

CPT/HCPCS procedure code with the highest facility charge will be billed at 100 percent of the charges established under this section; the CPT/HCPCS procedure code with the second highest facility charge will be billed at 25 percent of the charges established under this section; the CPT/HCPCS procedure code with the third highest facility charge will be billed at 15 percent 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 credible, from the MDR database. For any remaining CPT/HCPCS codes, the nationwide 80th percentile billed charges are obtained, where statistically credible, from the Part B component of the Medicare Standard Analytical File 5 percent Sample. For any remaining CPT/HCPCS codes, the nationwide 80th percentile billed charges are obtained, where statistically credible, from the Prevailing Healthcare Charges System nationwide commercial insurance database. For each of these CPT/HCPCS codes, nationwide total RVUs are obtained by taking the nationwide 80th percentile billed charges obtained using the preceding three databases and dividing by the untrended nationwide conversion factor for the corresponding CPT/HCPCS code group determined pursuant to paragraphs (f)(3) and (f)(3)(i) of this section. For any remaining CPT/HCPCS codes that have not been assigned RVUs using the preceding data sources, the nationwide total RVUs are calculated by summing the work expense and non-facility practice expense RVUs found in Ingenix/St.

Anthony's RBRVS. The resulting nationwide total RVUs obtained using these four data sources are multiplied by the geographic area adjustment factors determined pursuant to paragraph (f)(2)(iv) of this section to obtain the area-specific total RVUs.

(iii) *RVUs for CPT/HCPCS codes designated as unlisted procedures.* For CPT/HCPCS codes designated as unlisted procedures, total RVUs are developed based on the weighted median of the total RVUs of CPT/HCPCS codes within the series in which the unlisted procedure code occurs. A nationwide VA distribution of procedures and services is used for the purpose of computing the weighted median. The resulting nationwide total RVUs are multiplied by the geographic area adjustment factors determined pursuant to paragraph (f)(2)(iv) of this section to obtain the area-specific total RVUs.

(iv) *RVU geographic area adjustment factors for CPT/HCPCS codes that do not have Medicare RVUs, including codes that are designated as unlisted procedures.* The adjustment factor for each geographic area consists of the weighted average of the work expense and practice expense Medicare Geographic Practice Cost Indices for each geographic area using charge data for representative CPT/HCPCS codes statistically selected and weighted for work expense and practice expense.

(3) *Geographically-adjusted 80th percentile conversion factors.* CPT/HCPCS codes are separated into the following 23 CPT/HCPCS code groups: allergy immunotherapy, allergy testing, cardiovascular, chiropractor, consults, emergency room visits and observation care, hearing/speech exams, immunizations, inpatient visits, maternity/cesarean deliveries, maternity/non-deliveries, maternity/normal deliveries, miscellaneous medical, office/home/urgent care visits, outpatient psychiatry/alcohol and drug abuse, pathology, physical exams, physical medicine, radiology, surgery, therapeutic injections, vision exams, and well baby exams. For each of the 23 CPT/HCPCS code groups, representative CPT/HCPCS codes are statistically selected and weighted so as to give a weighted average RVU comparable to the weighted average RVU of the entire CPT/HCPCS code group (the selected CPT/HCPCS codes are set forth in the Milliman USA, Inc., Health Cost Guidelines fee survey); see paragraph (a)(3) of this section for Data Sources. The 80th percentile charge for each selected CPT/HCPCS code is obtained from the MDR database. A nationwide conversion factor (a monetary amount)