Federal Register

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Part II

Department of Veterans Affairs

38 CFR Part 17

Medical Care Collection or Recovery; Final Rule and Notice

DEPARTMENT OF VETERANS AFFAIRS

38 CFR Part 17

RIN 2900–AJ30

Medical Care Collection or Recovery

AGENCY: Department of Veterans Affairs.

ACTION: Final rule.

SUMMARY: This document amends 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 establishes methodology for charging ''reasonable charges'' consistent with the statutory amendment. The charges billed using this methodology, as appropriate, 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 will 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 therefore 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 continues to 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.

Also, the regulations are 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: *Effective Date:* September 1, 1999.

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: In a document published in the **Federal Register** on October 13, 1998 (63 FR 54756), we proposed to amend VA's medical regulations as set forth in the **SUMMARY** portion on this document. We provided a 60-day comment period that ended December 14, 1998. We received comments from six commenters in response to the proposal. These comments are discussed below. Based on the rationale set forth in the proposed rule and in this document, the provisions of the proposed rule are adopted as a final rule with changes explained below.

Podiatrists, Optometrists, and Physician Assistants

Three of the comments concerned the proposal at § 17.101(f) to charge for services of podiatrists and optometrists at 95% and 90%, respectively, of the amount that would be charged if the care had been provided by a physician. One of the comments concerned the proposal at § 17.101(f) to charge for services of physician assistants at 65% for assistance at surgery, 75% for other hospital care, and 85% for other non-hospital care. The commenters provided information establishing that under the Medicare program optometrists and podiatrists are paid the same as physicians for services provided and physician assistants are paid for all services at 85% of the amount that would be charged if the care had been provided by a physician. In this regard, the commenters asserted that we should adopt the Medicare payment percentages for VA charges. In the proposed rule we indicated that we intended to use ''the Medicare percentages when available because of their extensive use for billing and payment of claims'' (63 FR 54758). Accordingly, since we now understand that the Medicare regulations provide for payment for optometrists and podiatrists at the physician rate and provide for payment for physician assistants at 85% of the physician rate for all billable services, we changed the final rule to be consistent with Medicare.

Effective Date

We considered whether to make the final rule effective thirty days after publication in the **Federal Register** or whether to make the final rule effective after a longer period. After considering the comments, we have decided to make the final rule effective September 1, 1999 to allow more time for industry to prepare for the changes.

One commenter, a representative of an association of insurance companies, asserted that the effective date should be delayed for twelve months. The commenter asserted that additional time is needed for them to establish computer software to process the new VA charges. The commenter also asserted that now is a difficult time for such changes since available resources should be devoted as a priority to ''year two thousand compliance'' issues. The commenter also asserted that their 1999 premiums did not take into account increased payments and administrative costs that would occur under the new system. The commenter also asserted that the comment period should be extended to allow time for engaging outside actuarial or reimbursement consultants in order to provide substantive comments on the billing methodology. The comments were supplemented by the inclusion of examples of cost comparisons between current charges and charges implemented by the final rule.

Initially, we note that the comments, at least in part, are based on an incorrect premise. Under the final rule an affected entity is not necessarily required to pay the full charges. The final rule provides that an affected entity would continue to have the option of paying to the extent of its coverage either the billed charges or 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.

Further, we believe insurers have had ample opportunity to adjust premiums for 1999. Ever since the enactment of Public Law 105–33 on August 5, 1997, it has been general knowledge in the

insurance industry that VA would bill based on market pricing as soon as regulations could be established. Moreover, the legislative history from the House Conference Report (H. Rep. No. 105–217, July 30, 1997, at pp. 974–975) for Public Law No. 105–33 states that ''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.'' We believe that any further delay in implementing this remedial legislation beyond the September 1, 1999, effective date of these final regulations would be unreasonable.

Also, we believe that it is reasonable for affected entities to establish an appropriate mechanism to process VA's billed charges under this final rule by the time payments to VA become due. In this regard, we note that VA billing under this final rule more closely accords with industry practice. Therefore, this should facilitate development of computer software necessary to process VA charges. In addition, we believe that the methodology for determining our new charges is based on sound actuarial principles.

Local Markets

In the proposed rule, we acknowledged that we have insufficient data for direct determination of prevailing charges for all services in all local markets (63 FR 54757). One commenter questioned how VA could determine local reasonable charges under such circumstances for charges other than those based on DRGs. No changes are made based on this comment. We believe that our methodology provides an appropriate remedy. For outpatient facility charges and physician charges, we grouped CPT codes for each local market, then compiled averages for the CPT code groups for each locality, and then used these averages to obtain estimated charges for those CPT codes for which we had insufficient data. Further, for skilled nursing facility/sub-acute inpatient facility charges, we used state-wide averages to establish geographic area adjustment factors.

Co-payments for Non-service Connected Outpatient Care

One commenter appeared to assume that this rulemaking proceeding would affect co-payments for non-service connected outpatient care. This rulemaking proceeding does not address this issue. The co-payment for non-service connected outpatient care continues to be based on the VA-wide estimated average cost of an outpatient visit (see 38 U.S.C. 1710(g)(2)).

Effective Periods

With respect to inpatient facility charges, skilled nursing facility/sub-acute inpatient facility charges, outpatient facility charges, and physician charges, the proposed rule provided in the trending provisions of the charges methodology, that the effective period for charges after September 1999 would be from October 1 through September 30 of each year. We changed these effective periods to coincide with calendar years (January 1 through December 31) to be consistent with standard industry practice.

Also, we have added provisions stating that 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. Although this normally would result in lower charges than the methodology would allow, this is necessary to ensure that VA will not have to suspend charging in those cases in which the effective period for published charges has expired and new charges have not yet become effective.

The data for determining charges, published in the October 13 **Federal Register** and in a companion document published in this issue of the **Federal Register**, was designed for the period August 1998 through September 1999. Consistent with the principles explained above, we intend to use these data for the period September 1, 1999 through December 31, 1999. This will result in lower charges than we could otherwise charge. Even so, we do not believe it would be cost effective to recalculate these data and republish them since they will be used for such a short period of time.

Nonsubstantive Changes

Nonsubstantive changes are made for purposes of clarity.

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

In a document published in the **Federal Register** on October 13, 1998 (63 FR 54766), we set forth data (derived from the methodology of the final rule) for calculating inpatient facility charges, skilled nursing facility/sub-acute inpatient facility charges, outpatient facility charges, and physician charges at individual VA facilities. These data will be used for such charges from the effective date of this final rule through December 1999, except for those changes (consistent with the methodology of the final rule) set forth in a companion document published in the ''Notices'' section of this issue of the **Federal Register**. As stated in the proposal, VA will update annually in the ''Notices'' section of the **Federal Register** the data for calculating the charges at individual VA facilities.

Paperwork Reduction Act

The collection of information contained in the notice of the proposed rulemaking was submitted to the Office of Management and Budget (OMB) for review in accordance with the Paperwork Reduction Act (44 U.S.C. 3504(h)).

The information collection subject to this rulemaking concerns submission of evidence. Under the provisions of § 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 § 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). This information is 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.

Interested parties were invited to submit comments on the collection of information. However, no comments were received. OMB has approved this information collection under control number 2900–0606.

VA is not authorized to impose a penalty on persons for failure to comply with information collection requirements which do not display a current OMB control number, if required.

Regulatory Flexibility Act

The Secretary hereby certifies that this final 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 final 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 final rule is exempt from the initial and final regulatory flexibility analyses requirements of §§ 603 and 604.

OMB Review

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

Catalog of Federal Domestic Assistance Numbers

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

Approved: March 25, 1999.

Togo D. West, Jr.,

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.

§§ 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 and a parenthetical at the end of the section is added 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) *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 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 calendar year period thereafter, beginning January 1, 2000, 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., 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, 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 calendar year period thereafter, beginning January 1, 2000, 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 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 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 calendar year period thereafter, beginning January 1, 2000, 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 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 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 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 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 & 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 (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 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 calendar year period thereafter, beginning January 1, 2000, 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 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 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) *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)

§ 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), (h)(2), and (h)(4) through (h)(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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