

DEPARTMENT OF VETERANS AFFAIRS**38 CFR Part 17**

RIN 2900-AK39

Reasonable Charges for Medical Care or Services**AGENCY:** Department of Veterans Affairs.**ACTION:** Interim final rule.

SUMMARY: This document amends the Department of Veterans Affairs (VA) medical regulations concerning “reasonable charges” for medical care or services provided or furnished by VA to a veteran:

- 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;
- 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
- For a nonservice-connected disability incurred as a result of a motor vehicle accident in a State that requires automobile accident reparations insurance.

This document amends the regulations to update databases and other provisions for the purpose of providing more precise charges.

DATES: *Effective Date:* These amendments are effective November 2, 2000. Comments must be submitted by January 2, 2001.

ADDRESSES: Mail or hand-deliver written comments to: Director, Office of Regulations Management (02D), Department of Veterans Affairs, 810 Vermont Ave., NW, Room 1154, Washington, DC 20420; or fax comments to (202) 273-9289; or e-mail comments to OGCRegulations@mail.va.gov. Comments should indicate that they are submitted in response to “RIN 2900-AK39.” All comments received will be available for public inspection in the Office of Regulations Management, Room 1158, between the hours of 8 a.m. and 4:30 p.m., Monday through Friday (except holidays).

FOR FURTHER INFORMATION CONTACT: David Cleaver, VHA Revenue Office (174), Veterans Health Administration, Department of Veterans Affairs, 810 Vermont Avenue, NW., Washington, DC 20420, (202) 273-8210. (This is not a toll free number.)

SUPPLEMENTARY INFORMATION: This document amends VA’s medical

regulations that are set forth at 38 CFR part 17. More specifically, we are amending the regulations concerning “reasonable charges” for medical care or services provided or furnished by VA 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.

The regulations establish a methodology for “reasonable charges” for such medical care and services. The amount billed using this methodology consists of inpatient facility charges, skilled nursing facility/sub-acute inpatient facility charges, outpatient facility charges, physician charges, and other provider charges.

Under the provisions of 38 U.S.C. 1729, VA has the right to recover or collect its reasonable charges from a third party to the extent that the veteran or a provider of the care or services would be eligible to receive payment therefor from that third party if the care or services had not been furnished by a department or agency of the United States. With respect to a third-party payer liable under a health plan contract, consistent with the statutory authority, the third-party payer would have the option of paying, to the extent of its coverage, either the billed charges or the amount the third-party payer demonstrates 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.

This document modifies the existing regulations in three primary ways, and also makes various other less significant improvements. First, the original formula used a number of databases for 1995 through 1998 which are now being updated to use the 1997 through 2000 versions of these files (e.g., MedStat and MediCode databases). Second, a number of previously used data files are being replaced with more current and easier-to-use databases (e.g., use the 1998 Medicare MedPAR database in lieu of the 1995 Medicare Standard Analytical File 5% Sample). Lastly, the term “geographic area”, which was defined

as the “Metropolitan Statistical Area (MSA) or the local market, if the VA facility is not located in a MSA”, retains that definition for inpatient facility charges and skilled nursing facility/sub-acute inpatient facility charges, but is now defined as “a three-digit ZIP Code locality” for outpatient facility charges and physician charges. These changes and the various other improvements to the methodology are described in greater detail in the following paragraphs. These changes and improvements should not have a significant impact on any affected party, but will make this process more current, accurate, and logical.

The formulas for inpatient facility charges, skilled nursing facility/sub-acute inpatient facility charges, outpatient facility charges, and physician charges were designed to replicate, insofar as possible, the 80th percentile charge for a particular service in a specific location. We have made changes to ensure that the information used in the methodology is as current and precise as possible. As an example, the formula for outpatient facility charges included factors based on the 1995 MedStat claims database. We now are able to use the 1997 MedStat claims database. Therefore, we are changing the formula to use the updated database. We have made a number of other changes to obtain more precise information as explained below.

The formulas for inpatient facility charges, skilled nursing facility/sub-acute inpatient facility charges, outpatient facility charges, and physician charges include geographic area adjustment factors. The term “geographic area” was defined as the “Metropolitan Statistical Area (MSA) or the local market, if the VA facility is not located in a MSA.” This document retains this definition for inpatient facility charges and skilled nursing facility/sub-acute inpatient facility charges. However, for outpatient facility charges and physician charges this document changes the definition of geographic area to mean a three-digit ZIP Code locality. The three-digit ZIP Code methodology is more precise than the MSA and has been developed for outpatient facility charges and physician charges.

The formula for calculating inpatient facility charges includes per diem charges that are based in part on two nationwide databases. Previously, the formula used the 1995 Medicare Standard Analytical File 5% Sample and the 1995 MedStat claim database. We are amending the formula to use the 1998 Medicare MedPAR database in lieu of the 1995 Medicare Standard

Analytical 5% Sample. The 1998 Medicare MedPAR database is not only more current but also provides information in an easier-to-use format. We are also amending the formula to use the 1997 MedStat database in lieu of the 1995 MedStat database. This is a more current database of the same information. With these changes the formula will utilize the latest available data for calculating per diem charges.

The formula for inpatient facility charges includes charge component percentages. Previously, the formula used the 1995 Medicare Standard Analytical File 5% Sample. We are amending the formula to use the 1998 Medicare MedPAR database in lieu of the Medicare Standard Analytical 5% Sample. As noted above, the 1998 Medicare MedPAR database is not only more current but also provides information in an easier-to-use format.

The formula for skilled nursing facility/sub-acute inpatient facility charges includes per diem charges that are based on nationwide data concerning skilled nursing facility charges contained in the 1998 Milliman & Robertson, Inc. Health Cost Guidelines. We are amending the formula to use the data, which has been updated by Milliman & Robertson through July 1, 2000. With this change, the formula will use the latest available data for calculating per diem charges.

The formula for outpatient facility charges includes charge factors that are based on the 1995 MedStat claims database of nationwide commercial insurance. We are amending the formula to use the 1997 MedStat claims database of nationwide commercial insurance. With this change, the formula will use the latest available data for calculating the charge factors.

The formula for outpatient facility charges included 37 Current Procedural Terminology (CPT) procedure code groups from which the median charge was used for calculating the charge factors. We are amending the formula to use 45 CPT procedure code groups instead of the previous 37 to better group together those CPT procedure codes with similar characteristics. This will help ensure more accurate results for the charge factors.

Previously, the formula for outpatient facility charges established 80th percentile charge levels using two databases, MediCode and MedStat. The formula is changed to use the MedStat database for all CPT code groups since it contains all of the information needed for this purpose.

For physician charges other than anesthesia charges, in general, we have established several methods for

determining charges depending on the availability of information. Under the regulations, we employ methodology to provide the most precise charges. If work expense and practice expense Relative Value Units (RVUs) are established under Medicare, we employ methodology utilizing these factors. This enables us to use three geographic area adjustment factors (GAAFs) in calculating charges for each of these CPT procedure codes: one for the work expense RVUs, one for the practice expense RVUs, and one for the conversion factor. When work expense and practice expense RVUs are not available from Medicare, we use methodology based on total RVUs derived from Medicare's Clinical Diagnostic Laboratory Fee Schedule. For each of these CPT procedure codes, we are able to use two GAAFs in calculating the charges: one for the total RVUs and one for the conversion factor. If neither of these methods is available, we use methodology based directly on billed charges. For each of these CPT procedure codes, we develop total RVUs and a conversion factor, using one GAAF for RVUs and one GAAF for the conversion factor. As a last resort, if none of the above are available, we use methodology based on work expense and practice expense RVUs obtained from St. Anthony's RBRVS (Resource Based Relative Value Scale). For each of these CPT procedure codes, we develop total RVUs and a conversion factor, using one GAAF for RVUs and one GAAF for the conversion factor. Consistent with these principles, we are making changes based on new information to establish more precise charges for CPT procedure codes. The largest group of CPT procedure codes to be changed involves laboratory and pathology. Previously, we developed nationwide charges for these CPT procedure codes, to which we applied a single GAAF. We are now changing the methodology to develop total RVUs for these CPT procedure codes, enabling us to use two GAAFs, one for the total RVUs and one for the conversion factor.

With respect to the formula for physician charges, to make charges for laboratory and pathology CPT procedure codes more accurately reflect 80th percentile charges, we adjusted the relativities for laboratory and pathology charges by including the 2000 RBRVS work and practice expense RVUs, representing the professional component of these procedures, when applicable.

We have deleted provisions in the physician charges formula providing for the Medicare work adjuster. This was used as a budget constraint factor

designed for use in past years for Medicare calculations. This is no longer being used for Medicare calculations and, therefore, we are also deleting it from our formula.

The formula for physician charges included facility-adjusted work expense and practice expense RVUs for most CPT procedure codes and base unit values for anesthesia CPT procedure codes. Previously, the formula used information from the 1998 Medicare Geographic Practice Cost Index, 1998 Medicare RBRVS Unit Values, and 1998 St. Anthony's Complete RBRVS. We are amending the formula to use the 2000 Medicare Geographic Practice Cost Index, 2000 Medicare RBRVS Unit Values, and the 2000 St. Anthony's RBRVS. With these changes the formula will use the latest available data for calculating physician charges.

The formula for physician charges also included the Health Insurance Association of America nationwide commercial insurance database for obtaining the 80th percentile charge for facility-adjusted 80th percentile conversion factors. We have instead used the charge data compiled by MediCode since it is easier to use for this purpose.

The methodology for inpatient facility charges, skilled nursing facility/sub-acute inpatient facility charges, outpatient facility charges, and physician charges includes trending to update charges based on changes to the consumer price index. This methodology is updated to reflect changes described above regarding updated databases. This methodology is also amended to reflect that charges are trended to the midpoint of the calendar year in which the charges will be effective.

All of the above changes made by this document are for the purpose of adding precision to charges.

Also, changes are made to the regulations for purposes of clarification.

Administrative Procedure Act

This document amends the regulations to update databases and other provisions for the purpose of providing more precise charges. Although some charges might be slightly different, overall these changes would not affect total VA charges. Under these circumstances, we have concluded under 5 U.S.C. 553 that there is good cause for dispensing with prior notice and comment and a delayed effective date based on the conclusion that such procedure is impracticable, unnecessary, and contrary to the public interest.

Unfunded Mandates

The Unfunded Mandates Reform Act requires (in section 202) that agencies prepare an assessment of anticipated costs and benefits before developing any rule that may result in an expenditure by State, local, or tribal governments, in the aggregate, or by the private sector of \$100 million or more in any given year. This rule would have no consequential effect on State, local, or tribal governments.

Executive Order 12866

The Office of Management and Budget has reviewed this proposed rule under Executive Order 12866.

Regulatory Flexibility Act

The Secretary hereby certifies that this rule will not have a significant economic impact on a substantial number of small entities as they are defined in the Regulatory Flexibility Act, 5 U.S.C. 601–612. This rule would affect mainly large insurance companies and where small entities are involved they would not be impacted significantly since most of their business is not with VA. Accordingly, pursuant to 5 U.S.C. 605(b), this rule is exempt from the initial and final regulatory flexibility analysis requirements of sections 603 and 604.

The Catalog of Federal domestic assistance numbers for the programs affected by this rule are 64.005, 64.007, 64.008, 64.009, 64.010, 64.011, 64.012, 64.013, 64.014, 64.015, 64.016, 64.018, 64.019, 64.022, and 64.025.

List of Subjects in 38 CFR Part 17

Administrative practice and procedure, Alcohol abuse, Alcoholism, Claims, Day care, Dental health, Drug abuse, Foreign relations, Government contracts, Grant programs—health, Grant programs—veterans, Health care, Health facilities, Health professions, Health records, Homeless, Medical and dental schools, Medical devices, Medical research, Mental health programs, Nursing homes, Philippines, Reporting and recordkeeping requirements, Scholarships and fellowships, Travel and transportation expenses, Veterans.

Approved: August 30, 2000.

Hershel W. Gober,

Acting Secretary of Veterans Affairs.

For the reasons set out in the preamble, 38 CFR part 17 is amended as set forth below:

PART 17—MEDICAL

1. The authority citation for part 17 continues to read as follows:

Authority: 38 U.S.C. 501, 1721, unless otherwise noted.

2. Section 17.101 is amended by:

A. In paragraph (a)(4), revising the definition of *Geographic area*.

B. In paragraph (b)(2) introductory text, revising the first sentence; and by removing “their 1995 base” from the fifth sentence and adding, in its place “1998”.

C. In paragraph (b)(2)(i), removing “Medicare Standard Analytical File 5% Sample” and adding, in its place, “MedPAR file”.

D. In paragraph (b)(2)(ii), removing “Medicare” and adding, in its place, “1995 Medicare”.

E. Revising paragraph (b)(2)(iii).

F. In paragraph (c)(2) introductory text, removing “1998” each time it appears and adding, in its place, “2000”.

G. Revising paragraph (c)(2)(ii).

H. Revising paragraph (d)(3).

I. In paragraph (e)(1), removing “and pathology” each time it appears.

J. In the paragraph (e)(2)(i) heading and in the remaining text of the paragraph, removing “, pathology”.

K. In paragraph (e)(2)(i), introductory text, removing “(e)(2)(ii) and (e)(2)(iii)” and adding, in its place, “(e)(2)(ii) through (e)(2)(iv).”

L. Revising paragraph (e)(2)(i)(A).

M. In paragraph (e)(2)(i)(B), removing “1998” each time it appears and adding, in its place, “2000”.

N. Revising paragraphs (e)(2)(ii) through (e)(2)(iv); and adding new (e)(2)(v).

O. In paragraph (e)(3), introductory text, removing “1998” and adding, “2000”.

P. In paragraph (e)(3); removing “insurance data base compiled by the Health Insurance Association of America, 555 13th Street NW, Suite 600E, Washington, D.C. 20004 (medical data for 5/1/96–4/30/97, including radiology and pathology; surgical data for 3/1/96–2/28/97; anesthesia data for 3/1/96–2/28/97)).” and adding, in its place, “charge database compiled by MediCode, Inc., 5225 Wiley Post Way, Suite 500, Salt Lake City, Utah 84116).”

Q. In paragraph (e)(3)(ii), removing “representing charges for time periods detailed” and adding, in its place, “representing charge levels described”.

R. In paragraph (e)(3)(ii), removing “for the period August 1998 through September 1999, and for each 12-month calendar year period thereafter, beginning January 1, 2000”;

S. In paragraph (e)(3)(ii), removing “effective charge period” and adding, in its place, “calendar year in which charges will be effective”.

T. Revising paragraph (e)(4) introductory text.

U. In paragraph (e)(4)(i), removing “1998” each time it appears and adding, in its place, “2000”; and by removing “anesthesia time unit” and adding, in its place, “anesthesia average time unit”.

The additions and revisions read as follows:

§ 17.101 Collection or recovery by VA for medical care or services provided or furnished to a veteran for a non-service connected disability.

(a) * * *

(4) * * *

Geographic area, for purposes of inpatient facility and skilled nursing facility/sub-acute inpatient facility charges, means Metropolitan Statistical Area (MSA) or the local market, if the VA facility is not located in an MSA; and for outpatient facility charges and physician charges, means a three-digit ZIP Code locality.

* * * * *

(b) * * *

(2) * * * To establish a baseline, two nationwide average per diem charges for each DRG are calculated for fiscal year 1998, one from the 1998 Medicare MedPAR file and one from the MedStat claim database, a database of nationwide commercial insurance claims. Because the MedStat data is based on calendar year 1997, the MedStat charges were trended forward at an annual trend rate of 2.7%, based on the Inpatient Hospital component of the CPI–U. * * *

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(iii) *Trending forward*. 80th percentile charges for each DRG, representing charge levels described in (b)(2) of this section, are trended forward based on changes to the hospital inpatient component of the CPI–U. Actual CPI–U changes are used through the latest available month for room/board and ancillary charges. Trends from the latest available month to the midpoint of the calendar year in which charges become effective are based on the latest three-month average annual trend rate from the Inpatient Hospital component of the CPI–U. The projected total CPI trend is then applied to the 1998 80th percentile charges.

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(c) * * *

(2) * * *

(ii) *Trending forward*. The 80th percentile charge is trended forward to the midpoint of the calendar year in which the charges will be effective, based on the projected change in Medicare reimbursement from the Annual Report of the Board of Trustees of the Federal Hospital Insurance Trust Fund (this report can be found on the

Health Care Financing Administration Internet site at <http://www.hcfa.gov/> under the headings "Publications and Forms" and "Professional/Technical Publications").

* * * * *

(d) * * *

(3) *Charge factors.* Using the 1997 MedStat claims database of nationwide commercial insurance, the median billed facility charge is calculated for each applicable CPT procedure code. All outpatient facility CPT procedure codes are then separated into one of the 45 outpatient facility CPT procedure code groups as set forth in paragraph (d)(3)(i) of this section. Then, for each CPT procedure code in each such group, the median charge is adjusted to the 80th percentile as set forth in paragraph (d)(3)(ii) of this section. The resulting 80th percentile charge for each CPT procedure code is trended forward to the effective time period for the charges as set forth in paragraph d)(3)(iii) of this section. Using the resulting charges and the RVUs, mathematical approximation methodology based on least squares techniques is applied to the data for each CPT procedure code group to derive outpatient facility charges. For each CPT procedure code, the charge amount is calculated as an amount per incremental RVU and a fixed charge amount adjustment.

(i) *Outpatient facility CPT procedure code groups.*

(A) Surgery—Integumentary System—Skin, Subcutaneous & Accessory Structures/Nails;

(B) Surgery—Integumentary System—Repair—Simple, Intermediate, Complex, Adjacent Tissue Transfer or Rearrangement;

(C) Surgery—Integumentary System—Not Otherwise Classified;

(D) Surgery—Musculoskeletal System—Not Otherwise Classified;

(E) Surgery—Musculoskeletal System—Incision/Excision/Introduction/Removal;

(F) Surgery—Musculoskeletal System—Repair/Revision/Reconstruction/Arthrodesis/Manipulation/Amputation;

(G) Surgery—Musculoskeletal System—Fracture/Dislocation-Closed Treatment;

(H) Surgery—Musculoskeletal System—Fracture/Dislocation-Open Treatment;

(I) Surgery—Musculoskeletal System—Application of Casts and Strapping;

(J) Surgery—Musculoskeletal System—Endoscopy/Arthroscopy;

(K) Surgery—Respiratory System;

(L) Surgery—Cardiovascular System;

(M) Surgery—Digestive System—Not Otherwise Classified;

(N) Surgery—Digestive System—Endoscopy;

(O) Surgery—Urinary System;

(P) Surgery—Male Genital System;

(Q) Surgery—Female Genital System;

(R) Surgery—Maternity Care and Delivery;

(S) Surgery—Endocrine System/Nervous System;

(T) Surgery—Eye/Ocular Adnexa;

(U) Surgery—Auditory System;

(V) Radiology—Diagnostic—Head & Neck/Chest/Spine & Pelvis;

(W) Radiology—Diagnostic—Extremities/Abdomen/Gastrointestinal Tract/Urinary Tract/Gynecological & Obstetrical/Heart;

(X) Radiology—Diagnostic—Aorta & Arteries/Veins & Lymphatics;

(Y) Radiology—Diagnostic Ultrasound;

(Z) Radiology—Radiation Oncology/Nuclear Medicine/Therapeutic;

(AA) Radiology—Diagnostic—CAT Scans;

(BB) Radiology—Diagnostic—

Magnetic Resonance Imaging (MRI);

(CC) Medicine—Vaccines/Toxoids;

(DD) Medicine—Therapeutic or Diagnostic Infusions (Excludes Chemotherapy)/Therapeutic, Prophylactic, or Diagnostic Injections;

(EE) Medicine—Psychiatry/Biofeedback;

(FF) Medicine—Dialysis;

(GG) Medicine—Gastroenterology;

(HH) Medicine—Ophthalmology/Special Otorhinolaryngologic Services;

(II) Medicine—Cardiovascular/Non-Invasive Vascular Diagnostic Studies;

(JJ) Medicine—Pulmonary;

(KK) Medicine—Neurology & Neuromuscular Procedures/Central Nervous System Assessments & Tests;

(LL) Medicine—Chemotherapy Administration;

(MM) Medicine—Special Dermatological Procedures;

(NN) Medicine—Physical Medicine and Rehabilitation—Evaluation/Modalities; Photodynamic Therapy;

(OO) Medicine—Physical Medicine and Rehabilitation—Therapeutic Procedures/Tests and Measurements/

Other Procedures; Osteopathic Manipulative Treatment/Chiropractic Manipulative Treatment/Special Services, Procedures, & Reports/Other Services and Procedures;

(PP) Medicine—Evaluation & Management—Consultations;

(QQ) Medicine—Evaluation & Management—Hospital Observation Services;

(RR) Medicine—Evaluation & Management—Emergency Department Services/Critical Care Services; and

(SS) Medicine—Evaluation & Management—General

Ophthalmological Services/Office or Other Outpatient Services/Prolonged Services.

(ii) *80th percentile.* For each of the 45 outpatient facility CPT procedure code groups set forth in paragraph (d)(3)(i) of this section, the median charge is increased by the ratio of the 80th percentile charge to median charge obtained from the MedStat database of nationwide charges. To mitigate the impact of the variation in the intensity of services by CPT procedure code, the percent increase from the median to the 80th percentile in outpatient charges is compared to the percent increase from the median to the 80th percentile in inpatient semi-private room and board charges. Any percent increase in outpatient charges in excess of the inpatient semi-private room and board percent increase is multiplied by a factor of 0.50. The 80th percentile outpatient facility charge is reduced accordingly.

(iii) *Trending forward.* The charges for each CPT procedure code, representing charge levels described in paragraph (d)(3) of this section, are trended forward to the midpoint of the calendar year in which the charges will be effective. The trend factors are based on changes to the Outpatient Hospital component of the CPI-U. Actual CPI-U changes are used through the latest available month. The three-month average annual trend rate as of the latest available month is held constant to the midpoint of the effective charge period. The projected total CPI-U change from the source data period to the effective period is then applied to the 80th percentile charges, as described in paragraph (d)(3) of this section.

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(e) * * *

(2) * * *

(i) * * *

(A) *Facility-adjusted work expense RVUs.* For each CPT procedure code for each geographic area, the 2000 work expense RVU is multiplied by the work expense 2000 Medicare Geographic Practice Cost Index. The result constitutes the facility-adjusted work expense RVU.

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(ii) *RVUs based on laboratory and pathology CPT codes based on Medicare's Clinical Diagnostic Laboratory Fee Schedule.* For CPT procedure codes without modifiers that are not assigned separately identified work and practice units (in (e)(2)(i) of this section), total RVUs are developed based on the 2000 edition of Medicare's

Clinical Diagnostic Laboratory Fee Schedule (found on the Health Care Financing Administration public use files Internet site at <http://www.hcfa.gov/stats/pufiles.htm> under the heading "Payment Rates/ Non-Institutional Providers" and the title "Clinical Diagnostic Laboratory Fee Schedule"). Such Medicare payment amounts are upwardly adjusted such that the payment level is, on average, equivalent to standard RBRVS payment levels, using statistical comparisons to the 80th percentile derived from the MediCode charge database. These adjusted payment amounts are then divided by the 2000 Medicare conversion factor to derive RVUs corresponding to each CPT code. The total RVUs are added to the 2000 RBRVS work and practice expense RVUs for the corresponding professional component (if any) of a given CPT procedure code to derive nationwide total RVUs. The resulting nationwide total RVUs are multiplied by the geographic adjustment factors as set forth in paragraph (e)(2)(v) of this section to obtain the facility-specific total RVUs.

(iii) *RVUs for specified CPT procedure codes.* For CPT procedure codes without modifiers that are not assigned RVUs in (e)(2)(i) or (e)(2)(ii) of this section, total RVUs are developed based on various charge databases. For the following CPT procedure codes, the nationwide 80th percentile billed charges are obtained from the nationwide commercial insurance data base compiled by the Health Insurance Association of America (Health Insurance Association of America, 555 13th Street, NW, suite 600E, Washington, DC 20004): 15876, 15877, 15878, 15879, 21088, 21089, 26587, 32850, 33940, 36468, 36469, 47133, 48550, 69710, 76140, 78990, 79900, 92390, 92391, 99024, 99071, 99075, 99078, 99080, 99082, 99090,

99100, 99116, 99135, 99140, 99288, 99420, 99450, 99455, 99456. For the following CPT procedure codes, the nationwide 80th percentile billed charges are obtained from the Medicare Standard Analytical File 5% Sample: 23929, 26989, 29909, 86849, 90749, 96549, 99070, 99429. For the following CPT procedure codes, the nationwide 80th percentile billed charges are obtained from the MediCode data: 15824, 15825, 15826, 15828, 15829, 17380, 20930, 20936, 22841, 24940, 36415, 38792, 41820, 41821, 41850, 41870, 48160, 50300, 54440, 58974, 65760, 65765, 65767, 65771, 69090, 80050, 80055, 80103, 82251, 86485, 86586, 86850, 86860, 86870, 86890, 86891, 86901, 86910, 86911, 86915, 86920, 86921, 86922, 86927, 86930, 86931, 86932, 86945, 86950, 86965, 86970, 86971, 86972, 86975, 86976, 86977, 86978, 86985, 88000, 88005, 88007, 88012, 88014, 88016, 88020, 88025, 88027, 88028, 88029, 88036, 88037, 88040, 88045, 88142, 88143, 88144, 88145, 88147, 88148, 89250, 90371, 90375, 90376, 90389, 90471, 90472, 90585, 90586, 90632, 90633, 90634, 90645, 90646, 90647, 90648, 90657, 90658, 90659, 90665, 90675, 90680, 90690, 90691, 90882, 90889, 90989, 90993, 92531, 92532, 92533, 92534, 92590, 92591, 92592, 92593, 92594, 92595, 92992, 92993, 93786, 93788, 93790, 94642, 95120, 95125, 95130, 95131, 95132, 95133, 95134, 96110, 99000, 99001, 99002, 99025, 99050, 99052, 99054, 99056, 99058, 99190, 99191, 99192, 99358, 99359, 99360, 99361, 99362, 99371, 99372, and 99373. The nationwide 80th percentile billed charges so obtained are divided by the untrended nationwide conversion factor for the corresponding physician CPT procedure code group as set forth in paragraphs (e)(3) and (e)(3)(i) of this section. The resulting nationwide total RVUs are multiplied by the

geographic adjustment factors as set forth in paragraph (e)(2)(v) of this section to obtain the facility-specific total RVUs.

(iv) *RVUs for specified CPT procedure codes.* For CPT procedure codes without modifiers that are not assigned RVUs in paragraphs (e)(2)(i), (e)(2)(ii), or (e)(2)(iii) of this section, the nationwide total RVU is calculated by summing the work expense and practice expense RVUs found in the 2000 St. Anthony's Complete RBRVS (available from Relative Value Studies, Inc., St. Anthony Publishing, 11410 Isaac Newton Square, Reston, VA 20190): 38120, 44201, 60650, 76092, 76350, 78351, 93000, 93040, 93224, 93230, 93235, 93268, 93720, 93760, 93762, 93784, 99185, 99186. The resulting nationwide total RVUs are multiplied by the geographic adjustment factors as set forth in paragraph (e)(2)(v) of this section to obtain the facility-specific total RVUs.

(v) *RVU geographic area adjustment factors for specified CPT procedure codes.* The geographic area adjustment factor for each facility location consists of the weighted average of the 2000 work expense and practice expense Medicare Geographic Practice Cost Indices for each facility location using charge data for representative CPT procedure codes statistically selected and weighted for work expense and practice expense.

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(4) *Nationwide 80th percentile charges for anesthesia CPT procedure codes.* The nationwide charges are calculated by multiplying the RVUs as set forth in paragraph (e)(4)(i) of this section by the appropriate nationwide trended 80th percentile conversion factors as set forth in paragraph (e)(3) of this section.

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