

services, and supplies. We are proposing this change so that we will be able to bill for these procedures, services, and supplies when we provide or furnish them to our patients, and so that our charge structures and billing practices will more closely approximate industry standard charge structures and billing practices.

### Charge Types

Presently, the reasonable charges regulations set forth methodologies for four basic types of charges, as follows:

- Acute inpatient facility charges;
- Skilled nursing facility/sub-acute inpatient facility charges;
- Outpatient facility charges; and
- Physician charges.

Under the above organization of charge types, facility charges for observation care are included under outpatient facility charges, and charges for pathology/laboratory and anesthesia services are included under physician charges. This document proposes to amend the regulations to describe separate charge types for observation care, pathology/laboratory, and anesthesia.

Presently, we do not have partial hospitalization facility charges. This document proposes to amend the regulations to establish partial hospitalization facility charges.

Presently, we do not have separate charges for HCPCS Level II codes. This document proposes to amend the regulations to establish charges for HCPCS Level II codes.

Presently, our charges for prosthetic devices and DME provided on an outpatient basis are VA's actual cost, and our charges for outpatient dental care are based on VA costs in accordance with the methodology set forth in § 17.102. In place of these cost-related charges, this document proposes to amend the regulations to establish reasonable charges for prosthetic devices, DME, and outpatient dental care by establishing charges for the associated HCPCS Level II codes.

Presently, we do not have charges for ambulance or other emergency transportation services. This document proposes to amend the regulations to establish reasonable charges for ambulance and other emergency transportation services by establishing charges for the associated HCPCS Level II codes.

Associated with these changes, we are proposing to amend the regulations to organize reasonable charges into the following eleven charge types:

- Acute inpatient facility charges;
- Skilled nursing facility/sub-acute inpatient facility charges;

- Partial hospitalization facility charges;
- Outpatient facility charges;
- Physician and other professional charges except for anesthesia services and certain dental services;
- Professional charges for anesthesia services;
- Professional charges for dental services identified by HCPCS Level II codes;
- 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.

The reasons we are proposing these changes are (1) to enable us to bill for medical care, procedures, services, DME, drugs, injectables, medical items, and supplies for which we currently do not have charges; (2) to replace certain charges currently based on VA costs with charges based on community charges; (3) to enable us to bill separately for medical care, procedures, services, DME, drugs, injectables, medical items, and supplies whose charges are presently combined with other charges; and (4) to bring our charge structures and billing practices closer to industry standard charge structures and billing practices.

Additional information regarding each of the above charge types is provided in the following paragraphs.

### Acute Inpatient Facility Charges

Presently, the regulations provide methodologies for calculating two per diem charges for each diagnosis related group (DRG), one for room and board and one for ancillary services. These same per diem charges are used for both ICU days and non-ICU days. This document proposes to amend the regulations by providing methodologies for calculating different room and board per diem charges for ICU days and non-ICU days. With these changes, each DRG will have three per diem charges: a room and board per diem charge for ICU days, a different room and board per diem charge for non-ICU days, and an ancillary services per diem charge that applies to both ICU and non-ICU days. We are proposing these changes because they will result in charges for each patient that will be more specific to the care and services the patient received, and will result in VA charge structures and billing practices that more closely approximate industry standard charge structures and billing practices.

As noted earlier, we are proposing to change from MSAs to three-digit ZIP

Codes for geographic areas for acute inpatient facility charges. Presently, we calculate 80th percentile factors and geographic area adjustment factors for acute inpatient facility charges by MSA, based on charge data from the Medicare Standard Analytical File 5% Sample. Associated with the change to three-digit ZIP Codes, we are proposing to amend the regulations to base the calculation of these factors on the MedPAR file, which provides a complete record of all Medicare hospital admissions. This change from 5% to 100% of Medicare hospital admissions will produce more accurate 80th percentile factors and geographic area adjustment factors for the smaller three-digit ZIP Code areas.

### Skilled Nursing Facility/Sub-Acute Inpatient Facility Charges

Presently, we calculate skilled nursing facility/sub-acute inpatient facility all-inclusive per diem charges based on the nationwide average per diem charge presented in annual releases of the Milliman USA, Inc., Health Cost Guidelines. We are proposing to change the regulations to base these charges on the actual average per diem billed charge derived from the MedPAR skilled nursing facility file. This will more directly and accurately measure the nationwide baseline charge, and enable calculation of a more accurate nationwide 80th percentile charge. We are also proposing to change the trending methodology from one based on trends in Medicare reimbursement rates, as presented in the Annual Report of the Boards of Trustees of the Federal Supplementary Medical Insurance Trust Funds, to trends based on the inpatient hospital services component of the CPI-U. This change will result in trending that more accurately reflects changes in billed charge levels.

Presently, we calculate 80th percentile adjustment factors and geographic area adjustment factors based on the Medicare Standard Analytical File 5% Sample and the Milliman USA, Inc., Health Cost Guidelines, respectively. We are proposing to amend the regulations to base calculation of these factors on the MedPAR skilled nursing facility file. These changes will produce more accurate 80th percentile adjustment factors and geographic area adjustment factors.

### Partial Hospitalization Facility Charges

Presently, we do not have a per diem facility charge that is specific to partial hospitalization, nor do we have charges for any of the HCPCS Level II codes,