the Health Care Financing Administration (HCFA) has defined new work expense and practice expense RVUs for these codes.

Previously, the regulations establishing reasonable charges used information from the 2000 Medicare Geographic Practice Cost Index, 2000 Medicare RBRVS Unit Values, and 2000 St. Anthony's Complete RBRVS. We are amending the regulations to use the 2001 Medicare Geographic Practice Cost Index, 2001 Medicare RBRVS Unit Values, and the 2001 St. Anthony's RBRVS. With these changes the regulations will use the latest available data for calculating physician charges.

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

All of the above changes made by this document are for the purpose of adding precision to charges.

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

The charges methodology in the regulations covers outpatient facility charges for services not customarily performed in a physician's office. We have added language to the introductory paragraph (d) to clarify that these services include many procedures and tests, as well as evaluation and management services rendered to hospital outpatients.

The regulations contain provisions for the calculation of RVUs for pathology. In an Interim Final Rule published in the **Federal Register** on November 2, 2000, we intended to move these provisions from paragraph (e)(4)(ii) to paragraph (e)(2)(ii). These provisions were placed in paragraph (e)(2)(ii) as intended, but we inadvertently failed to delete paragraph (e)(4)(ii). Accordingly, we are deleting paragraph (e)(4)(ii).

Administrative Procedure Act

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

Unfunded Mandates

The Unfunded Mandates Reform Act requires (in section 202) that agencies prepare an assessment of anticipated costs and benefits before developing any rule that may result in an expenditure by State, local, or tribal governments, in the aggregate, or by the private sector of $100 million or more in any given year. This rule would have no consequential effect on State, local, or tribal governments.

Paperwork Reduction Act

This document contains no provisions constituting a collection of information under the Paperwork Reduction Act (44 U.S.C. 3501–3520).

OMB Review

The Office of Management and Budget has reviewed this proposed rule under Executive Order 12866.

Regulatory Flexibility Act

The Secretary hereby certifies that this 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 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 rule is exempt from the initial and final regulatory flexibility analysis requirements of §§ 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: April 3, 2001.

Anthony J. Principi,

Secretary of Veterans Affairs.

For the reasons set out in the preamble, 38 CFR part 17 is amended as set forth below:

PART 17—MEDICAL

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

Authority: 38 U.S.C. 501, 1721, unless otherwise noted.

2. Section 17.101 is revised to read as follows:

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

(a)(1) *General.* This section covers collection or recovery by VA, under 38 U.S.C. 1729, for medical care or services provided or furnished to a veteran:

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

(ii) For a nonservice-connected disability incurred incident to the veteran's employment and covered under a worker's compensation law or plan that provides reimbursement or indemnification for such care and services; or

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

(2) *Methodology.* Based on the methodology set forth in this section, the charges billed will include, as appropriate, inpatient facility charges, skilled nursing facility/sub-acute inpatient facility charges, outpatient

facility charges, physician charges, and non-physician provider charges. In addition, the charges billed for prosthetic devices and durable medical equipment provided on an outpatient basis will be VA's actual cost, and the charges billed for prescription drugs not administered during treatment will be 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**. In those cases in which the effective period for published charges has expired and new charges have not yet become effective, VA will continue to bill using the most recently published charges until new charges are published and become effective (for example, if the most recently published charges state that they are effective through December and new charges are not published and effective until February 1, then the charges set forth for the period through December will continue to be used through January 31).

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

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

Consolidated MSA means a consolidated Metropolitan Statistical Area.

CPI means Consumer Price Index.

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

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

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

DRG means diagnosis related group.

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

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 fiscal year 1998, one from the 1998 Medicare MedPAR file and one from the MedStat claim database, a database of nationwide commercial insurance claims. Because the MedStat data is based on calendar year 1997, the MedStat charges were trended forward at an annual trend rate of 2.7%, based on the Inpatient Hospital component of the CPI–U. Results obtained from these two databases are then combined into a single weighted average per diem charge for each DRG. The resulting weighted average per diem charge for each DRG is then separated into its two components, a room and board component and an ancillary component, with the amount for each component calculated to reflect the corresponding percentage set forth in paragraph (b)(2)(i) of this section. The resulting amounts for room and board and ancillary services for each DRG are then each multiplied by the final ratio set forth in paragraph (b)(2)(ii) of this section to reflect the 80th percentile charges. Finally, the resulting charges are each trended forward from 1998 to the effective time period for the charges, as set forth in paragraph (b)(2)(iii) of this section. The results constitute the room and board per diem charge and the ancillary per diem charge.

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

(ii) *80th percentile.* Using the medical and surgical admissions in the 1995 Medicare Standard Analytical File 5% Sample, 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.* 80th percentile charges for each DRG, representing charge levels described in paragraph (b)(2) of this section, are trended forward based on changes to the hospital inpatient component of the CPI–U. Actual CPI–U changes are used through the latest available month for room/board and ancillary charges. Trends from the latest available month to the midpoint of the calendar year in which charges become effective are based on the latest three-month average

annual trend rate from the Inpatient Hospital component of the CPI–U. The projected total CPI trend is then applied to the 1998 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 database. This results in four average per diem charges for each geographic area: room and board for surgical DRGs, ancillary for surgical DRGs, room and board for non-surgical DRGs, and ancillary for non-surgical DRGs. Four corresponding national average per diem charges are obtained from the 1995 Medicare Standard Analytical File 5% Sample, weighted by FY 1997 nationwide VA discharges and by average lengths of stay from the combined Medicare Standard Analytical File 5% Sample and the MedStat claim database. Four geographic area adjustment factors are then calculated for each geographic area by dividing each geographic area average per diem charge by the corresponding national average per diem charge.

(c) *Skilled nursing facility/sub-acute inpatient facility charges.* When VA provides or furnishes skilled nursing/sub-acute inpatient services within the scope of care referred to in paragraph (a)(1) of this section, skilled nursing facility/sub-acute inpatient facility charges billed for such services will be determined in accordance with the provisions of this paragraph. The skilled nursing facility/sub-acute inpatient facility charges are per diem charges that vary by VA facility. The facility charges cover care, including skilled rehabilitation services (e.g., physical therapy, occupational therapy, and speech 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, 2001, was obtained from the 2001 Milliman & Robertson, Inc., Health Cost Guidelines, a publication that includes nationwide skilled nursing facility charges (Milliman & Robertson, Inc., 1301 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 is trended forward to the midpoint of the calendar year in which the charges will be effective, based on the projected change in Medicare reimbursement from the Annual Report of the 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 database 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. This consists of outpatient facility charges for procedures, tests, and evaluation and management services, including the subset of evaluation and management codes which are designated as ''Office or Other Outpatient Services'' when those evaluation and management services are provided in the outpatient department of a hospital. Except for prosthetic devices and durable medical equipment, whose charges will be made separately at actual cost to VA, charges for outpatient facility services will vary by VA facility and by CPT procedure code. These charges will be calculated as follows:

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

(2) *Nationwide 80th percentile charges by CPT procedure code.* For each CPT procedure code for which outpatient facility charges apply, the 1998 practice expense RVUs (these RVU's 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 factors.* Using the 1998 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 45 outpatient facility CPT procedure code groups as set forth in paragraph (d)(3)(i) of this section. Then, for each CPT procedure code in each such group, the median charge is adjusted to the 80th percentile as set forth in paragraph (d)(3)(ii) of this section. The resulting 80th percentile charge for each CPT procedure code is trended forward to the effective time period for the charges as set forth in paragraph (d)(3)(iii) of this section. Using the resulting charges and the RVUs, mathematical approximation methodology based on least squares techniques are applied to the data for each CPT procedure code group to derive outpatient facility charges. For each CPT procedure code, the charge amount is calculated as an amount per incremental RVU and a fixed charge amount adjustment.

(i) *Outpatient facility CPT procedure code groups.* (A) Surgery—Integumentary System—Skin, Subcutaneous and Accessory Structures—Incision and Drainage, Excision-Debridement, Paring or Cutting, Biopsy, Removal of Skin Tags, Shaving of Epidermal or Dermal Lesions, and Surgery—Integumentary System—Nails;

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

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

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

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

(F) Surgery—Integumentary System—Destruction;

(G) Surgery—Integumentary System—Breast;

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

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

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

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

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

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

(N) Surgery—Respiratory System;

(O) Surgery—Cardiovascular System;

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

(Q) Surgery—Digestive System—All Body Regions—Endoscopy;

(R) Surgery—Urinary System;

(S) Surgery—Male Genital System;

(T) Surgery—Female Genital System;

(U) Surgery—Maternity Care and Delivery—Antepartum Services;

(V) Surgery—Maternity Care and Delivery—Excision, Introduction, Repair, Vaginal Delivery, Antepartum and Postpartum Care, Cesarean Delivery, Delivery After Previous Cesarean Delivery, Abortion, Other Procedures;

(W) Surgery—Endocrine System, Nervous System;

(X) Surgery—Eye and Ocular Adnexa;

(Y) Surgery—Auditory System;

(Z) Radiology—Diagnostic—Head and Neck, Chest, Spine and Pelvis—All Except CAT Scans and Magnetic Resonance Imaging (MRI);

(AA) Radiology—Diagnostic—Upper Extremities, Lower Extremities, Abdomen, Gastrointestinal Tract, Urinary Tract, Gynecological and Obstetrical, Heart—All Except CAT Scans and Magnetic Resonance Imaging (MRI);

(BB) Radiology—Diagnostic—Aorta and Arteries, Veins and Lymphatics—All Except CAT Scans and Magnetic Resonance Imaging (MRI);

(CC) Radiology—Diagnostic Ultrasound;

(DD) Radiology—Radiation Oncology, Nuclear Medicine, Therapeutic;

(EE) Radiology—Diagnostic—CAT Scans in All Categories;

(FF) Radiology—Diagnostic—Magnetic Resonance Imaging (MRI) in All Categories;

(GG) Medicine—Vaccines, Toxoids;

(HH) Medicine—Therapeutic or Diagnostic Infusions (Excluding Chemotherapy), Therapeutic, Prophylactic, or Diagnostic Injections;

(II) Medicine—Psychiatry, Biofeedback;

(JJ) Medicine—Dialysis;

(KK) Medicine—Gastroenterology;

(LL) Medicine—Ophthalmology—Special Ophthalmological Services, and Medicine—Special Otorhinolaryngologic Services;

(MM) Medicine—Cardiovascular—Other Vascular Studies;

(NN) Medicine—Cardiovascular—Therapeutic Services, Echocardiography, Cardiac Catheterization, Intracardiac Electrophysiological Procedures, and Medicine—Non-Invasive Vascular Diagnostic Studies;

(OO) Medicine—Pulmonary;

(PP) Medicine—Neurology and Neuromuscular Procedures, Central Nervous System Assessments and Tests;

(QQ) Medicine—Chemotherapy Administration;

(RR) Medicine—Special Dermatological Procedures;

(SS) Medicine—Physical Medicine and Rehabilitation—Evaluation, Modalities; and Medicine—Photodynamic Therapy;

(TT) Medicine—Physical Medicine and Rehabilitation—Therapeutic Procedures, Tests and Measurements, Other Procedures, Medicine—Osteopathic Manipulative Treatment, Medicine Chiropractic Manipulative Treatment, Medicine—Special Services, Procedures, and Reports, and Medicine—Other Services and Procedures;

(UU) Medicine—Evaluation & Management—Consultations;

(VV) Medicine—Evaluation & Management—Hospital Observation Services;

(WW) Medicine—Evaluation & Management—Emergency Department Services, Critical Care Services; and

(XX) Medicine—Evaluation & Management—Office or Other Outpatient Services, Prolonged Services, and Medicine—Ophthalmology—General Ophthalmological Services.

(ii) *80th percentile.* For each of the 45 outpatient facility CPT procedure code groups set forth in paragraph (d)(3)((i) of this section, the median charge is increased by the ratio of the 80th percentile charge to median charge obtained from the 1998 MedStat database of nationwide charges. To mitigate the impact of the variation in the intensity of services by CPT procedure code, the percent increase from the median to the 80th percentile in outpatient charges is compared to the percent increase from the median to the 80th percentile in inpatient semi-private room and board charges. Any percent increase in outpatient charges in excess of the inpatient semi-private room and board percent increase is multiplied by a factor of 0.50. The 80th percentile outpatient facility charge is reduced accordingly.

(iii) Trending forward. The charges for each CPT procedure code, representing charge levels described in paragraph

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

(4) *Geographic area adjustment factors.* For each VA outpatient facility location, a single geographic area adjustment factor is calculated as the arithmetic average of the outpatient geographic area adjustment factor (this factor constitutes the ratio of the level of charges for each geographic area to the nationwide level of charges) published in the 2001 Milliman & 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 2000 MediCode data. The MediCode-based geographic area adjustment factors are calculated as the ratio of the CPT-weighted average charge level for each VA outpatient facility location to the nationwide CPT-weighted average charge level.

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

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

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

(2)(i) *Total facility-adjusted RVUs for physician services other than anesthesia and specified CPT procedure codes.* The work expense and practice expense components of the RVUs for CPT procedure codes (other than anesthesia and those CPT procedure codes set forth at paragraphs (e)(2)(ii) through (e)(2)(iv) 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 substituted 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 2001 work expense RVU is multiplied by the work expense 2001 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 2001 practice expense RVU is multiplied by the practice expense 2001 Medicare Geographic Practice Cost Index. . The result constitutes the facility-adjusted practice expense RVU.

(ii) *RVUs based on laboratory and pathology CPT codes based on Medicare's Clinical Diagnostic Laboratory Fee Schedule.* For CPT procedure codes without modifiers that are not assigned separately identified work and practice units (in (e)(2)(i) of this section), total RVUs are developed based on the 2001 edition of Medicare's Clinical Diagnostic Laboratory Fee Schedule (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''). Such Medicare payment amounts are upwardly adjusted such that the payment level is, on average, equivalent to standard RBRVS payment levels, using statistical comparisons to the 80th percentile derived from the 2000 MediCode charge database. These adjusted payment amounts are then divided by the 2001 Medicare conversion factor to derive RVUs corresponding to each CPT code. The total RVUs are added to the 2001 RBRVS work and practice expense RVUs for the corresponding professional component (if any) of a given CPT procedure code to derive nationwide total RVUs. The resulting nationwide total RVUs are multiplied by the geographic adjustment factors as set forth in paragraph (e)(2)(v) of this section to obtain the facility-specific total RVUs.

(iii) *RVUs for specified CPT procedure codes.* For CPT procedure codes without modifiers that are not assigned RVUs in (e)(2)(i) or (e)(2)(ii) of this section, total RVUs are developed based on various charge databases. For the following CPT procedure codes, the nationwide 80th percentile billed charges are obtained from the 2000 MediCode data: 15824, 15825, 15826, 15828, 15829, 17380, 20930, 20936, 22841, 24940, 36415, 41820, 41821, 41850, 41870, 48160, 50300, 54440, 58974, 65760, 65765, 65767, 65771, 69090, 76092, 76350, 80050, 80055, 80103, 86485, 86586, 86850, 86860, 86870, 86890, 86891, 86901, 86910, 86911, 86915, 86920, 86921, 86922, 86927, 86930, 86931, 86932, 86945, 86950, 86965, 86970, 86971, 86972, 86975, 86976, 86977, 86978, 86985, 88000, 88005, 88007, 88012, 88014, 88016, 88020, 88025,

88027, 88028, 88029, 88036, 88037, 88040, 88045, 88142, 88143, 88144, 88145, 88147, 88148, 89250, 90371, 90375, 90376, 90389, 90471, 90472, 90585, 90586, 90632, 90633, 90634, 90645, 90646, 90647, 90648, 90657, 90658, 90659, 90665, 90675, 90680, 90690, 90691, 90882, 90889, 90989, 90993, 92531, 92532, 92533, 92534, 92590, 92591, 92592, 92593, 92594, 92595, 92992, 92993, 93760, 93762, 93784, 93790, 94642, 95120, 95125, 95130, 95131, 95132, 95133, 95134, 96110, 99000, 99001, 99002, 99025, 99050, 99052, 99054, 99056, 99058, 99185, 99186, 99190, 99191, 99192, 99358, 99359, 99360, 99361, 99362, 99371, 99372, and 99373. For the following CPT procedure codes, the nationwide 80th percentile billed charges are obtained from the 1998 Medicare Standard Analytical File 5% Sample: 21089, 23929, 26989, 29909, 76140, 78990, 79900, 86849, 90660, 90668, 90669, 90749, 92390, 92391, 96549, 97780, 97781, 99024, 99070, 99071, 99072, 99075, 99078, 99080, 99082, 99090, 99100, 99116, 99135, 99140, 99173, 99288, 99420, 99429, 99450, 99455, and 99456. For the following CPT procedure codes, the nationwide 80th percentile billed charges are obtained from the 1997 nationwide commercial insurance database compiled by the Health Insurance Association of America (Health Insurance Association of America, 555 13th Street, NW., Suite 600E, Washington, DC 20004): 15876, 15877, 15878, 15879, 21088, 26587, 32850, 33940, 36468, 36469, 47133, 48550, 55970, and 69710. The nationwide 80th percentile billed charges so obtained are divided by the untrended nationwide conversion factor for the corresponding physician CPT procedure code group as set forth in paragraphs (e)(3) and (e)(3)(i) of this section. The resulting nationwide total RVUs are multiplied by the geographic adjustment factors as set forth in paragraph (e)(2)(v) of this section to obtain the facility-specific total RVUs.

(iv) *RVUs for specified CPT procedure codes.* For CPT procedure codes without modifiers that are not assigned RVUs in paragraphs (e)(2)(i), (e)(2)(ii), or (e)(2)(iii) of this section, the nationwide total RVU is calculated by summing the work expense and practice expense RVUs found in the 2001 St. Anthony's Complete RBRVS (available from Relative Value Studies, Inc., St. Anthony Publishing, 11410 Isaac Newton Square, Reston, VA 20190): 36540, 43752, 63043, 63044, 86294, 90940, 91132, 91133, 93318, and 99172. The resulting nationwide total RVUs are multiplied by the geographic adjustment factors as set forth in paragraph (e)(2)(v) of this section to obtain the facility-specific total RVUs.

(v) *RVU geographic area adjustment factors for specified CPT procedure codes.* The geographic area adjustment factor for each facility location consists of the weighted average of the 2001 work expense and practice expense Medicare Geographic Practice Cost Indices for each facility location using charge data for representative CPT procedure codes statistically selected and weighted for work expense and practice expense.

(3) *Facility-adjusted 80th percentile conversion factors.* CPT procedure codes are separated into the following 24 physician CPT procedure code groups: allergy immunotherapy, allergy testing, anesthesia, cardiovascular, chiropractor, consults, emergency room visits and observation care, hearing/speech exams, immunizations, inpatient visits, maternity/cesarean deliveries, maternity/non-deliveries, maternity/normal deliveries, miscellaneous medical, office/home urgent care visits, outpatient psychiatry/alcohol and drug abuse, pathology, physical exams, physical medicine, radiology, surgery, therapeutic injections, vision exams, and well baby exams. For each of the 24 physician CPT procedure code groups, representative CPT procedure codes were statistically selected and weighted so as to give a weighted average RVU comparable to the weighted average RVU of the entire physician CPT procedure code group (the selected CPT procedure codes are set forth in the 2001 Milliman & Robertson, Inc., Health Cost Guidelines fee survey) (Milliman & 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 charge database compiled by 2000 MediCode, Inc., 5225 Wiley Post Way, Suite 500, Salt Lake City, Utah 84116). A nationwide conversion factor (a monetary amount) is calculated for each physician CPT procedure code group as set forth in paragraph (e)(3)(i) of this section. The nationwide conversion factors for each of the 24 physician CPT procedure code groups are trended forward as set forth in paragraph (e)(3)(ii) of this section. The resulting amounts for each of the 24 groups are multiplied by geographic area adjustment factors as set forth in paragraph (e)(3)(iii) of this section, resulting in facility-adjusted 80th percentile conversion factors for each VA facility geographic area for the 24 physician CPT procedure code groups for the effective charge period.

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

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

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

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

(i) *RVUs for anesthesia.* The 2000 base unit value for each anesthesia CPT procedure code is compiled (the base unit values can be found in the 2000 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 Health Care Financing Administration study, the time unit value is calculated as the average time unit value for all other anesthesia CPT procedure codes with the same base unit value. The sum of the anesthesia base unit value and the anesthesia average time unit value equals the total anesthesia RVUs.

(ii) [Reserved]

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

(1) Nurse practitioner: 85%.

(2) Clinical nurse specialist: 85%.

(3) Physician Assistant: 85%.

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

(5) Clinical psychologist: 80%.

(6) Clinical social worker: 75%.

(7) Podiatrist: 100%.

(8) Chiropractor: 100%.

(9) Dietitian: 75%.

(10) Clinical pharmacist: 80%.

(11) Optometrist: 100%.

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

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

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

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