

(D) *APC categories for the purpose of establishing 80th percentile to median factors.* For the purpose of the statistical methodology set forth in paragraph (e)(3)(i) of this section, APCs are assigned to the following APC categories:

- (1) Radiology.
- (2) Drugs.
- (3) Office, Home, and Urgent Care Visits.
- (4) Cardiovascular.
- (5) Emergency Room Visits.
- (6) Outpatient Psychiatry, Alcohol and Drug Abuse.
- (7) Pathology.
- (8) Surgery.
- (9) Allergy Immunotherapy, Allergy Testing, Immunizations, and Therapeutic Injections.
- (10) All APCs not assigned to any of the above groups.

(ii) *Nationwide 80th percentile charges for CPT/HCPCS codes which do not have APC assignments.* Nationwide 80th percentile billed charge levels by CPT/HCPCS code are computed from the outpatient facility component of the MDR database, from the MedStat claims database, and from the outpatient facility component of the Medicare Standard Analytical File 5% Sample. If the MDR database contains sufficient data to provide a statistically credible 80th percentile charge, then that result is retained for this purpose. If the MDR database does not provide a statistically credible 80th percentile charge, then the result from the MedStat database is retained for this purpose, provided it is statistically credible. If neither the MDR nor the MedStat databases provide statistically credible results, then the nationwide 80th percentile billed charge computed from the 5% Sample data is retained for this purpose. The nationwide 80th percentile charges are trended forward to the effective time period for the charges, as set forth in paragraph (e)(3)(iii) of this section.

(iii) *Trending forward.* The charges for each CPT/HCPCS code, obtained as described in paragraph (e)(3) of this section, are trended forward based on changes to the outpatient hospital services component of the CPI-U. Actual CPI-U changes are used from the time period of the source data through the latest available month as of the time the calculations are performed. The three-month average annual trend rate as of the latest available month is then held constant to the midpoint of the calendar year in which the charges are primarily expected to be used. The projected total CPI-U change so obtained is then applied to the 80th

percentile charges, as described in paragraph (e)(3) of this section.

(4) *Geographic area adjustment factors.* For each geographic area, a single adjustment factor is calculated as the arithmetic average of the outpatient geographic area adjustment factor published in the Milliman USA, Inc., Health Cost Guidelines (this factor constitutes the ratio of the level of charges for each geographic area to the nationwide level of charges), and a geographic area adjustment factor developed from the MDR database. See paragraph (a)(3) of this section for data sources. The MDR-based geographic area adjustment factors are calculated as the ratio of the CPT/HCPCS code weighted average charge level for each geographic area to the nationwide CPT/HCPCS code weighted average charge level.

(5) *Multiple surgical procedures.* When multiple surgical procedures are performed during the same outpatient encounter by a provider or provider team as indicated by multiple surgical CPT/HCPCS procedure codes, then the CPT/HCPCS procedure code with the highest facility charge will be billed at 100% of the charges established under this section; the CPT/HCPCS procedure code with the second highest facility charge will be billed at 25% of the charges established under this section; the CPT/HCPCS procedure code with the third highest facility charge will be billed at 15% of the charges established under this section; and no outpatient facility charges will be billed for any additional surgical procedures.

(f) *Physician and other professional charges except for anesthesia services and certain dental services.* When VA provides or furnishes physician and other professional services, other than professional anesthesia services and certain professional dental services, within the scope of care referred to in paragraph (a)(1) of this section, physician and other professional charges billed for such services will be determined in accordance with the provisions of this paragraph. Charges for professional dental services identified by CPT code are determined in accordance with the provisions of this paragraph; charges for professional dental services identified by HCPCS Level II code are determined in accordance with the provisions of paragraph (h) of this section. Physician and other professional charges consist of charges for professional services that vary by geographic area, by CPT/HCPCS code, by site of service, and by modifier, where applicable. These charges are calculated as follows:

(1) *Formula.* For each CPT/HCPCS code or, where applicable, each CPT/HCPCS code and modifier combination, multiply the total geographically-adjusted RVUs determined pursuant to paragraph (f)(2) of this section by the applicable geographically-adjusted conversion factor (a monetary amount) determined pursuant to paragraph (f)(3) of this section to obtain the physician charge for each CPT/HCPCS code in a particular geographic area. Then, multiply this charge by the appropriate factors for any charge-significant modifiers, determined pursuant to paragraph (f)(4) of this section.

(2)(i) *Total geographically-adjusted RVUs for physician services that have Medicare RVUs.* The work expense and practice expense RVUs for CPT/HCPCS codes, other than the codes described in paragraphs (f)(2)(ii) and (f)(2)(iii) of this section, are compiled using Medicare Physician Fee Schedule RVUs. The sum of the geographically-adjusted work expense RVUs determined pursuant to paragraph (f)(2)(i)(A) of this section and the geographically-adjusted practice expense RVUs determined pursuant to paragraph (f)(2)(i)(B) of this section equals the total geographically-adjusted RVUs.

(A) *Geographically-adjusted work expense RVUs.* For each CPT/HCPCS code for each geographic area, the Medicare Physician Fee Schedule work expense RVUs are multiplied by the work expense Medicare Geographic Practice Cost Index. The result constitutes the geographically-adjusted work expense RVUs.

(B) *Geographically-adjusted practice expense RVUs.* For each CPT/HCPCS code for each geographic area, the Medicare Physician Fee Schedule practice expense RVUs are multiplied by the practice expense Medicare Geographic Practice Cost Index. The result constitutes the geographically-adjusted practice expense RVUs. In these calculations, facility practice expense RVUs are used to obtain geographically-adjusted practice expense RVUs for use by provider-based entities, and non-facility practice expense RVUs are used to obtain geographically-adjusted practice expense RVUs for use by non-provider-based entities.

(ii) *RVUs for CPT/HCPCS codes that do not have Medicare RVUs and are not designated as unlisted procedures.* For CPT/HCPCS codes that are not assigned RVUs in paragraphs (f)(2)(i) or (f)(2)(iii) of this section, total RVUs are developed based on various charge data sources. For these CPT/HCPCS codes, the nationwide 80th percentile billed charges are obtained, where statistically