

§ 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 at <http://www.va.gov/revenue>, 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 at <http://www.va.gov/revenue>, 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 submitted 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.

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 healthcare 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 healthcare 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 healthcare 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: