

to 1999 data, and 1997 VA discharge data to 2001 data. We did not update databases related to geographic area adjustment factors and 80th percentile factors; in both cases, our experience indicates that updating these databases would not produce a material difference in charge levels.

The regulations regarding “reasonable charges” identify various charge databases utilized for the calculation of skilled nursing facility/sub-acute inpatient facility charges. This document updates the data source for per diem charges to the 2003 Milliman USA, Inc., Health Cost Guidelines. With this change, the regulations will have the latest available estimate of average billed charges for skilled nursing facility/sub-acute inpatient facility services. We do not update the data source for geographic area adjustment factors, as the Milliman USA, Inc., Health Cost Guidelines do not provide for a 2003 release of this particular data source. Also, we do not update databases related to 80th percentile factors; as with acute inpatient facility charges, our experience indicates that updating these databases would not produce a material difference in charge levels.

The regulations identify various charge databases utilized for the calculation of outpatient facility charges. At this time, we are preparing a more thorough update of these charges, to be based on Medicare Ambulatory Payment Classifications. Therefore, this interim final rule provides a trended update to charges published in 2001, without updating the basic underlying data sources.

The regulations identify various charge databases utilized for the calculation of professional charges. This document utilizes the latest appropriate versions of the various databases available to us at the time of calculation. In particular, we have relied on 2002 Medicare Physician Fee Schedule Relative Value Units (RVU) and geographic practice cost indices, 2002 Medicare Clinical Diagnostic Laboratory Fee Schedule, 2001 Medicare conversion factor, 2002 St. Anthony’s Resource Based Relative Value Scale RVUs, 2001 MDR database, 2000 Medicare Standard Analytical File 5% Sample database, 2001 Prevailing Healthcare Charges System database, and 2001 Milliman USA, Inc., Health Cost Guidelines fee survey. Note that due to corporate changes, the MDR database previously owned by MediCode is now owned by Ingenix; we previously referred to it as the MediCode database, but due to its change of ownership, we refer to it in

this document by its more specific designation of MDR database. Also note that the database previously compiled by the Health Insurance Association of America (HIAA) was sold by HIAA to Ingenix, who renamed it the Prevailing Healthcare Charges System database; it is a continuation of the same database under a new owner and new name.

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

All of the above changes made by this document are for the purpose of providing more current and more precise charges.

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

Previous Interim Final Rules and Responses to Comments

This document supersedes two previous interim final rules, one published in the **Federal Register** on November 2, 2000 (65 FR 65906, RIN 2900-AK39), and the other published in the **Federal Register** on May 8, 2001 (66 FR 23326, RIN 2900-AK73). We received no comments in response to the November 2, 2000, document. We received two comments in response to the May 8, 2001, document. These comments are discussed below.

One commenter stated that the terms “speech therapy” and “speech therapists” should be changed to “speech-language pathology” and “speech-language pathologists,” respectively. We agree, and we have made these changes in this interim final rule.

The same commenter also stated that we should add charges for codes G0193 through G0201 (these are HCPCS Level II codes). In addition, the commenter stated that we have identified audiology services furnished in conjunction with a hearing aid, CPT codes 92590 through 92595, as physician services, when in fact these services are performed solely by audiologists and should not be designated as physician services. We are developing a proposed rule to address these issues.

The second commenter submitted information regarding the work of certified registered nurse anesthetists (CRNAs) and recommended changes to the wording regarding VA’s charges for the services of CRNAs. Section 17.101(f) states the amounts that will be charged for certain providers as percentages of

the amounts that will be charged if the services had been provided by physicians. Previously, the wording for CRNAs was as follows:

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

For clarity, we are amending the wording to the following:

Certified registered nurse anesthetist:
50% when medically directed by an anesthesiologist;
100% when not medically directed by an anesthesiologist.

Other Changes and Clarifications

The regulations make two references to charges for prescription drugs, but the previous language in these paragraphs was different: § 17.101(a)(2) stated that these charges “will be a single nationwide average,” while § 17.101(g) stated that these charges “will be based on VA costs in accordance with the methodology set forth in § 17.102 of this part.” For consistency, the language in paragraph (a)(2) is being amended to read the same as in paragraph (g).

The methodology at § 17.101(e)(2) for the calculation of Relative Value Units (RVUs) for physician charges establishes a priority of data sources for RVUs. Except as noted earlier regarding updated data sources, we are not amending this methodology, but rather than listing information regarding specific CPT procedure codes in the regulations, we are including this information in the applicable **Federal Register** notice when the results of these calculations are released.

Administrative Procedure Act

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

Unfunded Mandates

The Unfunded Mandates Reform Act requires, at 2 U.S.C. 1532, that agencies prepare an assessment of anticipated costs and benefits before developing any rule that may result in an expenditure by State, local, or tribal governments, in the aggregate, or by the private sector of \$100 million or more in any given year.