

including those associated with partial hospitalization. We are proposing to amend the regulations to provide a methodology for establishing partial hospitalization facility charges. We are proposing this change so that we will be able to bill for these services when we provide or furnish them to our patients.

#### **Outpatient Facility Charges**

Presently, we calculate outpatient facility charges utilizing a statistical method based on 1998 Medicare practice expense RVUs, which we adopted as a proxy weighting system for the calculation of outpatient facility charges. We are proposing to amend the methodology to base nationwide average outpatient facility charges on Medicare Ambulatory Payment Classification (APC) groups, using data from the Medicare Standard Analytical File 5% Sample. This will provide the basis for a more accurate calculation, because APC payment groups are based on actual outpatient facility charge data, whereas the 1998 Medicare practice expense RVUs were based on physician charge data for overhead expenses.

One consequence of adopting APC groups for this purpose is that the statistical methodology we presently use to bundle CPT codes into CPT code groups will no longer be needed, because APCs provide appropriate groupings of codes. We are also proposing to amend the regulations to adjust APC charges, which represent Medicare average reimbursement levels, to nationwide 80th percentile billed charge levels. This adjustment will result in charges that more accurately reflect market-level charges.

For outpatient facility services which do not have APC assignments, we propose to calculate outpatient facility charges using data from the MDR database, the MedStat claims database, and the Medicare Standard Analytical File 5% Sample.

These changes to the regulations will result in VA charge structures and billing practices that more closely approximate industry standard charge structures and billing practices.

#### **Physician and Other Professional Charges Except for Anesthesia Services and Certain Dental Services**

Presently, the regulations incorporate the methodologies for charges for pathology/laboratory and anesthesia services in the methodology for physician charges. We are proposing to restructure the regulations so that pathology/laboratory charges and professional charges for anesthesia services are identified as separate charge types. We are also proposing to specify

in the regulations that charges for professional dental services identified by CPT code are determined in accordance with the same methodology as for physician charges, while professional dental services identified by HCPCS Level II code are treated as a separate charge type, with charges determined using a different methodology as discussed below. We are proposing these changes so that different charge types and different charge development methodologies will be separately identified and described in the regulations.

Presently, our charges are not influenced by the presence or absence of CPT code modifiers. This document proposes to amend the regulations to add methodology for developing charge adjustment factors for specified CPT/HCPCS code modifiers, using data from the Medicare Standard Analytical File 5% Sample. Some charge adjustment factors will act to increase the charge (for example, modifier 22, Unusual Procedural Services). Other charge adjustment factors will act to decrease the charge (for example, modifier 52, Reduced Services). This change will result in VA charge structures and billing practices that more closely approximate industry standard charge structures and billing practices.

Presently, language in the regulations is interpreted to mean that we do not have professional charges for categories of providers other than physicians unless the provider category is specifically named in the regulations. This document proposes to amend the regulations to set forth charge methodologies for physicians and other professionals that apply to all professional provider categories. This change will result in VA charge structures and billing practices that more closely approximate industry standard charge structures and billing practices.

#### **Professional Charges for Anesthesia Services**

Presently, professional charges for anesthesia services are based in part on average time units compiled from a Health Care Financing Administration study. Applying this methodology, the professional charge for a given anesthesia procedure is the same, regardless of the length of time the patient received anesthesia. This document proposes to amend the methodology so that professional charges for anesthesia services will vary according to the length of time the patient received anesthesia. This change will result in VA charge structures and billing practices that more closely

approximate industry standard charge structures and billing practices.

#### **Professional Charges for Dental Services Identified by HCPCS Level II Codes**

Presently, charges for outpatient dental care are based on VA costs in accordance with the methodology set forth in § 17.102. This document proposes to amend the methodology to establish reasonable charges for dental services identified by HCPCS Level II codes, using data from the Prevailing Healthcare Charges System, the National Dental Advisory Service nationwide pricing index, the Dental UCR (Usual, Customary, or Reasonable) Module of the Ingenix Comprehensive Healthcare Payment System, the Milliman USA, Inc., Dental Health Cost Guidelines, and the dental services component of the CPI-U. This change will result in VA charge structures and billing practices that more closely approximate industry standard charge structures and billing practices.

#### **Pathology and Laboratory Charges**

Presently, the regulations provide that for each pathology and laboratory CPT code, the technical component RVUs are added to the professional component RVUs, if any, resulting in only one charge for each pathology and laboratory CPT code. This document proposes to amend the methodology so that those pathology and laboratory procedures which require a professional interpretation will have two separate charges: a professional component charge determined according to the methodology set forth in the Physician and Other Professional Charges paragraph in the regulations, and a technical component charge determined according to the methodology set forth in the Pathology and Laboratory Charges paragraph in the regulations. This change will result in VA charge structures and billing practices that more closely approximate industry standard charge structures and billing practices.

#### **Observation Care Facility Charges**

Presently, our facility charges for observation care consist of outpatient facility charges for three observation care CPT codes, 99218, 99219, and 99220. These charges are per occurrence, regardless of the number of hours the patient received observation care. This document proposes to amend the regulations to provide a methodology for establishing observation care facility charges that will vary according to the number of hours the patient receives observation