



**DEPARTMENT OF VETERANS AFFAIRS**

**8320-01**

**38 CFR Part 17**

**RIN 2900-AQ69**

**Billing and Collection by VA for Medical Care and Services**

**AGENCY:** Department of Veterans Affairs.

**ACTION:** Proposed rule.

**SUMMARY:** The Department of Veterans Affairs (VA) proposes to amend its regulations concerning collection and recovery by VA for medical care and services provided to an individual for treatment of a nonservice-connected disability. Specifically, this rulemaking would revise the provisions of VA regulations that determine the charges VA will bill third-party payers for non-VA care provided at VA expense, would include a time limit for which third-party payers can request a refund, and would clarify that third-party payers cannot reduce or refuse payment because of the billing methodology used to determine the charge. These revisions would clarify VA billing practices, result in more equitable charges to third-party payers, and ensure that VA collects payments timely and effectively. Additionally, this rulemaking would make certain technical corrections to the existing regulations, and amend associated definitions.

**DATES:** Comments must be received by VA on or before **[Insert date 60 days after date of publication in the FEDERAL REGISTER]**.

**ADDRESSES:** Written comments may be submitted through

<http://www.Regulations.gov>, by mail or hand-delivery to Director, Office of Regulation Policy and Management (00REG), Department of Veterans Affairs, 810 Vermont Avenue, N.W., Room 1064, Washington, DC 20420; or by fax to (202) 273-9026. (This is not a toll-free number.) Comments should indicate that they are submitted in response to “RIN 2900-AQ69, Billing and Collection by VA for Medical Care and Services.” Copies of comments received will be available for public inspection in the Office of Regulation Policy and Management, Room 1064, between the hours of 8:00 a.m. and 4:30 p.m. Monday through Friday (except holidays). Please call (202) 461-4902 for an appointment. (This is not a toll-free number.) In addition, during the comment period, comments may be viewed online through the Federal Docket Management System (FDMS) at <http://www.Regulations.gov>.

**FOR FURTHER INFORMATION CONTACT:** Joseph Duran, Director of Policy and Planning, Office of Community Care (10D), Ptarmigan at Cherry Creek Denver, CO 80209, [Joseph.Duran2@va.gov](mailto:Joseph.Duran2@va.gov) or (303) 372-4629. (This is not a toll-free number.)

**SUPPLEMENTARY INFORMATION:** Under section 1729 of Title 38, United States Code (U.S.C.), VA has the right to recover or collect reasonable charges for medical care or services from a third party to the extent that the veteran or the provider of the care or services would be eligible to receive payment from the third party 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; 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 a nonservice-connected disability incurred as a result of a motor vehicle accident in a State that requires automobile accident reparations (no-fault) insurance. This proposed rule would revise two of VA's regulations (i.e., sections 17.101 and 17.106 of title 38, Code of Federal Regulations (CFR)) that implement 38 U.S.C. 1729.

In this proposed rule, we would revise 38 CFR 17.101, which establishes the instances when VA will collect and recover for medical care and services and the methodology used to determine the reasonable charges VA can bill for medical care and services. In this rulemaking, we propose to amend the amount VA will bill a third party when the medical care was provided at a non-VA facility at VA expense. We also propose to make several technical amendments to 38 CFR 17.101, to correct clerical errors and update office and data source names. Additionally, we propose to add two new definitions and remove one current definition to be consistent with the proposed technical amendments.

In addition to revising § 17.101, this rulemaking would also revise § 17.106. Section 1729 of 38 U.S.C. authorizes VA to collect the reasonable charges for medical care and services from a third-party payer and to compromise, settle, or waive a claim (such as a refund). Additionally, section 1729 prohibits any contract or other agreement operating to prevent recovery or collection by the United States.

Current 38 CFR 17.106 implements 38 U.S.C. 1729 by describing VA's rules for recovery and collection of reasonable charges from a third-party payer for medical care

and services provided for a nonservice-connected disability in or through any VA facility to a veteran who is a beneficiary under a thirty-party's plan. This section also explains that a third-party payer may not, without consent of the U.S. Government, offset or reduce any payment due under 38 U.S.C. 1729 or part 17 of 38 CFR in the instance that the third-party payer considers itself due a refund; and requires that any request for a refund be submitted in writing. Section 17.106 describes those conditions under which a third-party payer may not reduce, offset, or request a refund for payments made pursuant to 38 U.S.C. 1729. In this rulemaking, we propose to amend 38 CFR 17.106 to clarify the timeframe for submitting a written request for a refund for claims under part 17 or 38 U.S.C. 1729, and would explain that VA would not provide a refund for any reason, to include if a retroactive service-connection determination is made more than 18 months after the date payment is made by the third-party payer. We also propose to add a new condition under which a third-party payer could not refuse or reduce their payment for a claim under section 1729.

#### Changes to 17.101

As explained in more detail below, we would amend current § 17.101 by adding and removing definitions, changing the amount VA will bill a third party when the medical care was provided at a non-VA facility at VA expense, and making several technical amendments.

#### § 17.101(a)(5) Definitions.

We would revise § 17.101(a)(5) which defines certain terms used throughout §

17.101. We would add two new definitions and remove a current definition. In proposed § 17.101(a)(5), we would remove the definition of “MDR.” MDR stands for Medical Data Research, which is defined as a medical charge database published by Ingenix, Inc. It is referred to throughout § 17.101, as it was a database used to calculate charges. However, it is no longer used, and has been replaced by FAIR Health. We would insert a definition for “FAIR Health” immediately following the definition of “DRG,” and define “FAIR Health” in § 17.101(a)(5) to mean any of the FAIR Health Charge Benchmarks products developed by FAIR Health. This would be consistent with changes we propose to make throughout 17.101 to replace “MDR” with “FAIR Health.” This is explained in more detail later in this rulemaking.

In proposed § 17.101(a)(5), we would insert a definition of “MarketScan” immediately following the definition of “ICU.” We would define “MarketScan” to mean the MarketScan Commercial Claims & Encounters Database developed by Truven Health Analytics LLC. MarketScan has replaced MedStat, which is referenced throughout § 17.101 as it is a database used for billing purposes. Since it has been replaced by MarketScan, we would define it in § 17.101(a)(5). As explained in more detail later this rulemaking, we also would replace all references to MedStat with MarketScan.

#### §17.101(a)(7)

Pursuant to 38 U.S.C. 1729, VA is authorized to collect reasonable charges in certain circumstances, but the statute does not define what reasonable charges are. In current 38 CFR 17.101, VA established the methodology it uses to determine what

constitutes reasonable charges and directs when reasonable charges will be charged to third-party payers. Section 17.101 requires that VA charge the higher of the amount determined using the methodologies in this section (reasonable charges) or the amount VA actually paid to the provider for the care. We propose to amend § 17.101(a)(7) to bill third-party payers the reasonable charges rate that is determined using the methodology in § 17.101, as if the care was provided at a VA facility. In this regard, if an individual received surgery at a non-VA facility at VA expense, the charges billed to the individual's health insurance (or other third-party payer) would be the same as if the individual received the surgery at a VA facility.

The current practice of charging the higher of the amount determined using the methodologies in § 17.101 (reasonable charges) or the amount VA actually paid creates confusion in the field and additional administrative burdens when determining the appropriate amount to bill payers. Third-party payers have also indicated a preference for being charged using the same methodology regardless of whether the care was provided at a VA facility or at a non-VA facility at VA expense.

We believe that by removing the portion of the current regulation that requires VA to charge the higher of the two rates and, instead, requiring VA to bill the rate determined using the methodologies set forth in this section, it will provide greater clarity and uniformity in VA's billing practices. In this regard, requiring VA to charge the same rate regardless of whether the care was provided at a VA facility or a non-VA facility at VA expense will cut down on the administrative burden associated with determining the charges. Currently, the VA billing officials must first determine that the care was provided at a non-VA facility, then determine the rates based on two different

methodologies. Finally, the billing official must determine which is higher and enter that cost into the billing system. Under the proposed rule, VA billing officials will merely determine one rate using the same methodology regardless of where the care was furnished.

Additionally, we find that it is equitable to charge the same rates regardless of the facility in which the individual sought treatment; the third-party payer should not be disadvantaged and required to pay higher charges because the individual sought care at a non-VA facility. Moreover, the proposed revision is beneficial to the third-party payer as there is no scenario in which the third-party payer would be charged more under the proposed rule than they are charged under the current rule. Specifically, if the higher charge is the charge determined according to this section, the third-party payer will still be charged the amount determined in this section. However, if the higher amount is the actual cost VA paid, the third-party payer will be able to pay the lower, reasonable charges rate that was determined using the methodologies in this section. We note that in the vast majority of cases, the reasonable rates are higher than that amount actually paid and we do not think that this would ultimately change the amount that we are charging and collecting. This is consistent with generally accepted billing practices in the industry, as there is typically one set of rates that all health care providers charge. However, some of the amount charged is written off and the amount the payer ends up paying is usually lower than the amount billed.

## Technical Amendments to §17.101

We propose to make several technical amendments to ensure the information contained in § 17.101 is accurate and reflects changes to VA's organizational structure, the names of companies and data source references. VA has not updated the data sources and names since 2003, and there have been several changes to these since that time. See 68 FR 70714. However, in the annual publication of the data sources used to calculate charges, these changes have been reflected. See [https://www.va.gov/COMMUNITYCARE/revenue\\_ops/payer\\_rates.asp](https://www.va.gov/COMMUNITYCARE/revenue_ops/payer_rates.asp). We now propose to update § 17.101 to reflect these changes.

Currently, § 17.101(a)(2) and (3) jointly explain that the data for calculating actual charge amounts based on methodologies in § 17.101, the specific editions of the data sources used to calculate these amounts, and the information on where these data sources may be obtained will either be published in a notice in the Federal Register or will be posted on the Internet site of the Veterans Health Administration (VHA) Chief Business Office, currently at <http://www.va.gov/cbo>, under "Charge Data." Since the promulgation of § 17.101, the name of the responsible office for billing and collection has changed from Chief Business Office to Office of Community Care. Relatedly, the website has changed from <http://www.va.gov/cbo> to <https://www.va.gov/COMMUNITYCARE>.

To ensure the correct VHA offices and website are referenced in § 17.101, we propose to replace all references in § 17.101(a)(2) and (a)(3) to "Chief Business Office" with "Office of Community Care," and replace all references in § 17.101(a)(2) and (a)(3) to "<http://www.va.gov/cbo>, under 'Charge Data'" with

“<https://www.va.gov/COMMUNITYCARE>, under ‘Payer Rates and Charges.’” The relevant information on the charges data is located under “Payer Rates and Charges” and we would update § 17.101(a)(2) and (3) to reflect that.

We would amend § 17.101 by replacing all references to “Ingenix/St. Anthony’s” with “Optum Essential.” Ingenix/St. Anthony’s was a data source used to calculate charges under § 17.101. This data source was used to calculate such charges as physician and other professional charges (except for anesthesia and certain dental services); pathology and laboratory charges; relative value units for durable medical equipment (DME), drugs, injectables, and other medical services, items, and supplies. This data source is referenced in § 17.101(f)(2)(ii); (i)(2)(ii); and (l)(2)(i)(A)-(B), (M). Optum Essential has replaced Ingenix/St. Anthony’s, as Ingenix went out of business more than five years ago. We propose to revise § 17.101 to reference Optum Essential instead of Ingenix/St. Anthony’s, and we would want the regulation to be consistent with this change to the data source.

In § 17.101, we propose to replace all references to “MDR” and add in its place “FAIR Health” since FAIR Health has replaced MDR. We would propose to make these changes throughout § 17.101. MDR stands for Medical Data Research, which was a medical charge database published by Ingenix, Inc. It is referred to throughout current § 17.101, as it was a database used to calculate charges, including outpatient facility charges; physician and other professional charges (except for certain dental services; professional charges for anesthesia services; pathology and laboratory charges; and charges for DME, drugs, injectables, and certain other medical services, items, and supplies. For example, it is referenced in current § 17.101(e)(3)(ii), (e)(4), (f)(2)(ii),

(f)(3), (g)(3)(i), (i)(2)(i)-(ii), (i)(3), (l)(2)(iii), (l)(3), and (l)(5)(ii). However, Ingenix went out of business over five years ago, and FAIR Health became the successor company. MDR is thus no longer used and has been replaced by FAIR Health in calculating charges under § 17.101. We would update § 17.101 to reflect this change in the name. We propose to replace all references in § 17.101 to “MedStat” with “MarketScan” as the name of this data source has changed from MedStat to MarketScan. MedStat is referenced throughout § 17.101 as it is a database to calculate acute inpatient facility charges and outpatient facility charges. It is referenced in § 17.101(b)(2), (b)(3), and (e)(3)(ii). Since it has been replaced by MarketScan, we propose to replace all references to MedStat with MarketScan in § 17.101 to ensure this regulation reflects this change and the correct name of the data source.

Throughout § 17.101, we would replace all references to “Milliman USA, Inc.” and add in its place “Milliman, Inc.” since that is the correct name of the company which has changed since 2003. Milliman USA, Inc. is referenced in current § 17.101(e)(4), (f)(3), (g)(3)(i), (h)(3), (i)(3), (l)(3), and (l)(5)(iii). In § 17.101, Milliman USA, Inc. is referenced with regards to its various health cost guidelines and data sets. These guidelines and data sets have been used to calculate outpatient facility charges; physician and other professional charges (including anesthesia and dental services); and charges for DME, drugs, injectables, and other medical services, items, and supplies. Because the name has changed, we would update the regulation to accurately reflect the name of this company throughout § 17.101. We note that Milliman USA, Inc.’s Health Cost Guidelines fee survey which is referenced in current

paragraphs (f)(3) and (i)(3) is no longer used, and we propose to remove those references to it in these paragraphs, as explained later in this rulemaking.

We propose to amend § 17.101 by replacing all references to “percent Sample” with “Percent Sample” as percent should be capitalized. “Percent Sample” is included in several paragraphs within § 17.101 (including but not limited to § 17.101(d)(2), (e)(3)(i) through (ii), and (g)(3)(i)) in reference to the Medicare Standard Analytical File. This Percent Sample is used to calculate partial hospitalization facility charges, outpatient facility charges, physician and other professional charges except for anesthesia services and certain dental services, observation care facility charges, and ambulance and other emergency transportation charges. We would update § 17.101 to ensure that references to Percent Sample are correctly capitalized.

We would amend § 17.101(e)(3)(i)(C) by replacing the reference to “2.0” with “6.5”, and replacing the references to “6.5” with “2.0”. This specifically relates to the minimum and maximum 80th percentile charge to Medicare Ambulatory Payment Classification payment amount ratios, which are used to calculate outpatient facility charges under § 17.101. This is a clerical error, as 6.5 should be 2.0 and 2.0 should be 6.5. We now propose to correct this error in proposed § 17.101(e)(3)(i)(C).

For ease of reference, the following chart explains these technical changes to § 17.101 as discussed in the preceding paragraphs:

Section	Propose to Remove	Propose to Add
17.101(a)	Chief Business Office	Office of Community Care
17.101(a)	<i>http://www.va.gov/cbo</i> , under “Charge Data.”	<i>https://www.va.gov/COMMUNITYCARE</i> , under “Payer Rates and Charges.”

17.101	Ingenix/St. Anthony's	Optum Essential
17.101	MDR	FAIR Health
17.101	MedStat	MarketScan
17.101	Milliman USA, Inc.	Milliman, Inc.
17.101	percent Sample	Percent Sample
17.101(e)(3)(i)(C)	2.0	6.5
17.101(e)(3)(i)(C)	6.5	2.0

In addition to the changes proposed above, we would amend paragraph (f)(2)(ii) of § 17.101 by removing obsolete references. Section 17.101(f)(2)(ii) describes the methodology and data sources used to calculate physician and other professional charges except for anesthesia services and certain dental services. First, we would remove the language that states that 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. We would remove this language from the paragraph as the Prevailing Healthcare Charges System nationwide commercial insurance database is a data source that no longer exists, and is no longer applicable or used in calculating these charges (i.e., physician and other professional charges except for anesthesia services and certain dental services). There is no replacement so we would remove this language entirely from this paragraph.

Similarly, we would remove the word “three” in § 17.101(f)(2)(ii). In current paragraph (f)(2)(ii), we reference the number of databases used to determine the total

RVUs for Current Procedural Terminology (CPT) and Healthcare Common Procedure Coding System (HCPCS) codes that do not have Medicare Relative Value Units (RVUs) and are not designated as unlisted procedures. These three data sources are the MDR database, the Part B component of the Medicare Standard Analytical File 5 Percent Sample, and Prevailing Healthcare Charges System nationwide commercial insurance database. Because we are proposing to remove reference to the Prevailing Healthcare Charges System nationwide commercial insurance database, as explained in the preceding paragraph, there will no longer be three data sources used in this determination.

For the same reasons, we would remove from the final sentence in this paragraph the word “four” with regard to the number of data sources used. The data sources used to make this determination under § 17.101(f)(2)(ii) may vary. Thus, we would not list each data source used and would also not identify the specific number of data sources used. We would include the data source information on <https://www.va.gov/COMMUNITYCARE> or in a Federal Register notice (referenced in proposed § 17.101(a)(3)) instead of publishing them in regulation. Therefore, the public will still be informed of the sources used as that information will continue to be located on our websites or in a notice in the Federal Register, and updated on an annual basis. As explained previously, we are also proposing to update the VA website to reflect the correct web address (<https://www.va.gov/COMMUNITYCARE>). We note that the most recent Federal Register notices containing this information were published on December 14, 2017 and September 19, 2018. See 82 FR 59213 and 83 FR 47412.

We would also remove the word “untrended” from § 17.101(f)(2)(ii). This relates to nationwide conversion factor for the corresponding CPT/HCPCS code group. However, this term should not have been included in the original regulation as it is not a word, and removing it is merely a technical change as its removal would have no impact on our practices. We would continue to use the nationwide conversion factor for the corresponding CPT/HCPCS code group.

We propose to revise paragraphs (f)(3) and (i)(3) of § 17.101, which reference the Milliman USA, Inc., Health Cost Guidelines fee survey in calculating such charges as physician and other professional charges except for anesthesia and certain dental services and pathology and laboratory charges, respectively. We would remove this language from paragraphs (f)(3) and (i)(3), as this data source no longer exists. We would not replace it with any specific data source, as the data source used can vary. As previously explained, the data sources will be available to the public at <https://www.va.gov/COMMUNITYCARE> or in a Federal Register notice (referenced in proposed § 17.101(a)(3)) instead of publishing them in regulation.

Current § 17.101(h) describes the methodology for calculating professional charges for dental services identified by HCPCS Level II codes. Paragraph (h)(2) specifically explains the three data sources used to determine the 80th percentile charges for each HCPCS dental code. The sources referenced in this paragraph include Prevailing Healthcare Charges System database, National Dental Advisory Service nationwide pricing index; and the Dental UCR Module of the Comprehensive Healthcare Payment System. The Prevailing Healthcare Charges System database no longer exists. We would thus revise § 17.101 (h)(2) to remove the reference to that

data source. We would not replace it in paragraph (h)(2) with another database as that can vary. We propose to revise the first sentence of paragraph (h)(2) to state “various independent data sources” instead of “three independent data sources” to reflect the fact that the data sources used can vary. Because of this, we would not list every data source used in this paragraph. As previously mentioned, VA publishes the charges and data sources (including the specific editions of these data sources) used to calculate the charges either through a Federal Register notice or on <https://www.va.gov/COMMUNITYCARE> as referenced in proposed § 17.101(a)(3).

We would also revise the language in this same paragraph that references “UCR Module of the Comprehensive Healthcare Payment System, a release from Ingenix from a nationwide database of dental charges” and instead insert “FAIR Health module” as the FAIR Health module replaced the UCR Module of the Comprehensive Healthcare Payment System. Ingenix, which was the original creator of this comprehensive health care payment system, went out of business over five years ago, and FAIR Health became the successor company. The FAIR Health module replaced the UCR Module of the Comprehensive Healthcare Payment System, and thus we would revise paragraph (h)(2) accordingly.

We would then amend paragraph (h)(2)(i), which explains the methodology used to determine the average charge for any particular HCPCS dental code. This is done by computing a preliminary mean average of the three charges for each code. We would revise § 17.101(h)(2)(i) by removing the language “average” in reference to “preliminary mean” in the first sentence to correctly state how the charges are calculated. The words “average” and “mean” are redundant as these two words have the same

meaning. We use the preliminary mean and we would update the paragraph (h)(2)(i) to reflect this.

In that same sentence, we would also remove “three” and add “available” in reference to the charges for each code as the number of charges for each code can vary based on the number of sources used. This paragraph references three charges because three data sources are reflected in paragraph (h)(2). However, as mentioned previously, we are proposing to revise paragraph (h)(2) to reflect that one of these data sources (Prevailing Healthcare Charges System database) no longer exists, and the number of data sources used to calculate these charges under paragraph (h) can vary. Instead of listing the data sources and including the specific number of data sources, this information would continue to be made available to the public either through a Federal Register notice or on <https://www.va.gov/COMMUNITYCARE> as referenced in proposed § 17.101(a)(3).

In the second sentence in paragraph (h)(2)(i), we propose to remove the language “by testing whether any charge differs from the preliminary mean charge by more than 50 percent of the preliminary mean charge. In such cases, the charge most distant from the preliminary mean is removed as an outlier, and the average charge is calculated as a mean of the two remaining charges.” This language refers to how statistical outliers are identified and removed in calculating the average charge and is based on using three data sources. Because we propose to update § 17.101(h)(2) to eliminate the use of three data sources and because the number of data sources can vary, we would remove this language to correctly state how charges are calculated and allow for variability. Instead, this sentence would simply state that “statistical outliers

are identified and removed.” There may not be more than two data sources used, and thus there may not be two remaining charges. This paragraph would be updated to reflect this potential reality.

The last sentence of paragraph (h)(2)(i) explains that in cases where none of the charges differ from the preliminary mean charge by more than 50 percent of the preliminary mean charge, the average charge is calculated as a mean of all three reported charges. As previously explained in the preceding paragraphs, we would no longer use three data sources and the number of data sources can vary. We propose to remove the language in this last sentence of paragraph (h)(2)(i), specifically “differ from the preliminary mean charge by more than 50 percent of the preliminary mean charge” and replace that with “removed”. We would also remove “three” from the last sentence in this paragraph to correctly state how the charges are calculated and to reflect that the average charge is no longer based on three reported charges. Thus, the proposed revised sentence would explain that where none of the charges are removed, the average charge is calculated as a mean of all reported charges.

In calculating professional charges for dental services identified by HCPCS Level II codes, paragraph (h)(3) of § 17.101 describes how each geographic adjustment factor is determined using Milliman USA, Inc., Dental Health Cost Guidelines, and a normalized geographic adjustment factors computed from the Dental UCR Module of the Comprehensive Payment System compiled by Ingenix. FAIR Health module has replaced “UCR Module of the Comprehensive Healthcare Payment System compiled by Ingenix.” As previously mentioned, Ingenix was the original creator of this Dental UCR Module of the Comprehensive Payment System and went out of business over five

years ago. FAIR Health became the successor company, and the FAIR Health module is used in place of the Dental UCR Module of the Comprehensive Payment System. Thus, we propose to remove the reference to this dental UCR module and replace it with “FAIR Health module.”

We would revise § 17.101(i)(2)(ii) which describes the methodology and data sources used to calculate pathology and laboratory charges. Paragraph (i)(2)(ii) specifically describes how total RVUs for CPT/HCPCS codes that do not have Medicare-based RVUs are developed based on various charge data sources (including the MDR database, Part B component of the Medicare Standard Analytical File 5 Percent Sample, the Prevailing Healthcare Charges System nationwide commercial insurance database and Ingenix/St. Anthony's RBRVS). As explained previously in this rulemaking, we note that we propose to update the names of several of these databases (i.e., from MDR to FAIR Health, and from Ingenix/St. Anthony's to Optum Essentials). We propose to remove the current language that explains that 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. We would also remove the language that explains that 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 determined pursuant to paragraphs (i)(3) and (i)(3)(i) of this section. We would remove these sentences since the Prevailing Healthcare Charges System nationwide commercial insurance database is no longer available and there is no replacement.

We would revise the remaining sentences in this same paragraph to state that for any remaining CPT/HCPCS codes that have not been assigned RVUs using the preceding data sources (i.e., the FAIR Health database, Part B component of the Medicare Standard Analytical File 5 Percent Sample, the Optum Essentials RBRVS will be used in the calculation of nationwide total RVUs; and that the resulting nationwide total RVUs obtained using these data sources (i.e., FAIR Health database and Part B component of the Medicare Standard Analytical File 5 Percent Sample, and the Optum Essentials) will be multiplied by the geographic area adjustment factors determined pursuant to paragraph (i)(2)(iv) of this section in order to obtain the area-specific total RVUs. We would make these changes to the last two sentences in the paragraph to accurately reflect the process for determining total RVUs for CPT/HCPCS codes that do not have Medicare-based RVUs. This is because the Prevailing Healthcare Charges System nationwide commercial insurance database is no longer available and there is no replacement for that database. We would also revise the final sentence to reflect that we would use the data sources in this paragraph to determine RVUs. Because the data sources we use to make this determination under § 17.101(i)(2)(ii) may vary, we would not list each data source used and would also not identify the specific number of data sources used. Since the data sources used can vary, we would include the data source information on <https://www.va.gov/COMMUNITYCARE> or in a Federal Register notice (referenced in proposed § 17.101(a)(3)) instead of publishing them in regulation.

We would amend several paragraphs in § 17.101(l) to correctly state how the charges for DME, drugs, injectables, and other medical services, items, and supplies identified by HCPCS Level II codes are calculated. Paragraph (l)(3) explains how the

80th percentile charges for each applicable HCPCS code are extracted using three independent data sources: the MDR database; Medicare, as represented by the combined Part B and DME components of the Medicare Standard Analytical File 5 Percent Sample; and Milliman USA, Inc., Optimized HMO (Health Maintenance Organization) Data Sets. In paragraph (l)(3), we propose to remove “three” and “Milliman USA, Inc., Optimized HMO (Health Maintenance Organization) Data Sets” in the first sentence. We would make this change because the “Milliman USA, Inc. Optimized HMO Data Sets” no longer exists and there is no replacement. Thus, we now use two data sources instead of three. As explained previously in this rulemaking, we would update the reference to the MDR database to reflect that the FAIR Health database has replaced this database. MDR was a medical charge database published by Ingenix, Inc. However, it is no longer used, and has been replaced by the FAIR Health database. We would update § 17.101(l) to accurately reflect these changes.

We would also amend paragraph (l)(3)(ii) in § 17.101 to correctly state how the average 80th percentile trended charge for any particular HCPCS code is calculated. Currently, this paragraph explains that this average charge is calculated by computing a preliminary mean average of the three charges for each HCPCS code and explains how statistical outliers are identified and removed. Additionally, it explains that the average charge is calculated as a mean of three reported charges in cases where none of the charges differ from the preliminary mean charge by more than five times the preliminary mean charge, or less than 0.2 times the preliminary mean charge. We propose to revise this paragraph by removing from the first sentence “average” immediately following “preliminary mean”, and replacing in the same sentence “three” with

“available.” The words “average” and “mean” are repetitive and redundant, as these two words have meant the same to us in the context of this methodology, and we would thus remove the word “average” after “preliminary mean.”

We would also remove “three” in the first sentence of this same paragraph and replace it with “available.” As explained previously, Milliman USA, Inc., Optimized HMO (Health Maintenance Organization) Data Sets no longer exists, and the number of data sets used under paragraph (l)(3) is two (FAIR Health database and the combined Part B and DME components of the Medicare Standard Analytical File 5 Percent Sample). Because of this, we would revise § 17.101(l)(3)(ii) to reflect available charges instead of three charges.

We propose to further revise the language in paragraph (l)(3)(ii) that describes how statistical outliers are identified and removed. The paragraph explains that the methodology used to identify and remove statistical outliers based on the charges from the three databases which is done by testing whether any charge differs from the preliminary mean charge by more than five times the preliminary mean charge, or by less than 0.2 times the preliminary mean charge. The remaining sentences in this paragraph further explain that the charge most distance from the preliminary mean is removed as an outlier, and that the average charge is calculated as a mean of the two remaining charges. The last sentence further states that the average charge is calculated as a mean of all three reported charges where none of the charges differ from the preliminary mean charge by more than five times the preliminary mean charge, or less than 0.2 times the preliminary mean charge. As explained previously, because we use two data sources now instead of three, this language on how we would

determine the statistical outliers and the average charge is no longer accurate. There would no longer be two remaining charges in identifying and removing outliers. We would thus revise this paragraph to correctly state how charges are calculated. In addition to those changes we would make to paragraph (l)(3)(ii) as proposed in the preceding paragraphs, after the first sentence in this paragraph, we would state that “statistical outliers are identified and removed.” After this sentence, we would remove the remaining subsequent text of the paragraph and add a sentence to state that where none of the charges are removed, the average charge is calculated as a mean of all reported charges. This paragraph would be updated to reflect how average charges are determined under paragraph (l)(3) as we explained previously.

#### §17.106 VA collection rules; third-party payers.

As previously explained, section 1729 of 38 U.S.C. authorizes VA to collect the reasonable charges for medical care and services from a third-party payer and to compromise, settle, or waive a claim (such as a refund). Additionally, section 1729 prohibits any contract or other agreement operating to prevent recovery or collection by the United States. This is implemented in 38 CFR 17.106 as current § 17.106 authorizes VA to collect from third-party payers. Specifically, § 17.106(c)(4) directs that a third-party payer may not, without the consent of a U.S. Government official authorized to take action under 38 U.S.C. 1729 and this part, offset or reduce any payment due under 38 U.S.C. 1729 or this part on the grounds that the payer considers itself due a refund from a VA facility. A written request for a refund must be submitted

and adjudicated separately from any other claims submitted to the third-party payer under 38 U.S.C. 1729 or this part.

Currently, third-party payers are requesting refunds many months and sometimes years after the original payment was submitted and processed by VA. This creates difficulty for VA billing staff and makes it increasingly more difficult to approximate the funding needed to provide the refunds. Therefore, in this rulemaking, we propose to revise § 17.106(c)(4) to add a time frame of 18 months from the time the payer makes their original payment to request a refund. We also propose to add language to clarify that if a request for a refund is not submitted within this 18-month time frame, VA will not provide a refund to third-party payers for a claim paid for any reason. VA believes that adding a timeframe of 18 months provides ample time for the third-party payer to request the refund and also provides VA with greater finality when determining the budget. We also believe that we are able to require such a timeframe for third-party payer requests for these refunds as we interpret the broad language in 38 U.S.C. 1729 to authorize us to do so. As proposed in 38 CFR 17.106(c)(4), if a third-party payer requests a refund outside of the 18-month time frame, we would not provide a refund for a claim paid for any reason. As previously explained, we believe this is reasonable as 18 months is ample time to request a refund and would be consistent with our authority in 38 U.S.C. 1729. We note that if a retroactive service-connection determination is made more than 18 months after the date payment is made by the third-party payer, VA would not provide a refund to the third-party payer for a paid claim.

Section 1729(f) provides that no provision of any third-party payer's plan having the effect of excluding from coverage or limited payment for certain care if that care is

provided in or through any VA facility shall operate to prevent collection by the United States. Pursuant to this authority, VA promulgated § 17.106(f) which describes the conditions under which a third-party payer may not reduce, offset, or request a refund for payments made to VA. Currently, paragraph (f)(2) contains seven such conditions, and we now propose to add an eighth condition. In proposed paragraph (f)(2)(viii), we would state that a provision in a third-party payer's plan that directs payment for care or services be refused or lessened because the billing is not presented in accordance with a specified methodology (such as a line item methodology) is not by itself a permissible ground for refusing or reducing third-party payment of the charges billed by VA. Most private sector hospitals in the United States perform itemized billing, meaning they bill for those ancillary services, room and board, and supplies provided to the patient and include charges for each individual item or service that was provided to the patient. VA does not use itemized billing when determining charges, and does not break down each item or service provided and include charges for such item or service. Instead, VA uses a per diem methodology, under which there are separate per diem charges for room and board and for all ancillary services. VA then sends the third-party payer the bill using the per diem methodology. However, as mentioned, this does not break down the charges by item or service, and third-party payers have raised issues with this methodology because they are unable to determine the charge for each individual item or service provided. Because VA's billing methodology does not conform to some third-party payers' line-item billing methodology, some third-party payers have refused to pay either the full charges or part of the charges for VA care or medical services. We believe revising § 17.106(f)(2) as proposed would be equitable to all third-party payers

by applying the same standard to all third-party payers and would require all third-party payers to pay regardless of whether our billing methodologies are the same as their preferred method. In addition, upon request from the payer, in accordance with the instructions on the billing document, VA would provide the medical records that provided the basis for the billing. This is not described in the regulation, but is provided here to explain that we provide these medical records. Providing the medical records would ensure that the third-party payer would have an opportunity to review the billing document alongside the medical records to fully understand the nature of the charges. .

#### Effect of Rulemaking

The Code of Federal Regulations, as proposed to be revised by this proposed rulemaking, would represent the exclusive legal authority on this subject. No contrary rules or procedures would be authorized. All VA guidance would be read to conform with this proposed rulemaking if possible or, if not possible, such guidance would be superseded by this rulemaking.

#### Paperwork Reduction Act

Although this proposed rule contains a provision constituting a collection of information, at 38 CFR 17.101, under the Paperwork Reduction Act of 1995 (44 U.S.C. 3501-3521), no proposed new or modified collections of information are associated with this rule. The information collection provision for § 17.101 is currently approved by the Office of Management and Budget (OMB) and has been assigned OMB control number 2900-0606.

### Regulatory Flexibility Act

The Secretary hereby certifies that this proposed rule would 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. We have not proposed any new requirements that would have such an effect. The changes being made to these regulations are mostly technical in nature, and conform to existing statutory requirements and existing practices in the program. Therefore, pursuant to 5 U.S.C. 605(b), this amendment would be exempt from the initial and final regulatory flexibility analysis requirements of 5 U.S.C. 603 and 604.

### Executive Orders 12866, 13563, and 13771

Executive Orders 12866 and 13563 direct agencies to assess the costs and benefits of available regulatory alternatives and, when regulation is necessary, to select regulatory approaches that maximize net benefits (including potential economic, environmental, public health and safety effects, and other advantages; distributive impacts; and equity). Executive Order 13563 (Improving Regulation and Regulatory Review) emphasizes the importance of quantifying both costs and benefits, reducing costs, harmonizing rules, and promoting flexibility. The Office of Information and Regulatory Affairs has determined that this rule is not a significant regulatory action under Executive Order 12866.

VA's impact analysis can be found as a supporting document at <http://www.regulations.gov>, usually within 48 hours after the rulemaking document is published. Additionally, a copy of the rulemaking and its impact analysis are available

on VA's Web site at <http://www.va.gov/orpm/>, by following the link for VA Regulations Published from FY2004 through FYTD. This rule is not an EO 13771 regulatory action because this rule is not significant under EO 12866.

### Unfunded Mandates

The Unfunded Mandates Reform Act of 1995 requires, at 2 U.S.C. 1532, that agencies prepare an assessment of anticipated costs and benefits before issuing any rule that may result in the expenditure by State, local, and tribal governments, in the aggregate, or by the private sector, of \$100 million or more (adjusted annually for inflation) in any one year. This proposed rule would have no such effect on State, local, and tribal governments, or on the private sector.

### Catalog of Federal Domestic Assistance Numbers

The Catalog of Federal Domestic Assistance numbers and titles for the programs affected by this document are 64.008, Veterans Domiciliary Care; 64.011, Veterans Dental Care; 64.012, Veterans Prescription Service; 64.013, Veterans Prosthetic Appliances; 64.014, Veterans State Domiciliary Care; 64.015, Veterans State Nursing Home Care; 64.029—Purchase Care Program; 64.033—VA Supportive Services for Veteran Families Program; 64.034—VA Grants for Adaptive Sports Programs for Disabled Veterans and Disabled Members of the Armed Forces; 64.035—Veterans Transportation Program; 64.039—CHAMPVA; 64.040—VHA Inpatient Medicine; 64.041—VHA Outpatient Specialty Care; 64.042— VHA Inpatient Surgery; 64.043—VHA Mental Health Residential; 64.044— VHA Home Care; 64.045—VHA

Outpatient Ancillary Services; 64.046—VHA Inpatient Psychiatry; 64.047—VHA Primary Care; 64.048—VHA Mental Health clinics; 64.049—VHA Community Living Center; 64.050—VHA Diagnostic Care.

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 home care, Philippines, Reporting and recordkeeping requirements, Scholarships and fellows, Travel, Transportation expenses, Veterans.

Signing Authority

The Secretary of Veterans Affairs approved this document and authorized the undersigned to sign and submit the document to the Office of the Federal Register for publication electronically as an official document of the Department of Veterans Affairs. Robert L. Wilkie, Secretary, Department of Veterans Affairs, approved this document on May 6, 2019, for publication.

---

**Consuela Benjamin,**

*Regulation Development Coordinator,  
Office of Regulation Policy & Management,  
Office of the Secretary,  
Department of Veterans Affairs.*

For the reasons stated in the preamble, the Department of Veterans Affairs proposes to amend 38 CFR part 17 as follows:

PART 17--MEDICAL

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

Authority: 38 U.S.C. 501, and as noted in specific sections.

\* \* \* \* \*

Section 17.101 is also issued under 38 U.S.C. 101, 1701, 1705, 1710, 1721, 1722, 1729.

\* \* \* \* \*

2. Amend 17.101 by:

- a. In paragraph (a)(5), removing the definition of “MDR.”

- b. In paragraph (a)(5), adding alphabetically the definitions of “FAIR Health” and “MarketScan” .

- c. Revising paragraphs (a)(7), (f)(2)(ii), (f)(3), (h)(2) introductory text, (h)(2)(i), (h)(2)(ii), (h)(3), (i)(2)(ii), (i)(3), (l)(3) introductory text, and (l)(3)(ii).

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 nonservice-connected disability.

\* \* \* \* \*

(a) \* \* \*

(5) \* \* \*

\* \* \* \* \*

*FAIR Health* means any of the Fair Health Charge Benchmarks products developed by Fair Health.”

\* \* \* \* \*

*MarketScan* means the MarketScan Commercial Claims & Encounters Database developed by Truven Health Analytics LLC.

\* \* \* \* \*

(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 charges determined according to this section.

\* \* \* \* \*

(f) \* \* \*

(2) \* \* \*

(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, that nationwide 80th percentile billed charges are obtained, where statistically credible, from the FAIR Health 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 each of these CPT/HCPCS codes, nationwide total RVUs are obtained by taking the nationwide 80th percentile billed charges obtained using the preceding databases and dividing by the 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 Optum Essential RBRVS. The resulting nationwide total RVUs obtained using these 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.

\* \* \* \* \*

(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 code group; see paragraph (a)(3) of this section for Data Sources. The 80th percentile charge for each selected CPT/HCPCS code is obtained from the FAIR Health database. A nationwide

conversion factor (a monetary amount) is calculated for each CPT/HCPCS code group as set forth in paragraph (f)(3)(i) of this section. The nationwide conversion factors for each of the 23 CPT/HCPCS code groups are trended forward to the effective time period for the charges, as set forth in paragraph (f)(3)(ii) of this section. The resulting amounts for each of the 23 groups are multiplied by geographic area adjustment factors determined pursuant to paragraph (f)(3)(iii) of this section, resulting in geographically-adjusted 80th percentile conversion factors for each geographic area for the 23 CPT/HCPCS code groups for the effective charge period.

\* \* \* \* \*

(h) \* \* \*

(2) *Nationwide 80th percentile charges by HCPCS code.* For each HCPCS dental code, 80th percentile charges are extracted from various independent data sources, including the National Dental Advisory Service nationwide pricing index and the Dental FAIR Health module (see paragraph (a)(3) of this section for Data Sources). Charges for each database are then trended forward to a common date, based on actual changes to the dental services component of the CPI-U. Charges for each HCPCS dental code from each data source are combined into an average 80th percentile charge by means of the methodology set forth in paragraph (h)(2)(i) of this section. HCPCS dental codes designated as unlisted are assigned 80th percentile charges by means of the methodology set forth in paragraph (h)(2)(ii) of this section. Finally, the resulting amounts are each trended forward to the effective time period for the charges, as set forth in paragraph (h)(2)(iii) of this section. The results constitute the nationwide 80th percentile charge for each HCPCS dental code.

(i) *Averaging methodology.* The average charge for any particular HCPCS dental code is calculated by first computing a preliminary mean of the available charges for each code. Statistical outliers are identified and removed. In cases where none of the charges are removed, the average charge is calculated as a mean of all reported charges.

(ii) *Nationwide 80th percentile charges for HCPCS dental codes designated as unlisted procedures.* For HCPCS dental codes designated as unlisted procedures, 80th percentile charges are developed based on the weighted median 80th percentile charge of HCPCS dental 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.

\* \* \* \* \*

(3) *Geographic area adjustment factors.* A geographic adjustment factor (consisting of the ratio of the level of charges in a given geographic area to the nationwide level of charges) for each geographic area and dental class of service is obtained from Milliman Inc., Dental Health Cost Guidelines, a database of nationwide commercial insurance charges and relative costs; and a normalized geographic adjustment factor computed from the Dental FAIR Health module, as follows: Using local and nationwide average charges reported in the FAIR Health database, a local weighted average charge for each dental class of procedure codes is calculated using utilization frequencies from the Milliman Inc., Dental Health Cost Guidelines as weights (see paragraph (a)(3) of this section for Data Sources). Similarly, using nationwide average charge levels, a nationwide average charge by dental class of procedure codes

is calculated. The normalized geographic adjustment factor for each dental class of procedure codes and for each geographic area is the ratio of the local average charge divided by the corresponding nationwide average charge. Finally, the geographic area adjustment factor is the arithmetic average of the corresponding factors from the data sources mentioned in the first sentence of this paragraph (h)(3).

\* \* \* \* \*

(i) \* \* \*

(2) \* \* \*

(ii) *RVUs for CPT/HCPCS codes that do not have Medicare-based RVUs and are not designated as unlisted procedures.* For CPT/HCPCS codes that are not assigned RVUs in paragraphs (i)(2)(i) or (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 FAIR Health database. For any remaining CPT/HCPCS codes, the nationwide 80<sup>th</sup> 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 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 Optum Essential RBRVS. The resulting nationwide total RVUs obtained using these data sources are multiplied by the geographic area adjustment factors determined pursuant to paragraph (i)(2)(iv) of this section to obtain the area-specific total RVUs.

\* \* \* \* \*

(3) *Geographically-adjusted 80th percentile conversion factors.* 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 pathology/laboratory CPT/HCPCS code group. The 80th percentile charge for each selected CPT/HCPCS code is obtained from the FAIR Health database. A nationwide conversion factor (a monetary amount) is calculated as set forth in paragraph (i)(3)(i) of this section. The nationwide conversion factor is trended forward to the effective time period for the charges, as set forth in paragraph (i)(3)(ii) of this section. The resulting amount is multiplied by a geographic area adjustment factor determined pursuant to paragraph (i)(3)(iv) of this section, resulting in the geographically-adjusted 80th percentile conversion factor for the effective charge period.

\* \* \* \* \*

(l) \* \* \*

(3) *Nationwide 80th percentile charges for HCPCS codes without RVUs.* For each applicable HCPCS code, 80th percentile charges are extracted from two independent data sources: the FAIR Health database and the combined Part B and DME components of the Medicare Standard Analytical File 5 Percent Sample. Charges from each database are then trended forward to the effective time period for the charges, as set forth in paragraph (l)(3)(i) of this section. Charges for each HCPCS code from each data source are combined into an average 80th percentile charge by means of the methodology set forth in paragraph (l)(3)(ii) of this section. The results constitute the nationwide 80th percentile charge for each applicable HCPCS code.

\* \* \* \* \*

(ii) *Averaging methodology.* The average 80th percentile trended charge for any particular HCPCS code is calculated by first computing a preliminary mean of the available charges for each HCPCS code. Statistical outliers are identified and removed. In cases where none of the charges are removed, the average charge is calculated as a mean of all reported charges.

\* \* \* \* \*

### 3. § 17.101 [Amended]

In the table below, for each section indicated in the left column, remove the words indicated in the middle column from wherever it appears in the section, and add the words indicated in the right column.

Section	Remove	Add
17.101	Chief Business Office	Office of Community Care
17.101	<i>http://www.va.gov/cbo</i> , under “Charge Data.”	<i>https://www.va.gov/COMMUNITYCARE</i> , under “Payer Rates and Charges.”
17.101	Ingenix/St. Anthony’s	Optum Essential
17.101	MDR	FAIR Health
17.101	MedStat	MarketScan
17.101	Milliman USA, Inc.	Milliman, Inc.
17.101	percent Sample	Percent Sample
17.101	2.0	6.5
17.101	6.5	2.0

4. Amend § 17.106 by:

a. Revising paragraph (c)(4).

b. Adding new paragraph (f)(2)(viii).

The revisions and additions read as follows:

§ 17.106 VA collection rules; third-party payers.

\* \* \* \* \*

(c) \* \* \*

(4) A third-party payer may not, without the consent of a U.S. Government official authorized to take action under 38 U.S.C. 1729 and this part, offset or reduce any payment due under 38 U.S.C. 1729 or this part on the grounds that the payer considers itself due a refund from a VA facility. A written request for a refund must be submitted within 18 months from the original payment date and adjudicated separately from any other claims submitted to the third-party payer under 38 U.S.C. 1729 or this part. If third-party payers do not submit requests for a refund within this 18-month time frame, VA will not provide a refund to third-party payers for a paid claim for any reason.

\* \* \* \* \*

(f) \* \* \*

(2) \* \* \*

(viii) A provision in a third-party payer's plan that directs payment for care or services be refused or lessened because the billing is not presented in accordance with a specified methodology (such as a line item methodology) is not by itself a permissible ground for refusing or reducing third-party payment.

\* \* \* \* \*

[FR Doc. 2019-22972 Filed: 10/25/2019 8:45 am; Publication Date: 10/28/2019]