

product of the three RVUs times the corresponding geographical indices for the locality times the conversion factor. If the geographic indices for the locality are 0.988(W), 0.948 (PE), and 1.174 (M), then the maximum payment calculation is:

$$\begin{aligned} & [(2.48)(0.988) + (3.63)(0.948) + (0.48)(1.174)] \\ & \times \$61.20 \\ & [2.45 + 3.44 + .56] \times \$61.20 \\ & 6.45 \times \$61.20 = \$394.74 \end{aligned}$$

**§ 10.808 Does the fee schedule apply to every kind of procedure?**

Where the time, effort and skill required to perform a particular procedure vary widely from one occasion to the next, the Director may choose not to assign a relative value to that procedure. In this case the allowable charge for the procedure will be set individually based on consideration of a detailed medical report and other evidence. At its discretion, OWCP may set fees without regard to schedule limits for specially authorized consultant examinations, for examinations performed under 5 U.S.C. 8123, and for other specially authorized services.

**§ 10.809 How are payments for medicinal drugs determined?**

Payment for medicinal drugs prescribed by physicians shall not exceed the amount derived by multiplying the average wholesale price of the medication by the quantity or amount provided, plus a dispensing fee.

(a) All prescription medications identified by National Drug Code (NDC) will be assigned an average wholesale price representing the product's nationally recognized wholesale price as determined by surveys of manufacturers and wholesalers. The Director will establish the dispensing fee.

(b) The NDCs, the average wholesale prices, and the dispensing fee shall be reviewed from time to time and updated as necessary.

**§ 10.810 How are payments for inpatient medical services determined?**

(a) OWCP will pay for inpatient medical services according to pre-determined, condition-specific rates based on the Prospective Payment System (PPS) devised by HCFA (42 CFR parts 412, 413, 424, 485, and 489). Using this

system, payment is derived by multiplying the diagnosis-related group (DRG) weight assigned to the hospital discharge by the provider-specific factors.

(1) All hospital discharges will be classified according to the DRGs prescribed by the HCFA in the form of the DRG Grouper software program. On this list, each DRG represents the average resources necessary to provide care in a case in that DRG relative to the national average of resources consumed per case.

(2) The provider-specific factors will be provided by HCFA in the form of their PPS Pricer software program. The software takes into consideration the type of facility, census division, actual geographic location (MSA) of the hospital, case mix cost per discharge, number of hospital beds, intern/beds ratio, operating cost to charge ratio, and other factors used by HCFA to determine the specific rate for a hospital discharge under their PPS. The Director may devise price adjustment factors as appropriate using OWCP's processing experience and internal data.

(3) OWCP will base payments to facilities excluded from HCFA's PPS on consideration of detailed medical reports and other evidence.

(4) The Director shall review the pre-determined hospital rates at least once a year, and may adjust any or all components when he or she deems it necessary or appropriate.

(b) The Director shall review the schedule of fees at least once a year, and may adjust the schedule or any of its components when he or she deems it necessary or appropriate.

**§ 10.811 When and how are fees reduced?**

(a) OWCP shall accept a provider's designation of the code to identify a billed procedure or service if the code is consistent with medical reports and other evidence. Where no code is supplied, OWCP may determine the code based on the narrative description of the procedure on the billing form and in associated medical reports. OWCP will pay no more than the maximum allowable fee for that procedure.