

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, where three-digit ZIP Codes are the first three digits of standard U.S. Postal Service ZIP Codes.

*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 health care 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 health care 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

health care 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:

(i) In the event that a new identifier (DRG, CPT code, or HCPCS code) is assigned to a particular type or item of medical care or service, then until such time as VA establishes a charge for the new identifier, VA's charge for such care or service will be VA's most recent established charge for the identifier previously assigned to that type or item of medical care or service; otherwise,

(ii) In the event that the medical care or service is provided or furnished at VA expense by a non-VA provider, then VA's charge for such care or service will be the amount VA paid to the non-VA provider; otherwise,

(iii) VA's charges for prosthetic devices and durable medical equipment will be VA's actual cost; otherwise,

(iv) If a Medicare allowed charge amount can be determined for the care or service, then VA's charge will be the Medicare participating provider allowed charge amount geographically adjusted using the applicable geographic area adjustment factors determined pursuant to this section; otherwise,

(v) If a charge cannot be established under paragraphs (a)(8)(i) through (iv) of this section, then VA will not charge for the care or service under this section.

(b) *Acute inpatient facility charges.* When VA provides or furnishes acute inpatient services within the scope of care referred to in paragraph (a)(1) of this section, acute inpatient facility charges billed for such services will be determined in accordance with the provisions of this paragraph. Acute inpatient facility charges consist of per diem charges for room and board and for ancillary services that vary by geographic area and by DRG. These charges are calculated as follows:

(1) *Formula.* For each acute inpatient stay, or portion thereof, for which a particular DRG assignment applies, the total acute inpatient facility charge is the sum of the applicable charges determined pursuant to paragraphs (b)(1)(i), (ii), and (iii) of this section. For purposes of this section, standard room and board days and ICU room and board days are mutually exclusive: VA will bill either a standard room and board per diem charge or an ICU room and board per diem charge, as applicable, for each day of a given acute inpatient stay.

(i) *Standard room and board charges.* Multiply the nationwide standard room and board per diem charge determined pursuant to paragraph (b)(2) of this section by the appropriate geographic area adjustment factor determined pursuant to paragraph (b)(3) of this section. The result constitutes the area-specific standard room and board per diem charge. Multiply this amount by the number of days for which standard room and board charges apply to obtain the total acute inpatient facility standard room and board charge.

(ii) *ICU room and board charges.* Multiply the nationwide ICU room and board per diem charge determined pursuant to paragraph (b)(2) of this section by the appropriate geographic area adjustment factor determined pursuant to paragraph (b)(3) of this section. The result constitutes the area-specific ICU room and board per diem charge. Multiply this amount by the number of days for which ICU room and board per diem charges apply to obtain the total acute inpatient facility ICU room and board charge.

(iii) *Ancillary charges.* Multiply the nationwide ancillary per diem charge determined pursuant to paragraph (b)(2) of this section by the appropriate geographic area adjustment factor determined pursuant to paragraph (b)(3) of this section. The result constitutes the area-specific ancillary per diem charge. Multiply this amount by the number of days of acute inpatient care to obtain the