

under "Charge Data." We are proposing this change so that a change in the edition of a data source or in the information on where a database may be obtained will not, by itself, require any change to the regulations.

#### **Definitions—Additions, Changes, and Deletions**

This document proposes to add definitions for APC (Ambulatory Payment Classification), CMS (Centers for Medicare and Medicaid Services), DME, HCPCS (Healthcare Common Procedure Coding System) code, ICU (Intensive Care Unit), non-provider-based, provider-based, and RBRVS (Resource-Based Relative Value Scale). We are proposing to amend the definition of the term "CPT procedure code" to indicate that the same definition applies equally to the term "CPT code."

Presently, geographic area is defined, for acute inpatient facility charges and skilled nursing facility/sub-acute inpatient facility charges, as Metropolitan Statistical Area (MSA) or the local market, if the VA facility is not located in an MSA; and is defined, for outpatient facility charges and physician charges, as three-digit ZIP Code locality. We are proposing to amend the definition of geographic area to mean simply a three-digit ZIP Code area. This change reflects the fact that we are proposing to use three-digit ZIP Code areas as the geographic areas for all of our charge types. We are proposing this change for acute inpatient facility charges and skilled nursing facility/sub-acute inpatient facility charges because, due to the variability of charges within MSA and non-MSA areas, changing to three-digit ZIP Code areas will produce charges that are more accurate for the location in which the care was provided.

We are proposing to delete the definition for CPI-W (Consumer Price Index—Urban Wage Earners and Clerical Workers) because we have not used CPI-W information anywhere in the regulations, and have no plans to do so. We are also proposing to delete the separate definition for CPI (Consumer Price Index), because that term appears in the regulations only as part of the defined term CPI-U (Consumer Price Index—All Urban Consumers).

#### **Provider-Based and Non-Provider-Based Entities and Charges**

For a specific item of medical care or service provided on an outpatient basis, we may have a professional charge, or an outpatient facility charge, or both. Presently, for all outpatient services for which we have both a professional

charge and an outpatient facility charge, these charges are developed so as to be mutually exclusive, with the expectation that both charges will be billed for the same occasion of service. In addition, most of our outpatient facility charges are expected to be billed by all VA facilities that perform the applicable service, regardless of the type of facility. In other words, these charges are equally available to be billed by the outpatient departments of VA medical centers (VAMCs), by VA community-based outpatient clinics (CBOCs) operating similar to private-sector ambulatory surgery centers, by VA CBOCs operating like private-sector doctors' offices, etc. Presently, the only outpatient facility charges not available to be billed by all VA facilities are those for office or other outpatient evaluation and management (E&M) services CPT codes 99201 through 99215. Billing of the outpatient facility charges for the ten services covered by these codes is presently restricted to the outpatient departments of 169 VAMCs.

This document proposes to amend the regulations to provide that each VA healthcare entity will be designated as either provider-based (entitled to bill outpatient facility charges) or non-provider-based (not entitled to bill outpatient facility charges), based on CMS criteria for provider-based and non-provider-based entities. Further, application of the proposed methodologies presented in this document will provide two sets of charges for outpatient care, one set for use by provider-based entities and one for use by non-provider-based entities. For those outpatient services that have both a professional charge and an outpatient facility charge, the professional charge for use by provider-based entities will be lower, based on Medicare's lower facility practice expense Relative Value Units (RVUs), in consideration of the fact that both the professional charge and the outpatient facility charge will be billed. For the same services, the professional charge for use by non-provider-based entities will be higher, based on Medicare's higher non-facility practice expense RVUs, in consideration of the fact that only the professional charge will be billed. We are proposing these changes because they will result in VA charge structures and billing practices that more closely approximate industry standard charge structures and billing practices.

#### **Charges for Medical Care or Services Provided by Non-VA Providers at VA Expense**

Presently, the phrase in the regulations, "medical care or services provided or furnished by VA," is understood to include medical care or services provided by non-VA providers at VA expense, and the charges billed for such care are those determined according to this section. This document proposes to amend the regulations by adding language to confirm this understanding.

#### **Charges for Medical Care or Services for Which VA Does Not Have an Established Charge**

Presently, the regulations do not address the issue of charges for medical care or services for which VA does not have an established charge or does not specifically make other provision for charges. The result has been that VA has not been charging for such care or services. This document proposes to amend the regulations by adding language to provide for charges, under specified circumstances, when we do not have established charges.

Under the proposed change, when VA provides or furnishes medical care or services and VA does not have an established charge for such care or services, then the charges billed for such care or services will be determined according to the provisions of the proposed new paragraph (a)(8) of the regulations, which sets forth four criteria for establishing a charge and provides that, if none apply, then no charge will be made. We believe that these proposed changes provide a fair and reasonable basis for such charges. We are proposing these changes to provide appropriate charges, under these specified circumstances, where presently we have no charges.

#### **Unlisted and Unspecified Procedures, Services, and Supplies**

Both the American Medical Association and CMS, in compiling CPT and HCPCS Level II, respectively, recognize that there may be procedures, services, or supplies provided by physicians and other healthcare professionals which have not yet been defined. Accordingly, both CPT and HCPCS Level II provide specific codes for reporting unlisted and unspecified procedures, services, and supplies. Presently, the regulations do not provide charges for unlisted CPT codes or for any HCPCS Level II codes. This document proposes methodologies that will enable us to provide charges for unlisted and unspecified procedures,