

§ 17.98

of Veterans Affairs pharmacy under 38 U.S.C. 1712(h), may be reimbursed.

[32 FR 13816, Oct. 4, 1967. Redesignated and amended at 61 FR 21965, 21967, May 13, 1996]

§ 17.98 Mental health services.

(a) Following the death of a veteran, bereavement counseling involving services defined in 38 U.S.C. 1701(6)(B), may be furnished to persons who were receiving mental health services in connection with treatment of the veteran under 38 U.S.C. 1710, 1712, 1712A, 1713, or 1717, or 38 CFR 17.84 of this part, prior to the veteran's death, but may only be furnished in instances where the veteran's death had been unexpected or occurred while the veteran was participating in a VA hospice or similar program. Bereavement counseling may be provided only to assist individuals with the emotional and psychological stress accompanying the veteran's death, and only for a limited period of time, as determined by the Medical Center Director, but not to exceed 60 days. The Medical Center Director may approve a longer period of time when medically indicated.

(b) For purposes of paragraph (a) of this section, an unexpected death is one which occurs when in the course of an illness the provider of care did not or could not have anticipated the timing of the death. Ordinarily, the provider of care can anticipate the patient's death and can inform the patient and family of the immediacy and certainty of death. If that has not taken place, a death can be described as unexpected.

(Authority: 38 U.S.C. 1701(6)(B))

[53 FR 7186, Mar. 7, 1988. Redesignated and amended at 61 FR 21965, 21967, May 13, 1996]

BREAKING APPOINTMENTS

§ 17.100 Refusal of treatment by unnecessarily breaking appointments.

A patient under medical treatment who breaks an appointment without a reasonable excuse will be informed that breaking an additional appointment will be deemed to be a refusal to accept VA treatment. If such a patient fails to keep a second appointment, without at least 24 hours notice, such action will be deemed as a refusal to

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accept VA treatment. Thereafter, no further treatment will be furnished until the veteran has agreed to cooperate by keeping appointments. Treatment will not be discontinued until the treating physician has reviewed the treatment files, concurred in the action and signed a statement to this effect in the record. Consideration will be given to the veteran's ability to make a rational decision concerning the need for medical care and/or examination. The veteran will be advised of the final decision. Nothing in this section will be construed to prevent treatment for an emergent condition that may arise during or subsequent to this action. Where an appointment is broken without notice and satisfactory reasons are advanced for breaking the appointment and circumstances were such that notice could not be given, the patient will not be deemed to have refused treatment.

(Authority: 38 U.S.C. 7304)

[51 FR 8672, Mar. 13, 1986. Redesignated at 61 FR 21965, May 13, 1996; 64 FR 54218, Oct. 6, 1999]

CHARGES, WAIVERS, AND COLLECTIONS

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

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

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

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

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

(2) *Methodologies.* Based on the methodologies set forth in this section, the charges billed will include the following types of charges, as appropriate:

Acute inpatient facility charges; skilled nursing facility/sub-acute inpatient facility charges; partial hospitalization facility charges; outpatient facility charges; physician and other professional charges, including professional charges for anesthesia services and dental services; pathology and laboratory charges; observation care facility charges; ambulance and other emergency transportation charges; and charges for durable medical equipment, drugs, injectables, and other medical services, items, and supplies identified by HCPCS Level II codes. In addition, the charges billed for prescription drugs not administered during treatment will be based on VA costs in accordance with the methodology set forth in §17.102. Data for calculating actual charge amounts based on the methodologies set forth in this section will either be published in a notice in the FEDERAL REGISTER or will be posted on the Internet site of the Veterans Health Administration Chief Business Office, currently at <http://www.va.gov/cbo>, under "Charge Data." For care for which VA has established a charge, VA will bill using its most recent published or posted charge. For care for which VA has not established a charge, VA will bill according to the methodology set forth in paragraph (a)(8) of this section.

(3) *Data sources.* In this section, data sources are identified by name. The specific editions of these data sources used to calculate actual charge amounts, and information on where these data sources may be obtained, will be presented along with the data for calculating actual charge amounts, either in notices in the FEDERAL REGISTER or on the Internet site of the Veterans Health Administration Chief Business Office, currently at <http://www.va.gov/cbo>, under "Charge Data."

(4) *Amount of recovery or collection—third party liability.* A third-party payer liable under a health plan contract has the option of paying either the billed charges described in this section or the amount the health plan demonstrates is the amount it would pay for care or services furnished by providers other than entities of the United States for the same care or services in the same geographic area. If the amount sub-

mitted by the health plan for payment is less than the amount billed, VA will accept the submission as payment, subject to verification at VA's discretion in accordance with this section. A VA employee having responsibility for collection of such charges may request that the third party health plan submit evidence or information to substantiate the appropriateness of the payment amount (*e.g.*, health plan or insurance policies, provider agreements, medical evidence, proof of payment to other providers in the same geographic area for the same care and services VA provided).

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

APC means Medicare Ambulatory Payment Classification.

CMS means the Centers for Medicare and Medicaid Services.

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

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

DME means Durable Medical Equipment.

DRG means Diagnosis Related Group.

Geographic area means a three-digit ZIP Code area, where three-digit ZIP Codes are the first three digits of standard U.S. Postal Service ZIP Codes.

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

ICU means Intensive Care Unit, including coronary care units.

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

MedPAR means the Medicare Provider Analysis and Review file.

Non-provider-based means a VA health care entity (such as a small VA community-based outpatient clinic) that functions as the equivalent of a doctor's office or for other reasons does not meet CMS provider-based criteria,

and, therefore, is not entitled to bill outpatient facility charges.

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

RBRVS means Resource-Based Relative Value Scale.

RVU means Relative Value Unit.

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

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

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

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

the first of the following subparagraphs that applies:

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

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

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

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

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

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

(1) *Formula.* For each acute inpatient stay, or portion thereof, for which a particular DRG assignment applies, the total acute inpatient facility charge is the sum of the applicable charges determined pursuant to paragraphs (b)(1)(i), (ii), and (iii) of this section. For purposes of this section, standard room and board days and ICU room and board days are mutually exclusive: VA

will bill either a standard room and board per diem charge or an ICU room and board per diem charge, as applicable, for each day of a given acute inpatient stay.

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

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

(iii) *Ancillary charges.* Multiply the nationwide ancillary per diem charge determined pursuant to paragraph (b)(2) of this section by the appropriate geographic area adjustment factor determined pursuant to paragraph (b)(3) of this section. The result constitutes the area-specific ancillary per diem charge. Multiply this amount by the number of days of acute inpatient care to obtain the total acute inpatient facility ancillary charge.

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

acute inpatient facility charges for the different DRGs.

(2) *Per diem charges.* To establish a baseline, two nationwide average per diem amounts for each DRG are calculated, one from the MedPAR file and one from the MedStat claims database, a database of nationwide commercial insurance claims. Average per diem charges are calculated based on all available charges, except for care reported for emergency room, ambulance, professional, and observation care. These two data sources may report charges for two differing periods of time; when this occurs, the data source charges with the earlier center date are trended forward to the center date of the other data source, based on changes to the inpatient hospital services component of the CPI-U. Results obtained from these two data sources are then combined into a single weighted average per diem charge for each DRG. The resulting charge for each DRG is then separated into its two components, a room and board component and an ancillary component, with the per diem charge for each component calculated by multiplying the weighted average per diem charge by the corresponding percentage determined pursuant to paragraph (b)(2)(i) of this section. The room and board per diem charge is further differentiated into a standard room and board per diem charge and an ICU room and board per diem charge by multiplying the average room and board charge by the corresponding DRG-specific ratios determined pursuant to paragraph (b)(2)(ii) of this section. The resulting per diem charges for standard room and board, ICU room and board, and ancillary services for each DRG are then each multiplied by the final ratio determined pursuant to paragraph (b)(2)(iii) of this section to reflect the nationwide 80th percentile charges. Finally, the resulting amounts are each trended forward from the center date of the trended data sources to the effective time period for the charges, as set forth in paragraph (b)(2)(iv) of this section. The results constitute the nationwide 80th percentile standard room and board, ICU room and board, and ancillary per diem charges.

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

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

(iii) *80th percentile.* Using cases from the MedPAR file with separately identifiable semi-private room rates, the ratio of the day-weighted 80th percentile semi-private room and board per diem charge to the average semi-private room and board per diem charge is obtained for each geographic area. The geographic area-based ratios are averaged to obtain a final 80th percentile ratio.

(iv) *Trending forward.* 80th percentile charges for each DRG, obtained as described in paragraph (b)(2) of this section, are trended forward based on changes to the inpatient hospital services component of the CPI-U. Actual CPI-U changes are used from the center date of the trended data sources through the latest available month as

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

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

(c) *Skilled nursing facility/sub-acute inpatient facility charges.* When VA provides or furnishes skilled nursing/sub-acute inpatient services within the scope of care referred to in paragraph (a)(1) of this section, skilled nursing facility/sub-acute inpatient facility charges billed for such services will be determined in accordance with the provisions of this paragraph. The skilled nursing facility/sub-acute inpatient facility charges are per diem charges that vary by geographic area. The facility charges cover care, including room and board, nursing care, pharmaceuticals, supplies, and skilled rehabilitation services (e.g., physical therapy, inhalation therapy, occupational

therapy, and speech-language pathology), that is provided in a nursing home or hospital inpatient setting, is provided under a physician's orders, and is performed by or under the general supervision of professional personnel such as registered nurses, licensed practical nurses, physical therapists, occupational therapists, speech-language pathologists, and audiologists. These charges are calculated as follows:

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

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

tive time period for the charges, as set forth in paragraph (c)(2)(ii) of this section.

(i) *80th percentile adjustment factor.* Using the MedPAR skilled nursing facility file, the ratio of the day-weighted 80th percentile room and board per diem charge to the day-weighted average room and board per diem charge is obtained for each geographic area. The geographic area-based ratios are averaged to obtain the 80th percentile adjustment factor.

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

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

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

(1) *Formula.* For each partial hospitalization stay, multiply the nationwide per diem charge determined pursuant to paragraph (d)(2) of this section by the appropriate geographic area adjustment factor determined pursuant to paragraph (d)(3) of this section. The

result constitutes the area-specific per diem charge. Finally, multiply the area-specific per diem charge by the number of days of care to obtain the total partial hospitalization facility charge.

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

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

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

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

(e) *Outpatient facility charges.* When VA provides or furnishes outpatient facility services that are within the scope of care referred to in paragraph (a)(1) of this section, the charges billed for such services will be determined in

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

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

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

(ii) Other VA provider-based entities; and

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

(2) *Formula.* For each outpatient facility charge CPT/HCPCS code, multiply the nationwide 80th percentile charge determined pursuant to paragraph (e)(3) of this section by the appropriate geographic area adjustment factor determined pursuant to paragraph (e)(4) of this section. The result constitutes the area-specific outpatient facility charge. When multiple surgical procedures are performed during the same outpatient encounter by a provider or provider team, the outpatient facility charges for such procedures will be reduced as set forth in paragraph (e)(5) of this section.

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

(i) *Nationwide 80th percentile charges for CPT/HCPCS codes which have APC assignments.* Using the outpatient facility charges reported in the outpatient facility component of the Medicare

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

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

(B) *Nationwide 80th percentile to median charge ratios.* For each CPT/HCPSC code, a geographically normalized nationwide 80th percentile billed charge amount is divided by a similarly normalized nationwide median billed charge amount. The weighted average of these ratios for each APC is then ob-

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

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

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

- (1) Radiology.
- (2) Drugs.
- (3) Office, Home, and Urgent Care Visits.
- (4) Cardiovascular.
- (5) Emergency Room Visits.
- (6) Outpatient Psychiatry, Alcohol and Drug Abuse.
- (7) Pathology.
- (8) Surgery.
- (9) Allergy Immunotherapy, Allergy Testing, Immunizations, and Therapeutic Injections.
- (10) All APCs not assigned to any of the above groups.
 - (ii) *Nationwide 80th percentile charges for CPT/HCPSC codes which do not have*

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

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

(4) *Geographic area adjustment factors.* For each geographic area, a single adjustment factor is calculated as the arithmetic average of the outpatient geographic area adjustment factor published in the Milliman USA, Inc., Health Cost Guidelines (this factor constitutes the ratio of the level of charges for each geographic area to the nationwide level of charges), and a geographic area adjustment factor devel-

oped from the MDR database (see paragraph (a)(3) of this section for Data Sources). The MDR-based geographic area adjustment factors are calculated as the ratio of the CPT/HCPSC code weighted average charge level for each geographic area to the nationwide CPT/HCPSC code weighted average charge level.

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

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

(1) *Formula.* For each CPT/HCPSC code or, where applicable, each CPT/HCPSC code and modifier combination,

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

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

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

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

(ii) *RVUs for CPT/HCPCS codes that do not have Medicare RVUs and are not designated as unlisted procedures.* For CPT/HCPCS codes that are not assigned

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

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

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

(3) *Geographically-adjusted 80th percentile conversion factors.* CPT/HCPSC codes are separated into the following 23 CPT/HCPSC code groups: allergy immunotherapy, allergy testing, cardiovascular, chiropractor, consults, emergency room visits and observation care, hearing/speech exams, immunizations, inpatient visits, maternity/cesarean deliveries, maternity/non-deliveries, maternity/normal deliveries, miscellaneous medical, office/home/urgent care visits, outpatient psychiatry/alcohol and drug abuse, pathology, physical exams, physical medicine, radiology, surgery, therapeutic injections, vision exams, and well baby exams. For each of the 23 CPT/HCPSC code groups, representative CPT/HCPSC codes are statistically selected and weighted so as to give a weighted average RVU comparable to the weighted average RVU of the entire CPT/HCPSC code group (the selected CPT/HCPSC codes are set forth in the Milliman USA, Inc., Health Cost Guidelines fee survey); see paragraph (a)(3) of this section for Data Sources. The 80th percentile charge for each selected CPT/HCPSC code is obtained from the MDR database. A nationwide conversion factor (a monetary amount) is calculated for each CPT/HCPSC code group as set forth in paragraph (f)(3)(i) of this section. The nationwide conversion factors for each of the 23 CPT/HCPSC code groups are trended forward to the effective time period for the charges, as set forth in paragraph (f)(3)(ii) of this section. The resulting amounts for each of the 23 groups are multiplied by geographic area adjustment factors determined pursuant to paragraph (f)(3)(iii) of this section, resulting in geographically-adjusted 80th percentile conversion factors for each

geographic area for the 23 CPT/HCPSC code groups for the effective charge period.

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

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

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

(4) *Charge adjustment factors for specified CPT/HCPSC code modifiers.* Surcharges or charge discounts are calculated in the following manner: from the Part B component of the Medicare Standard Analytical File 5 percent Sample, the ratio of weighted average billed charges for CPT/HCPSC codes

with the specified modifier to the weighted average billed charge for CPT/HCPCS codes with no charge modifier is calculated, using the frequency of procedure codes with the modifier as weights in both weighted average calculations. The resulting ratios constitute the surcharge or discount factors for specified charge-significant CPT/HCPCS code modifiers.

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

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

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

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

(g) *Professional charges for anesthesia services.* When VA provides or furnishes professional anesthesia services within the scope of care referred to in paragraph (a)(1) of this section, professional anesthesia charges billed for such services will be determined in accordance with the provisions of this paragraph. Charges for professional anesthesia services personally performed by anesthesiologists will be 100 percent of the charges determined as set forth in this paragraph. Charges for professional anesthesia services provided by non-medi-

cally directed certified registered nurse anesthetists will also be 100 percent of the charges determined as set forth in this paragraph. Charges for professional anesthesia services provided by medically directed certified registered nurse anesthetists will be 50 percent of the charges otherwise determined as set forth in this paragraph. Professional anesthesia charges consist of charges for professional services that vary by geographic area, by CPT/HCPCS code base units, and by number of time units. These charges are calculated as follows:

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

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

(3) *Geographically-adjusted 80th percentile conversion factors.* A nationwide 80th percentile conversion factor is calculated according to the methodology set forth in paragraph (g)(3)(i) of this section. The nationwide conversion factor is then trended forward to the effective time period for the charges, as set forth in paragraph (g)(3)(ii) of this section. The resulting amount is multiplied by geographic area adjustment

factors determined pursuant to paragraph (g)(3)(iii) of this section, resulting in geographically-adjusted 80th percentile conversion factors for each geographic area for the effective charge period.

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

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

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

80th percentile conversion factor also described in paragraph (g)(3)(i). The resulting ratios are the adjustment factors for each geographic area.

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

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

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

percentile charge for each HCPCS dental code.

(i) *Averaging methodology.* The average charge for any particular HCPCS dental code is calculated by first computing a preliminary mean average of the three charges for each code. Statistical outliers are identified and removed by testing whether any charge differs from the preliminary mean charge by more than 50 percent of the preliminary mean charge. In such cases, the charge most distant from the preliminary mean is removed as an outlier, and the average charge is calculated as a mean of the two remaining charges. In cases where none of the charges differ from the preliminary mean charge by more than 50 percent of the preliminary mean charge, the average charge is calculated as a mean of all three reported charges.

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

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

(3) *Geographic area adjustment factors.* A geographic adjustment factor (consisting of the ratio of the level of charges in a given geographic area to

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

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

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

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

(ii) *RVUs for CPT/HCPCS codes that do not have Medicare-based RVUs and are not designated as unlisted procedures.* For CPT/HCPCS codes that are not assigned RVUs in paragraphs (i)(2)(i) or (i)(2)(iii) of this section, total RVUs are developed based on various charge data sources. For these CPT/HCPCS codes, the nationwide 80th percentile billed charges are obtained, where statistically credible, from the MDR database. For any remaining CPT/HCPCS codes, the nationwide 80th percentile billed charges are obtained, where statistically credible, from the Part B component of the Medicare Standard Analytical File 5 percent Sample. For any remaining CPT/HCPCS codes, the nationwide 80th percentile billed charges are obtained, where statistically credible, from the Prevailing Healthcare Charges System nationwide commercial insurance database. For each of these CPT/HCPCS codes, nationwide total RVUs are obtained by taking the nationwide 80th percentile billed charges obtained using the preceding three databases and dividing by the untrended nationwide conversion factor determined pursuant to paragraphs (i)(3) and (i)(3)(i) of this section. For any remaining CPT/HCPCS codes that have not been assigned RVUs using the preceding data sources, the nationwide total RVUs are calculated by summing the work expense and non-facility practice expense RVUs found in

Ingenix/St. Anthony's RBRVS. The resulting nationwide total RVUs obtained using these four data sources are multiplied by the geographic area adjustment factors determined pursuant to paragraph (i)(2)(iv) of this section to obtain the area-specific total RVUs.

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

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

(3) *Geographically-adjusted 80th percentile conversion factors.* Representative CPT/HCPCS codes are statistically selected and weighted so as to give a weighted average RVU comparable to the weighted average RVU of the entire pathology/laboratory CPT/HCPCS code group (the selected CPT/HCPCS codes are set forth in the Milliman USA, Inc., Health Cost Guidelines fee survey). The 80th percentile charge for each selected CPT/HCPCS code is obtained from the MDR database. A nationwide conversion factor (a monetary amount) is calculated as set forth in paragraph (i)(3)(i) of this section. The nationwide conversion factor is trended forward to the effective time period for the charges, as set forth in paragraph (i)(3)(ii) of this section. The resulting amount is multiplied by a geographic

area adjustment factor determined pursuant to paragraph (i)(3)(iv) of this section, resulting in the geographically-adjusted 80th percentile conversion factor for the effective charge period.

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

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

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

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

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

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

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

(3) *Geographic area adjustment factors.* The geographic area adjustment factors for observation care facility

charges are the same as those computed for outpatient facility charges under paragraph (e)(4) of this section.

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

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

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

(ii) *Nationwide 80th percentile mileage charge.* To calculate a nationwide mileage charge, all ambulance and other emergency transportation claims are

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

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

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

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

and by modifier, when applicable. These charges are calculated as follows:

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

(2) *Nationwide 80th percentile charges for HCPCS codes with RVUs.* For each applicable HCPCS code, RVUs are compiled from the data sources set forth in paragraph (1)(2)(i) of this section. The RVUs are multiplied by the charge amount for each incremental RVU determined pursuant to paragraph (1)(2)(ii) of this section, and this amount is added to the fixed charge amount also determined pursuant to paragraph (1)(2)(ii) of this section. Then, for each HCPCS code, this charge is multiplied by the appropriate 80th percentile to median charge ratio determined pursuant to paragraph (1)(2)(iii) of this section. Finally, the resulting amount is trended forward to the effective time period for the charges, as set forth in paragraph (1)(2)(iv) of this section to obtain the nationwide 80th percentile charge.

(i) *RVUs for DME, drugs, injectables, and other medical services, items, and supplies.* For the purpose of the statistical methodology set forth in paragraph (1)(2)(ii) of this section, HCPCS codes are assigned to the following HCPCS code groups. For the HCPCS codes in each group, the RVUs or amounts indicated constitute the RVUs:

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

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

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

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

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

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

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

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

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

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

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

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

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

(ii) *Charge amounts.* Using combined Part B and DME components of the Medicare Standard Analytical File 5% Sample, the median billed charge is calculated for each HCPCS code. A mathematical approximation methodology based on least squares techniques is applied to the RVUs specified for each of the groups set forth in paragraph (1)(2)(i) of this section, yielding two charge amounts for each HCPCS code group: a charge amount per incremental RVU, and a fixed charge amount.

(iii) *80th Percentile to median charge ratios.* Two ratios are obtained for each HCPCS code group set forth in paragraph (1)(2)(i) of this section by dividing the weighted average 80th percentile charge by the weighted average median charge derived from two data sources: Medicare data, as represented by the combined Part B and DME components of the Medicare Standard Analytical File 5% Sample; and the MDR database. Charge frequencies from the Medicare data are used as weights when calculating all weighted averages. For each HCPCS code group, the smaller of the two ratios is selected as the adjustment from median to 80th percentile charges.

(iv) *Trending forward.* The charges for each HCPCS code, obtained as described in paragraph (1)(2)(iii) of this section, are trended forward based on changes to the medical care commodities component of the CPI-U. Actual CPI-U changes are used from the time period of the source data through the latest available month as of the time the calculations are performed. The three-month average annual trend rate as of the latest available month is then

held constant to the midpoint of the calendar year in which the charges are primarily expected to be used. The projected total CPI-U change so obtained is then applied to the 80th percentile charges, as described in paragraph (1)(2)(iii) of this section.

(3) *Nationwide 80th percentile charges for HCPCS codes without RVUs.* For each applicable HCPCS code, 80th percentile charges are extracted from three independent data sources: the MDR database; Medicare, as represented by the combined Part B and DME components of the Medicare Standard Analytical File 5 percent Sample; and Milliman USA, Inc., Optimized HMO (Health Maintenance Organization) Data Sets (see paragraph (a)(3) of this section for Data Sources). Charges from each database are then trended forward to the effective time period for the charges, as set forth in paragraph (1)(3)(i) of this section. Charges for each HCPCS code from each data source are combined into an average 80th percentile charge by means of the methodology set forth in paragraph (1)(3)(ii) of this section. The results constitute the nationwide 80th percentile charge for each applicable HCPCS code.

(i) *Trending forward.* The charges from each database for each HCPCS code, obtained as described in paragraph (1)(3) of this section, are trended forward based on changes to the medical care commodities component of the CPI-U. Actual CPI-U changes are used from the time period of each source database through the latest available month as of the time the calculations are performed. The three-month average annual trend rate as of the latest available month is then held constant to the midpoint of the calendar year in which the charges are primarily expected to be used. The projected total CPI-U change so obtained is then applied to the 80th percentile charges, as described in paragraph (1)(3) of this section.

(ii) *Averaging methodology.* The average 80th percentile trended charge for any particular HCPCS code is calculated by first computing a preliminary mean average of the three charges for each HCPCS code. Statistical outliers are identified and removed by testing whether any charge differs

from the preliminary mean charge by more than 5 times the preliminary mean charge, or by less than 0.2 times the preliminary mean charge. In such cases, the charge most distant from the preliminary mean is removed as an outlier, and the average charge is calculated as a mean of the two remaining charges. In cases where none of the charges differ from the preliminary mean charge by more than 5 times the preliminary mean charge, or less than 0.2 times the preliminary mean charge, the average charge is calculated as a mean of all three reported charges.

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

(5) *Geographic area adjustment factors.* For the purpose of geographic adjustment, HCPCS codes are combined into two groups: drugs and DME/supplies, as set forth in paragraph (1)(5)(i) of this section. The geographic area adjustment factor for each of these groups is calculated as the ratio of the area-specific weighted average charge determined pursuant to paragraph (1)(5)(ii) of this section divided by the nationwide weighted average charge determined pursuant to paragraph (1)(5)(iii) of this section.

(i) *Combined HCPCS code groups for geographic area adjustment factors for DME, drugs, injectables, and other medical services, items, and supplies.* For the purpose of the statistical methodology set forth in paragraph (1)(5) of this section, each of the HCPCS code groups set forth in paragraph (1)(2)(i) of this section is assigned to one of two combined HCPCS code groups, as follows:

- (A) Chemotherapy Drugs: Drugs.
- (B) Other Drugs: Drugs.
- (C) DME—Hospital Beds: DME/supplies.
- (D) DME—Medical/Surgical Supplies: DME/supplies.

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(E) DME—Orthotic Devices: DME/supplies.

(F) DME—Oxygen and Supplies: DME/supplies.

(G) DME—Wheelchairs: DME/supplies.

(H) Other DME: DME/supplies.

(I) Enteral/Parenteral Supplies: DME/supplies.

(J) Surgical Dressings and Supplies: DME/supplies.

(K) Vision Items—Other Than Lenses: DME/supplies.

(L) Vision Items—Lenses: DME/supplies.

(M) Hearing Items: DME/supplies.

(ii) *Area-specific weighted average charges.* Using the median charges by HCPCS code from the MDR database for each geographic area and utilization frequencies by HCPCS code from the combined Part B and DME components of the Medicare Standard Analytical File 5 percent Sample, an area-specific weighted average charge is calculated for each combined HCPCS code group.

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

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

NOTE TO §17.101: The charges generated by the methodology set forth in this section are the same charges prescribed by the Office of Management and Budget for use under the

Federal Medical Care Recovery Act, 42 U.S.C. 2651-2653.

(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.)

[68 FR 70715, Dec. 19, 2003, as amended at 69 FR 1061, Jan. 7, 2004]

§ 17.102 Charges for care or services.

Except as provided in §17.101, charges at the indicated rates shall be made for Department of Veterans Affairs hospital care or medical services (including, but not limited to, dental services, supplies, medicines, orthopedic and prosthetic appliances, and domiciliary or nursing home care) as follows:

(a) *Furnished in error or on tentative eligibility.* Charges at rates prescribed by the Under Secretary for Health shall be made for inpatient or outpatient care or services (including domiciliary care) authorized for any person on the basis of eligibility as a veteran or a tentative eligibility determination under §17.34 but he or she was subsequently found to have been ineligible for such care or services as a veteran because the military service or any other eligibility requirement was not met, or

(b) *Furnished in a medical emergency.* Charges at rates prescribed by the Under Secretary for Health shall be made for any inpatient or outpatient care or services rendered any person in a medical emergency who was not eligible for such care or services as a veteran, if:

(1) The care or services were rendered as a humanitarian service, under §17.43(c)(1) or §17.95 to a person neither claiming eligibility as a veteran nor for whom the establishment of eligibility as a veteran was expected, or

(2) The person for whom care or services were rendered was a Department of Veterans Affairs employee or a member of a Department of Veterans Affairs employee's family; or

(c) *Furnished beneficiaries of the Department of Defense or other Federal agencies.* Except as provided for in paragraph (f) of this section and the second sentence of this paragraph,